AGENDA

STRATEGY AND OPERATIONS (S&O) COMMITTEE (Part 1)

To be held at 0930 on Wednesday 07 December 2022

V = Verbal D = Document P = Presentation

Ref Nº.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0930***
SO218/22 (P)	**Patient Story** *Purpose: To **receive** the patient story*	*No*	*L Barnes*	15 mins
SO219/22 (V)	**Chair's welcome and note of apologies** *Purpose: To **record** apologies for absence and confirm the meeting is quorate.*	*No*	*Chair*	
SO220/22 (D)	**Declaration of interests** *Purpose: To **record** any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
SO221/22 (D)	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 02 November 2022.*	No	*Chair*	10 mins
SO222/22 (D)	**Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions.*	*No*	*Chair*	
INTEGRATED PERFORMANCE REPORT				**0955**
SO223/22 (D)	**Integrated Performance Report (IPR)** a) Quality and Safety b) Operations c) Finance d) Workforce *Purpose: To **receive and note** the IPR for assurance.*	*No*	*L Barnes* *K Clark* *L Barnes* *L Neary* *J McLuckie* *J Royds*	20 mins
QUALITY & SAFETY				**1015**
SO224/22 (D)	**Quality and Safety Committee AAA Highlight Report** *Purpose: To **receive** the Quality and Safety AAA Highlight report*	*No*	*G Brown*	10 Mins

SO225/22 (D)	**Quarterly Maternity Assurance Report** *Purpose: To **note** the Maternity Assurance Report*	*No*	*L Barnes*	15 mins
SO226/22 (D)	**Learning from Deaths** a) Quarterly Report b) Annual Report *Purpose: To **receive** the Learning from Deaths Quarterly and Annual Reports*	*No*	*K Thomas*	15 mins
WORKFORCE				**1055**
SO227/22 (D)	**Workforce Committee AAA Highlight Report** *Purpose: To **receive** the Workforce Committee AAA Highlight Report*	*No*	*L Knight*	10 Mins
SO228/22 (D)	**Freedom to Speak Up Reports** a) Freedom to Speak Up Report Quarter 2 (2022/23) *Purpose: To **note** the Freedom to Speak Up Quarter 2 Report*	*No*	*L Barnes /L Douglas*	20 mins
SO229/22 (D)	**Library and Knowledge Service Strategy (2023 to 2026)** *Purpose: To **approve** the Library and Knowledge Service Strategy (2023 to 2026)*	*No*	*J Royds*	15 mins
FINANCE, OPERATIONS AND INVESTMENT				**1140**
SO230/22 (D)	**Finance, Performance and Investment Reports** a) Committee AAA Highlight Report *Purpose: To **receive** the Finance, Performance and Investment Reports*	*No*	*J Kozer*	10 mins
CORPORATE				**1150**
SO231/22 (D)	**Executive Committee AAA Highlight Report** *Purpose: To **receive** the Executive Committee AAA Highlight Report*	*No*	*AM Stretch*	10 Mins
CONCLUDING BUSINESS				**1200**
SO232/22 (V)	**Questions from Members of the Public** *Purpose: To **respond** to questions from members of the public received in advance of the meeting.*		*Chair*	*5 mins*

SO233/22 (V)	**Any Other Business** *Purpose: To* ***receive*** *any urgent business not included on the agenda*	*Chair*	*5 mins*
	Date and time of next meeting: 0930 Wednesday 01 February 2023		***1215 close***

RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC

The Board of Directors through its delegation to the Strategy and Operation Committee, resolves that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Chair: Richard Fraser

Minutes of the Strategy and Operations Committee (Part 1)
Held on Microsoft Teams
Wednesday 02 November 2022
(Approved by the Strategy and Operations Committee on 07 December 2022)

Present

Name	Initials	Title
Richard Fraser	RF	Chair, STHK
Ann Marr	AM	Chief Executive
Anne-Marie Stretch	AMS	Managing Director
Lynne Barnes	LB	Director of Nursing, Midwifery and Therapies
Gill Brown	GB	Non-Executive Director, STHK & S&O
Nicola Bunce	NB	Director of Corporate Services
Kate Clark	KC	Medical Director
Rob Cooper	RC	Director of Operations and Performance, STHK
Jeff Kozer	JK	Non-Executive Director, STHK
Gareth Lawrence	GL	Director of Finance, STHK
John McLuckie	JMcL	Director of Finance
Lesley Neary	LN	Chief Operating Officer
Sue Redfern	SR	Director of Nursing, Midwifery and Governance, STHK
Nina Russell	NR	Director of Transformation
Rani Thind	RT	Associate Non-Executive Director, STHK
Christine Walters	CW	Director of Informatics, STHK

In Attendance

Name	Initials	Title
Helen Hurst	HH	Associate Director of Nursing and Therapies, Planned Care *(Item SO197/22 only)*
Mary McNabb	MM	Urology Specialist Nurse *(Item SO197/22 only)*
Juanita Wallace	JW	Assistant to Director of Corporate Services (minute taker)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Geoffrey Appleton	GA	Non-Executive Director, STHK
Ian Clayton	IC	Non-Executive Director, STHK & S&O
Paul Growney	PG	Non-Executive Director, STHK
Lisa Knight	LK	Associate Non-Executive Director, STHK
Jane Royds	JR	Director of HR and OD
Peter Williams	PW	Medical Director, STHK

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
SO0197/22	**Patient Story**	
	HH introduced the patient story video in which Peter talked about his recent diagnosis of prostate cancer. Peter described his journey from initial symptoms, and his experience of the tests required to support his diagnosis and the treatment and support he was currently receiving.	

RF asked if the delays in receiving the test results had been caused by staff shortages and MM advised that there was a national shortage of radiologists. However, the Trust had recently introduced an early diagnosis support worker role who would track patients through the pathways, monitor results and keep everyone informed of progress and it was expected that this would help speed up the process and reduce patient anxiety.

GB reflected on the impact on patients because of the national issues with histology and Magnetic Resonance Imaging (MRI) capacity and asked if the patient had needed to go to the cancer centre in the Wirral, however MM advised that he had been able to have radiotherapy at Aintree Hospital. Patients were given a choice of where to receive their treatment and some opted to go to Liverpool or Wirral because the waiting times could be shorter.

GB asked about the support that the Trust provided for relatives and friends and MM advised that this would be discussed at the first appointment with the patient and their relatives were invited to attend this appointment. There were several support groups that relatives and friends of the patient could attend with the patient's consent and a Clinical Psychologist was also available to provide support.

LN advised that the position with histology reporting had recently improved because of securing additional capacity because of the additional funding that had been secured for the Community Diagnostic Centre (CDC). Also, the Targeted Investment Fund (TIF) would increase MRI capacity to 12 hours per day for seven days per week. These recent investments would make a real impact for patients such as this, by reducing the time to receive a definitive diagnosis.

LB thanked the patient, who had continued working as a volunteer at the Trust throughout his treatment, for sharing his story and for everything he did for other patients.

RESOLVED

The Strategy and Operations Committee **received** the Patient Story

SO198/22 Chair's Welcome and Note of Apologies

RF welcomed all to the meeting.

RF acknowledged the following Awards and Recognition that the Trust had received recently:

- Bradley Grant - NHS Rising Star Award (NHS Communicate Awards 2022)

- Erica Isherwood - RCN North West Award for Outstanding Contribution to Equality, Diversity and Inclusion
- Dave Saul, Laura Atherton, and Chris Goddard completed their Aqua Advanced Improvement Practitioner course
- At the Preceptorship Awards, the following won awards:
  - Preceptee of the year - Lucy Gore
  - Preceptor of the year - Claire White
  - Line Manager of the year - Louise Ferguson
  - Practice Educator of the year - Ashleigh Latham

Apologies for absence were **noted** as detailed above.

SO199/22 Declaration of interests

There were no declarations of interests in relation to the agenda items.

SO200/22 Minutes of the previous meetings

The Committee reviewed the minutes of the previous meeting held on 05 October 2022 and approved them as a correct and accurate record of proceedings subject to the following amendments:

- SO183/22 (third paragraph) to be amended to read '*GB reflected on the Professional Nurse Advocacy Programme which had been discussed at the Patient Experience Day in June 2022 and asked about the one-to-one sessions with nursing staff as these were not referenced in the Nursing & Midwifery Strategy.*'

RESOLVED:
The Strategy and Operations Committee **approved** the minutes from the meeting held 05 October 2022

SO201/22 Matters Arising and Action Logs

The meeting considered updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions

RESOLVED:
The Strategy and Operations Committee **approved** the action log

STRATEGIC AND GOVERNANCE

SO202/22 Audit Committee AAA Highlight Report

GB, on behalf of IC, presented the AAA Highlight Report from the meeting held on 19 October 2022 and alerted the Committee to the following:

- Board Assurance Framework (BAF) - there had been a discussion about whether and to what extent the identified actions would mitigate the gaps

in assurance and controls and therefore reduce the risk scores, following the discussion, members were assured of the process.

GB advised that

- the Anti-Fraud Specialist had met with the Head of Education, Training and OD to discuss fraud awareness being included as part of induction and mandatory training.
- the Audit Committee had approved the change to the internal audit plan to accommodate the required Emergency Preparedness, Resilience and Response (EPRR) audits in 2022/23 and that the planned Clinical Business Units (CBU) governance audits had been displaced to accommodate this.

RESOLVED:

The Strategy and Operations Committee **received** the Audit Committee AAA Highlight Report

SO202/22 **2022/23 Trust Objectives – Mid Year Review**

AMS presented the 2022/23 Trust Objectives Mid-Year Review report which provided an update on progress in delivering the agreed Trust objectives. AMS reminded the Committee that this was the first time the Trust had set corporate objectives and she was pleased with the progress that had been achieved to date. In particular AMS highlighted the following:

- Objective 2.2 Improve the effectiveness of discharge processes (red) – this was not being achieved as planned and was an issue for the NHS as a whole. The Trust had actions planned that would come to fruition in the second half of the year, such as the successful bid for 14 additional community beds commissioned with Chase Heys and the conversion of a ward to a Nurse-Led Ward which would provide care for patients who were ready for discharge (RFD). The impact of these initiatives on discharges would continue to be monitored and reported via the monthly IPR reports.
- Excellent progress had been made on Objective 1.4 (Continue roll out and development of the S&O Hospitals Clinical Assessment & Accreditation Scheme (SOCAAS) to demonstrate a cycle of continuous quality improvement.
- The six amber rated objectives (may not be fully achieved by March 2023) were all impacted by the operational challenges that the Trust faced, and progress was being made.

RF felt that the paper reflected the positive progress the Trust was making in a wide range of areas to fulfil its strategic aims, despite the challenges currently facing the NHS. AMS agreed and particularly wanted to thank the

Emergency Department (ED) for the continued focus on improving services and patient experience, despite the challenges that the department faced.

RESOLVED:
The Strategy and Operations Committee noted the progress achieved in delivering the 2022/23 Objectives at this point in the year.

INTEGRATED PERFORMANCE REPORT

SO204/22 The Committee received the Integrated Performance Report (IPR) Summary which provided an update on the Trust's performance against key national and local performance metrics during September 2022.

a) Quality and Safety Performance Report

LB and KC presented the report which provided an overview of performance against the quality and safety metrics and LB highlighted the following:

- The overall registered nurse/midwife Staffer staffing rate was 97.7% and following a review, it had been noted that this was a 10% increase since the start of the year. The Trust had met the Health Care Assistants (HCA) fill rate target for the first time and the recruitment and retention work was ongoing.
- Three hospital acquired pressure ulcers had been reported and the newly appointed Tissue Viability Nurse was working closely with St Helens and Knowsley Teaching Hospitals (STHK) NHS Trust around reporting. There was a focus on the training of pressure ulcer champions.
- There had been a reduction in the number of patient falls, however, work was still ongoing to increase the knowledge and understanding of the requirements for enhanced levels of care that were provided at ward level.
- The Friends and Family Test rate had decreased to 85.8% in September. When investigated it had been found that the only area to deteriorate had been the Adult Emergency Department, because of the increased waiting times and congestion in the department.
- In September 55.6% of complaints had been responded to within the agreed timescales. LB reported that there was an action plan in place to reduce this backlog and improve the response times.

RF reflected on his recent ED attendance at another Trust and commented on the police presence and prison in mates receiving healthcare and asked if S&O had a similar issue. LN advised that S&O did not often experience this issue, however, there had been an increase in mental health patients that were supported by security or police depending on the patient's level of needs and this could sometimes be disruptive. KC commented that the ED had commissioned an external company to provide support to mental health patients in distress and the feedback received has been positive.

KC highlighted the following:

- The had been five cases of Clostridioides Difficile (C.diff) that had been reported and a review of all cases was being undertaken to identify areas of learning. It was noted that one lapse of care had been identified and actions had been taken within the ward environment and rolled out to other areas.
- There had been an increase in the number of Escherichia coli (E. coli) both regionally and nationally and this was being monitored.

RESOLVED

The Strategy and Operations Committee **received** the Quality and Safety Performance Report

b) Operational Performance Report

LN presented the report which provided a summary of operational activity and constitutional standards and highlighted the following:

- The Trust remained challenged against the Urgent and Emergency Care (UEC) 4hour performance standard at 72.37% and whilst slightly lower than the previous month (73.7%) the Trust still compared positively to peers and was the best performing acute Trust in the Cheshire and Merseyside (C&M) region (71.6%) and nationally at 70.1%.
- Bed occupancy levels remained above 100% and this contributed to a slight increase in 12-hour breaches in ED (14%).
- There had been an increase in the number of decisions to admit (DTAs) because of patient acuity and this also impacted patient flow. In September 2021 there were on average 12 DTAs every morning and this has increased to more than 20 DTAs in September 2022.
- The average Length of Stay (LoS) (greater than seven days) was 15% more than in 2019/20 and the +14 LoS had increased by 19% compared to 2019/20.
- LN had chaired a system-wide Long Length of Stay meeting and the biggest challenge to discharging patients was access to packages of care, including complex packages that were taking longer to put in place to meet the patients on-going care needs.
- Despite the slight improvement in ambulance handover times from 38.3% in August to 41.1% in September, there were still challenges due to patient flow and there had been continued focus on implementing the North West Ambulance Service NHS Trust (NWAS) handover checklist. KC commented that she had attended an event around ambulance handover times, and it had been noted that the average ambulance handover was now 53 minutes.
- A session had been held with the Clinical Business Units (CBU) Triumvirate to discuss key actions ahead of winter.

- Elective recovery target performance was 93.7 % of 2019/20 and 91.6% against plan. The Trust had no 104-week waiters.
- Diagnostic activity was above 2019/20 levels, however, there remained challenges with waiting times across several modalities. The establishment of a Community Diagnostic Centre (CDC) at the Southport site would support improvements because of the increased capacity.
- Cancer 14-day performance had improved to 78.3 % against the national average of 75.5 %. 62-day performance had deteriorated to 53.6 % (61.9 % nationally), however, the Trust had treated 72 patients during this period which was the highest number of patients treated in a single month since Covid-19. It was noted that the Trust had been flagged by the Integrated Care Board (ICB) as a Trust that had shown significant improvement.

RF reflected that it was good to see improvements in performance in several areas.

KC reflected on the event that she had attended about ambulance handover times and commented that her takeaway impression from the day was that the Trust was in a better position than many other trusts. Additionally, she commented that the Kendall Bluck report had highlighted opportunities for improvement through developing Same Day Emergency Care (SDEC) pathways.

RESOLVED
The Strategy and Operations Committee **received** the Operational Performance Report

c) Financial Performance Report

JMcL presented the report which detailed performance against financial indicators and advised that the Trust had reported a £9.5m deficit at month 6 in line with the 2022/23 Plan.

JMcL highlighted the following:

- The Elective Recovery Fund (ERF) income was a risk to the delivery of the 2022/23 Plan because the recovery plan activity was not being delivered, and elective operational pressures were continuing. The impact of inflation and continuation of escalation costs were other pressures that created risk for delivery of the 2022/23 plan.
- The Trust remained on track to deliver the Cost Improvement Programme (CIP) with £8.1m schemes being delivered to date.
- The cash balance at the end of September was £5.4m and this was a reduction. Additional cash support had been received from the ICB.
- Capital spend was slightly ahead of plan.

RESOLVED
The Strategy and Operations Committee **received** the Financial Performance Report

d) Workforce Performance Report

LN, on behalf of JR, presented the Workforce Performance report and advised that:

- Performance Development Review (PDR) completion compliance had decreased in September to 74.8% against the target of 85 % and JR had written to all managers requesting action plans to address this.
- Mandatory training was marginally behind the stretch target of 90% at 88 % and the training needs analysis was being reviewed in line with the STHK model.
- Sickness absence had decreased from 6.1 % in August to 5.9 % in September, however, there were several challenged areas (Theatres and ED) and the team was looking at how to support staff from a health and wellbeing perspective.

RF asked if the area had seen an influx of refugees from Ukraine and if they could be recruited to work at the Trust as he was aware this was happening in other areas of the country. AMS responded that so far there was not a large number of refugees from Ukraine who had been accommodated locally, however this was something that could be looked into further. In the past there had been a scheme to support refugees to help convert their qualifications to allow them to practice in the UK and it would be good to revisit this programme now.

GB reflected on the amazing resilience displayed by the staff at both S&O and STHK despite the challenges they faced. LN commented that the staff appreciated the NEDs visits and thanked everyone for making the effort.

RT reflected on her visit to the stroke ward and the enthusiasm of the team, and the way staff had embraced the new stroke pathways.

RESOLVED
The Strategy and Operations Committee **received** the Workforce Performance Report

QUALITY AND SAFETY

SO205/22 Quality and Safety Reports

a) Quality and Safety Committee AAA Highlight Report

GB presented the AAA Highlight report and alerted the Committee to the following:

- Significant delays in the Community Neurotherapy service across both ICBs have caused delays and this has impacted on access to community stroke rehabilitation. This has been escalated to each Place and regionally.
- The absence of a Clinical Director (CD) in Obstetrics and Gynaecology resulted in no medical attendance at the Maternity & Neonatal Safety Champions meeting. It had been noted that an external clinician was doing a piece of medical engagement work to support the Consultants with team working and individual responsibilities and was providing support to the four Consultants who were currently covering the responsibilities of the CD role until the post was filled.
- The number of complex discharges for patients on the Spinal Injuries Unit (SIU) had resulted in delayed discharges.

GB advised that the validation of hospital acquired pressure ulcers had been discussed and further work was anticipated with the recruitment of the new Tissue Viability Nurse (TVN) lead.

AMS advised that the new Associate Director of Midwifery and Nursing would be starting with the Trust on 14 November and a comprehensive induction plan had been developed. Furthermore, the Head of Midwifery, STHK, was providing professional oversight in the interim.

KC reported the four consultants covering the Obstetrics and Gynaecology Clinical Director duties were benefiting from this period of development and it was hoped that they could be encouraged to apply for the substantive role.

LN advised that STHK were now taking referrals for dermatology to ensure there was access for patients from West Lancashire following the closure to new out of area referrals at some other hospitals.

GB confirmed that if an item was flagged as an alert it was included in the AAA Highlight Report as an update the following month, so that actions taken in response to the risk were also noted.

RESOLVED:
The Strategy and Operations Committee **received** the AAA Highlight Report from the Quality and Safety Committee.

WORKFORCE

SO206/22 Workforce Report

a) **Workforce Committee AAA Highlight Report**

AMS, on behalf of LK, presented the AAA Highlight report and alerted the Committee to the following:

- The compliance rate of PDRs remained below target; however, work was ongoing to provide support to managers.
- The Guardian of Safe Working (GoSW) role remained vacant. The role of the GoSW was to provide a safe haven for junior doctors to raise any concerns about their contract and it was noted that there was still a process in place for them to raise any concerns and action to be taken, even though there was not currently a guardian in post.

Assurance was provided that:
- Several successful HCA recruitment events had taken place and future events were planned.
- The Staff Network sessions were planned to start in November 2022.

As part of 'Black History Month', two of the international nurses joined the meeting and shared their positive experiences of working at S&O and explained the reason behind the '# my name is campaign'.

b) People Plan Update

AMS, on behalf of JR, presented the Quarterly People Plan Update and advised that there had been progress made against the 19 key deliverables:
- 17 in progress (green)
- Two with identified issues that needed to be resolved (amber)

AMS advised that:
- There had been a reduction in the number of staff completing the Pulse Survey, a new national quarterly survey, and noted that most trusts had also seen a reduction in their response rates. AMS stated that it was not clear if this reduction was due to the frequency of the survey or if it reflected how staff felt about the NHS in general.
- There had been an increase in the number of requests received for flexible working.
- The Trust had been awarded the Navajo Charter Mark which signified good practice, commitment and knowledge of the specific needs, issues and barriers that faced the lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual (LGBTIQA+) community.
- The Staff Voice Partnership (SVP) engagement strategy was progressing and regular Board to Ward visits had been taking place.

GB reflected on a recent Board to Ward visit during which she had asked staff whether they would recommend the Trust to friends and family and a staff member had referred to an incident that had taken place several years ago and this had highlighted that not all staff members were up to date on all the developments and service improvements in different part of the Trust, and that their impressions were impacted by personal experiences. AMS advised that staff were proud of the service that they delivered but there was

still work to be done to create awareness of the wider Trust's improvements. Achievements, performance, and developments were reported at the weekly Trust Brief Live.

RF commented on the progress the Trust was making and reflected on the sometimes negative media coverage of the NHS, which influenced people's perceptions.

RESOLVED:
The Strategy and Operations Committee **received** the Workforce reports

FINANCE, OPERATIONS AND INVESTMENT	
SO207/22	**Finance, Performance, and Investment Committee AAA Highlight Reports** JK presented the AAA Highlight report and alerted the Committee to the following: • The Trust reported a £9.5m deficit at month 6, which was in line with the financial plan. • The cash balance at the end of September was £5.4m. • Overall A&E performance in September 2022 compared positively to peers and top quartile nationally and the Trust was the best acute performer in the C&M region but was still below the national standard. • There had been challenges with discharges due to capacity issues across the system. JK advised the following: • The network remediation programme was making good progress and as part of the improvements made there had been improved performance to the telephony system. • Following the update to the STHK Electronic Prescribing and Medicines Administration (EPMA) system that had taken place the implementation of the system at S&O could commence. • The Committee had received a paper from the Medical Director on feedback from the Kendall Bluck Review and the key recommendations and actions were being taken forward. • Whilst still below the national standards, the Trust had seen improvements across the cancer access metrics. Assurance was provided that: • The Cheshire and Merseyside Fire Brigade was satisfied with the progress being made on compartmentation and the fire alarm system • The new laundry service contract had started on 01 October • The Better Payment Practice Code (BPPC) performance at month 5 was slightly above the 95% target at 95.5%

- The capital programme spend at month 6 was slightly above the plan of £6.2m at £6.5m.
- The North Mersey Stroke implementation continued to go well, and patients and staff feedback remained positive.

RESOLVED:
The Strategy and Operations Committee **received** the AAA Report from the Finance, Performance, and Investment Committee.

SO208/22 Emergency Planning Reports

a) Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment

LN presented the Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment and advised that, as part of the statutory requirements, the Trust was required to complete the EPRR Core Standards self-assessment annual assurance process and, as part of this self-assessment, the Trust was compliant in 62 of the 64 areas applicable to acute trusts and was able to declare that it was substantially compliant against the EPRR Core Standards. LN advised that the Trust was partially compliant in the following areas:

- Command and Control – this was a newly added standard and required all on-call staff to have completed the Principles of Health Command Training. It was noted that nine staff members had already completed this training and the remaining five staff members were booked onto the course. LN added that all on-call staff had completed the in-house training and that this external training was an additional requirement.
- Business Continuity – it had been agreed at the Audit Committee held on 19 October 2022 that a review of the Business Continuity Plan (BCP) would be undertaken as part of the internal audit work plan. LN advised that the BCP had been tested over the preceding months and that she did not anticipate any significant concerns being raised.

RESOLVED:
The Strategy and Operations Committee **approved** that the EPRR Core Standards Self-Assessment

CORPORATE GOVERNANCE

SO209/22 Executive Committee Report

AMS presented the AAA highlight report that detailed the activity and reports considered by the Executive Committee during September and advised that several items noted in the report had been addressed earlier in the meeting. AMS alerted the Strategy and Operations Committee to the following:

- The Trust had received a notification about Exercise Artic Willow which was due to be conducted during the week starting 14 November. This was a national exercise to establish the level of preparedness of each Trust in the event of potential Industrial Action, by health care staff.
- AMS advised that the Trust had received a letter from the Chair of the Cheshire and Merseyside Quality and Safety Surveillance Group about Quality Assurance for Maternity services and commented that this had been unexpected as the Trust had been actively engaged with both the regional and Local Maternity and Neonatal System (LMNS) on several actions following the incident in April 2022. The letter had highlighted the gap in midwifery leadership for two weeks until the new Head of Midwifery took up post and the absence of a substantive Clinical Director. AMS had responded and detailed the Trust's mitigation plans. AM commented that clarity was needed on the role of the different maternity groups at C&M and regional level.
- The Executive Committee had received an update following a Mersey Internal Audit review of the Trust's response to the Ockenden report which included the systems and processes that the Trust had in place to monitor the implementation of recommendations, and required actions, as outlined within the Ockenden Report. It was noted that substantial assurance had been received.

RESOLVED:
The Strategy and Operations Committee **received** the AAA Highlight Report from the Executive Committee

CONCLUDING BUSINESS

SO210/22 **Questions from Members of the Public**

It was noted that no questions had been received from members of the public.

SO211/22 **Any Other Business**

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12.07

The next meeting would be held on **Wednesday 07 December 2022 at 09.30**

Strategy and Operations Committee Attendance 2022/23												
STHK Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser	✓	✓	✓	✓		✓	✓	✓				
Ann Marr	✓	✓	✓	A		✓	✓	✓				
Anne-Marie Stretch	✓	A	✓	✓		✓	✓	✓				
Geoffrey Appleton	✓	✓	✓	A		✓	✓	A				
Gill Brown	✓	A	✓	A		✓	✓	✓				
Nicola Bunce	✓	✓	✓	✓		✓	✓	✓				
Ian Clayton	✓	✓	✓	A		✓	✓	A				
Rob Cooper	✓	✓	A	✓		✓	✓	✓				
Paul Growney	A	A	A	A		A	A	A				
Lisa Knight	✓	✓	✓	✓		✓	✓	A				
Jeff Kozer	✓	✓	✓	✓		✓	✓	✓				
Gareth Lawrence	A	✓	A	✓		✓	✓	✓				
Rowan Pritchard Jones	A	✓	✓									
Sue Redfern	✓	✓	✓	✓		✓	✓	✓				
Alan Sharples	✓	✓	✓									
Rani Thind	✓	✓	✓	✓		✓	✓	✓				
Peter Williams				✓		✓	✓	A				
Christine Walters	✓	✓	✓	✓		✓	✓	✓				
S&O Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Lynne Barnes	✓	✓	✓	✓		✓	A	✓				
Kate Clark	✓	✓	A	✓		✓	✓	✓				
John McLuckie	✓	✓	✓	✓		✓	✓	✓				
Lesley Neary	✓	✓	✓	✓		✓	✓	✓				
Jane Royds	✓	✓	✓	✓		✓	A	A				
Nina Russell	✓	✓	A	✓		✓	✓	✓				
Richard Weeks						✓	✓	✓				
✓ = In attendance A = Apologies												

Title of Meeting	STRATEGY AND OPERATIONS (S&O) COMMITTEE	Date	07 December 2022
Agenda Item	SO223/22	FOI Exempt	NO
Report Title	INTEGRATED PERFORMANCE REPORT (IRP)		
Executive Lead	Executive Management Team (EMT)		
Lead Officer	Michael Lightfoot, Head of Information Katharine Martin, Performance and Delivery Manager		
Action Required	☐ To Approve ☐ To Assure	☐ To Note ✓ To Receive	

Purpose

To provide an update on the Trust's performance against key national and local priorities.

Executive Summary

The performance report includes the Trust indicators relating to the NHS Constitutional standards, the 2022/23 National Priorities and internal performance indicators which the Trust has identified as essential measures of operational delivery and assurance. The performance indicators are grouped according to the domains used by regulators in the Well Led Framework. Each indicator, with the exception of the Finance section, has a Statistical process Control (SPC) chart and commentary.

The Performance Summary highlights key changes in Trust performance and outlines specific actions linked to the Trust's improvement plan and key programmes of work.

Recommendations

The Strategy and Operations Committee is asked to receive the Integrated Performance Report detailing the Trust's performance in October, unless otherwise stated

Previously Considered By:

☐ **Strategy and Operations Committee**	☐ **Executive Committee**
✓ **Finance, Performance & Investment Committee**	✓ **Quality & Safety Committee**
☐ **Remuneration & Nominations Committee**	✓ **Workforce Committee**
☐ **Charitable Funds Committee**	☐ **Audit Committee**

Strategic Objectives

- ✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
- ✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
- ✓ **SO3** Efficiently and productively provide care within agreed financial limits
- ✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
- ✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
- ✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	Presented By:
Katharine Martin, Performance & Delivery Manager	Executive Management Team

Strategy & Operations Committee - Integrated Performance Report

Performance Summary

The Trust Integrated Performance Report covers 4 areas aligned to the Trust Objectives as follows;

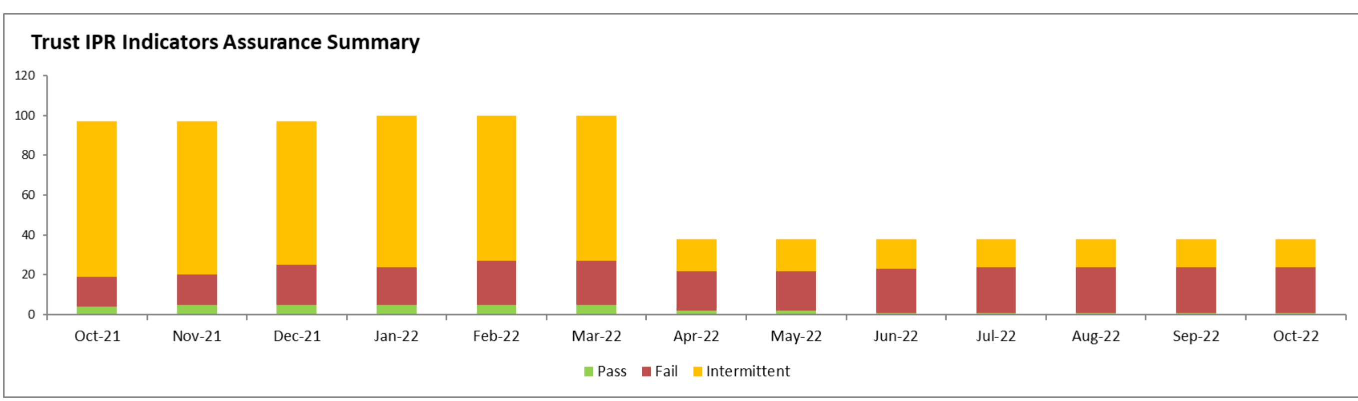
Quality - reflects those metrics aligned to Trust Objective – Care & Safety

Operations - Trust Objective – Service

Finance - Trust Objective – Financial performance and productivity.

Workforce - Trust Objectives – Supporting our workforce and Open and honest culture.

The indicator assured this month is Percentage of Patient Safety Incidents - Moderate/Major/Death(related). Finance indicators are not being reported using SPC.



Harm Free, Infection Prevention & Control, Maternity, Mortality and Patient Experience

The CQC rated the Trust as **requires improvement** overall following its inspection in July/August 2019. The caring domain was rated as **good** and well-led, safety, responsive and effective domains rated as **requires improvement**. An unannounced CQC visit to Medicine and Emergency Care in March 2021 provided overall positive feedback with 9 'should-do' recommendations.

There were no Never Events reported in October 2022. However, a data recording issue has meant a Never Event reported in July was not captured within this IPR. This has now been rectified resulting in 2 being reported year to date.

There were no cases of MRSA in October. (2022/23 YTD = 0).

There were three C. Difficile (CDI) positive cases reported in October 2022 (2022/23 YTD = 30).

The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for October 2022 was 92.5%. This is based on 97.2% for Registered Nurses and 87.2% for Un-Registered Nurses.

There was one category 3 hospital acquired pressure ulcer reported in October (2022/23 YTD = 16). The Trust reports all Deep Tissue Injuries and Unstageable Pressure Ulcers as Category 3. Following validation, all category 3 pressure ulcers reported in 2022/23 are deep tissue injuries or unstageable pressure ulcers, with no avoidable category 3 pressure ulcers being reported in 2022/23 to date.

There were 63 patient falls in October of which two resulted in moderate harm (2022/23 13 Falls with Harm). No falls resulting in severe harm or death have been reported in 2022/23 to date.

The Patient Friends & Family Test - % that rate the Trust as 'Very Good or Good' (Trust overall) increased to 86.9% in October, from 85.8% in September.

The % of complaints responded to within timescales has achieved 46.7% in October against the 80% target. An action plan has been included.

The Percentage of Patient Safety Incidents resulting in Moderate or above harm continues to be assured with performance lower than the target (target based on NHSE average NRLS published data).

Operational Performance

Overall Accident and Emergency performance for October 2022 was 73.6%. This compares favourably with peers, with an England average of 67.4%, Northwest 65.9% and Cheshire & Mersey 70% (NHS Trusts only). Combined attendances for SDGH and ODGH were 7468 in October compared to 7037 in September. 32.5% of Ambulance Handovers occurred within 15mins, a decrease on September (41.1%) against the 65% target. 64.8% of Ambulance Handovers were within 30mins, compared to 69.5% in September and short of the 95% target. 78 Ambulance Handovers breached 60mins in October, an increase on the 62 reported in September.

Performance against the 14-day GP referral to Outpatients was 72.9% in September 2022, (78.3% in August), this is against an average of 72.4% for England, 68.2% North West and 65.8% for Cheshire & Mersey. This is also against the highest ever patient numbers seen with referrals to date for 2022 already 33% higher than the total received in 2019.

Operational Performance continued

The 62-day cancer standard was below the target of 85.0% in month (September 2022) at 59.7% (55.6% in August). The Trust is below the average for Cheshire & Mersey (68%), England (60.3%) but in-line with the Northwest (59.6%) (NHS Trusts only). This is against the second highest activity recorded since pre covid.

The Trust did not achieve the 96% target for the 31-day target in September 2022 with 81% performance in month (August 87.1%). By way of comparison, in September, the England average was 91%, Northwest 91.1% and Cheshire & Mersey 92.3%.

The average daily number of stranded patients in October 2022 increased to 212 (September 211). The number of super-stranded patients decreased to an average of 80 in October, from 85 in September.

The Criteria to Reside metric is in excess of the 35 target, averaging 59 in October, one more than the previous month. All these metrics were impacted by patient acuity, delays in care packages, availability of community beds and care home capacity.

The 18-week Referral to Treatment target (RTT) was not achieved in October 2022 with 67.5% compliance, (70.5% in September), against the 92% target. The Trust continues to perform well in comparison to peers, for example the average for NHS Trusts in England was 59%, Northwest 53.7% and Cheshire & Mersey 56.5% (latest data September 2022).

There were 218 52+ week waiters at the end of October, an increase on the 194 reported in September, with 10 patients waiting longer than 78 weeks, the target is to achieve zero by the end of April 2023. There remained no 104-week waiters. SOHT is the top performing acute trust across C&M for both 52 week and 78 week waits.

The Diagnostic target was not achieved in October 2022 with 25.2% patients waiting longer than 6 weeks, a further improvement on the previous month (32.6%) against a target of 1%. This compares to and NHS Trust average of England 30.7%, North-West 29.8% and Cheshire & Mersey 23.5% (September 2022 data).

The Covid crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled. All patients have been, and continue to be, clinically triaged to ensure urgent and cancer patients remain a priority for treatment.

Financial Performance

The Trust is reporting a £10.9m deficit at Month 7 in line with 2022/23 Plan.

Continued escalation and operational pressures are currently being offset by allocations for elective restoration and executive contingency.

The Trust has assumed 100% ERF funding to M7 on the basis of full allocations paid to Trusts to-date. Calculation of ERF performance across the ICS is still pending confirmation.

The Trust is reporting delivery of CIP to M7 – The 2022/23 financial plan sets out a CIP requirement of 3.5% (£7.8m), plus a further £3.0m Stretch Target profiled into Q4.

Financial Performance continued

ERF performance is highlighted as a risk to delivery of the Financial Plan in view of continued escalation and operational pressures experienced into 2022/23 – and subject to ICB decisions on the distribution of ERF in H2.

Key risks to delivery of Forecast Outturn currently include H2 ERF performance (£2.6m); 22/23 Pay Award (£0.5m full year); Inflation (c£1.2m full year); Energy prices (currently within plan); additional Bank Holiday (£60k).

Cash - the cash balance at the end of October was £4.7m. A reduction of £0.7m from September's position. This was despite receiving £2m of Regional cash support in October.

Capital – the Trust remains broadly on plan at the end of month 7 – spend of £8.6m against a plan of £8.8m. In month spending amounted to £2m with the significant elements Veolia boiler change £800k, CDC additional scopes £357k, EPR clinical noting £204k and fire safety projects £366k.

Workforce

Personal Development Review compliance has increased in October to 77% against the 85% target. Performance in September was 74.8%. The 90% stretch target for Mandatory Training was implemented from June 2022 and the indicator is behind the target at 87.6% for October, a decrease on the previous month (88%).

In month overall sickness is above target, increasing to 6.8% from 5.9% reported in September. The rolling 12-month figure is 7.1%. This is against sickness targets for 2022/23 of 6% (5% non-Covid, 1% Covid). Non-Covid Sickness has increased in October to 5.9% (4.8% in September).

The overall Trust vacancy rate has reduced to 9.1% in October, from 10.6% in September, against the 7.4% target. In-month Staff turnover has increased marginally to 1.2% in October from 1% in September (target 0.83%).

NHS
Southport and
Ormskirk Hospital
NHS Trust

Integrated Performance Report
Strategy & Operations Committee
Report

October 2022

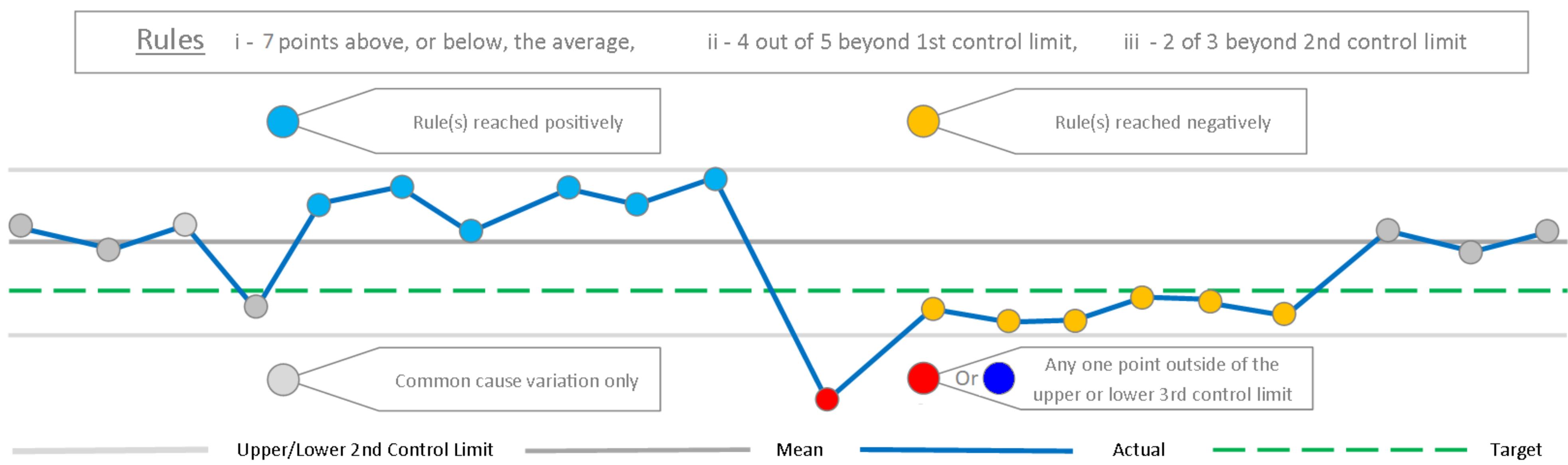
Guide to Statistical Process Control

Statistical process control (SPC) is an analytical technique – underpinned by science and statistics – that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action. Understanding how to react to data is the most important thing, not the detail of the statistical rules that underpin SPC.

There are two excellent presentations available on the NHS Improvement Making Data count webpage (link below) that explain why Statistical Process Control is so valuable to Healthcare and how to understand SPC charts. We strongly recommend you view these to help you get the most out of this report. There are also other useful resources on the NHS Improvement page that you may find useful so it is definitely worth visiting **http://www.improvement.nhs.uk/resources/making-data-count**

The SPC charts in this report are time series line charts with three reference lines that will hopefully help you appreciate variation in the data. The centre reference line (**dark grey**) is the mean, and the two light grey lines are the upper and lower control limits. The aim of these charts is to distinguish special cause variation from common cause variation. There are a number of tests applied to the data to identify special cause variation which is then highlighted on the charts by colouring the corresponding data point markers. The tests applied in this report and the corresponding colours of the data point markers where special cause variation is found are outlined in the example chart below.

The report then uses the SPC icons developed by NHS Improvement to summarise the messages from SPC charts - an explanation of these icons can be found on the Executive Summary page of the report.



Executive Summary

Alert Indicators

Complaints - % closed within 40 working days

Accident & Emergency - 4 Hour compliance

62 day GP referral to treatment
Stranded Patients (>6 Days LOS)
Super Stranded Patients (>20 Days LOS)
Personal Development Review

Quality

Harm Free

Never Events

A data recording issue has meant a Never Event reported in July was not captured within this IPR. This has now been rectified. This Never Event related to 2 patients seen in the same clinic in 2019, Patient 1's gastroscopy referral contained Patient 2's clinical details, resulting in them having a Gastroscopy and biopsies which was potentially not needed. The incident was reported to StEIS and a RCA has been completed.

Safe Staffing/Care Hours Per Patient Day

Issues
- The Safe Staffing indicator is showing special cause improvement and has been above target for nine consecutive months, although performance has reduced in October.
- Performance of 92.5% in October relates to 97.2%% for Registered Nurses and 87.2% for Un-Registered Nurses.
- Performance in October is indicative of the high number of vacancies within HCA roles.

Management Action
- Safer staffing remains high, which is reflective of the recruitment of nurses to the trust.
- Ongoing recruitment of HCAs to improve position.

Pressure Ulcers

Issues
- The category 3 and 4 indicator is performing statistically as expected.
- The number reported has reduced in October and is inline with the monthly target.
- All Hospital Acquired Category 3's reported in 2022/23 to date are Deep Tissue Injuries or Unstageable Pressure Ulcers. There have been no confirmed Hospital Acquired Category 3 Pressure Ulcers this financial year to date.

Management Action
- The new lead Tissue Viability Nurse is now in post and is actively validating all reported Hospital Acquired Pressure Ulcers.
- Matron is leading a piece of work looking at pressure relieving mattresses & chair cushions with particular focus on A&E.
- Link Nurse meetings 1 ½ hr session bi-monthly commencing January 2023.
- SSKIN bundle training twice a month as part of Pressure Ulcer Prevention training – commenced x3 in October.
- Pressure Ulcer Prevention (PUP) champions – lead by our wound care HCA with adhoc training for HCA's on the ward. Basics of PUP, react to red, management of moisture associated skin damage (MASD), category 1 pressure ulcers & barrier creams.

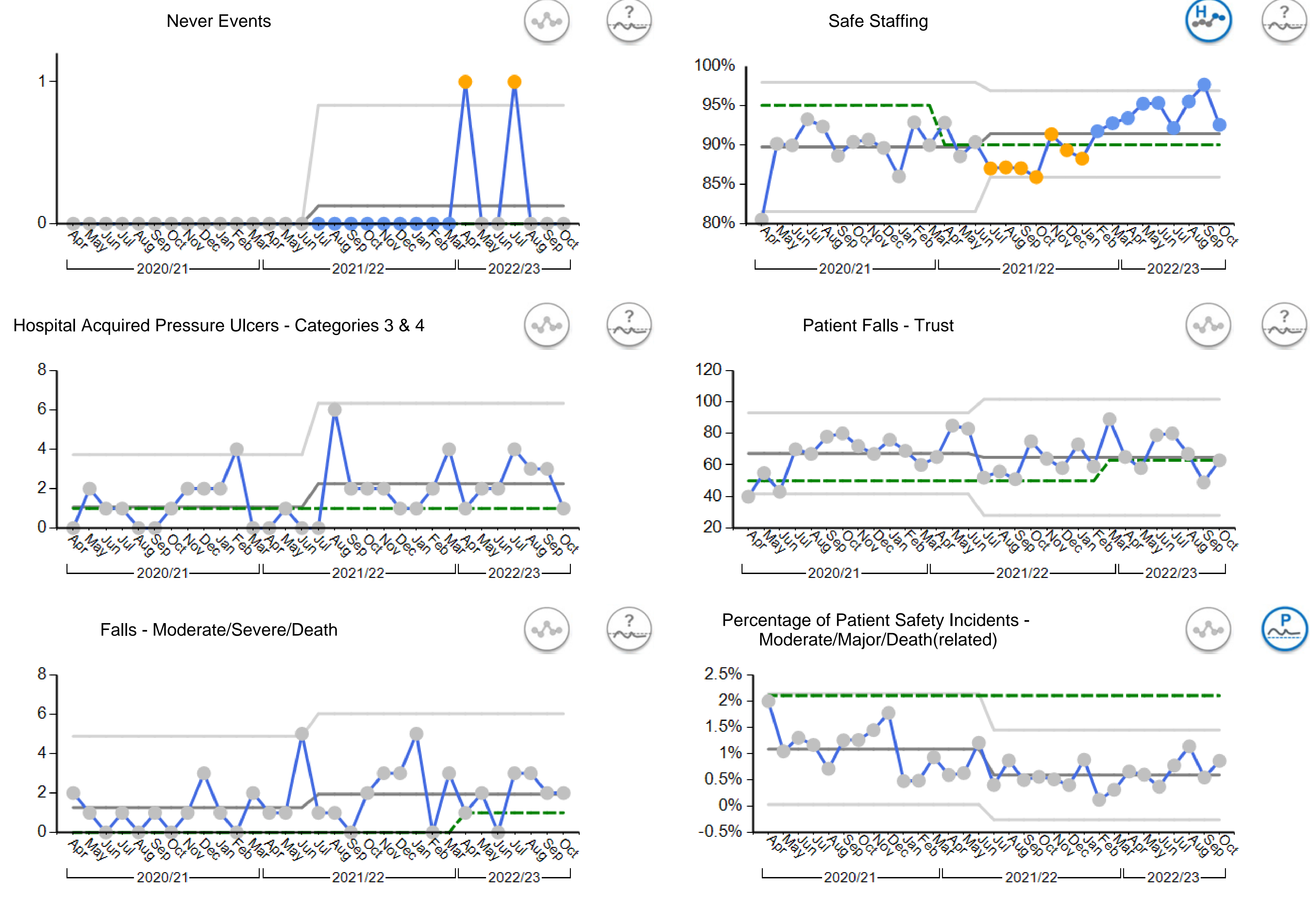
Patient Falls

Issues
- The overall number of falls reported remains statistically as expected, and although has increased in October, is in line with the monthly target.
- Reporting by bed days shows an improvement, from 5.94 per 1,000 bed days in 2020/21, to 5.58 in 2021/22 and 5.11 for the current financial year, with an October figure of 4.64.

• Two falls resulting in moderate or above harm were reported in October, the same as the previous month. Whilst not statistically significant, this is above target.
• Of the 13 falls resulting in moderate or above harm reported in 2022/23 to date, 3 resulted in severe harm or worse.
• The results from the National Audit of Inpatient Falls have been published and our results have vastly improved across all KPIs. In 2020 we were significantly behind national average in all 3 KPIs and the most recent audit we have exceeded national average in all three areas.

Management Action
• Deep dive completed into wards with high falls numbers and actions implemented (including review of staffing numbers, falls hotspot ward plan commenced, additional staff training).
• Continuing work to increase knowledge and understanding of the requirements for enhanced levels of care being given at a ward level.
• Enhanced level of care assessment being reviewed to make it more user friendly and fit for purpose.
• Application made to charitable funding for additional mobility equipment for each ward to use for assessment (red walking sticks – awaiting delivery).
• Staff focus groups completed and issues raised to be fed back through falls group to add into trust wide action plan.
• Deconditioning project ongoing on 7b (pilot).
• Guidance for when and how to implement a low bed being written to support staff with the decision-making process.
• D&D team have produced a short-term sedation guideline (in draft form at present).
• Documentation (falls care plan and post falls assessment) reviewed to add additional prompts to support staff in following policy and post-fall guidance flowchart.
• Continuing daily walk round, 1 ward per day to review risk assessments, environment, resources etc as time allows with immediate feedback/action plan provided.
• Reviewing what aspects of falls prevention are considered in SOCAAS and adding to this as appropriate.
• Continuing to roll out flojac training to clinical staff as time allows.
• Process of medication falls review to be reviewed with pharmacy to ensure a robust system for falls medication reviews is in place.
• Inpatient welcome pack being produced to include general falls prevention advice.
• Staff training on falls prevention ongoing at organised education days/ward meetings/therapy inservice training sessions.
• Meeting with community falls leads to consolidate relationship between acute and community services to share learning where able.
• Attendance at the Cheshire and Merseyside Falls Prevention Steering Group to commence in September.
• Completing a review of patients who have fallen following sedation which will support the work the D&D team are completing on their guideline.
• The Ramblegard equipment has now been serviced (completed Sept) and we are back up to original level across the trust.
• Use of regular additional streams of information through trust news (including monthly falls newsletter) and social media to inform of lessons learnt and key messages.
• A project to review the seating available to our AED and inpatients is ongoing to work towards the reduction of deconditioning (and pressure areas).

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Never Events	0	0	0	Oct 22		0	0	Sep 22	0	2	?
	Safe Staffing	90%	92.5%	N/A	Oct 22	H	90%	97.7%	Sep 22	90%	94.5%	?
	Hospital Acquired Pressure Ulcers - Categories 3 & 4	1	1	1	Oct 22		1	3	Sep 22	12	16	?
	Patient Falls - Trust	63	63	63	Oct 22		63	49	Sep 22	756	461	?
	Falls - Moderate/Severe/Death	1	2	2	Oct 22		1	2	Sep 22	17	13	?
	Percentage of Patient Safety Incidents - Moderate/Major/Death (related)	2.1%	0.9%	8	Oct 22		2.1%	0.5%	Sep 22	2.1%	0.7%	P


Never Events
Safe Staffing
Hospital Acquired Pressure Ulcers - Categories 3 & 4
Patient Falls - Trust
Falls - Moderate/Severe/Death
Percentage of Patient Safety Incidents - Moderate/Major/Death(related)
2020/21
2021/22
2022/23

Quality

Infection Prevention and Control

C.Diff

Issues
• The indicator is performing statistically as expected.
• 3 reported cases in October, 2 Hospital Onset Hospital Acquired (HOHA) and 1 Community Onset Hospital Acquired (COHA). This is a reduction on the previous month and lower than target.
• Themes relate to elderly patients with multiple co-morbidities including infections that required treatment with antibiotics.

Management Action
• Each of the patients have been reviewed by the Microbiologist and the clinical team, with Antimicrobial pharmacist also supporting and providing teaching to medics.
• Typing has been requested for one patient as a link has been identified with another patient. This RCA is scheduled to be completed this month.
• Patients identified with C.diff are isolated and treated for C Diff infection and vacated bed spaces and equipment are cleaned with chlorine dioxide infection.
• One case identified that the antibiotic potentially could have been stopped sooner/ changed to oral if discussions with microbiology had taken place and samples obtained e.g. urine samples This has been fed back via medical meetings and the Antimicrobial pharmacist has provided education at ward level.
• Staff have had further training on SIGHT principles and the ward area have developed an education board to share the learning and to be discussed at daily Huddles.

E-Coli

Issues
• The indicator is performing statistically as expected, with 2 Hospital Onset Hospital Acquired cases reported in October, this is a reduction on the 5 reported in September and is below the monthly target.

Management Action
• Each of the cases were reviewed by the Microbiologist and the patient's doctor, and treatment was prescribed based on microbiological and diagnostic evidence.
• No lapses in care have been identified.

No MRSA cases were reported in October.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	MRSA	0	0	0	Oct 22		0	0	Sep 22	0	0	
	C-Diff	4	3	3	Oct 22		4	5	Sep 22	49	30	
	E. Coli	4	2	2	Oct 22		4	5	Sep 22	51	30	

MRSA
1
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct
2020/21
2021/22
2022/23
E. Coli
12
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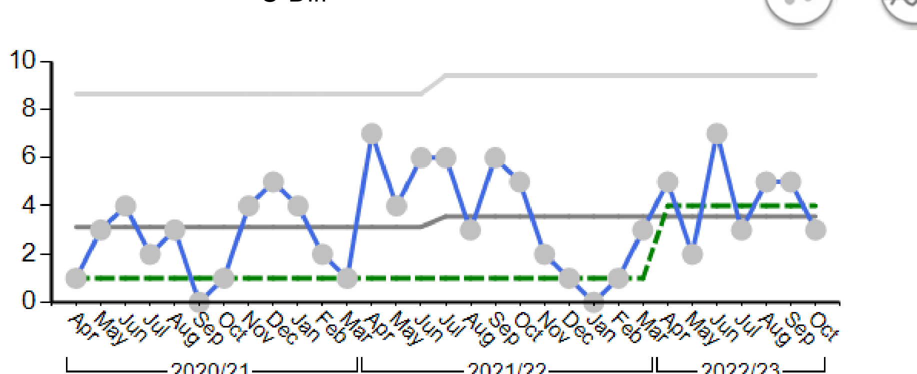
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct
2020/21
2021/22
2022/23


C-Diff
10
8
6
4
2
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct
2020/21
2021/22
2022/23

Quality

Patient Experience

Complaints - % closed within 40 working days
• See accompanying action plan.

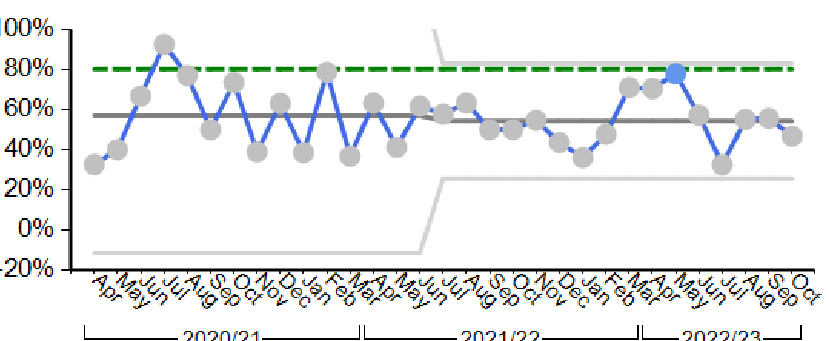
Friends and Family Test

Issues
• The Trust overall indicator continues to fail the assurance measure and shows special cause concern but has improved by 1.1% in October.
• Improvements are noted within A&E and Labour Ward with slight deteriorations in Acute Inpatients, Outpatients and Postnatal Ward.
• The score for Acute Inpatients has decreased slightly to 92.8% from 93.3%. This remains below the internal indicator of 94% and September NHSE average of 94%. Themes alongside negative ratings are environment, staff attitude and implementation of care.
• An increased score from 78.2% to 80.5% in A+E overall. This relates to 77.57% from Adults A&E and 88% from Children's. The overall percentage remains above the Trust indicator of 77.8% and above September NHSE average of 76%.
• The experience of long waiting times in the adult A&E department continues to cause a higher number of negative responses and comments.
• Outpatients - A slight decrease in score from 94.6% to 94.1% when compared to previous month. This is above the September NHSE average of 93% and internal target of 92.8%.
• Labour Ward - Increase in overall score to 97.1% from 95.6%, this is above the September NHSE average of 92% and internal indicator of 94%.
• Postnatal Ward - A slight decrease in performance from 95.7% to 95%, this is above the September NHSE average of 92% and internal indicator of 92%.

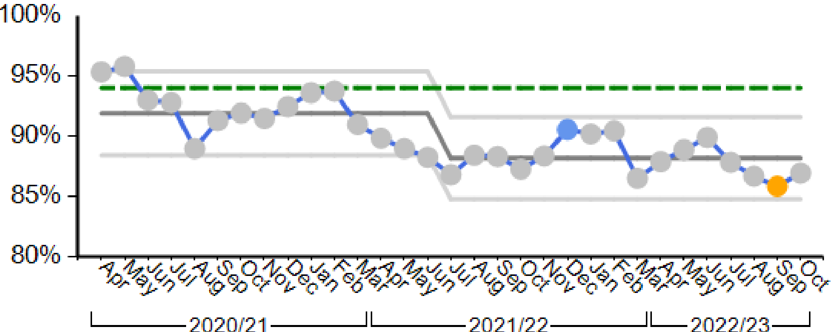
Management Action
• Monthly FFT summaries are shared with CBU's and are monitored through the Patient Experience and Community Engagement group where CBU updates and actions to improve FFT are provided.
• Inpatient areas continue to review comments to identify any emerging themes or trends to inform a 'You said, we did' approach to improvement. FFT results are reviewed at ward/department level through a performance review process.
• Progress on the 2021 National Inpatient Survey action plan continues to be monitored via the Trust Patient Experience and Community Engagement group.
• The local Maternity Voices Partnership meeting is now reinstated and will provide opportunities to work collaboratively and gather further feedback from this patient group.
• The 2022 National Maternity Survey results have been received, action plan to be developed and presented to PECE for approval.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
!	Complaints - % closed within 40 working days	80%	46.7%	N/A	Oct 22		80%	55.6%	Sep 22	80%	52.4%	F
	Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall	94%	86.9%	N/A	Oct 22	L	94%	85.8%	Sep 22	94%	87.8%	F

Complaints - % closed within 40 working days

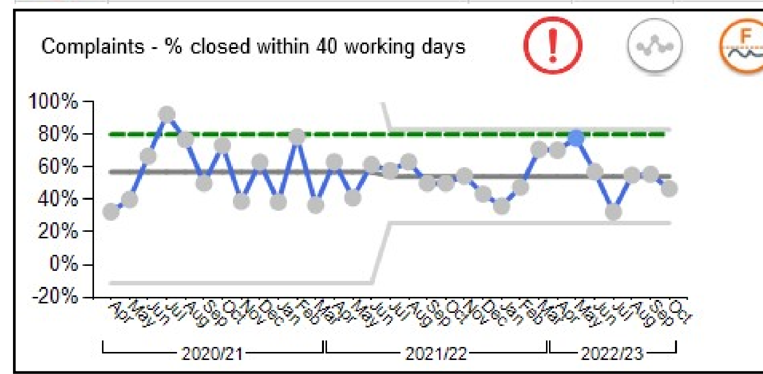


Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall

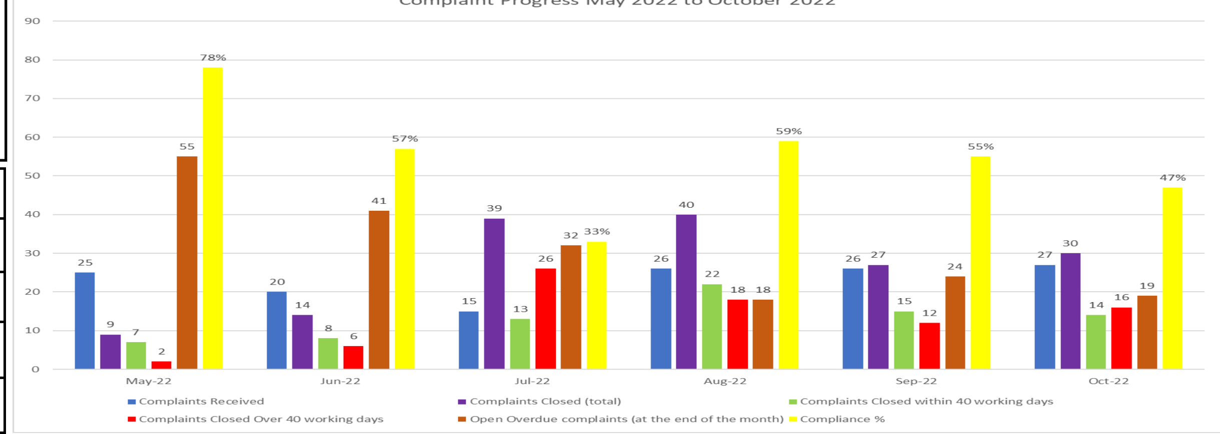


Complaints—% closed within 40 working days

Alert	Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
!	Complaints - % closed within 40 working days	80%	46.7%	N/A	Oct 22		80%	55.6%	Sep 22	80%	52.4%	F



Situation: This indicator has historically struggled to achieve the 80% target. Following 4 months of sustained improvement between February and May 2022, performance in July 2022 declined to the lowest level reported for more than 2 years. There has been some improvement in August and September but performance continues to be challenged.



	May 2022	Oct 2022
Overdue Complaints	55	19
Total Number of complaints closed	9	30
Overdue Complaints closed	2	16
Complaints closed within 40 working days	7	14

Issues:

Backlog of overdue complaints.

Resource in CBU Governance Teams.

Delays with Quality Assurance processes.

Competing priorities of Clinicians to complete statements and responses.

Actions:
The Medicine and Emergency Care (MEC) CBU have implemented a clear escalation policy to ensure timely escalation if responses are not received. MEC have changed the complaint investigation process to make it easier and quicker for clinical staff to respond, with the Governance Team supporting to turn the responses into a letter of response.
The resource within the MEC Governance Team is being used more effectively to ensure that each Patient Safety Manager looks after both incidents and complaints for specific areas, meaning they build up a rapport with their own areas and understand each area better to support responses.
Planned Care have been impacted by a vacancy within the Governance Team. The vacancy has now been recruited to and the process within the CBU has been altered to utilise the Matrons and Ward Managers to formulate an initial response with the Governance Team providing QA. Temporary staff are being used whilst recruitment processes are complete.

Mitigations: Positive progress that has been made over the past six months, with reducing the backlog of overdue complaints whilst trying to maintain and improve compliance with providing a response within 40 working days. The table above shows the improvement in the number of overdue complaints from May to October.

Operations

Access

A&E

Issues
• All metrics relating to A&E performance are failing their assurance measures and showing special cause concern.
• The Trust remains challenged against the 4hour standard although performance in October improved on the previous month.
• The Trust remains in the top quartile nationally for ED performance, achieving 73.6% in October for the 4-hour standard. Significant pressures in relation to staff sickness, skill mix, patient acuity and limited discharges continues to affect performance in October 22. Trust performed ahead of the National average (67.4%), Northwest (65.9%) and Cheshire & Mersey (70%) (NHS Trusts only).
• 13.9% of patients spent longer than 12 hours in the department (1037 patients), this is a smaller percentage than the previous month but the highest number so far this year.
• A&E performance impacted by high bed occupancy levels, contributed to by IPC measures, surges in attendances and a requirement for all specialty reviews to be undertaken in A&E.
• Bed pressures lead to an increased LOS in ED with increased treatments and reviews undertaken in the department for patients who would previously have been admitted.

Management Action
• Concentrated effort required to not use CDU as bedded area to enable flow.
• Development of RATS (Rapid Assessment and Treatment model) to improve triage times and time to treatment to implemented September.
• 3 times daily huddles with flow and ED teams to maximise communication.
• Use of discharge lounge to expedite discharges.
• Planned reconfiguration of ED department to safely manage patients with an admission.
• Development of clear clinical pathways for SDEC and CDU to maximise patient experience and avoid admission as clinical appropriate.

Ambulance Turnaround Times

Issues
• All metrics failing their assurance measure and have deteriorated in October.
• The Ambulance Handovers - % within 15 Mins is showing special cause concern with the lowest reported for more than two years.
• Despite the challenges with achieving the Ambulance Handover targets, the Trust compares favourably with peers. Southport has the 2nd shortest time for Arrival to Handover and the 3rd shortest average turnaround time in Cheshire & Mersey.
• 27% decrease in ambulance arrivals against same month 2019/20.
• Challenges continue with timely release of cubicles to enable crews to handover promptly, high numbers of patients awaiting admission who remain in ED until an inpatient bed becomes available, CDU continues to be used as an escalation area which reduces capacity and the impact of IPC cleaning requirements also remains.

Management Action
• Use of NWAS checklist to assist with timely handover of patients from crews to the department where clinically appropriate .
• Standardised NWAS clinical criteria for SDEC Medical used by crews across LUFT, STHK and S&O to enable clinical consistency in patients appropriate for direct streaming.
• ALO support to nursing staff to mitigate clinical risk.
• Use of additional ED Clinical Co-ordinator to ensure handover times adhered to by monitoring incoming ambulances, liaising with bed manager and undertaking early transfers from ED to wards.
• Senior clinician based in triage during periods of surge.
• Ensure appropriate patients are fit to sit to release cubicles and trolleys for those who clinically require them.
• Direct referral into SDEC pathways from Primary Care commencing from December Commencement of Rapid Access Treatment pathways to release capacity from department.

Referral to Treatment

Issues
• The Referral to treatment: on-going indicator continues to fail assurance and shows special cause concern with a 3% deterioration in October.
• The number of 52-week waits is above the trajectory and has deteriorated in October.
• The Trust continues to perform well in comparison to peers, for example the average for NHS Trusts in England was 59%, North West 53.7% and Cheshire & Mersey 56.5%.
• There were 10 78-week waits at the end of October.
• SOHT continues to be top performing acute trust across C&M for both 52 week and 78 week waits.
• Overall elective admitted activity achieved 83% of plan in October, a 3% improvement on the previous month.
• Consultant sickness impacted ENT activity throughout October.
• Reduction in demand for haematology procedures, resulting in a decrease in daycase activity.
• Ophthalmology remains a fragile service which is closed to referrals. This is impacting new outpatients and daycase activity. Workforce issues continue.

Management Action
• Continued risk stratification of the waiting list.
• Trust is part of the Cheshire & Mersey wider elective restoration group.
• ENT – Consultant returned to work, clinic templates reviewed and increased from November 2022. Improvement expected from December 2022.
• Clinical Haematology – STHK supporting capacity levels by providing 3 additional sessions per week which equates to an additional 6 new patients weekly.
• Ophthalmology – Associate position advert closes November 2022. Expected recruitment into position by March 2023. Continue to seek support through agencies. Discussions underway with STHK regarding collaborative support. Initial meeting in November 2022.

Diagnostics

Issues
• The Diagnostic Waits indicator is failing assurance but is performing statistically as expected in October.
• Performance against the 1% target has improved by 7.4% in October to 25.2%.
• The Trust is no longer an outlier for this indicator, with performance for NHS Trusts in September of England 30.7%, North-West 29.8% and Cheshire & Mersey 23.5%.

• Total diagnostics activity is 92.6% of plan for October and 109% of 19/20 activity.
• Diagnostic scopes over-performed in October, delivering 116.9% against the plan.
• Scans underperformed in October, delivering 90% of the plan.
• 90 Endoscopy patients waiting longer than 13 weeks for procedure, reduction on the 166 reported last month.
• ECG – sickness continued to impact on delivery of activity. Retirement planned for December 22 could impact on delivery.
• CDC – Recruitment of Consultant Radiologists required to support CDC.

Management Action
• Endoscopy - 5 gastroscopy patients at Broadgreen Hospital for TNE procedure. Your Medical has commenced insourcing sessions. This will continue until December.
• ECG – Date confirmed re Mutual aid with STHK to support 120 scans per month which will start 20th November 2022. Backlog cleared by January 2023.
• CDC – 7 WTE consultant radiologists to be recruited. Process commenced November 2022 – expected completion of recruitment April 2023. Agency/locum support until vacancies filled.

Stroke

Issues
• Performance against the 90% stay on a Stroke ward continues to be challenged but has increased from 52% in August to 57.1%% in September.
• Compliance in September has been impacted by consistently high levels of attendance to the Trust which has resulted in bed capacity issues and therefore has had an impact on the ability to maintain ringfenced Stroke beds. Also impacted by late identification and awaiting a decision re admission from Aintree Stroke consultant.
• Compliance has been challenged by late referrals to the Stroke team and late diagnosis. These accounted for 2 of the 9 breaches.
• 1 of 9 breaches was due to awaiting a decision re admission from the Aintree Stroke consultant.
• 1 of 9 breaches was a delay in transfer due to ward taking multiple repats and admissions in time period.

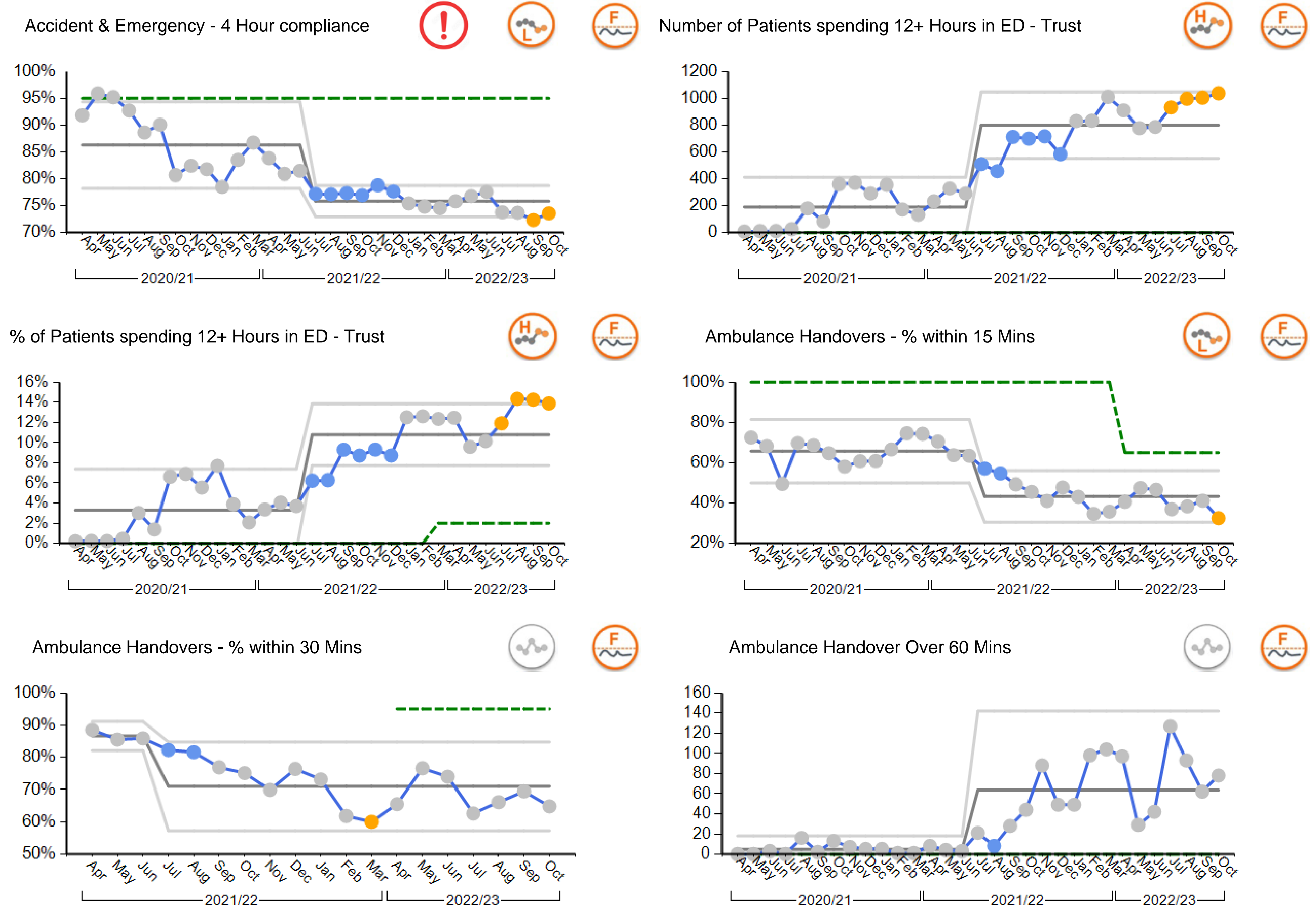
Management Action
• The monthly Stroke Operational Group continues to focus on quality and pathway improvements
• Stroke Nurses continue to provide ad-hoc teaching in ED to support earlier diagnosis.
• Bed meetings take place 4 x daily where a plan for Stroke admissions, and a contingency where there is a lack of ringfenced bed, is established.

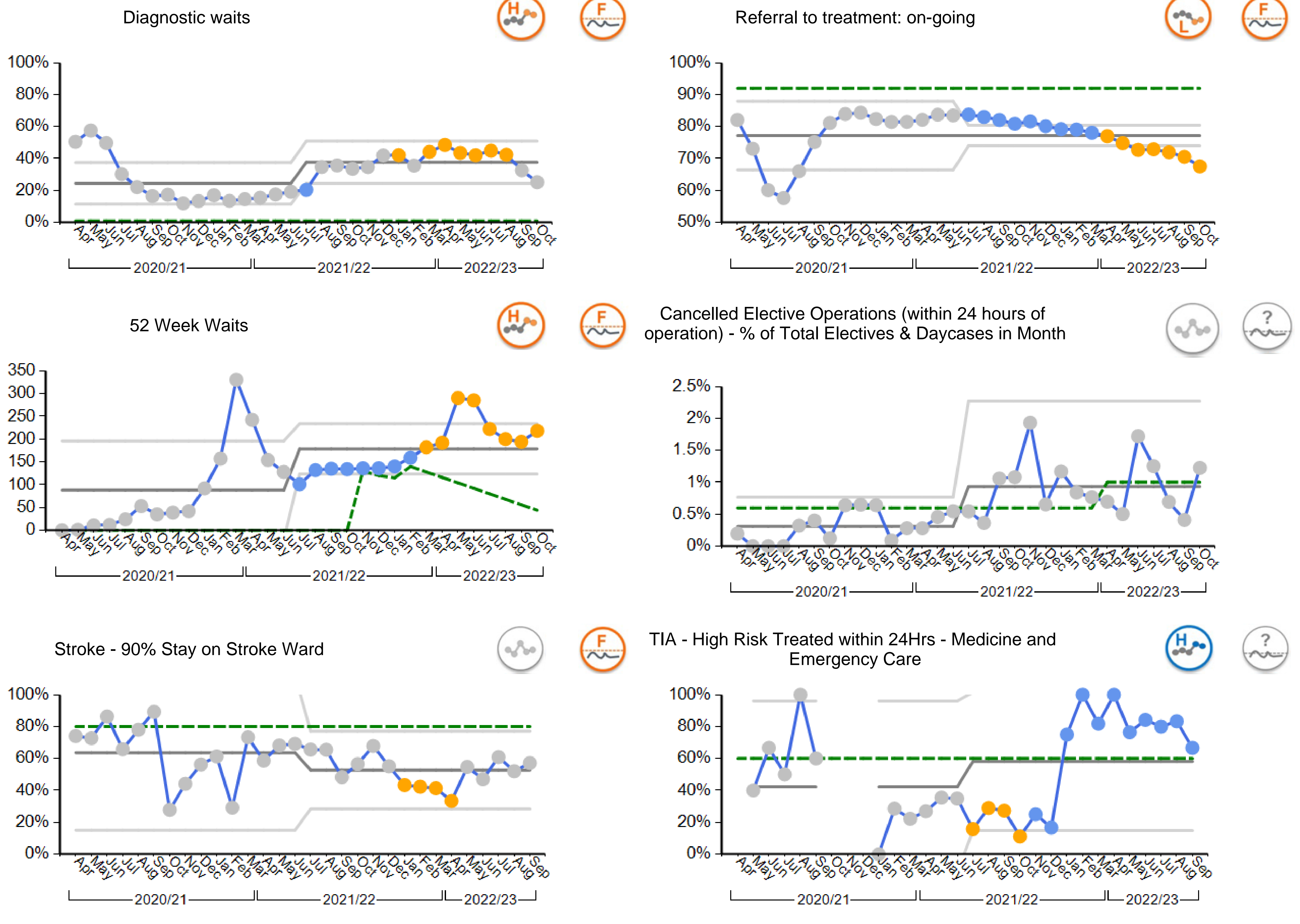
Discharge Communications

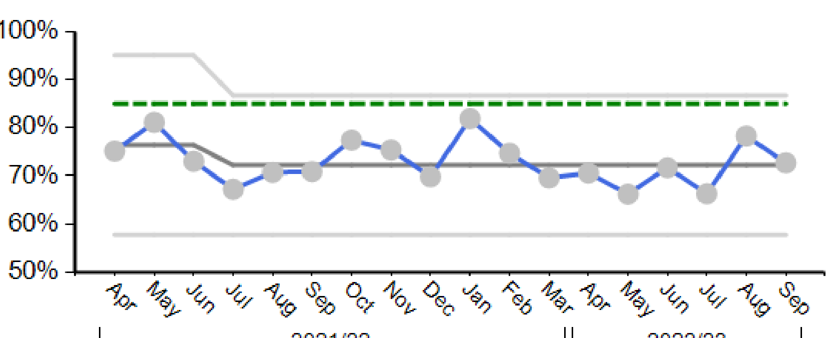
Issues
• Both indicators are failing their assurance measures, but current performance is statistically as expected.

Management Action
• Meeting held with Pharmacy to understand the issues affecting E-Discharge compliance.
• Focus on wards using pink TTO's, identification of wards with lower compliance and targeted training.

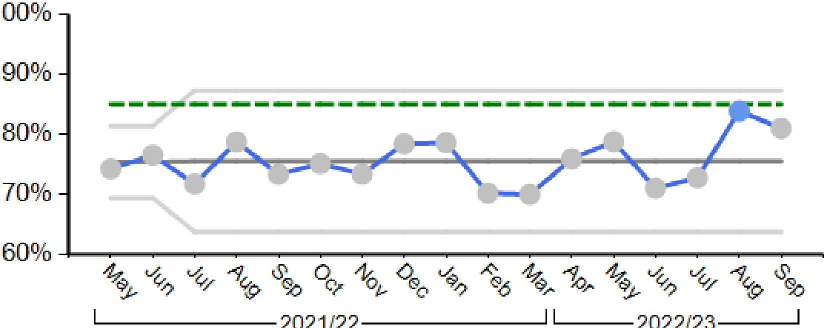
		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
!	Accident & Emergency - 4 Hour compliance	95%	73.6%	2768	Oct 22	L	95%	72.3%	Sep 22	95%	74.8%	F
	Number of Patients spending 12+ Hours in ED - Trust	0	1037	N/A	Oct 22	H	0	1004	Sep 22	0	6442	F
	% of Patients spending 12+ Hours in ED - Trust	2%	13.9%	N/A	Oct 22	H	2%	14.3%	Sep 22	2%	12.3%	F
	Ambulance Handovers - % within 15 Mins	65%	32.5%	725	Oct 22	L	65%	41.1%	Sep 22	65%	40.6%	F
	Ambulance Handovers - % within 30 Mins	95%	64.8%	378	Oct 22		95%	69.5%	Sep 22		68.5%	F
	Ambulance Handover Over 60 Mins	0	78	78	Oct 22		0	62	Sep 22	0	528	F
	Diagnostic waits	1%	25.2%	1293	Oct 22	H	1%	32.6%	Sep 22	1%	40.7%	F
	Referral to treatment: on-going	92%	67.5%	5029	Oct 22	L	92%	70.5%	Sep 22	92%	72.3%	F
	52 Week Waits	44	218	218	Oct 22	H	56	194	Sep 22	0	242	F
	Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month	1%	1.2%	30	Oct 22		1%	0.4%	Sep 22	1%	0.9%	?
	Stroke - 90% Stay on Stroke Ward	80%	57.1%	9	Sep 22		80%	52%	Aug 22	80%	50.3%	F
	TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	60%	66.7%	2	Sep 22	H	60%	83.3%	Aug 22	60%	82.2%	?
	Outpatient Letters to GP's within 7 Days	85%	72.7%	2922	Sep 22		85%	78.3%	Aug 22	85%	71%	F
	E-Discharges within 24hrs	85%	81%	266	Sep 22	H	85%	83.8%	Aug 22		77.1%	F


Accident & Emergency - 4 Hour compliance
Number of Patients spending 12+ Hours in ED - Trust
% of Patients spending 12+ Hours in ED - Trust
Ambulance Handovers - % within 15 Mins
Ambulance Handovers - % within 30 Mins
Ambulance Handover Over 60 Mins
2020/21
2021/22
2022/23


Diagnostic waits
Referral to treatment: on-going
52 Week Waits
Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month
Stroke - 90% Stay on Stroke Ward
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care
2020/21
2021/22
2022/23



E-Discharges within 24hrs



Operations

Cancer

Issues

- The 14 Day GP referral to Outpatients is failing the assurance measure and has deteriorated in September, achieving 72.9% against the 93% target. This mirrors a national picture, with the Trust performing well in comparison to 72.4% for England, 68.2% North West and 65.8% for Cheshire & Mersey (NHS Trusts only). This is also against the highest ever patient numbers seen with referrals to date for 2022 already 33% higher than the total received in 2019.
- Key areas that are performing below the standard are Lower GI, Head & Neck, and Upper GI.
- Key areas achieving the standard are Gynaecology, Haematology, Lung, Skin & Urology.
- The failure to achieve the two week wait target has an effect on the speed that patients receive their diagnosis, resulting in the failure of the 28 day standard.
- The 31-day target is showing special cause concern, reporting the lowest level for more than 2 years, at 81% against the 96% target in September. The Trust is an outlier, with an England average of 91%, Northwest 91.1% and Cheshire & Mersey 92.3%. However activity levels are high, the number of patients reported within this metric is the second highest this financial year.
- The 62-day GP referral to treatment continues to fail the assurance measure although has improved in September, achieving 59.7% against the 85% target. This is below the NHS Trust average for Cheshire & Mersey (68%), England (60.3%) but in-line with the Northwest (59.6%). This is against the second highest number of patients seen this financial year. The only area currently compliant is skin.
- Lack of clear structure in the management team for cancer services.
- RCA process needs reinforcing.
- Management of back log for all tumour groups, impact of longest waiting patients over 104 days.
- Issues with the High Risk FIT programme that went live in April, relating to delays in endoscopy, capacity of CNS team for triage and delays to 1st appointments.
- Histology challenges impacting on 7-day turnaround time. Vacancies in the lab and national shortages of pathologists has impacted turn around times of reports.
- Diagnostic capacity, particularly in MRI due to increase in inpatient requests and an increase in the urgency of requests for cancer and urgent.

Management Action

- Fixed-term Directorate Manager recruited started date of 21st November 2022.
- RCAs are beginning to be completed in a timely manner. Focus has been on staging but RCA completion to be part of business as usual. New cancer matron to start in post 5th December.
- Weekly PTL reporting with COO oversight. The backlog continues to decrease below the planned trajectory.
- Fortnightly steering group to escalate High Risk FIT issues and update on wait times. There is a lack of clinical triage at the beginning of the pathway. The RAS will be split in 2 and patients will be triaged to identify those that can go straight to test. (November 2022)
- Cellular pathology manager attends the cancer performance meeting on a fortnightly basis to provide latest turnaround times.
- Improvement plan submitted for radiology. Significant improvements have been made with CT. Continue to liaise with local partners for mutual aid.
- Processes to be implemented in Radiology to support BPTP beginning with Urology (November 2022)
- DCOO and cancer manager to meet to discuss plans for the role taking into consideration the BPTP project.

Alert	Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
	14 day GP referral to Outpatients	93%	72.9%	378	Sep 22		93%	78.3%	Aug 22	93%	77.6%	F
	31 day treatment	96%	81%	15	Sep 22	L	96%	87.1%	Aug 22	96%	90.8%	?
!	62 day GP referral to treatment	85%	59.7%	25	Sep 22		85%	55.6%	Aug 22	85%	59.9%	F
	28 Day Faster Diagnosis Standard	75%	64.6%	414	Sep 22		75%	63.1%	Aug 22		64.7%	F

14 day GP referral to Outpatients

100%
95%
90%
85%
80%
75%
70%
65%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep
2020/21 2021/22 2022/23

31 day treatment

100%
95%
90%
85%
80%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep
2020/21 2021/22 2022/23

62 day GP referral to treatment

100%
80%
60%
40%
20%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep
2020/21 2021/22 2022/23

28 Day Faster Diagnosis Standard

100%
90%
80%
70%
60%
Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep
2021/22 2022/23

Operations

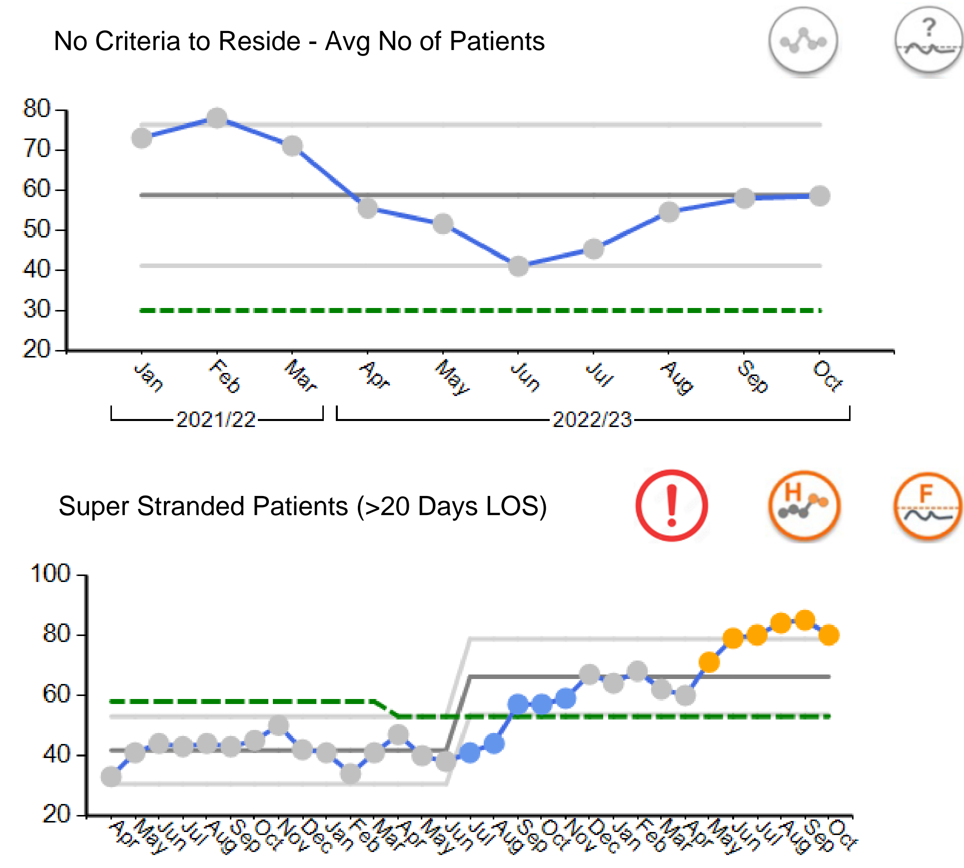
Productivity

Stranded/Super Stranded Patients/Criteria to Reside

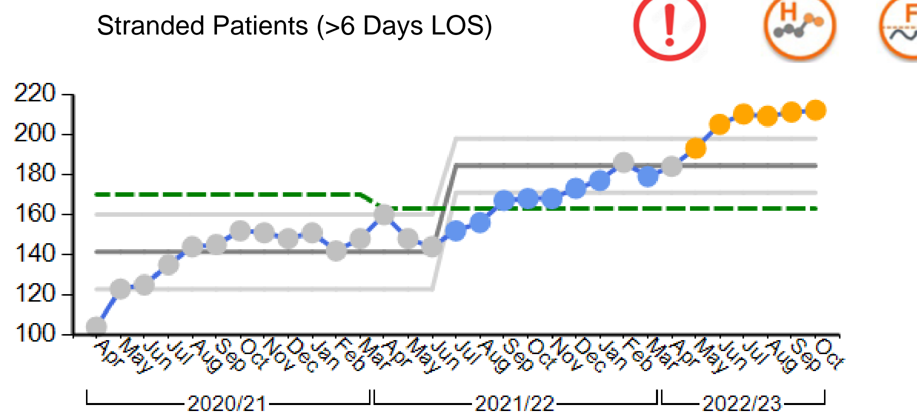
Issues
• Both indicators are failing their assurance measures and showing special cause concern with performance in excess of the target for the last 13 months.
• The number of Stranded patients indicators has increased further in October to the highest level for more than 2 years.
• The number of Super-Stranded patients remains high but has reduced on the previous month.
• The number of 'No Criteria to Reside' patients remains static at 59 against a target of 30.
• The increased number of stranded and super-stranded patients attributable to patients requiring to remain in hospital following covid, availability of packages of care, care homes accepting new patients and patients who are recovering from covid.
• Bed occupancy remained high throughout October.
• Increase in acuity of patients.
• Capacity of community services, care homes and local authority to support patients.

Management Action
• Focus on improvement of patients discharged by 5pm to ensure the trajectory is met.
• Ensuring patients are discharged home before lunchtime to enable early transfer of patients waiting to be admitted in ED.
• A new model of rehabilitation and nursing care will be provided and trailed in an acute ward from December, to improve patient outcomes and reduce level of ongoing support when leaving hospital.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	No Criteria to Reside - Avg No of Patients	30	59	58.58	Oct 22		30	58	Sep 22			?
!	Stranded Patients (>6 Days LOS)	163	212	212	Oct 22	H	163	211	Sep 22	163	1424	F
!	Super Stranded Patients (>20 Days LOS)	53	80	80	Oct 22	H	53	85	Sep 22	53	539	F



No Criteria to Reside - Avg No of Patients
80
70
60
50
40
30
20
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
2021/22
2022/23
Super Stranded Patients (>20 Days LOS)
100
80
60
40
20
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct
2020/21
2021/22
2022/23



Stranded Patients (>6 Days LOS)
220
200
180
160
140
120
100
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct
2020/21
2021/22
2022/23

Workforce

Organisational Development

Personal Development Reviews
• See accompanying action plan.

Mandatory Training

Issues
• The indicator is failing its assurance measure since the stretch target of 90% was implemented.
• Core mandatory training compliance has seen a decline in recent months to 87.6%, remaining 2.4% under the 90% target implemented in June 2022.
• The decline in compliance for conflict resolution is significantly impacting the Trust's ability to achieve the 90% core mandatory target.

Management Action
• It is acknowledged that a return to the 3 yearly renewal from an interim annual renewal for Conflict Resolution training during the Covid 19 pandemic will support an increase and re-align the Trust with the Core Skills Framework. Approval of the change is agreed with the Health & Safety Team and the aim is to implement the change with immediate effect in December 2022.

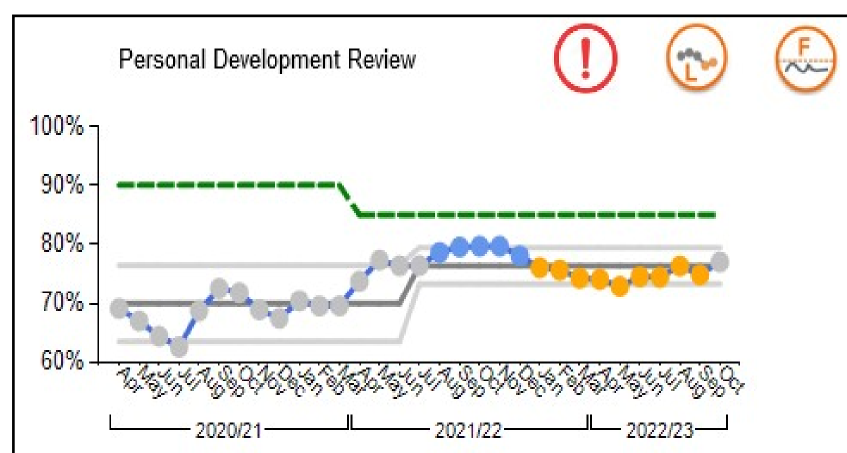
		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
!	Personal Development Review	85%	77%	N/A	Oct 22	L	85%	74.8%	Sep 22	85%	74.9%	F
	Mandatory Training	90%	87.6%	N/A	Oct 22		90%	88%	Sep 22	90%	88.4%	F

Personal Development Review

Mandatory Training

Non Medical Appraisal/Personal Development Reviews

Alert	Indicator	Latest: Plan	Latest: Actual	Latest: Patients	Latest: Period	Latest: Variation	Previous: Plan	Previous: Actual	Previous: Period	Year to Date: Plan	Year to Date: Actual	Assurance
!	Personal Development Review	85%	77%	N/A	Oct 22	L	85%	74.8%	Sep 22	85%	74.9%	F



Background: The annual appraisal/PDR is an AfC requirement for all non medical staff at the Trust and from April 2021 will be linked to pay progression. The Trust has an 85% compliance target and they form part of the Trust's performance framework and are monitored at PIDA. Appraisals are an indicator of overall staff engagement and form a crucial activity in the management of human resources.

Situation: PDR compliance up by 2.2% in month with some areas performing better than others but no CBU in the trust is reaching target. It is worth noting that Specialist Services have improved by over 10% in last two months. Planned Care have had a slight reduction this month as has Capital and Estates. Medicine and Emergency care have improved slightly. Corporate has a falling rate of late and direct intervention is planned again this month.

Issues: Poor definition of the purpose of appraisals at the Trust

Poor management appraisal skills

Poor documentation and process

Lack of consistent recording impacting on the quality of data

Actions: Monthly and weekly lists of outstanding PDRs provided to managers with HR admin team targeting managers of staff who have had no PDR recorded in last 3 years.

PDR compliance raised at CBU SLT and Department Governance meetings

PDR compliance raised at monthly budget meetings

How to guides provided to managers in respect of recording in ESR

Escalation to SOLT for more senior direct intervention

Task and finish group looking at simplifying paperwork and training for managers.

CBUs were tasked with achieving the target level of compliance by 30th September. As this has not been achieved, the meetings will be arranged at Director level to establish the reasons for PDRs remaining incomplete and to identify any additional measures to support improvement.

The HR Business Partners for each CBU continue to address the areas of low compliance with the Senior Leadership teams and support by continuing the actions outlined above.

Mitigations:

An improving picture for October

Hospitals remain busy and managers are reporting that this is impacting on their ability to complete PDRs

Exec intervention remains a necessity – HRD has been proactive

PDR document changes – final versions ad guides expected April 2023

Workforce

Sickness, Vacancy and Turnover

Sickness

Issues
• The in-month sickness rate has increased by 0.9% in October, although remains statistically as expected.
• The increase in sickness rates is directly attributable to non-Covid sickness, which has risen by 1.1% in October. In September there were an average of 156 non covid absences per day and this increased to an average of 194 per day in October.
• Covid absence remains fairly static, averaging around 30 per day in September although increasing marginally to around 32 in October.
• The rolling 12 month sickness rate continues to fail the assurance measure.
• Main reasons for absence during October were attributable to coughs / col / flu illnesses – definitely the start of the Winter seasonal rise. In addition, there were a significant number of gastro absences, averaging around 25 per week. Headaches / migraine absences and stress / anxiety / depression / other psychological absences have featured in the top reasons for absence in each moth in October.

Management Action
• Staff are being encouraged to take up both covid and flu vaccines at this time.
• The majority of absences are short term in nature and analysis of the data on a weekly basis does show that most absences commence and close within a week.

Vacancies

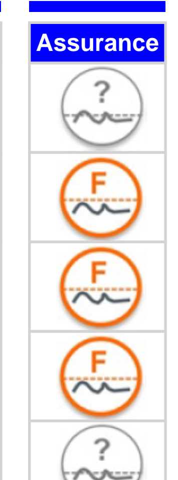
Issues
• The Trust overall vacancy rate continues to fail its assurance measure but has decreased by 1.5% in October to the lowest level since August 2021.
• Medical vacancies remain below target, and Nursing vacancy rates have hit the 9% target.
• The main area of concern within Nursing is the HCA vacancy rate.
• AHP/Therapy vacancy rates, have exceeded the target with a significant 2.3% reduction in October. This is the lowest level reported.

Management Action
• The vacancy rate is coming down steadily and the Trust has WTE of 230 under offer.
• The recruitment team are working hard to ensure that we progress all checks as quickly as possible to rapidly improve the staffing levels.
• The Trust has been running recruitment events to boost the number of HCAs. There are currently 61 HCA posts under offer and further recruitment activity is planned.
• There are a further 13 AHP posts under offer, and with the planned international recruitment this will improve further.
• Recruitment wise the Trust is still making a significant number of Medical post offers, and indeed attracting a good number of candidates. There are 31 posts currently under offer and 6 have started so far in November.
• The Trust is now working on some of the more difficult to fill vacancies and are holding regular meetings with the CBUs to ensure progress is being made.

Staff Turnover

Staff turnover is improving across all areas, and work is ongoing to improve the induction for some of our high turnover areas, in particular those who are new to care and coming into HCA roles. They are being providing with a 6 month induction programme and pastoral support to help their transition into the role.

Alert	Indicator	Latest					Previous			Year to Date		
		Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Sickness Rate	6%	6.8%	N/A	Oct 22		6%	5.9%	Sep 22	6%	6.8%	
	Sickness Rate (Rolling 12 Month)	6%	7.1%	N/A	Oct 22		6%	7.2%	Sep 22	6%	7.2%	
	Sickness Rate (not related to Covid 19) - Trust	5%	5.9%	N/A	Oct 22		5%	4.8%	Sep 22	5%	5.3%	
	Trust Vacancy Rate – All Staff	7.4%	9.1%	N/A	Oct 22		7.4%	10.6%	Sep 22	7.4%	10%	
	Staff Turnover	0.83%	1.2%	N/A	Oct 22		0.8%	1%	Sep 22	9%	6.8%	



Sickness Rate
12%
10%
8%
6%
4%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct
2020/21
2021/22
2022/23
Sickness Rate (Rolling 12 Month)
7.5%
7%
6.5%
6%
5.5%
5%
4.5%
Sickness Rate (not related to Covid 19) - Trust
6.5%
6%
5.5%
5%
4.5%
4%
Trust Vacancy Rate – All Staff
12%
11%
10%
9%
8%
7%
6%
Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct
20...
Staff Turnover
2.5%
2%
1.5%
1%
0.5%
0%

Finance

Finance

The Trust is reporting a £10.9m deficit at Month 7 in line with 2022/23 Plan.

Continued escalation and operational pressures are currently being offset by allocations for elective restoration and executive contingency.

Forecast Outturn - The Trust has assumed 100% ERF funding to M7 on the basis of full allocations paid to Trusts to-date. Calculation of ERF performance across the ICS is still pending confirmation.
ERF performance is highlighted as a risk to delivery of the Financial Plan in view of continued escalation and operational pressures experienced into 2022/23 – and subject to ICB decisions on the distribution of ERF in H2.
Key risks to delivery of Forecast Outturn currently include H2 ERF performance (£2.6m); 22/23 Pay Award (£0.5m full year); Inflation (c£1.2m full year); Energy prices (currently within plan); additional Bank Holiday (£60k).

CIP - The 2022/23 financial plan sets out a CIP requirement of 3.5% (£7.8m), plus a further £3.0m Stretch Target profiled into Q4. The Trust is reporting full delivery of CIP to M7.

Cash The cash balance at the end of October was £4.7m. A reduction of £0.7m from September's position. This was despite receiving £2m of Regional cash support in October.
Regional cash support of £9m has now been received (£2m in October and a further £7m on 1st November). This ensures that provided the Trust can achieve its planned £14.2m deficit, that there will be sufficient cash resources available to avoid any need for revenue support loans from DHSC.
There's currently a slight risk as £5.305m of capital (majority relating to backlog maintenance) although approved at a Regional level is still with the national team awaiting final approval.
The major change in the forecast is that the regional cash support (£9m) is shown as repayable in March 2023. To do this the Trust will require a DHSC revenue support loan. It may be possible to reduce the value of the loan requirement dependant on capital creditors at year-end but for planning purposes have shown that the Trust will need to borrow the full £9m from DHSC in March.

Capital – The Trust remains broadly on plan at the end of month 7 – spend of £8.6m against a plan of £8.8m. In month spending amounted to £2m with the significant elements Veolia boiler change £800k, CDC additional scopes £357k, EPR clinical noting £204k and fire safety projects £366k.
Executive Team have reallocated Ward IPC monies to the following priority schemes: Theatre recovery, maternity MDT rooms, 15a & b side rooms, Southport boiler and new external LED lights at both sites.
The forecast has been updated to reflect the latest known information and this indicates that the Trust will fully utilise the resources given to it.

	Latest				Forecast			Year to Date	
Indicator	Plan	Actual	Period		Plan	Actual		Plan	Actual
I&E surplus or deficit/total revenue	7.3%	7.3%	Oct 22		6.0%	6.0%		7.88%	7.85%
Capital Spend	£2,600K	£2,100K	Oct 22		£27,800K	£27,800K		£8,800K	£8,600K
Cash Balance	£5,300K	£4,700K	Oct 22						

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	QUALITY & SAFETY COMMITTEE (QSC)
MEETING DATE:	28 November 2022
LEAD:	Gill Brown

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Nil to alert at SOC

ADVISE

Updates on **Alerts** raised at previous meetings:

- Community Neurotherapy delays escalated to North Mersey Stroke Collaborative for further action.
- Fixed term paediatric consultant locum posts approved and out to advert while waiting for service to complete business case for longer term solution.
- Roles agreed between O&G consultants to ensure attendance at internal and external meetings inc. Maternity Champions Meeting.
- Review of dermatology pathways in place with focus on overdue and support from HBS. Position has deteriorated slightly.
- Legal support to SIU to manage delayed discharges.

November Alerts

Learning from Deaths (LfD) Annual Report and Quarter 2 (2022/23) update

- Progress presented by the Associate Medical Director for Patient Safety. To be presented at SOC.
- Positive progress from the Medical Examiners process.
- Structure Judgement Reviews (SJRs) – Capacity and timeliness to complete SJRs has been challenging. New process and expansion of review team agreed.
- Shared Learning, themes and review of processes noted.

Operational Performance

- ED: Adults & Paediatric performance: Pressures remain but performance compares well to peers.
- Challenges remain with patient discharges due to difficulties in complex packages of care and placement for complex patients.
- Cancer Improvement Plans - improved position noted.
- Long-wait patients on PTL – Improvement noted despite pressures.
- S&O de-escalated from Tier 2

CQC Improvement Plan

- Update noted regarding workstreams for improvements. Further assurance requested for next meeting

Maternity Quarterly Report

- The Committee received the report. This will be presented to SOC in December 2023.
- CNST – Partial compliance reported against safety actions 4 and 8 - actions ongoing to mitigate the gaps as a priority prior to submission in Feb 2023.
- New Associate Director of Midwifery and Nursing in post. Plan in place for Clinical Director

ASSURE

- MIAA Corporate Response to Ockenden Report received which offered substantial assurance regarding systems and processes in place to monitor recommendations and required actions.

- IPR reviewed.

- End of Life Annual Report 2021/22 was presented by Dr Finnegan, Consultant in Palliative Medicine. Updated EoL Strategy being launched this week with a focus on education, training and clear treatment plans, reflecting the Trust's Objectives for 2022-23.

- Patient Safety Update Report received.

- AAA reports received from:
  - Clinical Effectiveness Committee.
  - IPC Committee
  - Safeguarding Assurance Group.
  - Patient Experience & Community Engagement Group.
  - Quality Improvement Programme Board.

- SOCAAS quarterly update presented, reporting some improvements and providing further assurance. The assessment ratings are being revised with the aim of introducing a Diamond Accreditation.

New Risk identified at the meeting	• No new risks were identified at the meeting.
Review of the Risk Register NA	

Title of Meeting	QUALITY & SAFETY COMMITTEE	Date	07 December 2022
Agenda Item	SO225/22	FOI Exempt	NO
Report Title	MATERNITY SERVICES QUARTERLY UPDATE REPORT FOR BOARD		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Dawn Meredith, Associate Director of Midwifery/Nursing		
Action Required	☐ To Approve ☐ To Assure	☐ To Note ✓ To Receive	

Purpose

To receive the Maternity Services Quarterly Update Report Reporting November 2022 (reporting for July – October 2022 inclusive). This report will give update on:

- Ockenden.
- Maternity Self-Assessment Tool.
- The East Kent Report.
- CNST.
- Midwifery Continuity of Carer.
- Quality & Safety.
- Perinatal Mortality Quarterly Report.
- Maternity and Neonatal Improvements.
- Workforce.

Executive Summary

Quality & Safety (ASSURE)
In May 2022, in response to a serious incident in Maternity, a S&O Quality Review was in place to support the organisation. This has now been discontinued. The action plan from the incident and Insight visit will be fully complete in December 2022.

Maternity Unit Closure (ASSURE)
There has been one closure/diverts within this reporting period.

Safety Champions (ASSURE)
The Safety Champions continue to meet monthly and conduct a safety walkabout weekly. Safety concerns are escalated and actioned appropriately. Medical representation has been escalated to the Medical Director and has now been resolved.

Ockenden (ADVISE)
The Ockenden action plan has been broadened to encompass the recommendations from both the initial and final Ockenden Report. Progress is on track and is being monitored.

East Kent "Reading the signals" Report (ADVISE)
The investigation focused on cases which occurred from 2009-2020.

Due to the timing in relation to the Ockenden Report, the similarities and extent of the actions from that report. This report focused recommendations on four main areas for action at National, Regional and Local level. These were:

- Key Action Area 1: Monitoring safe performance – finding signals among noise
  (Becoming better at identifying poorly performing units)

- Key Action Area 2: Standards of clinical behaviour – technical care is not enough
  (Giving care with compassion and kindness)
- Key Action Area 3: Flawed teamworking – pulling in different directions
  (Teamworking with a common purpose)
- Key Action Area 4: Organisational behaviour – looking good while doing badly
  (Responding to challenge with honesty)

NHS England leadership has responded to the report setting out that they will be working with the Department of Health and Social Care and partner organisations to review the recommendations and implications for maternity and neonatal services and the wider NHS.

Following this in 2023, a single delivery plan for maternity and neonatal care will be published which will bring together the actions required following this report, the Ockenden Report, and the NHS Long-Term Plan and Maternity Transformation Programme deliverables.

CNST MIS Year 4 (ADVISE)
On the 06h May 2022, the CNST scheme was relaunched with extension for compliance now being the 05 January 2023. In light of the Ockenden Report some of the safety actions have been reviewed and new requirements added. Alerts noted on Safety actions 4 (Workforce) and 8 (Multidisciplinary Training), the remaining 8 safety actions are compliant.

Continuity of Carer (ADVISE)
Targets for Midwifery Continuity of Carer have been removed and local services are to develop plans that work for them. Focus will be on retention and growth of the workforce with plans made specific to the needs of local populations and current staffing.

Therefore, this Trust has continued to suspend further rollout at this time. There is a plan for launching two enhanced teams for vulnerable women once the situation has improved.

Maternity Dashboards (ADVISE)
Performance is monitored through our local and regional maternity dashboards. Regionwide dashboards are discussed at forums such as the Regional Clinical Expert Group and Safety Special Interest Group quarterly**.**

Where Maternity Services are outliers with their peers, this is challenged by the Local Maternity & Neonatal System

Current areas where the Trust is viewed as an outlier are:
- Induction of labour for the indication reduced fetal movements only.
- Emergency caesarean section at full dilatation.

The guidelines and patient information leaflets relating to these areas have been reviewed to compliance with best practice guidance.

The Trust has been noted as a positive outlier for having the lowest postpartum haemorrhage (PPH) rate in the region. Following a request, the Trust PPH guideline and proformas have been shared across the region.

Perinatal Mortality Quarterly Report (ADVISE)
The quarterly report is attached in full as an appendix to the Maternity Board report. The report is

based on the Cheshire and Mersey Local Maternity System standardised regional reporting template. Within this quarter there have been one late fetal loss at 22 weeks gestation and two antepartum stillbirths at 28 and 33 weeks gestation. All cases are being reviewed by the PMRT process. **Serious Incidents (ALERT)** STEIS reporting has been following the Insight visit in June 2022. HSIB cases will also be reported going forward in line with other providers including STHK.	
Recommendations	
The Strategy and Operations Committee is asked to receive the report and confirm that it is assured that Maternity and Neonatal services are: • Making progress against the Ockenden actions. • Managing staffing levels safely. • Progressing against requirements for CNST. • Facilitating appropriate oversight of Perinatal mortality cases within the Trust.	
Previously Considered By:	
☐ **Strategy and Operations Committee** ☐ **Finance, Performance & Investment Committee** ☐ **Remuneration & Nominations Committee** ☐ **Charitable Funds Committee**	☐ **Executive Committee** ✓ **Quality & Safety Committee** ☐ **Workforce Committee** ☐ **Audit Committee**
Strategic Objectives	
✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	
☐ **SO2** Deliver services that meet NHS constitutional and regulatory standards	
☐ **SO3** Efficiently and productively provide care within agreed financial limits	
☐ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	
☐ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Janet Calland, Matron Maternity Services	Lynne Barnes, Director of Nursing, Midwifery and Therapies

Maternity Services

Trust Board Report

November 2022

(Maternity Services Quarterly Update Report Reporting November 2022 (Reporting for July – October 2022 inc. July included due to previous report being taken to Board a month early)

Prepared by Janet Calland, Matron Maternity Services
November 2022

Title:	Maternity Services Quarterly Update July – October 2022 inclusive (July included in report as previous report went to Board in July as no Board in August)
Responsible Director:	Lynne Barnes, Director of Nursing & Midwifery
Presented by:	Dawn Meredith, Associate Director of Midwifery/Nursing

Introduction

In line with Maternity Services agenda, this report is intended to provide the Trust Quality & Safety Committee and Strategy Operations Committee with an overview and update on Maternity Services in line with the Annual Cycle of Business.

This report will give an update on:

- Ockenden
- Maternity Self-Assessment Tool
- The East Kent Report
- CNST
- Midwifery Continuity of Carer
- Quality & Safety
- Workforce

Despite competing priorities and demands within the Trust such as A&E targets and pressures, impact and ongoing issues of COVID and other key priorities, Maternity Services is high on the agenda and KPI's are presented monthly at the Strategy and Operations Committee and the Maternity report is received quarterly

1. Ockenden Report

Following receipt of the Final Ockenden report in March 2022, the Maternity team have reviewed the report and provided an overview and presentation at the Trust Quality & Safety Committee and Strategy Operations Committee in April 2022. Benchmarking against the 92 actions using the Cheshire & Mersey Local Maternity & Neonatal Network (LMNS) standardised self-assessment template has been completed.

A peer review with St Helens and Knowsley (StHK) of the assessment template has also taken place and looking to opportunities on working together and to share practice has been undertaken.

Direction regarding key priorities is awaited from the Local Maternity and Neonatal System. This is expected to happen in the near future following the recent release of the East Kent report.

Priorities from the Ockenden 2 report have been workforce, patient safety and bereavement support. This is progressing with new roles and an increase provision of services. The Trust has been successful in gaining Ockenden funding to extend the additional practice development midwife post focused on preceptorship and retention of newly qualified midwives by a further year (£50,000). Improve the provision of Bereavement training (£4,470), increase the number of PAs to support and enhance local obstetric leadership capacity (£4,750) and to continue the employment of a dedicated resource for development and retention of support staff working in maternity services (28,500).

The progress of the Ockenden action plan is overseen by the CBU Triumvirate and Deputy Director of Quality, Risk and Assurance at the fortnightly Maternity Improvement plan meeting.

2. Maternity Self-Assessment Tool

The Maternity Self-Assessment Tool (NHS England, version 5 Feb 2020) has been designed to support Maternity Services to benchmark their service against best practice standards, guidance and regulatory requirements. The tool reflects good safety principles, CQC and Ockenden findings and is recommended by the Chief Midwifery Officer as a means to keeping the Trust Board and Commissioners aware of the current position of their Maternity Services.

A self-assessment benchmark exercise has been completed by the previous Associate Director of Midwifery, ongoing development and actions will be led by the new Associate Director of Midwifery and Nursing. Following a check and challenge exercise with peers from StHK, leads and completion dates have been assigned and included in the overarching Maternity Improvement Plan supported by the PMO and with a plan to update the Board on progress via the quarterly Maternity Report.

3. Maternity and neonatal services in East Kent: 'Reading the signals' report

Report of the independent investigation commissioned by Nadine Dorries and led by Bill Kirkup which took place at East Kent Hospitals University NHS Foundation Trust. The investigation focused on failings in maternity and neonatal care which occurred during the period since 2009, when the Trust came into being, until 2020. 202 cases were examined with the investigation finding that the outcome could have been different on 48% of cases (n = 97).

Main Initial Findings

- Pattern of suboptimal care leading to significant harm
- Failure to listen to the families involved and acting in ways which made the experience of families unacceptably and distressingly poor.
- The Trust wrongfully took comfort from the fact that the great majority of births resulted in no damage to mother or baby
- A failure to learn in the aftermath of obvious safety incidents
- Gross failures in teamworking across the Trust's maternity and neonatal services which hindered the ability to recognise developing problems.
- Divisions amongst the midwives which at times included bullying to the extent it affected the safety of the service
- The dysfunctional relationships between staff were visible to the families they cared for.
- A deflection of responsibility when something had gone wrong.
- Lack of kindness and compassion
- Safety investigations conducted narrowly and defensively
- Failure to learn from incidents.
- Failure in the Trust's response, including at Board level
- In specific cases the Trust found it easier to attribute the cases to clinical error rather than system failings.
- The Trust was ineffective in controlling unacceptable behaviour of some consultants.
- Staff in managerial roles who identifies and challenged poor behaviour were replaced.
- Regulatory bodies failed to identify the shortcomings early enough to ensure real improvement.
- Missed opportunities by the Trust to recognise and make improvements.

Learning From Previous National Reports

There were many similarities to the findings of previous reports on maternity care, therefore it was recognised that recommendations from this report would inevitably repeat previous recommendations. Consequently, this report did not seek to identify numerous recommendations for trusts, and it was acknowledged that NHS trusts already have many recommendations and ongoing actions plans resulting from reports such as the Ockenden reports and Morecambe Bay Kirkup report.

Recommendations
The report identified four broad areas for action at National, Regional and Local level based on the findings, but which, had wider application.

- **Key Action Area 1: Monitoring safe performance – finding signals among noise**
  Recommendation 1 –

    - The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

- **Key Action Area 2: Standards of clinical behaviour – technical care is not enough**
  Recommendation 2 –

    - Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.
    - Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.

- **Key Action Area 3: Flawed teamworking – pulling in different directions**
  Recommendation 3 –

    - Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.
    - Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development.

- **Key Action Area 4: Organisational behaviour – looking good while doing badly**
  Recommendation 4 –

    - The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.
    - Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.
    - NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership

A further recommendation for East Kent was that the Trust accept the reality of the findings and embark on a restorative process to address the problems identified in partnership with families, publicly and with external input.

NHS England leadership has responded to the report setting out that they will be working with the Department of Health and Social Care and partner organisations to review the recommendations and implications for maternity and neonatal services and the wider NHS.

Following this in 2023 a single delivery plan for maternity and neonatal care will be published which will bring together the actions required following this report, the Ockenden report, and the NHS Long-Term Plan and Maternity Transformation Programme deliverables.

4. Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS)

The Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to CNST by rewarding Trusts that meet all ten safety actions, designed to improve safety and the delivery of best practice in both maternity and neonatal care, supporting the Safer Maternity Care Ambition

The MIS was launched 2017/2018 and is now in its fourth year. Published in August 2021 Year 4 Safety Actions remained the same albeit that there were a number of amendments made to further embed and strengthen previous safety actions.

In December 2021, in recognition of pressures in Maternity Services and the NHS, there was a temporary pause in the reporting procedure.

On the 6th May 2022, the CNST scheme was relaunched and in light of the Ockenden report some of the safety actions have been further reviewed and new requirements added.

The extension for Board Declaration of Compliance has also been extended to February 2023. Prior to submission there is a requirement that the Head of Midwifery and Clinical Director to provide a joint presentation to Trust Board detailing compliance of the 10 safety actions prior to the Board declaration form to NHS Resolution being submitted.

The 10 Maternity Safety actions are summarised below:

Safety action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Safety action 2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
Safety action 3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?
Safety action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?
Safety action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?
Safety action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version 2?

Safety action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Safety action 8	Can you evidence that a local training plan to ensure that all six core modules of the core competency framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and Newborn life support, starting from the launch of MIS year 4?
Safety action 9	Can you demonstrate that the trust safety champions (obstetrician, midwife and neonatologist) are meeting bimonthly with Board level champions to escalate locally identified issues
Safety action 10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification scheme from the 1st April 2021 to 5th December 2022?

The Trust is now fully compliant with 8 out of the 10 safety actions. A paper on CNST compliance is being presented at Quality and Safety Committee, below is a summary of the 2 safety actions which are RAG rated 'Amber' for this reporting period. These are:

Alerts

<table>
<tr><td>Safety Action 4
Amber</td><td>Can you demonstrate an effective system of clinical workforce planning to the required standard? Neonatal medical workforce</td></tr>
<tr><td colspan="2">Neonatal medical workforce
• The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. - an immediately available resident Tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located paediatrics unit (e.g., between 0900 – 22.00hrs 7 days per week)

The Current situation is:
• A review of the neonatal junior medical staffing workforce has been undertaken by Paediatrics with oversight of the ADO.A business case is being developed with proposals for Medical/Advance Nurse Practitioner roles to support the Neonatal staffing model. The Business case is expected to be completed by the end of November 2022 and will demonstrate the Trust's workforce planning process.</td></tr>
<tr><td>Safety Action 8
Amber</td><td>Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years starting from the launch of MIS year 4
In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?</td></tr>
<tr><td colspan="2">The Trust is currently not compliant with 3 out of the 4 elements of safety action 8 relating to the multi-professional training of staff for</td></tr>
</table>

- Maternity emergencies
- Antenatal and intrapartum fetal surveillance
- Newborn life support (NLS) (or in house neonatal life support training dependant on role)
  The requirement is to be 90% compliant in all areas over 12 consecutive months by 5th January 2023. The Maternity Improvement Group is overseeing Women and Children's CBU planning trajectories with action owners and overseeing compliance with these trajectories.

It is proposed that Trust Board is updated on progress accordingly at the quarterly Maternity reporting to Board.

5. Continuity of Carer

Midwifery Continuity of Carer (MCoC) has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births' and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for MCoC to be the default model of care for maternity services and be available to all pregnant women in England.

NHS England issued a statement on 21st September 2022 which set out essential and immediate changes to the national maternity programme in the light of the continued workforce challenges that maternity services face. There will no longer be a target date for services to deliver Midwifery Continuity of Carer (MCoC) and local services will instead be supported to develop local plans that work for them. There is no longer a national target for MCoC. Local midwifery and obstetric leaders will focus on retention and growth of the workforce and develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths.

Preparation for the roll out of MCoC has been temporarily suspended. Maternity Care at S&O currently has one team (Sapphire Team) providing some continuity, the plan will be to launch two enhanced teams based on the Sapphire Team model for women and babies of Black, Asian and mixed ethnicity and those living in the most deprived neighbourhoods.

5. Quality and Safety

4.1 Perinatal Quality Surveillance Model (PQSM)

A national recommendation from the Ockenden Report was the proposed introduction of a Perinatal Quality Surveillance Model (PQSM).

The purpose of the PQSM nationally is to implement five principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families. The principles integrate perinatal clinical quality into developing integrated care system (ICS) structures and provide clear lines for responsibility and accountability for addressing quality concerns at each level of the system.

The five principles are:

Principle 1 – Strengthening trust-level oversight for quality
Principle 2 – Strengthening Local Maternity System and ICS role in quality oversight
Principle 3 – Regional oversight for perinatal clinical quality
Principle 4 – National oversight for perinatal clinical quality
Principle 5 – Identifying concerns, taking proportionate action, and triggering escalation

The regional NHSE/I team and the LMNS reviewed its governance framework and reporting processes. A monthly Quality and Safety Surveillance Group has now been developed and will report to the LMNS Assurance Board.

In line with the Perinatal Quality Surveillance Model (NHS 2021) to use a suite of metrics pulling together staff survey results, user feedback, and safety and quality metrics the Regional Safety Special Interest Group are reviewing a template produced by the Wirral with a view to adopt regionwide.

4.2 Clinical Outcomes/ Dashboard

Maternity Dashboards
Performance is monitored through our local (IPR) and regional maternity dashboards. Region wide dashboards are discussed at forums such as the Regional Clinical Expert Group and Safety Special Interest Group quarterly**.**

Where Maternity Services are outliers with their peers, this is challenged by the Local Maternity & Neonatal System.

The LMNS are streamlining procedures for reviewing spikes or outliers on the Cheshire & Mersey regional dashboard to ensure Trusts are responsive to deadlines and there is a consistent approach to what is reported

Current areas where the Trust is viewed as an outlier are

- Induction of labour for the indication reduced fetal movements only
- Emergency caesarean section at full dilatation

The guidelines and patient information leaflets relating to these areas have been reviewed to compliance with best practice guidance.

The Trust has been noted as a positive outlier for having the lowest postpartum haemorrhage (PPH) rate in the region. Following a request, the Trust PPH guideline and proformas have been shared across the region.

4.3 Perinatal Mortality

Perinatal mortality includes stillbirths and neonatal deaths in the first week of life. MBRACE-UK is notified of all eligible perinatal deaths and are reviewed using the national Perinatal Mortality Review Tool (PMRT)
All stillbirths and deaths are reviewed at the weekly patient safety meetings and reported to SIRG via a rapid review report.

There was one late fetal loss and 2 stillbirths in this reporting period

September 2022	33 weeks gestation	Patient booked at Royal Edinburgh Hospital attended ODGH with reduced fetal movements whilst visiting family in area. Intrauterine death confirmed on admission	Currently being reviewed via PMRT process

October 2022	22 weeks gestation	Abnormality noted on private scan, referred to Fetal Medicine at Liverpool Womens, fetal demise confirmed on attendance. Delivered at ODGH	Currently being reviewed via PMRT process
October 2022	28 weeks gestation	Contacted Triage with history of no fetal movements for 24 hours. On attendance Intrauterine death confirmed.	Currently being reviewed via PMRT process

In January 2022, Cheshire & Mersey Local Maternity System agreed a standardised regional reporting template for reporting stillbirths to Board quarterly to ensure a standardised approach. This template has been utilised for reporting perinatal mortality for this reporting period and the full report is attached as appendix 1.

4.4 Serious Incidents

Never Events

There have been no never events for this reporting period

STEIS Reportable Incidents

Serious incidents (SIs) continue to be reported monthly on the regional dashboard by all maternity providers in Cheshire & Mersey and in Lancashire and South Cumbria. SIs are also reported to the LMNS by the Trust with the Quality and Safety Surveillance Group having further oversight of all SI's across the region. Following the Insight visit in June 2022, the Trust has reviewed maternity and neonatal STEIS reporting as it was suggested by regional colleagues that these were under reported. All babies that a therapeutically cooled will be reported via STEIS as well as HSIB.

Maternity Theatre

In response to lessons learnt from the maternal death, the elective theatre pathway has been reviewed and all elective caesarean sections are now taking place in the main theatre complex. The Standard Operating Procedure for the Process for the Management of Elective Caesarean Sections has been reviewed and compliance with the procedure is audited for assurances.

All actions identified from the incident and the insight visits will be complete by Dec 2022. The Executive Director of Nursing, Midwifery and Therapists and Medical Director will be providing a full update at the LMNS Quality Surveillance Group in January 2022.

Mutual aid

As a 'lessons learnt' from the serious incident regarding the maternal death, one of the actions from the Regional Quality Review Meeting was to agree a process for seeking mutual aid. This was to support risk assessing women and making decisions that would include looking outside of our own unit for support.

In response to this daily 'sitreps' were implemented between S&O and StHK maternity teams. These continued up until 23rd August when they were stood down as mutual aid had not been required through this process. The weekly Gold Command 'sitrep' calls with Cheshire & Mersey region continue with the option for any maternity unit to call additional meetings as required.

Any need for mutual aid will be recorded on DATIX. The Standard Operating Procedures for 'Process for the Management of Elective Caesarean Sections' (MSOP 97) and 'Maternity Escalation' (MSOP 53) have been updated to include this process.

4.5 Health Care Safety Investigation Branch (HSIB)

HSIB undertake independent investigations into incidents within maternity services which fall under defined criteria that include maternal deaths, stillbirths and babies that require cooling.

The Trust is provided with a monthly update of cases by HSIB to support effective communication and to support the progression of the investigation. HSIB case reviews are shared with the Trust for accuracy prior to being finalised and shared with the woman and her family.

Cases to date (as of end of November 2022)	
Total referrals	15
Referrals / cases rejected	7 (2003-1866, MI-003565, MI-008637, MI-008655, MI-03125, MI-014249, MI-015036)
Total investigations to date	8
Total investigations completed	4
Current active cases	2
Exception reporting	0

Within the current reporting period there has been 4 referrals with 3 rejected by HSIB and 1 ongoing.

All HSIB cases are reported as STEIS to ensure Executive oversight and will now be in line with StHK.

4.6 Saving Babies Lives Care Bundle (Version 2)

Saving Babies Lives Care Bundle (version 2) has been produced to build on the recommendations from version one and to further address perinatal mortality. This bundle includes 5 elements which focus on the recognition and detection of risks associated with perinatal mortality and morbidity, reporting and referral processes, training of staff and auditing of practice and outcomes. The five elements being:

- Reducing Smoking in Pregnancy
- Risk Assessment and Surveillance of Fetal Growth Restriction:
- Raising Awareness of Reduced Fetal movements
- Effective monitoring in labour
- Preventing Pre-term birth

We have demonstrated full compliance with Saving Babies Lives Care Bundle 2. The leads are continuing to embed the process by monitoring compliance via audits.

CNST Safety Action 6 refers to compliance with all five elements of the Saving Babies Lives version 2. Over the past quarter training compliance for fetal monitoring has dipped to 84% (requirement >90%), a plan is now in progress to exceed the target by the end of the current assessment period in December.

4.7 Care Quality Commission CQC Review

Our current ratings are:

Safe	Effective	Caring	Responsive	Well Led	Overall
Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

The first SOCAAS inspection and joint mock CQC inspection took place on the 5th July 2022 including external representation. Findings were women said they had received good care and staff culture was good.

Some improvements were required on medicines management and information governance which the Maternity team are working supported by the Corporate Quality Team on improvements required.

The SOCAAS team have commenced individual area inspections on Maternity with the first inspection for Maternity Ward completed with the rating of Bronze. Staff across inpatient areas are focused on improving their position ready for the next inspection.

4.8 Safety Champion Report

The aim of Safety Champions is to support seamless communication from ‘floor to board’ and to ensure Board focus on Maternity issues and improving safety and outcomes. Monthly meetings and weekly Safety Champions walkabouts are in place to speak with staff and women and their families.

Safety walkabouts in the reporting period have included safe sleeping, neonatal life support training, ambulance response times for home birth and BSOTTS implementation.

A Triple A report of the outcomes is submitted to the Clinical Effectiveness Committee. Concerns have been raised regarding lack of medical attendance at the Committee.

The absence of maternity medical and the turnover of midwifery leadership has been raised by the LMNS with Executive. A comprehensive response with assurances has been provided. The new Associate Director of Midwifery and Nursing is now in post.

5.0 Workforce: Neonatal & Maternity Staffing

Midwifery

Alongside the Associate Director of Midwifery and Nursing, a new Consultant Midwife is due to start with the Trust on 1st January.

Maternity Services have seen significant changes and development over the last decade driven by national safety ambitions and the vision to deliver better quality of care to women and the families. More recently there have been national inquiries and scrutiny of maternity services such as Kirkup (2015) and Ockenden (2022) central to these is safe staffing levels.

NICE guidance *‘Safe Midwifery Staffing for Maternity Settings’* (2015) sets out recommendations for systematically reviewing midwifery establishment at least every 6 months which also meets CNST requirements for Safety Action 5. It also recommends using a nationally recognised midwifery staffing tool and red flag indicators.

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge is informed of the incident. The midwife in charge will then determine whether midwifery staffing is the cause, and what action is required.
The following are the recommended red flags:

- Delayed or cancelled time critical activity.
- Missed or delayed care (delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (e.g. diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.

- Delayed recognition of and action on abnormal vital signs (e.g., sepsis or urine output). Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

S&O Maternity Services 'Standard Operating Procedure for Maternity Services Staffing' reflects this recommended guidance. This data is collected via the DATIX incident reporting system. Any incidents are cross referenced against staffing levels and any incidents regarding staffing levels discussed at weekly patient safety meeting.

For this reporting period the red flag data demonstrated:

- *Missed or delayed care (delay of 60 minutes or more in washing and suturing*) (**1**)
- *Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour* (**5**)

One to one care is when a woman is cared for in labour by a Midwife who is looking just after her. Maternity services aim to achieve 100%. All 6 incidents related to cases where the midwife looking after the woman in labour was also required to care for a woman who was having care on Delivery Suite but was not in labour. No harm has been noted and the women involved are debriefed post-natally by the Quality and Audit midwife has contacted the women involved to see whether the lack of one to one care had a negative impact on their experience. Below are a sample of their comments:

"I've had 3 babies here and this was best experience yet."

"Felt I did have 1 to 1 care.".

"The Midwife who looked after me was unreal, couldn't have done anymore for me, she was so, so good and supportive of both me and my partner."

"Feel like I got 1 to 1 care, don't know why that has been ticked, she was always with me.".

"My care in labour was perfect."

Whilst these responses were assuring, the Quality and Audit Midwife has a plan in place to continue with this form of monitoring.

Maternity Unit Closure

During this reporting period there has been one Maternity Unit closures or diverts requested. The regional process was followed and StHK supported the divert. All women received an apology. This has been STEIS reported and presented to the LMNS by the Director of Nursing, Midwifery and Therapies at the C&M SI Maternity Panel.

Staffing Numbers & Outcomes

Staffing is discussed as part of the Delivery Suite Shift Coordinator hand over. This takes place at least twice a day, and ward dependency, acuity and overall staffing ratios/ gaps are discussed. The following actions are agreed to support a reduction of risk:

1. Moving from outpatient areas
2. Moving staff from one ward to another
3. Moving from or to Community midwifery
4. Sanctioning additional staff if required due to a patient safety risk
5. Consider requesting mutual aid from other maternity units or divert/closure

The *Maternity Standard Operating Procedure for Staffing Levels* and *The Maternity Standard Operating Procedure for Escalation* is in place to support the decision making process.

Supernumerary Status of the Delivery Suite Shift Coordinator

The role of the Delivery Suite Shift Coordinator is a key role on the Delivery Suite and therefore the Shift Coordinator is present for 24 hour period 7 days a week. The Delivery Suite Coordinator is supernumerary to enable them to fulfil their role, which is pivotal in providing effective leadership, clinical expertise, facilitating communication between professionals and overseeing appropriate use of resources. Where Supernumerary status cannot be achieved, this is escalated to the Matron and recorded on the Safety Huddle proforma.

The Clinical Leads for each area work in a semi supervisory capacity. However, there are times due to staffing challenges or peak in activity when it is not always achieved as patient care will always take president over management activities.

Maternity Bleep Holder

The Maternity Unit provides a maternity bleep holder 24 hrs per day. From 07:30-20:00 this is a separate role held on a rota basis and may be a Matron, Clinical Lead Midwife or Delivery Suite Shift Coordinator. From 19:30-07:30 the bleep is held by the Delivery Suite Shift Coordinator

The maternity bleep holder is a key role in supporting the daily operational running of the maternity services based at Ormskirk site. The role also provides senior clinical guidance and oversight to the maternity teams based both within the hospital and community settings.

Birthrate Plus

Birthrate Plus is a framework for workforce planning based on an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG. The most recent Birthrate Plus assessment was in November 2021, based on 3 month's birth data and bookings for the following 6 months to predict the birth rate for this period, the final report being received in January 2022.

Findings

There are five clinical indicators which are weighted to reflect the degree of need of mother and baby throughout the antenatal, intrapartum and postnatal period both in hospital and community setting. These are as follows:

Table 1

Category	**Need**	**S&O Maternity Services Case Mix**	
		2019	**2021**
1	Normal labour and outcome. These women are usually midwifery led care	4.1%	4.1%
2	This is also a normal outcome very similar to Category I, but may include perineal tear, longer labour or IV Infusion	14.1%	14.1%
3	Moderate risk/need such as Induction of Labour, instrumental deliveries, and continuous fetal monitoring.	30.8%	23.6%
4	More complicated cases affecting mother and/or baby will be in this category, such as elective	23.2%	27.5%

	caesarean section; pre-term births; low Apgar and birth weight and women having epidural pain relief		
5	This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy	27.8%	30.7%

1) It is evident that there has been a shift in women needing more support and intervention with category 3 shifting into categories 4 and 5
2) The calculated total workforce requirement for Southport & Ormskirk NHS Trust is 115.14wte the comparative current funded establishment is 116.19wte which means that there is a variance of -1.05wte registered midwives

The case mix is unique to each service The overall ratio for Southport & Ormskirk NHS Trust of 22.6 births to 1WTE.The overall ratio for number of births to number of midwives for Maternity Services are not directly comparable to other Maternity providers because of the local factors involved.

The recommended establishment is based on a 'traditional' way of working and does not incorporate Continuity of Carer caseload teams although this has been debated at regional level.

Ockenden (2022) has identified the requirement for professional bodies and NHSE to review the feasibility and accuracy of the Birthrate Plus tool and associated methodology and that minimum staffing levels must include a locally calculated uplift representative of the last three years data for all absences including sickness, mandatory training annual leave and maternity leave. This piece of work will commence in the near future and paper presented at Trust Board accordingly

Intrapartum Acuity

Maternity Services has implemented the Birthrate Intrapartum Acuity tool. Data is inputted into the system every 4 hours by the Delivery Suite Coordinator on the Delivery Suite and Shift lead on the Maternity Ward which measures the acuity and number Midwives on shift to determine the 'acuity score'. This acuity score is defined by Birthrate as the 'volume of need for midwifery care at any one time based on the number of women and degree of dependency'. Staff have now been trained in its use and the plan is now to access data monthly. This will help review of staffing to ensure correct numbers of Midwives are available to work in the clinical areas which match the acuity levels and to ensure the Maternity Service Standard Operating Procedure (Number 52) for Staffing Levels and Maternity Services Standard Operating Procedure (Number 53) for Maternity Escalation adequately supports the movement of staff around the unit during periods of high acuity.

In September a linked version of the acuity tool was rolled out across Cheshire and Mersey with the ability for regional oversight of the acuity in each Unit. In addition, the daily sit rep to the region has been enhanced to facilitate electronic submission. These tools together with a weekly Gold Command meeting facilitate Units across the region being able to identify early pressure points in the system and arrange mutual aid when required.

Maternity Staff engagement

Following on from the staff engagement away days earlier in the year the next phase is to build on this and encourage involvement across the maternity service. Therefore approximately 25 maternity staff will be attending a series of workshops in January/ February which will support them in gaining the necessary skills

to lead and support staff to develop a positive and progressive learning culture. These workshops will be facilitated by Tallant Jones.

A leadership development program for the Maternity ‘Quad’ has been commissioned by NHSEI for all units. S&O will commence in the new year.

Consultant Obstetricians

The Consultant Obstetric & Gynaecology team are now fully established with 12 Consultants now in post. Whilst the Clinical Director post remains vacant, Clinical Director support for the Consultants has been made available from Blackpool Teaching Hospital NHS Foundation Trust. The Medical Director is confident that a Clinical Director for O&G will be in place by the new year.

Neonatal Nursing Workforce

Neonatal staffing is aligned to BAPM standards and monitored by the Regional Neonatal Operational Delivery Network. The 4WTE band 6 posts funded by the Network are now recruited to and in post. The team are consequently able to roster a supernumerary shift coordinator on Neonatal across all shifts.

Medical rosters have been reviewed and a business case has been developed to offer compliance for CNST safety standards.

The Associate Director for Midwifery & Nursing and the Matron for Paediatrics continues to work collaboratively with the Neonatal Network.

Neonatal Medical Workforce

As referenced in Section 3 (CNST) Tier 2 doctor rota cover is not compliant with CNST requirements. A business plan has been developed which if supported will ensure the Neonatal Medical Workforce is compliant.

Next Steps/Priorities

The following are priorities for the next 3 months:

1. Continue to embed improvement plan for Ockenden 1
2. Work towards actions/recommendations of Ockenden and Kirkup final reports
3. Work towards completion of CNST Year 4 Safety actions
4. Continue to work collaboratively with LMS and MVP’s
5. Establish new leadership team
6. Continue to work collaboratively with StHK
7. Await direction from regional team regarding key priorities

Appendices:

Appendix 1

Cheshire and Mersey Maternity Quarterly Perinatal Board Report
Southport & Ormskirk Hospital NHS Trust

Appendix 1

Cheshire and Mersey Maternity Quarterly Perinatal Board Report

Southport & Ormskirk Hospital NHS Trust

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PROVIDER:	SOUTHPORT & ORMSKIRK HOSPITAL NHS TRUST
COMPLETED BY:	**CATHERINE BOYLE RISK & GOVERNANCE MIDWIFE**
DATE COMPLETED:	**08/11/2022**

1. BACKGROUND and INTRODUCTION

The National Perinatal Mortality Reporting Tool has been available for use since March 2018 via the Mothers and Babies: Reducing Risks through Audits and Confidential Enquiry across the UK (MBRRACE-UK) online portal to which the Trust is fully participating in.

The aim is to ensure systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care. This will involve a grading of the care provided.

There is active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process and the production of a which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented.

In addition there is a structured process of review, learning, reporting and actions to improve future care.

The PMRT has been designed to support the review of the care of the following babies:

- All late fetal losses 22+0 to 23+6
- All antepartum and intrapartum stillbirths
- All neonatal deaths from birth at 22+0 to 28 days after birth
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 days following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die

The PMRT is not designed to support the review of the following perinatal deaths:

- Termination of pregnancy at any gestation (Appendix 1)
- Babies who die in the community 28 days after birth or later who have not received neonatal care
- Babies with brain injury who survive

The Trust / Health Board where the baby died is responsible for leading the review but all units involved in the care should be part of the review group to ensure that all aspects of the care are considered.

2. EXECUTIVE SUMMARY: Key findings section at the start of report to include

This report details the information in relation to the Perinatal Mortality for Quarters 1 and 2 for 2022-2023

a. *Quarter 1 & Quarter 2 stillbirth rate (including termination of pregnancy)*

During quarter 1 the stillbirth rate was 3.41 per 1000

During quarter 2 the stillbirth rate was 1.66 per 1000

b. *Quarter 1 & Quarter 2 neonatal mortality rate is 0 /1000*

There were no neonatal deaths at ODGH during this timeframe and therefore the neonatal mortality was 0 for quarters 1 & 2.

c. *Progress on PMRT reports & action plans*

Update on reviews

Update on progress with reports from 2021/2022

During Quarter 3 there were 3 reviews. All the PMRT meetings have taken place and reports completed.

During Quarter 4 there was one review and the report has been completed.

PMRT cases from quarters 1 & 2

Date of Incident	Type of Incident	A/N Care Provider	Date Reported to MBRRACE	Date PMRT commenced	Date Report Published	Date Parent's Sent
05/04/22	Intrapartum stillbirth	Southport & Ormskirk	06/04/22	Trust rapid review 08/04/22 PMRT meeting date 07/09/22	In progress	
18/04/22	Antenatal Intrauterine death	Southport & Ormskirk	21/04/22	29/04/22	With panel	
10/09/22	Antenatal Intrauterine death	Edinburgh Royal Infirmary	16/09/22	06/10/22	In progress	

At the time of reporting all cases from quarters 1 & 2 have been reviewed.

During quarter 1 there were 2 cases. One case has been reviewed by an external panel commissioned by the Trust and via the PMRT process. The report is being drafted.

The second case has been reviewed via the PMRT process and the report is with the panel for final approval.

3. DASHBOARD AND BENCHMARKING

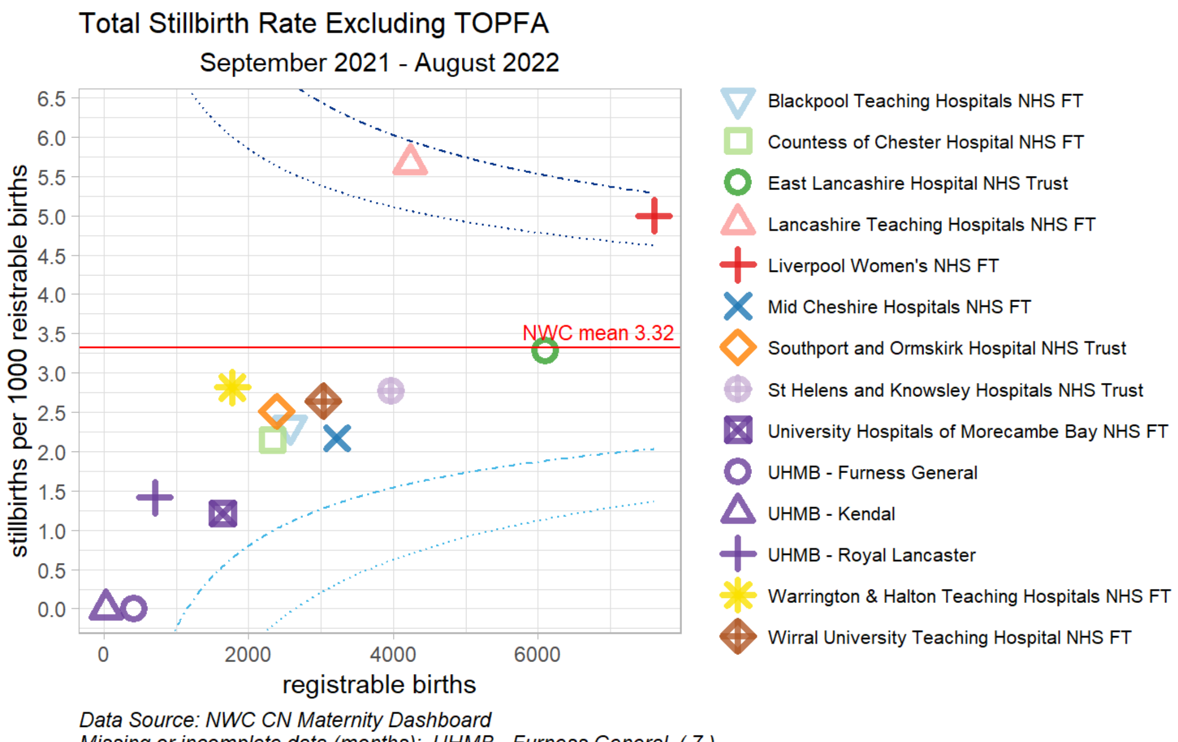
Table. 1 Stillbirths and neonatal death dashboard

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	April -22	May -22	June -22	July 22	Aug 22	Sept 22	TOTAL
Total stillbirths	0	2	1	0	1	0	2	0	0	0	0	1	7
Stillbirths (excluding terminations)	0	2	1	0	1	0	2	0	0	0	0	1	7
Births	205	213	192	196	174	209	194	201	191	206	187	210	2378
Stillbirth Rate/1000 births	0	9.39	5.1	5.1	5.74	0	10.31	0	0	0	0	4.76	
Stillbirth Rate (excluding TOP)/1000													
	Oct-21	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	April -22	May -22	June -22	**Jul 22**	**Aug 22**	**Sept 22**	**Total**
Total Neonatal Mortality	0	0	0	0	0	0	0	0	0	0	0	0	0
Deliveries	205	213	192	192	170	204	194	200	188	203	184	209	2354
Neonatal Mortality Rate/1000 deliveries	0	0	0	0	0	0	0	0	0	0	0	0	0

Table 2: Stillbirth (excluding terminations) & Neonatal Death Rate per quarter

Quarter	Stillbirth Rate	NMR
2021-2022		
Q3	4.92	0
Q4	1.73	0
2022-2023		
Q1	3.41	0
Q2	1.66	0
Q3		
Q4		

Fig.1 *Feedback from Cheshire & Merseyside*



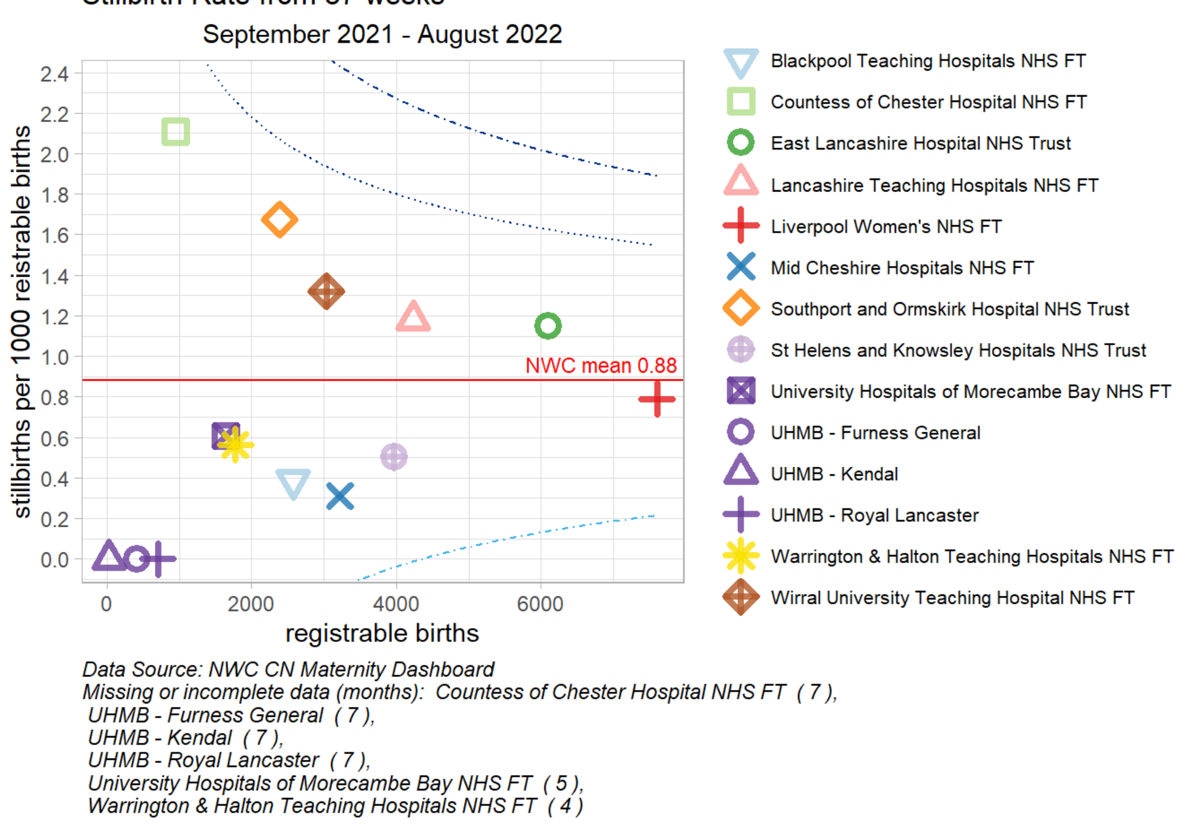


Table 3: Stillbirth and NN Mortality by cause (*Quarter 1 22/23*)

We are awaiting the availablity of information to complete this section for Quarter 2.

Information from the 2 cases for quarter 1

Reported cause of death (based on CESDI 2018)	No.	In-utero transfers
Stillbirth		
Termination of pregnancy for fetal abnormality		
Fetal abnormality		
Pre-eclampsia		
Antepartum haemorrhage		
Medical disorder		
Multiple pregnancy		

IUGR		
Mechanical	1 Ruptured uterus	
Infection		
Specific placental condition	1	
Unclassified		
Neonatal death		
Prematurity		
Infection		
Hypoxic ischaemic encephalopathy		
Congenital malformation		
Respiratory		
Abdominal		
Other		

Update from Quarter 4 2021/2022

Please see table below for the cause of death from the cases in Quarter 4 for completed reviews

Overall 1 case in Quarter 4

Reported cause of death (based on CESDI 2018)	No.	In-utero transfers
Stillbirth		
Termination of pregnancy for fetal abnormality		
Fetal abnormality		
Pre-eclampsia		
Antepartum haemorrhage		
Medical disorder		

Multiple pregnancy		
IUGR		
Mechanical		
Infection		
Specific placental condition	1	
Unclassified		
Neonatal death		
Prematurity		
Infection		
Hypoxic ischaemic encephalopathy		
Congenital malformation		
Respiratory		
Abdominal		
Other		

4. MORTALITY REVIEWS AND KEY THEMES

At the PMRT panel review all areas of care are graded for the mother and baby up to the point of antenatal / intrapartum death; following confirmation of the death of the baby; newborn care following the birth up to the death and maternal care following the death of the baby:

- Care of the mother and baby up to the point that the baby was confirmed as having died
- Care of the baby from birth up to the death of the baby
- Care of the mother following confirmation of the death of her baby

Grading

A.	There were no issues with care identified
B.	Improvements in care were identified which would have made NO difference to the outcome
C.	Improvements in care were identified which MAY have made a difference to the outcome
D.	Improvements in care were identified which were LIKELY to have made difference to outcome

Table 4. PMRT review panel grading of care provided in cases of Stillbirth

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A		3
PMRT grade B	2	
PMRT grade C		
PMRT grade D	1	
Total cases	= 3	

Table 4.1. PMRT review panel grading of care provided in cases of Neonatal Death

PMRT grading	Care provided to the mother up to the point that the baby was confirmed as having died	Care provided to the baby up to the point that the baby was confirmed as having died	Care provided to the mother following confirmation of the death of her baby
PMRT grade A			
PMRT grade B			
PMRT grade C			
PMRT grade D			
Total cases			

Nil applicable for quarters 1 & 2

Table 5. Reasons for review panel grading C&D

<table>
<tr><th>Review panel grading</th><th>Reason for grading</th><th>Level of investigation (StEIS/Level 2/Level 1/PMRT with external)</th><th>HSIB (yes/no)</th><th>Learning</th><th>QI plan aligned to theme</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="6">Case 1 quarter 1 caesarean section was rescheduled
Panel review grade D
Case reviewed by an external panel and via PMRT
Ongoing action plan in place and surveillance of caesarean section activity within the Maternity Unit</td></tr>
<tr><td colspan="6"></td></tr>
</table>

a. PMRT PANEL ATTENDANCE

External representatives for the PMRT panels are provided via the Cheshire and Merseyside Safety Collaborative. The Trust has a set timeslot for PMRT meetings the first Wednesday of the month and requests are made for external representation as standard practice via this process.

However, external representation has not been secured in all cases as reflected in the table below. Where an external Obstetrician is unavailable there are 2 internal Consultant Obstetricians present at the review. Two internal Senior Midwives are present for every review.

Case	External Obstetrician	External Midwife	External Neonatologist
Case 1 Meeting date 07/09/22	✓	✓	x
Case 2 Meeting date 29/04/22	x	x	N/A
Case 3 Meeting date 06/10/22	x	✓	N/A
% external representatives	33%	67%	0% of applicable cases

5. INTRAPARTUM & TERM STILLBIRTHS

There was 1 intrapartum stillbirth in Quarter 1

There were 0 intrapartum stillbirths in Quarter 2

There were 2 term stillbirths in Quarter 1

There were 0 term stillbirths in Quarter 2

6. TERM NEONATAL DEATHS (in-hospital deaths – for Level 3 units add deaths in Alder Hey)

There were 0 term neonatal deaths in Quarters 1 & 2.

7. SAFEGUARDING/UNBOOKED AND LATE BOOKERS

No women in Quarters 1 & 2 had safeguarding issues identified

8. SOCIO-DEMOGRAPHICAL

1. Birth at ODGH	G2P1 31 years BMI 34.9 Booked for Consultant Led Care due to previous obstetric history of a caesarean section
2. Birth at ODGH	G2P0 27 years BMI 40 Booked for Consultant Led Care due to maternal history of polycystic ovary syndrome & raised BMI Maternal history of depression
3. Birth at ODGH	G1P0 43 years Booked for care and delivery at Edinburgh Royal Infirmary–visiting area

9. LANGUAGE BARRIER

There were no issues identified with language difficulties during the PMRT review process.

10. SMALL FOR GESTATIONAL AGE

There were no stillbirths where the baby was identified as small for gestational age.

11. FETAL ABNORMALITIES DEATHS (known and unknown)

There were no deaths related to fetal abnormalities in this reporting period.

12. LEARNING FROM DEATHS

Update on learning from Quarter 4 report – completed review

Issue	Action	Implementation plan
Case 1 quarter 4 During the review there were improvements in care identified that would have made no difference to the outcome and some lessons learned to improve practice		
Non attendance for antenatal care	Consideration of condensing appointments for women who are unable to attend routine appointments – shared learning	Shared learning for Antenatal Clinic staff - completed

Update on learning from reviews in Quarter 1 (reporting from quarter 2 will be included in the next report)

Issue	Action	Implementation plan
Case 1 Quarter 1 During the review there were improvements in care identified which were likely to have made a difference to the outcome and some lessons learned to improve practice		
Rescheduling of a planned caesarean section for a woman with risk factors	There is a detailed action plan in place which is being monitored by the Senior Triumverate and the Trust Executive Team	

Issue	Action	Implementation plan
Case 2 quarter 1 The grading of care is being finalised awaiting review of the post mortem result but improvements in care identified and actions		
This mother had a risk factor(s) for having a growth restricted baby but serial scans were not performed at correct times/intervals	Review of the ultrasound scan appointments to 3-4 weekly (Radiology Standard Operating Procedure) to be in line with the Cheshire & Merseyside Regional pathway. Antenatal Clinic outcome request form updated with clear instructions on time scales for appointment Escalation lists to ensure ultrasound scans are performed within guideline timescale.	Radiology standard operating procedure revised by the lead Consultant Obstetrician and approved via the Maternity Care Forum – in progress Amendment of the clinic outcome forms for clarity on the timeframe for appointments - completed Monitoring of scan lists by the Clinical Lead Midwife for Antenatal Clinic and Directorate Manager and escalation via the Maternity Care Forum – in progress and ongoing
This patient was advised to attend Delivery Suite, however but attended Maternity Assessment Suite	Introduction of the Birmingham Symptom System Specific Obstetric Triage (BSOTS) to ensure patients have clear instructions on where to attend	BSOTS implemented – completed
No documentation of time of arrival	Audit of documentation of time of arrival	Audit of arrival at Triage - completed

Update for quarter 4 report

The quarter 4 report action update detailed feedback from the case reported to HSIB in May 2021 and the outstanding actions of the implementation of human factors training and the implementation of a Patient Information Leaflet for all women regarding modes of delivery. Both actions have been completed and the action plan updated and completed.

13. LEARNING / GOOD PRACTICE.

In all cases there was continued input and support from the Bereavement Midwife with ongoing support once discharged home.

14. HORIZON SCANNING

As part of intelligence gathering the following sources were used for horizon scanning:

CQC, NCEPOD,NHS Digital, NHSE/I (includes LMS), NHSR, PHE, RCOG, RCM, MBRRACE-UK, HSIB, Ockenden, CNST Maternity Incentive Scheme

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Integrated Performance Report

Maternity Dashboard

October 2022

Quality

Maternity

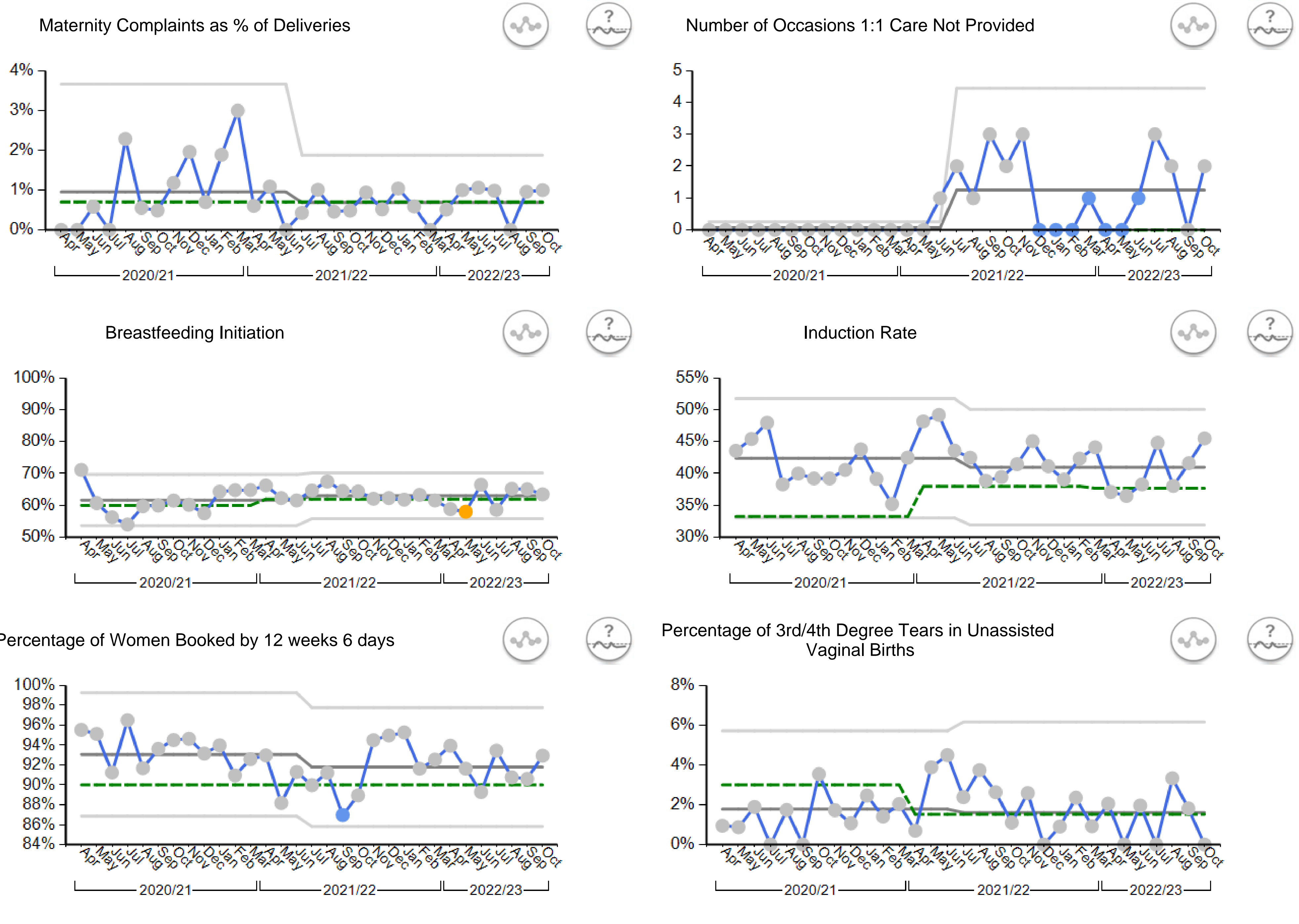
Number of Occasions 1:1 Care Not Provided

Two breaches were reported in October. These were due to staffing within Maternity, impacted by an increase in sickness rates (8.1% in October, compared to 6.7% in September). The Quality and Audit midwife contacts all women who don't receive 1:1 care to follow-up and obtain feedback.

Induction Rate

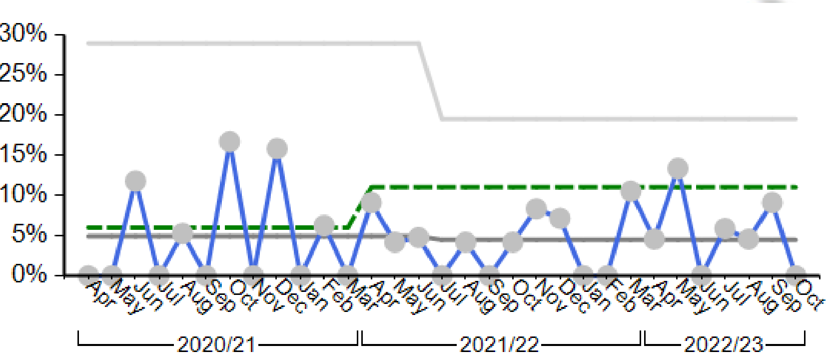
Whilst not statistically significant, the induction rate has increased by almost 4% in October. This is as a result of an increase in women being induced for reduced foetal movements. There are ongoing audits of all inductions with any learning fed back to the clinical teams as necessary.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Maternity Complaints as % of Deliveries	0.7%	1%	2	Oct 22		0.7%	1%	Sep 22	0.7%	0.8%	
	Number of Occasions 1:1 Care Not Provided	0	2	2	Oct 22		0	0	Sep 22	0	8	
	Breastfeeding Initiation	62%	63.5%	73	Oct 22		62%	65.1%	Sep 22	62%	62.2%	
	Induction Rate	37.7%	45.5%	91	Oct 22		37.7%	41.6%	Sep 22	37.7%	40.3%	
	Percentage of Women Booked by 12 weeks 6 days	90%	92.9%	13	Oct 22		90%	90.6%	Sep 22	90%	91.8%	
	Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Births	1.5%	0%	0	Oct 22		1.5%	1.8%	Sep 22	1.5%	1.3%	
	Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births	11%	0%	0	Oct 22		11%	9.1%	Sep 22	11%	5%	


Maternity Complaints as % of Deliveries
4%
3%
2%
1%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct
2020/21
2021/22
2022/23
Number of Occasions 1:1 Care Not Provided
5
4
3
2
1
0
Breastfeeding Initiation
100%
90%
80%
70%
60%
50%
Induction Rate
55%
50%
45%
40%
35%
30%
Percentage of Women Booked by 12 weeks 6 days
100%
98%
96%
94%
92%
90%
88%
86%
84%
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Births
8%
6%
4%
2%
0%

Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births

?


30%
25%
20%
15%
10%
5%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct
2020/21
2021/22
2022/23

Quality

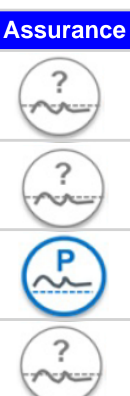
Mortality

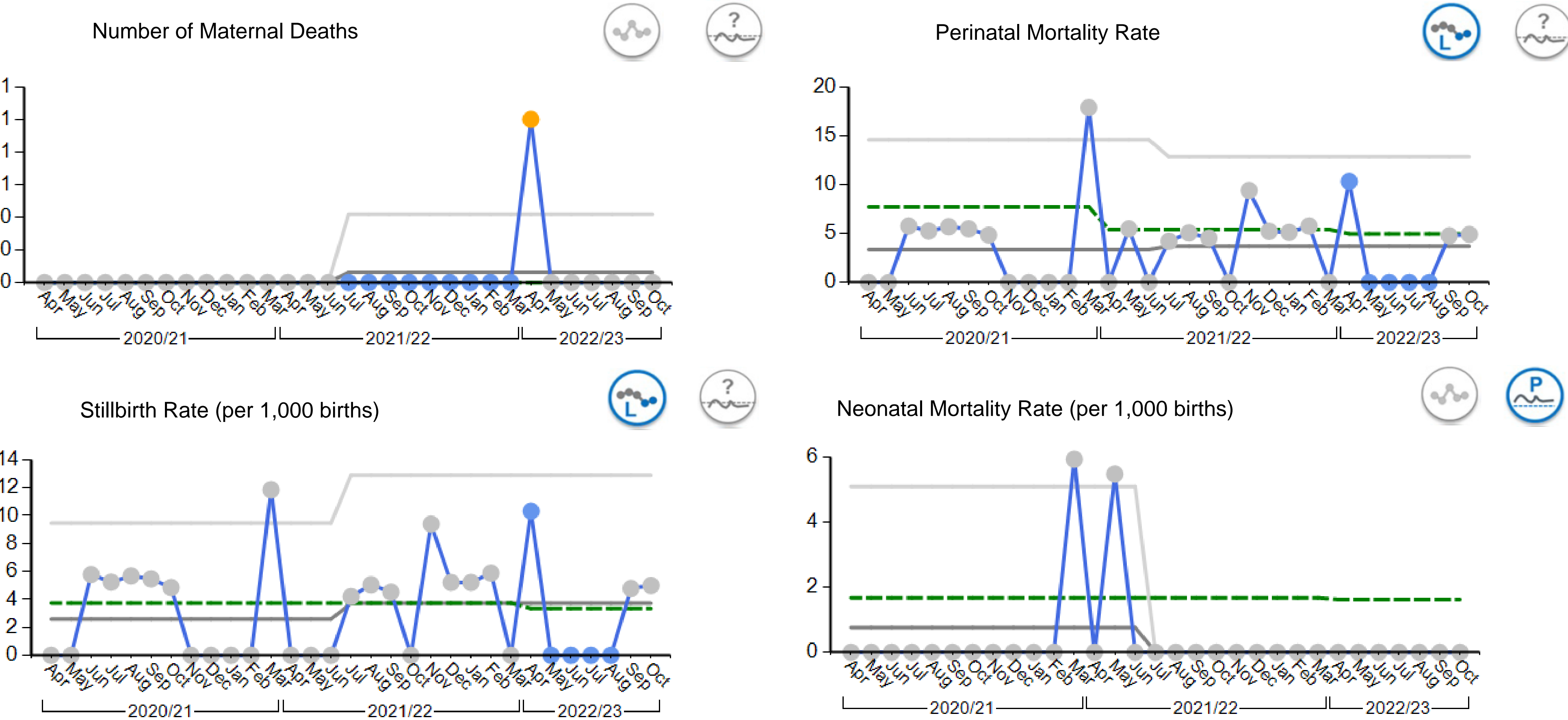
Issues

• There was one stillbirth recorded in October.

Management Action

• All stillbirths are subject to a Perinatal Mortality Review.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Perinatal Mortality Rate	4.96	4.9	4.9	Oct 22		5	4.8	Sep 22	4.96	2.9	
	Stillbirth Rate (per 1,000 births)	3.35	5	1	Oct 22		3.4	4.8	Sep 22	3.35	2.9	
	Neonatal Mortality Rate (per 1,000 births)	1.62	0	N/A	Oct 22		1.6	0	Sep 22	1.62	0	
	Number of Maternal Deaths	0	0	0	Oct 22		0	0	Sep 22	0	1	


Number of Maternal Deaths
Perinatal Mortality Rate
Stillbirth Rate (per 1,000 births)
Neonatal Mortality Rate (per 1,000 births)
2020/21
2021/22
2022/23

Quality

Patient Experience

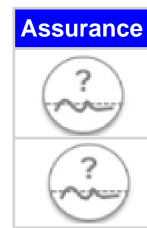
Friends and Family Test

Issues

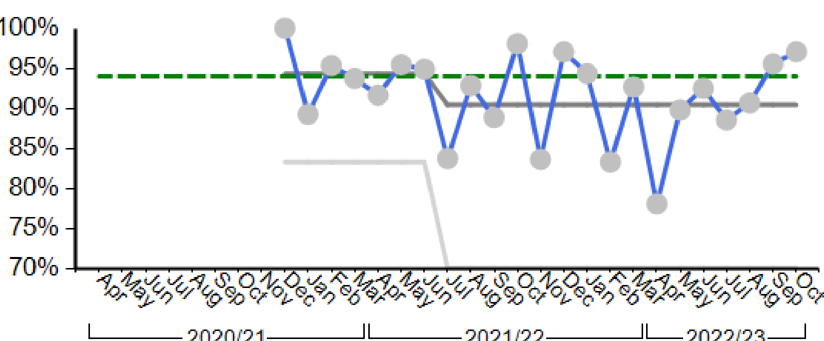
- Labour Ward - Increase in overall score to 97.1% from 95.6%, this is above the September NHSE average of 92% and internal indicator of 94%.
- Postnatal Ward - A slight decrease in performance from 95.7% to 95%, this is above the September NHSE average of 92% and internal indicator of 92%.

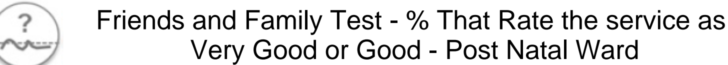
Management Action

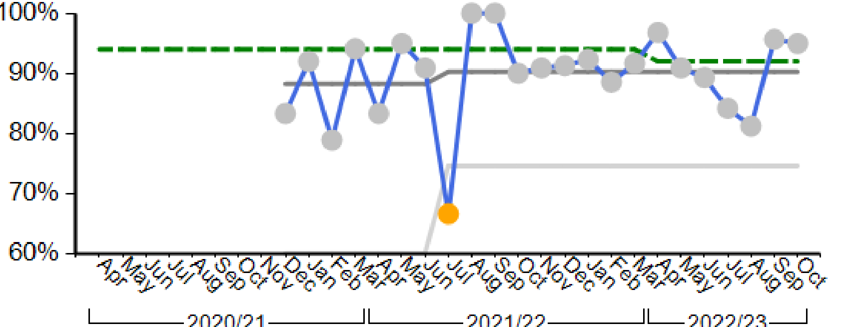
- The local Maternity Voices Partnership meeting is now reinstated and will provide opportunities to work collaboratively and gather further feedback from this patient group.
- The 2022 National Maternity Survey results have been received, action plan to be developed and presented to PECE for approval.

Alert	Indicator	Latest					Previous			Year to Date		
		Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Friends and Family Test - % That Rate the service as Very Good or Good - Labour Ward	94%	97.1%	N/A	Oct 22		94%	95.6%	Sep 22	94%	91.3%	
	Friends and Family Test - % That Rate the service as Very Good or Good - Post Natal Ward	92%	95%	N/A	Oct 22		92%	95.7%	Sep 22	92%	91.2%	

Friends and Family Test - % That Rate the service as Very Good or Good - Labour Ward







Title of Meeting	**STRATEGIC AND OPERATIONAL COMMITTEE**	**Date**	**07 December 2022**
Agenda Item	**SO226/22**	**FOI Exempt**	**NO**
Report Title	**LEARNING FROM DEATHS QUARTER 2 UPDATE (2022-23)**		
Executive Lead	Dr Kate Clark Executive Medical Director		
Lead Officer	Dr Chris Goddard Associate Medical Director for Patient Safety		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To inform the Strategy and Operations Committee of the issues identified related to mortality in Quarter 2 (2022-23).

Executive Summary

Main features:

- Standardised mortality rates within or better than tolerance.
- SMR for fractured neck of femur is rising.
- One avoidable mortality this quarter due to problems in healthcare.
- Clinical communication systems require improvement.
- Processes need to improve to identify and prioritise patients for weekend review.
- The biggest single area for improvement in quality is the identification and communication with patients ‘sick enough to die’ to ensure the possibility of death is discussed.

Interventions:

- Discussion with Orthopaedic team to identify any factors of concern.
- Significant trust action plan in Maternity.
- Short and medium-term solutions to communication issues (RF pagers and careflow connect).
- Working with medical registrars to improve handover processes.
- End of life care a trust priority. Multiple possible interventions depending on resource.

This report was presented to the Quality and Safety Committee on 28h November 2022.

Recommendations

The Strategy and Operations Committee is asked to receive the report and support the ongoing actions.

Previously Considered By:

☐ **Strategy and Operations Committee**	☐ **Executive Committee**
☐ **Finance, Performance & Investment Committee**	✓ **Quality & Safety Committee**
☐ **Remuneration & Nominations Committee**	☐ **Workforce Committee**
☐ **Charitable Funds Committee**	☐ **Audit Committee**

Strategic Objectives

✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services

☐ **SO2** Deliver services that meet NHS constitutional and regulatory standards

☐ **SO3** Efficiently and productively provide care within agreed financial limits

✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	**Presented By:**
Dr Chris Goddard, Associate Medical Director for Patient Safety	Mr Kevin Thomas, Deputy Medical Director

Learning From Deaths

Quarter 2 2022-23

Contributors

Medical Examiners Office

- Dr Annie Leigh
- Dr Ciara Cruise
- Dr John Kirby
- Dr Michael Vangikar
- Dr Paddy McDonald
- Dr Sudakar Kandasamy
- Mandy Power

Compiled By

- Dr Chris Goddard

MOG

- Dr Clare Finnegan

SJR Reviewers

- Emma Roney
- Dr Nas Babajan
- Janette Mills

Integrated Governance

- Pete Gale

Informatics

- Mike Lightfoot

Key national and local mortality indicators

	2021/22							2022/23					Target
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	
Rolling 12 Month HSMR	77.1	74.4	73.3	73.2	72.4	74.8	75.5	76.0					*100.0*
Monthly HSMR	77.9	54.3	66.5	77.7	76.7	99.9	74.3	80.2					*100.0*
SHMI	100.9	100.9	100.1	99.6	99.7	102.5	102.6	102.4					*100.0*
Local HSMR Bronchitis	29.3	30.2	20.3	18.6	28.2	47.6	46.4	54.4					*100.0*
Local HSMR LRTI	90.6	77.0	76.1	52.9	46.3	49.4	54.4	54.7					*100.0*
Local HSMR Pneumonia	82.0	78.1	74.6	71.4	71.5	77.4	81.0	82.2					*100.0*
Local HSMR Septicemia	78.9	79.8	78.2	79.7	78.6	79.0	76.9	75.3					*100.0*
Local HSMR Stroke	86.3	79.1	81.4	78.4	76.5	77.8	79.4	81.0					*100.0*
Local HSMR UTI	89.4	77.3	66.0	64.9	70.3	61.3	53.6	50.0					*100.0*
Local HSMR Acute Renal Failure	81.1	84.6	87.0	79.9	81.9	82.0	79.0	83.1					*100.0*
Local HSMR FNOF	50.4	54.0	55.9	51.0	60.7	69.9	75.8	85.8					*100.0*
Mortality Screens - %	95.95%	94.23%	92.65%	97.62%	97.33%	95.56%	97.33%	97.47%	98.44%	100.00%	96.72%	97.44%	*90.00%*
SJRs	3.0	1.0	3.0		7.0	3.0		5.0		1.0	2.0	8.0	*0.0*
2nd Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	*0.0*
In Hospital Deaths	74.0	52.0	68.0	84.0	75.0	90.0	75.0	79.0	64.0	55.0	62.0	78.0	*77.0*
In Hospital Deaths Crude Rate	24.8	18.5	22.2	31.7	30.2	35.1	28.4	31.1	20.2	22.3	24.9	33.5	*31.0*
LD Deaths	2.0	0.0	1.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	5.0	1.0	*1.0*
Sickness Absence Medics	1.91%	3.15%	1.93%	2.89%	4.84%	4.42%	4.25%	3.01%	2.47%	3.24%	4.41%	3.34%	*1.00%*

Explicit values for a rolling 12 month period, when no national target is available a baseline from last year has been used

- Overall headline figures remain within or better than statistical norms
- Expected variation in crude death rate and in-month figures continues
- Rolling HSMR and SHMI remain stable
- There is a trend for increasing SMR for Fractured Neck of Femur
- SMR for Bronchitis is increasing whilst the SMR for LRTI is decreasing. This requires further evaluation.

Avoidable deaths Quarter 2 2022-23

Concluded investigations in Quarter 2 identified one avoidable death.

This was the death of a lady due to the complications of major haemorrhage suffered in the late stages of pregnancy.

The lady was due to have an elective caesarean section which was postponed due to a lack of operating time and competing clinical priorities.

She represented as an emergency seriously unwell. She had an emergency caesarean section under general anaesthesia where a uterine rupture was diagnosed. A major haemorrhage ensued involving 34 units of red blood cells and associated blood products and haemostatic agents. Two cardiac arrests occurred and a hysterectomy was performed. Unfortunately the foetus had died prior to delivery.

Despite eventual stabilisation of the mother and transfer to intensive care, she suffered a severe hypoxic brain injury as a consequence of these events and died in ICU.

<u>Avoidable deaths Quarter 2 2022-23</u>

Learning:

There is still an ongoing coroners inquest for this case; but an external clinical review and an SI investigation have identified the following factors

- Improved Documentation:
  - SOPs and clinical templates have been audited and reviewed
- Consistent processes for booking and rescheduling:
  - Weekly C-section planning meetings, clinical risk identification, strengthened mutual aid processes
- Improved Capacity:
  - 7 elective c-section lists per week, recruitment scrub staff to release midwives
- Clinical Learning / Enhanced support for staff:
  - There was task fixation on identifying foetal viability instead of recognising maternal serious illness, human factors training introduced, difficulties in estimating blood loss, Psychology input.

Other incidents related to death Quarter 2 2022-23

Learning:

- There have been 2222 calls which have failed to activate on the ASCOM handsets.
  - Clinical comms systems are being reviewed to ensure emergency systems are robust

- DNACPR decisions and their communication is vital
  - Lack of handover led to initiation of CPR in a patient with a valid DNACPR

- Discussion of DNACPR should not be deferred
  - Sudden death in the elderly does occur (3 identified this quarter) and having had the discussion ensures that the patients wishes are known and taken into account in this clinical decision

- Ward teams need to have a clear understanding of which consultant / consultant team is responsible for every patient.
  - Work is underway to ensure that outlying is minimised and that consultant teams are identifiable and contactable

<u>SJR Quarter 2 2022-23</u>

14 SJRs were completed in Q2

Avoidability of death rating as follows:

Definitely not avoidable: 12
Possibly avoidable but not very likely (< 50:50): 1
Not stated: 1 (review of this death suggests definitely not avoidable)

The thematic analysis of these, medical examiner scrutiny and incident reports is presented on the following slides

Quarter 2 Thematic Analysis.

Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

End of life care

- Where clinical recovery is uncertain, and patients are sick enough to die, there is a theme of ongoing clinical investigation where the investigation results are unlikely to change treatment decisions or outcomes, or the available treatment options may be deemed inappropriate given the specific clinical circumstances. For example - aggressive management of ACS in pts with advanced metastatic malignancy.

- Timely recognition that diagnosis, prognosis or recovery is uncertain, and that the patient is sick enough to die during this admission, enables honest and open conversations about the purpose of the proposed investigations and the benefits and burdens of proposed treatments. These conversations, alongside exploring "what matters most" to the patient, enables shared decision making between the patient and the clinician about what level of investigation and treatment is appropriate for them at this point in time.

- When the possibility of dying is anticipated and communicated sensitively with patients and their families, patients can be involved in decisions about their care and treatment. This allows a focus on symptom control and allows the spiritual, social and psychological needs of the patient to be assessed and addressed in a timely manner.

Quarter 2 Thematic Analysis.

Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

- Overwhelming response positive, caring and sensitive staff prepared to go the extra mile. Communication and explanations generally of a good standard.

Weekend working

- Reviewers noted patients not being seen over the weekend on medical wards. Clearly there is not the resource at a weekend to review, and write in the notes of every single stable patient. However, there is opportunity to document of a Friday the expected plan for the weekend and any criteria to prompt a weekend review.

- Where clinical recovery is uncertain, and there is the possibility of clinical deterioration overnight or over the weekend, treatment escalation planning can guide decision making by the on-call teams. Conversations about uncertain recovery early in admission, highlighting patients who may be sick enough to die, enable a clear plan to be developed with the patient and their family which clearly describes a realistic plan which "hopes for the best and prepares for the worst".

Quarter 2 Thematic Analysis.

Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

Cardiac Arrest

- In cardiac arrests of likely coronary thrombotic cause thrombolysis can be considered in the same way that it would be considered for the treatment of a massive PE.
- In a number of cardiac arrest reviews it was noted that the patient mental capacity was considered and documented appropriately, although this was not always the case.

Clinical Monitoring

- Issues have been noted with fluid balance documentation, mainly with daily totals not calculated. This has caused problems with the ability to observe fluid restriction appropriately.
- Documenting GCS in ED. In a couple of cases the documentation of GCS as per NICE guidance in head injury could not be found – this may be being collected electronically.
- Regular measurement of patients weight in conditions such as heart failure to guide diuretic therapy

Quarter 2 Thematic Analysis.

Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

- The monitoring standards after unplanned cardioversion of a tachy-arrythmia need agreeing and communicating. The monitoring plan documented was unclear.

Consent

- In a number of cases documentation of consent and best interests was done very well as part of the documentation of procedures.
- In one case however a family member (without Lasting Power of Attorney for health and welfare) was asked to consent for a procedure. This is not the legal process, which is to consult those close to patients to enable a decision to be made in their best interests by the treating team.

Efficiency of Care

- A patient admitted with heart failure didn't have an echo requested for 4 days, when completed it demonstrated severe aortic stenosis with LV dysfunction. The patient died suddenly 3 days after being referred to LHCH for a valve replacement after developing an AKI and hyperkalaemia. This was likely due to heart failure and aortic stenosis. This case was judged to be possibly avoidable but less than 50:50.

Quarter 2 Thematic Analysis.

Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

- A trend of ward round ‘jobs’ such as investigation requests or procedures not being completed has been noted. This delays care and extends length of stay in hospital.

- In appropriate patients, early investigation can improve outcome; one patient with a long history of constipation was diagnosed with metastatic malignancy, whilst another taking a PPI for 15 years had oesophageal cancer. The decision to investigate or not should be taken with the patient and documented

Title of Meeting	STRATEGY AND OPERATIONAL COMMITTEE	Date	07 December 2022
Agenda Item	SO226/22	FOI Exempt	NO
Report Title	LEARNING FROM DEATHS ANNUAL REPORT Q3 2021 – Q2 2022		
Executive Lead	Dr Kate Clark Executive Medical Director		
Lead Officer	Dr Chris Goddard Associate Medical Director for Patient Safety		
Action Required	☐ To Approve ☐ To Assure	☐ To Note ✓ To Receive	

Purpose

To inform the Strategy and Operations Committee of the learning and improvement driven by the analysis of mortality in the reporting period.

Executive Summary

The Strategy and Operations Committee is asked to note:

- two deaths identified in the reporting period due to problems in healthcare, both of which have generated change.
- Improved screening with implementation of MEO.
- Delays in completion of SJRs in timely manner – Actions in progress.
- Learning shared through MOG and clinical governance.
- Themes relating to communication and end of life care are being addressed as a Quality Priority.
- Review of processes for emergency response and handover in progress supported with digital solutions.
- External review of mortality services planned as a follow up to the NHSE review in 2017.

This was presented to the Quality & Safety Committee on 28 November 2022.

Recommendations

The Strategy and Operations Committee is asked to receive the annual Learning from Deaths report.

Previously Considered By:

☐ **Strategy and Operations Committee**	☐ **Executive Committee**
☐ **Finance, Performance & Investment Committee**	✓ **Quality & Safety Committee**
☐ **Remuneration & Nominations Committee**	☐ **Workforce Committee**
☐ **Charitable Funds Committee**	☐ **Audit Committee**

Strategic Objectives

✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services

✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards

☐ **SO3** Efficiently and productively provide care within agreed financial limits

✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated

✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values

✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	Presented By:
Dr Chris Goddard, Associate Medical Director for Patient Safety	Mr Kevin Thomas, Deputy Medical Director

Learning From Deaths

Annual Report Q3 2021 – Q2 2022

Southport and Formby District General Hospital
Ormskirk and District General Hospital
North West Regional Spinal Injuries Centre

Headline Performance

- Total in-hospital deaths: **856**
- Deaths felt to be more likely than not due to problems in healthcare: **2**
- Current SHMI: **101.04**
- Current HSMR: **76.20**

- Mortality Screening: **91%**
- Medical Examiner coverage: **Monday to Friday**
- Referral rate for SJR: **11% (104)**
- SJR completion rate **32% (33)**

Deaths due to problems in healthcare

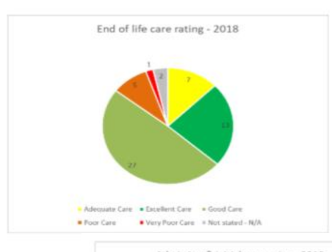
- Delayed nephrostomy for patient with a single functioning kidney due to previous covid +ve test
- Renal function worsened until anti-coagulation contra-indicated and death from stroke due to AF
  - Updated SOP and SLA with LUHFT for interventional radiology
  - Induction processes updated in Urology
  - Learning around balancing risk of delay vs excess risk in concurrent covid-19

- Maternal death from major haemorrhage after postponed elective c-section
  - Splitting of emergency and elective c-section teams
  - Dedicated elective theatre and staff
  - Theatre recovery improvements for maternity patients
  - Improved process for prioritisation and postponement of elective c-sections and mutual aid.

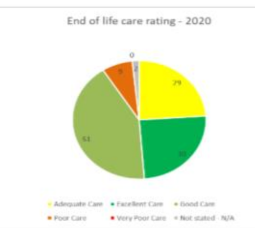
Southport and Ormskirk Hospital
NHS Trust

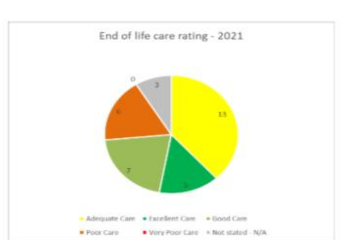
Quality of Care (SJR)

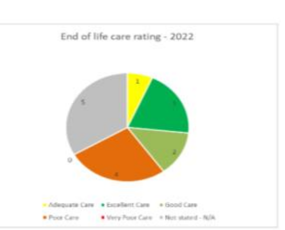
- Reduction in overall Good / Excellent scores since 2020
- Some improvement in 2022
- Significant reduction in SJR numbers since 2020 – 2022 numbers small
- Drop in overall quality driven by end of life care and care in the first 24 hours



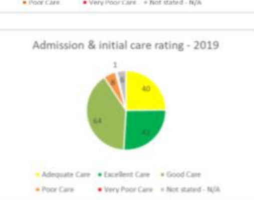
End of life care rating - 2019

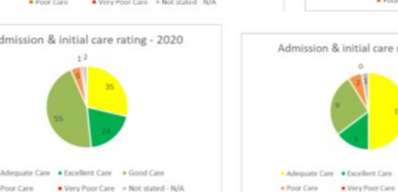






Admission & initial care rating - 2018





Avoidability (SJR)

- Definitely not avoidable: **28**
- Slight evidence of avoidability: **2**
- Possibly avoidable but not very likely (<50:50): **1**
- Not commented on: **2**

Improvement Activity

- Process Changes due to Medical Examiners Office
  - SJR referrals managed by ME Office – Independence
  - Trigger rate 11% (national guidance 10-20%)
  - All coronial and non-coronial deaths screened by MEOs

- SJR completion is delayed (86 days against a target of 30 days)
  - Process change agreed at MOG to bring 1st SJRs to the for group review
  - SJR reviewers to be expanded to specialist non-medical roles (resus officer, advanced critical care practitioner)
  - Process review of how SJR cases are allocated to reviewers

Improvement Activity

- Communication within and between teams
  - Project underway to improve and standardise the process for ward medical teams to be contacted for routine patient care.
  - Re-introduction of RF pagers to emergency teams as other systems not robust.
  - Supportive of the roll-out of Careflow connect.
  - Handover of tasks between on call teams is part of this work.
  - Boards to inform all staff of key risks such as the need for log-rolling or being NBM have been successfully trialled in ED.

Improvement Activity

- Communication with patients and relatives
  - Feedback considers communication, particularly with relatives of patients who are dying, as a strength of the trusts staff.
  - Marked improvement in this since hospital visiting returned and processes consistent and uniformly applied.

- Resuscitation
  - The management and transfer of patients requiring transcutaneous pacing for bradycardia has been found to be inconsistent and an SOP is under construction by the resus team.

Improvement Activity

- System Pressure
  - Outlying patients recognised as an area for improvement. A SOP is in development to clarify the responsibilities for medical outliers.

- Endoscopy
  - Recognition that the acute endoscopy state requires improvement. Finance secured to deal with these concerns. Of particular note is the lack of a dedicated recovery.
  - SOP in place for the use of theatre recovery should this be required.
  - UGI bleed process with LUFT is ongoing work.

Improvement Activity

- End of life Care
  - Embedding the idea of patients being 'sick enough to die' as a mechanism to enable the discussion of patients wishes and priorities in staff.
    - Consistent language
    - Consistent training
    - Support from palliative care and critical care
    - Treatment escalation proforma due to be launched as a part of the clerking proforma.
    - Promotion of discussion and engagement
    - Presence of family members at the moment of death
  - Review event 5 years after the External Mortality review
    - Return of external review lead to reflect on what's improved
    - Opportunity to deliver complexities at the end of life training to senior clinicians

Summary

- Improved screening with implementation of MEO
- Delays in completion of SJRs in timely manner – Actions in progress
- Learning shared through MOG and clinical governance
- Themes relating to communication and end of life care are being addressed as a Quality Priority
- Review of processes for emergency response and handover in progress supported with digital solutions
- External review of mortality services planned as a follow up to the NHSE review in 2017.

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

COMMITTEE/GROUP:	Workforce Committee
MEETING DATE:	29 November 2022
LEAD:	Lisa Knight

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Potential Industrial Action – Awaiting results of Unison ballot with the expectation that the vote will go in favour of industrial action. Proactive management in planning for potential industrial actions is undertaken via Silver Command meetings.
- PDRs – Director of Human Resources to meet with managers of staff that have not had a PDR within the last three years.

ADVISE

- Health & Wellbeing - continued increase in uptake of vaccines for flu and Covid.
- Recruitment – reduction in nurse vacancy rate.
- Recruitment – reduction in overall vacancy rate.
- Assurance provided in relation to reduction in risk 2424 for Clinical Education from12 down to eight.
- Staff networks gone live as at this week.
- Acknowledgement that the Trust needs to promote partnership working with staff side around communication with staff on the forthcoming change in relationship between S&O and STHK.

ASSURE

- Library & Knowledge Service Strategy was approved and will go to SOC in January 2023.
- Freedom to Speak Up Month – October 2022 had led to a rise in staff coming forward and giving 100 pledges and 20 people have expressed an interest in becoming a Champion.
- AHP vacancy rates have reduced in month to the lowest level for two years.
- Healthcare Assistants – 71 posts out to offer. Future recruitment events planned in January 2023.
- Flu vaccinations on trajectory – currently at 71%.

New Risks identified at the meeting: risk of industrial action which has been added to corporate risk register

Review of the Risk Register: Yes

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**07 December 2022**
Agenda Item	**SO228/22**	**FOI Exempt**	**YES / NO**
Report Title	**FREEDOM TO SPEAK UP REPORT (QUARTER 2 – 01 JULY TO 30 SEPTEMBER 2022)**		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Linda Douglas, Freedom to Speak Up Guardian		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ☐ **To Receive**	

Purpose

The Strategy and Operations Committee is asked to receive this report as assurance that staff members feel able to raise their concerns from a wide constituent across the organisation and that the appropriate systems and processes are in place for staff to do this safely and confidently, knowing that appropriate action will be taken.

Executive Summary

This report identifies the number of concerns raised through the Freedom to Speak Up service (FTSU) during Quarter 2 of 2022 (01 July to 30 September 2022*).* Over the quarter, eight concerns have been raised through FTSU. During this quarter, two concerns have had Human Resources input either directly via the Guardian or Manager.

To help with the overview, some statistics are included from the last twelve months.

To put the data into context, some statistics are included from the last twelve months.

The report also provides assurance of the significant improvement journey that *speaking up* has made since the National Guardian's Office case review in summer 2017.

During Quarter 2 the themes of concerns raised have included:
- Car park ticket being issued and concern regarding bailiffs
- Lack of support for International Nurses
- Medical secretary being asked to make decisions on priority of patients' appointments
- Staff speaking rudely and unprofessionally to a patient

Recommendations

The Strategy and Operations Committee is asked to note the Freedom to Speak Up Report for Quarter 2 (01 July to 30 September 2022).

Previously Considered By:

☐ **Strategy and Operations Committee**	☐ **Executive Committee**
☐ **Finance, Performance & Investment Committee**	☐ **Quality & Safety Committee**
☐ **Remuneration & Nominations Committee**	✓ **Workforce Committee**
☐ **Charitable Funds Committee**	☐ **Audit Committee**

Strategic Objectives

☐ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services

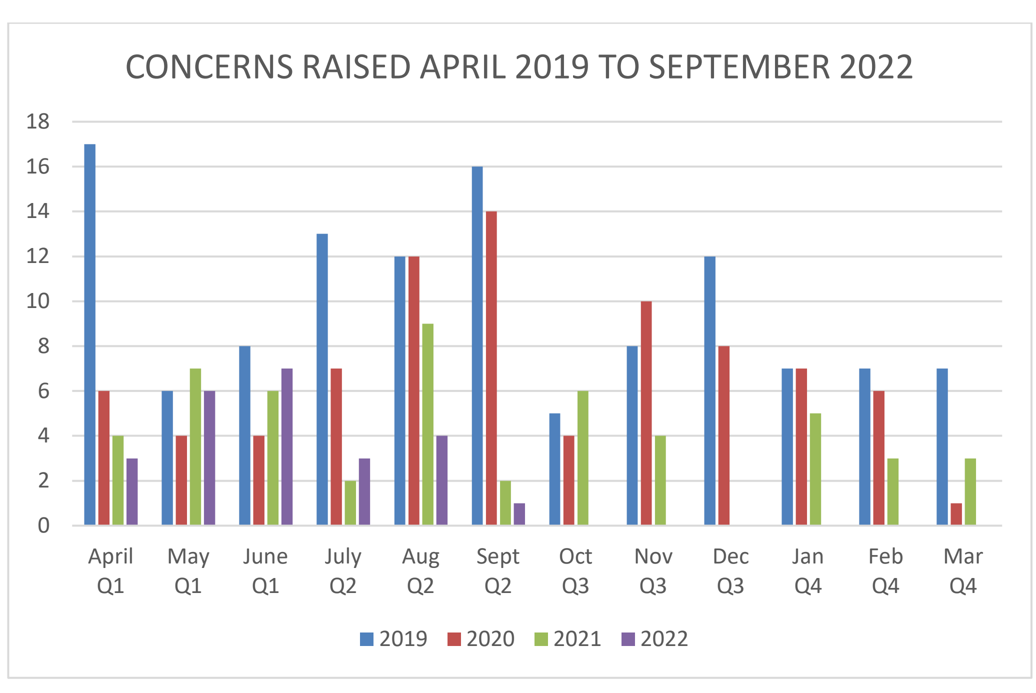
☐ **SO2** Deliver services that meet NHS constitutional and regulatory standards

☐ **SO3** Efficiently and productively provide care within agreed financial limits	
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Linda Douglas, Freedom to Speak Up Guardian	Linda Douglas, Freedom to Speak Up Guardian

Report on Submission to National Guardian's Office

Quarter 2	01 July – 30 September 2022
Date submitted to NGO:	18 October 2022
Date National Data to be published:	To Be Confirmed
Number of Concerns Raised	**8** concerns (July 3 , August 4, September 1) All of these were directly raised through the Freedom to Speak Up (FTSU) Guardian and three were directly raised with the FTSU Champions. When concerns are raised directly with FTSU champions, the FTSUG always gives support and advice, often meeting those who raise the concern, and sometimes being used in a consultative role.

Below is a graph showing the last 4 years Concerns Raised, from April 2019 up to September 2022. This enables easy comparison for the last few years. Our Quarter 2, July, August, September is the most current.



1.1 Themes of Concerns

For reasons of confidentiality, only general themes are recorded within this report. During the quarter these have included:

- Car park ticket being issued and concern regarding bailiffs
- Lack of support for International Nurses
- Medical secretary being asked to make decisions on priority of patients' appointments
- Staff speaking rudely and unprofessionally to a patient

In terms of proportion, the table below expresses concerns raised as a percentage:
(Please note the themes in the %table and the graph are the categories required by the National Guardian's Office for submission)

Each concern can fall into multiple categories which is reflected in the tables below:

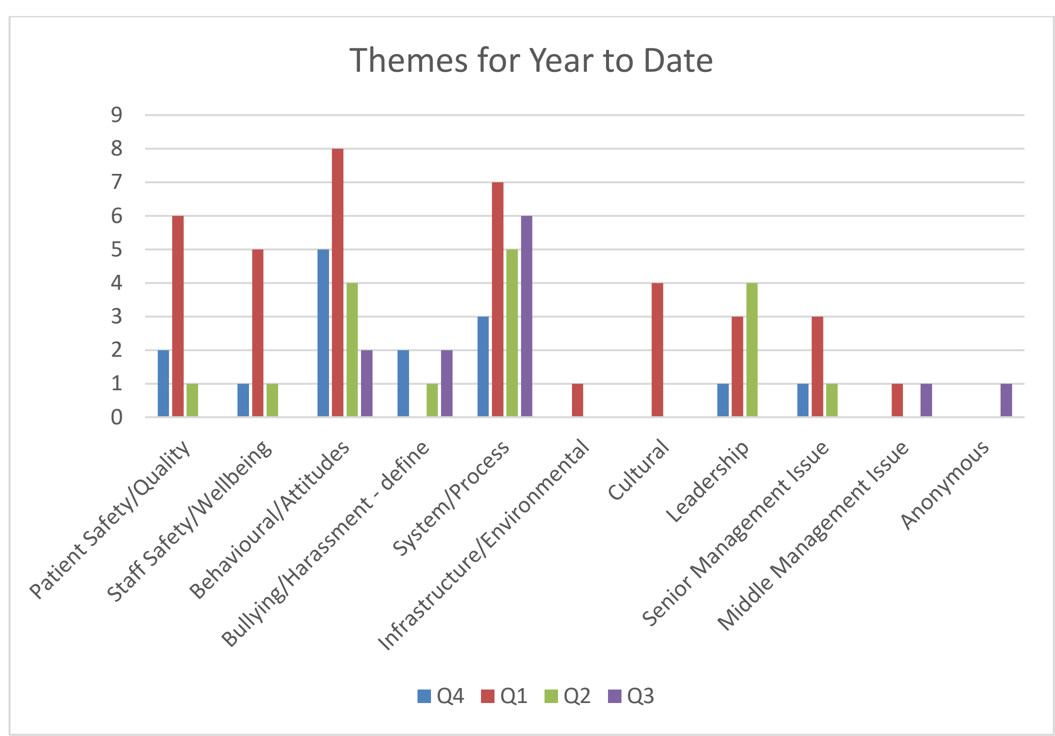
Issues this quarter: Q2 (Q1 also shown for Comparison)

Theme	% this Quarter (Q2)	Last Quarter (Q1)
Behavioural / Relationship	23.52%	21.05%
System / Process	29.41%	18.42%
Cultural	0%	10.52%
Bullying/Harassment	5.88%	0%
Middle Management issue	0%	2.63%
Not Known	0%	0%
Staff Safety	5.88%	13.15%
Infrastructure/Environment	0%	2.63%
Leadership	23.52	7.89%
Senior Management Issue	5.88	7.89%
Patient Safety/Quality	5.88	15.78%

Graph of Themes for Year to Date

Below is a graph expressing the themes of concerns raised over the last four quarters:

(Please note quarter 2 is the most recent (0t July – 30 September).



1.2 Anonymous Concerns

During Quarter 2, there were zero anonymous concerns. This is where the person raising the concern cannot be contacted as there are no contact details, eg anonymous letter / phone call/email. This quarter there were six concerns where the person did not want their name associated with the concern and their details remain confidential, other than to the FTSU Guardian and administrator. Out of the concerns raised this quarter none were worried about potential repercussions, but still did not want their name to be known outside FTSU.

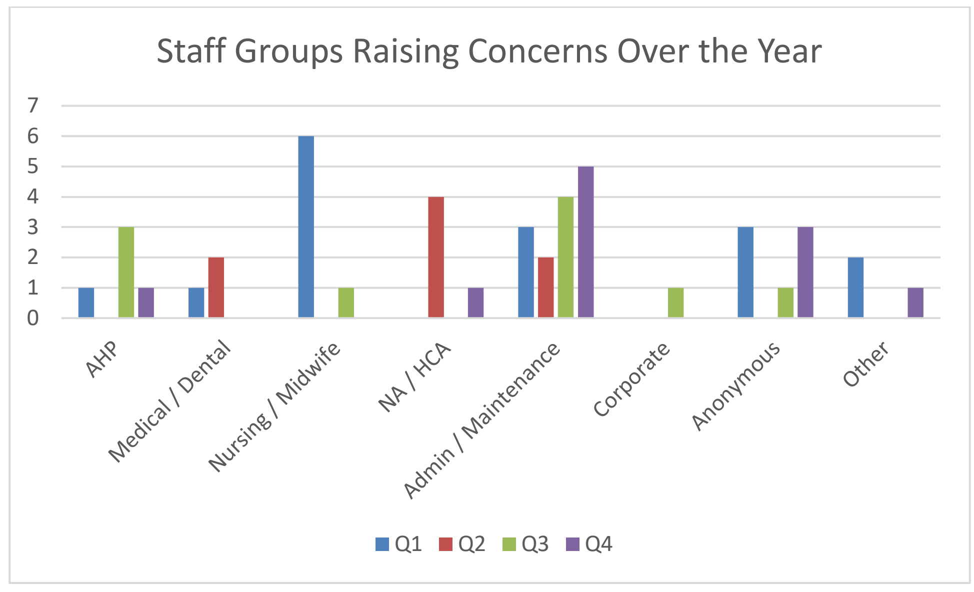
1.3 Staff Groups Raising Concerns

Concerns this quarter have been raised by a cross-section of staff, as shown below. These follow the definition of the National Guardian's Office. For comparison the last Quarter's results are also shown.

Staff Group	% this Quarter (Q2)	% last Quarter (Q1)
AHP	0%	6.25%
Medical and Dental	25%	6.25%
Nursing / Midwives	0%	37.5%
HCA	50%	0%
Admin	25%	18.75%
Corporate	0%	0%
Anonymous	0%	18.75%
Other	0%	12.50%

1.4 Staff Groups Raising Concerns Over the Year

The Graph below shows the last 4 Quarters for comparison (Quarter 2 being our most recent)



1.5 Situations where detriment was expressed because of speaking up

In the last quarter there have been no new situations of perceived detriment highlighted.

1.6 Feedback Post Raising Concerns

The National Guardian's Office requires the FTSUG to invite those who have raised concerns, and have had their concerns closed, to offer feedback, specifically:

- Would they use the FTSUG again to raise a concern?
- Would they like to offer further comments about the service or the process?

During this quarter feedback was received from six people who have raised concerns with the FTSU service.

All of the feedback received this quarter was Positive

- *Even if person raising concern was mistaken, they should still speak up so it can be looked into to alleviate their concern*
- *Had felt system they were working in was unfair – but good to talk it over*
- *Helpful after raising concern with FTSU to speak to their manager and should be encouraged to do so*
- *Would happily speak up again*

1.7 Changes as a Result of Speaking Up

The question is often asked '*What things have changed as a result of people speaking up?'* Each quarter we try to offer a short overview of some of the changes.

Recent conversations have also highlighted FTSU as providing:

- Exit interviews followed up
- Access to Medical Director for doctors to raise concerns
- Robust finance systems in place
- Advice on speaking about concerns to immediate manager and help to do so if required

1.8 How Concerns are Managed

Concerns are managed on a concern-by-concern basis, in line with the trust's FTSU policy. The FTSUG has regular one to one's with the FTSU Executive lead and the Managing Director.

1.9 Guardians Support

The FTSU guardian continues to be a member of the Regional and National network of Guardians. Although these are not meeting face to face, there is a monthly "teams" regional support meeting or workshop, with input from the national office.

2. Update on Freedom To Speak Up, Raising Concerns Policy (Corp 69)

The policy has now had final approval by PRG and is accessible on the intranet. The updated Policy is in line with NGO/NHS England guidance and has been approved in Workforce Committee (due to be uploaded on the Intranet).

3. Concerns Taken Directly to CQC

During Quarter 2, there were no concerns referred directly to CQC.

4. Freedom to Speak Up Champions – new guidance from the NGO

We continue to recruit Champions under the National Guardian's Office (NGO). We have recently successfully recruited two new Champions in the last quarter, and we continue to grow in the role of Champions across the Trust.

5. The National Picture

October was the National Freedom to Speak up Month and this year's theme was 'Freedom to Speak Up for Everyone'. Over the four weeks of October each week had a specific focus –

- Week One: Speak up for Safety – the safety of people who use and work in our services is core to how we work. Week one highlighted the importance of speaking up about anything that gets in the way of you doing a good job, particularly relating to patient care and worker safety. Use this week to speak up for something you think can help us learn and improve for the benefit of patients and colleagues.

- Week Two: Speak up for Civility – Week two focussed on being kind to colleagues and not forgetting to be kind to yourself. Civility Saves Lives say that 'Almost all excellence in healthcare is dependent on teams and teams work best when all members feel safe and have a voice'.

- Week Three: Speak up for Inclusion – Week three is all about promoting inclusion and breaking down the barriers we know exist to enable all workers to feel safe to speak up and be heard. This week we are also celebrating Black History Month alongside Speak up Month. We used this week to promote equality, diversity and inclusion and engaged with staff networks.

- Week Four: Freedom to Speak Up for Everyone – Week four brought together all professionals, worker groups and sectors, both within health and social care and beyond. We want to make speaking up business as usual for everyone, regardless of job role, background, or circumstance.

5.1 Southport and Ormskirk NHS Trust – FTSU Month – October 2022

Here at Southport and Ormskirk NHS Trust we held information stands on both sites outside the restaurants in Southport and Ormskirk on alternating weeks on the Tuesdays and Wednesdays throughout the month of October. The Guardian, Champions and administrator were available to answer questions and encourage people to sign a Pledge to Speak Up if they saw something that wasn't right. We are proud to say that over 100 workers have made a 'pledge'.

Staff were also encouraged to look at becoming Champions if this interested them and further information was sent out to them and they were encouraged to access the information videos on the Trust Intranet homepage,

'Goody' bags were also given out including information, a fun wordsearch, pens, trolley tokens, sweets and all in a handy waterproof hessian reusable lunch bag. These proved very popular.

We also wore and encouraged others to wear green tops for '**Wear Green Wednesdays'** throughout October to show their visible support for Freedom to Speak Up. I am delighted to say we had some great shows of **green** throughout the month.

Collation of the Pledges that were collected during October showed an excellent awareness of people happy to speak up and a sample of these are shown below including from our Guardian and the Director of Nursing, Midwifery and Therapies (Appendix A)

"*As part of our commitment to openness and transparency, it is vital that all our workers know the importance and the difference to staff and patient experience, that can be made by speaking up"* - Linda Douglas FTSU Guardian

"Freedom to speak up gives me, as an Executive champion, the opportunity to identify any areas of improvement for patient safety" - Lynne Barnes, Director of Nursing, Midwifery and Therapies.

Appendix B - Photos taken at our stands throughout the month of October -

5.2 NGO Feedback on Speak up Month

A big thank you to all those who were involved in Speak Up Month 2022. We saw some outstanding activities from guardians across social media and within organisations promoting the **#FTSUforEveryone** message.

Throughout the month, we received blogs, videos and messages of support from across healthcare.

We got Stuck in a lift with some Freedom to Speak Up guardians, painted social media green every **#WearGreenWednesday** and welcomed guests Dr Henrietta Hughes, Dr Chris Taylor, Lord Victor Adebowale, Danny Mortimer on the Speak Up Listen Up Follow Up Podcast.

Jayne has recorded a personal message and we have created a summary video as a thank you for your work making speaking up business as usual. Can you spot anyone you know?

You can catch up on all things Speak Up Month 2022 on our website.

Watch the Summary Video

Catch up on the NGO website

(To open above - right click and open hyperlink)

5.3 National Guardian's Office Annual Speaking Up Data Summary-

Appendix C -

5.4 Interim Head of Office appointed

Charlie Cassell has been appointed as the new NGO Interim Head of Office.

Charlie has worked in the NGO for the past year as National Lead for Corporate and Governance focusing on developing the organisation's assurance processes and building our relationships with our funding partners. Charlie has 15+ years of experience working in healthcare both in the UK and abroad. She possesses extensive experience in culturally diverse and demanding public, private and third sector environments.

6 Finally

Linda verbal announcement.

National Guardian

National Guardian

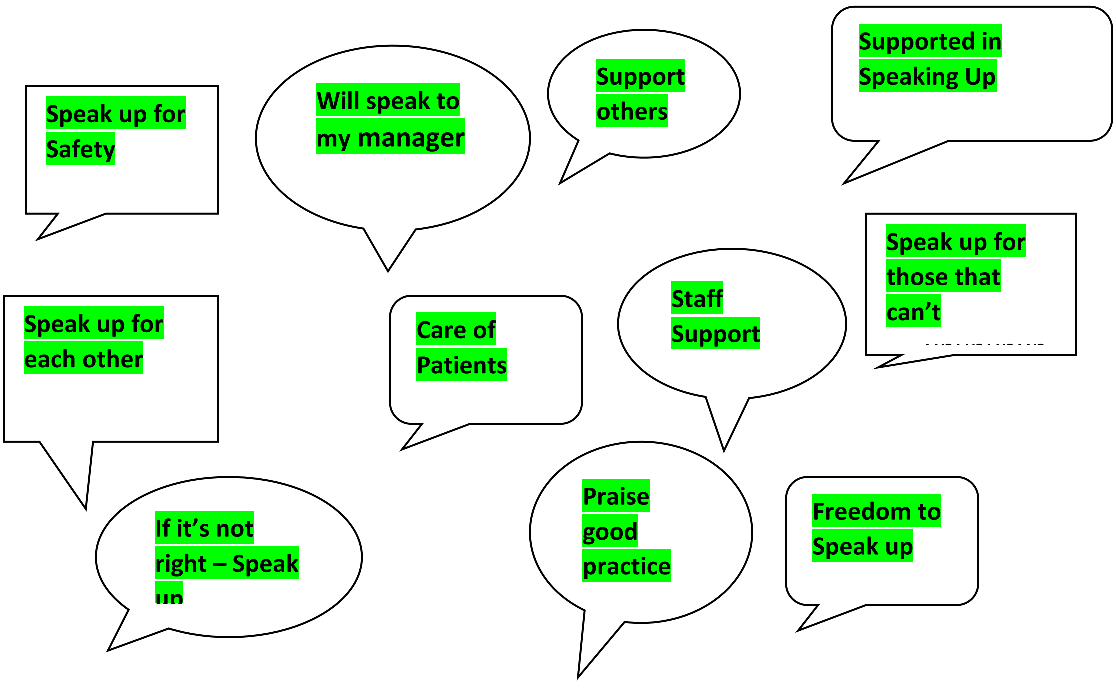
Freedom to Speak Up

FTSU Pledges from Southport & Ormskirk Hospital

I Pledge to……

- ***Speak up if I see/hear anything that worries me to protect our patients and staff***
- ***Speak up to support others who may not have a voice***
- ***Speak up if I am concerned about care and treatment of myself, a patient or colleague***
- ***Would speak up again if I needed too***
- ***Speak up for safe staffing levels***
- ***Speak up to keep the hospital, patients and staff safe***
- ***If it's not right I would always speak up***
- ***Speak up if I witness something that concerns me***
- ***Speak up about my wards staffing levels***
- ***Speak up if I perceive bad practice***
- ***Advocate freedom to speak up to all in the hospital***

- ***Speak up about good as well as bad***



Speak Up Month 2022

The theme for Speak Up Month 2022 is **"Freedom to Speak Up for Everyone"** with each week having a specific focus:

#SpeakUpforSafety

The safety of people who use and work in our services is core to how we work. Week 1 highlights the importance of speaking up about anything that gets in the way of you doing a good job, particularly relating to patient care and worker safety. Use this week to speak up for something you think can help us learn and improve for the benefit of patients and colleagues

#SpeakUpforCivility

Week 2 focuses on being kind to colleagues and not forgetting to be kind to yourself. Civility Saves Lives say that "Almost all excellence in healthcare is dependent on teams, and teams work best when all members feel safe and have a voice." Use this week to connect with colleagues.

#SpeakUpforInclusion

Week 3 is all about promoting inclusion and breaking down the barriers we know exist to enable all workers to feel safe to speak up and be heard. This week we are also celebrating Black History Month alongside Speak up Month. Use this week to promote equality, diversity and inclusion and engage with staff networks.

#FTSUforEveryone

Week 4 brings together all professions, worker groups and sectors, both within health and social care and beyond. We want to make speaking up business as usual for everyone, regardless of job role, background, or circumstance.

Here at Southport and Ormskirk NHS Trust we will be holding information stands on both sites, you can meet our Guardian and, your local FTSU Champions to celebrate Speak Up Month.

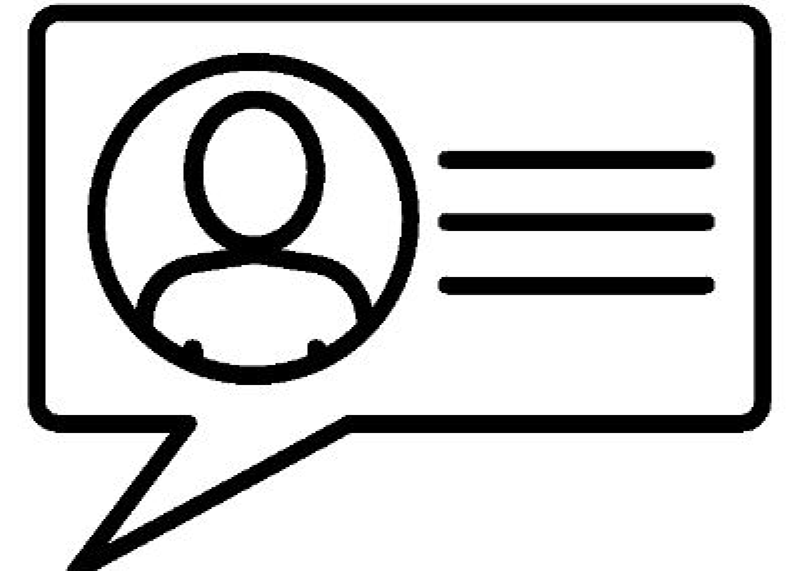
The National Guardians Office are encouraging everyone to take part in **"Wear Green Wednesdays"** throughout October to show their visible support for Freedom to Speak Up.

#FTSUForEveryone

Freedom to Speak Up
Guardian
You can speak up about anything which gets in the way of you doing your job
It could be something you're worried about or an idea for improvement
Your voice matters
Call or text your local guardian in confidence on 07771 993557
I pledge to ...
#SpeakUpPledge

I pledge to ...
Speak up
for patients and
Staff members
#SpeakUpPledge
I pledge to ...
I pledge to Speak up
I witness Something
that Concerns
me.
#SpeakUpPledge
I pledge to ...
I pledge to speak up for patient &
Staff safety for the benefit of All ♡
Theresa.
#SpeakUpPledge
I pledge to ...
to Speak up
#SpeakUpPledge
Up Month

TOTAL CASES



20,362 cases

were raised with

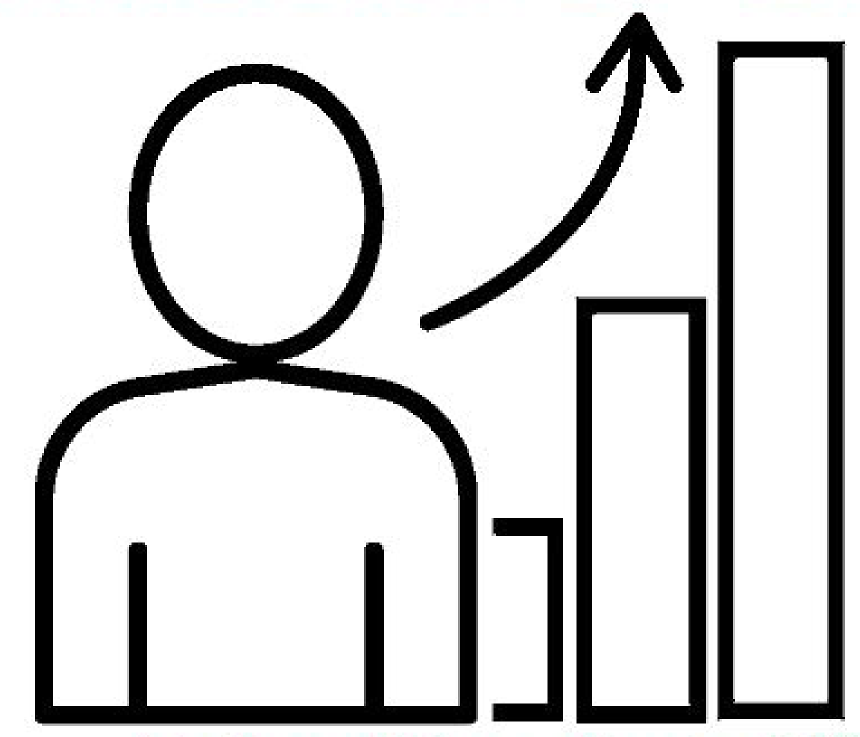
Freedom to Speak Up Guardians

In 2021/22

A similar number of cases were raised in 2020/21 (20,388)

National Guardian's Office Annual Speaking Up Data Summary

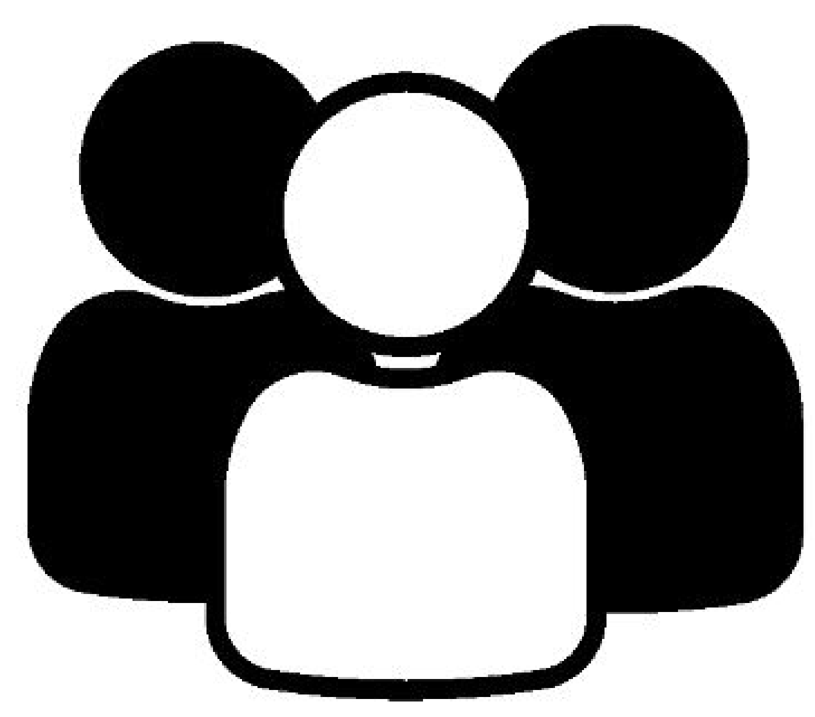
QUARTER 3 HAD THE LARGEST AMOUNT OF CASES



October to December 2021 had the highest number of cases reported in a single quarter (5,705) since Freedom to Speak Up guardians were established in 2016. This may be as a result of the awareness raising which takes place during Speak Up Month every October.

National Guardian's Office Annual Speaking Up Data Summary

PROFESSIONAL GROUPS



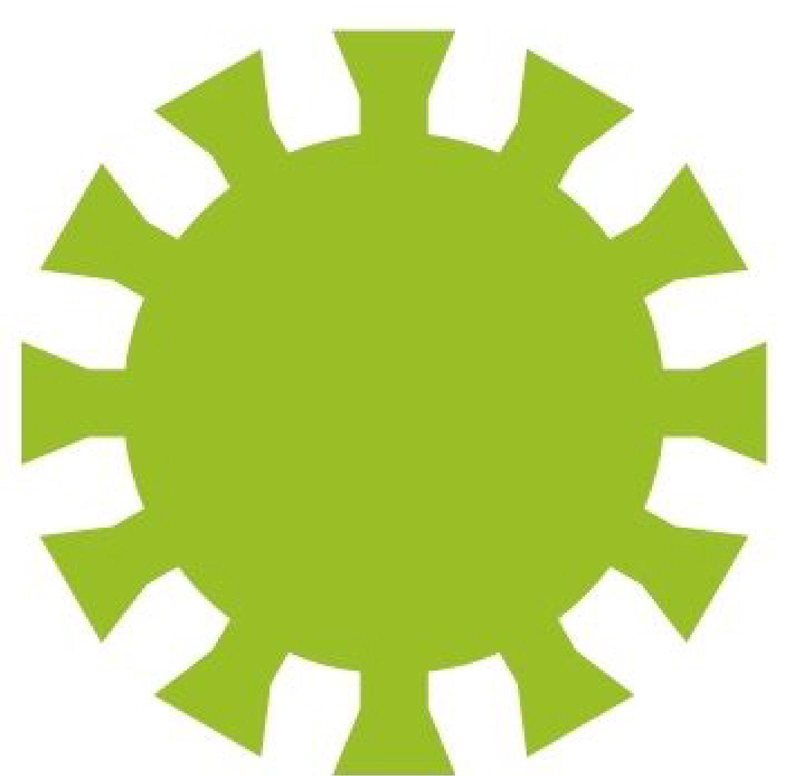
Workers from a range of professional groups spoke up to Freedom to Speak Up Guardians.

Nurses and midwives

accounted for the biggest portion (28.5%) of cases raised.

National Guardian's Office Annual Speaking Up Data Summary

COVID-19 PANDEMIC

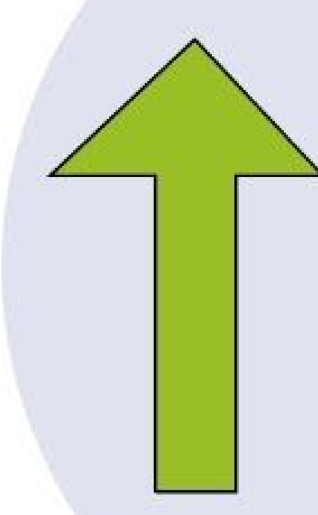


Worker safety was a strong theme in Freedom to Speak Up guardians' reflections on the data they provide, with the impact of reduced staffing levels included in patient safety concerns, increased workloads and staff wellbeing.

This theme was particularly linked to the COVID-19 pandemic, which had led to increased sickness, from COVID-19 itself and from stress/burnout.

National Guardian's Office Annual Speaking Up Data Summary

PATIENT SAFETY AND QUALITY



Nineteen per cent (19.1%) of cases raised included an element of patient safety/quality, a slight increase from 18% in 2020/21.

National Guardian's Office Annual Speaking Up Data Summary

BULLYING AND HARRASSMENT

32.3% of cases had an element of bullying and harassment, up from 30.1% in 2020/21.

National Guardian's Office Annual Speaking Up Data Summary

ANONYMOUS CASES

The percentage of cases which were raised anonymously has fallen to ten percent (10.4%). This continues the downward trajectory from 2017, when 17.7% of cases were raised anonymously.

DETRIMENT

Detriment for speaking up was indicated in 4.3% of cases, this has risen since last year (3.1% in 2020/21).

National Guardian's Office Annual Speaking Up Data Summary

National Guardian
Freedom to Speak Up

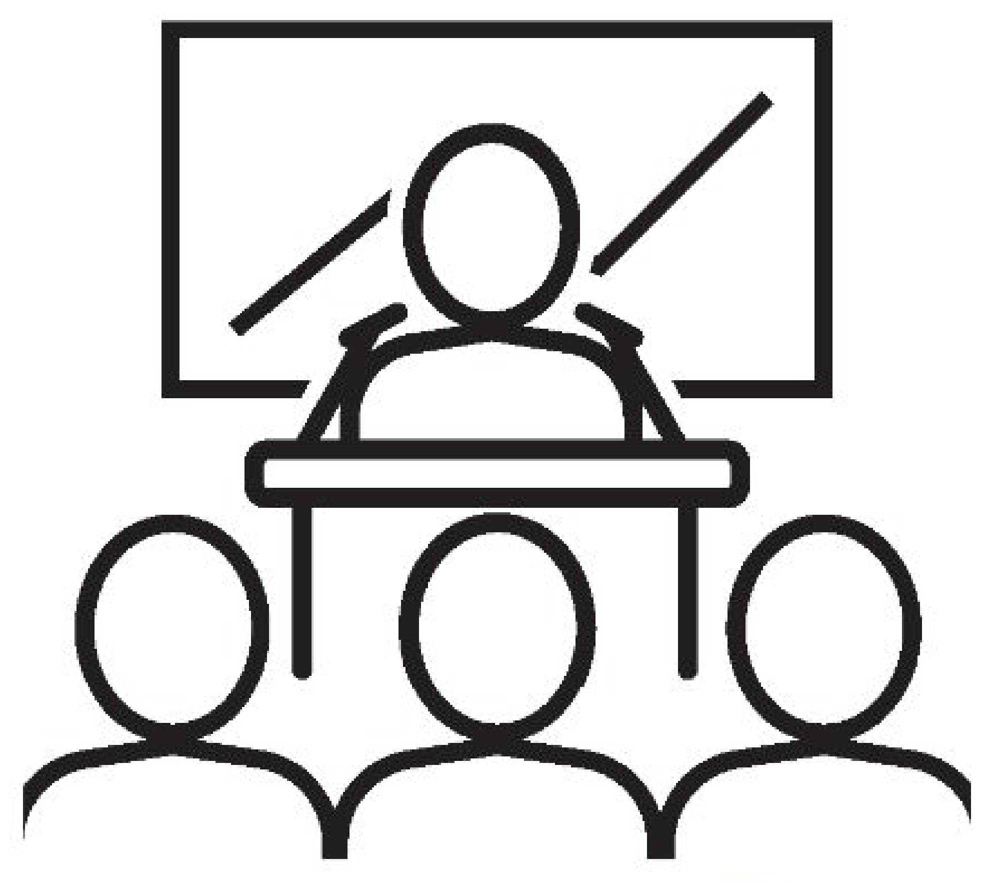
FEEDBACK

Over four-fifths (86.7%) of those who gave feedback said they would speak up again

National Guardian's Office Annual Speaking Up Data Summary

COMMUNICATION

Communication issues were a key learning point, including workers being informed about changes, style of communication and differing local interpretations of guidance.



National Guardian's Office Annual Speaking Up Data Summary

Title of Meeting	STRATEGY AND OPERATIONS (S&O) COMMITTEE	Date	07 December 2022
Agenda Item	SO229/22	FOI Exempt	YES / NO
Report Title	LIBRARY & KNOWLEDGE SERVICE STRATEGY 2023-26		
Executive Lead	Jane Royds, Director of HR & OD		
Lead Officer	Margaret-Mary O'Mahony, Library & Knowledge Service Manager		
Action Required	✓ To Approve ☐ To Assure	☐ To Note ☐ To Receive	

Purpose

The Library & Knowledge Service Strategy 2023-26 needs to be approved at Trust Board Board level. Approval is a requirement for our Quality and Improvements Framework Submission to Health Education England. https://library.hee.nhs.uk/quality-and-impact/quality-and-improvement-framework

Executive Summary

This document defines the strategic direction for Southport & Ormskirk Library & Knowledge Service from 2023 to 2026. It outlines the Vision, Aims and Objectives for delivering high quality evidence, discovery, and knowledge services. It also responds to the national and local NHS drivers, demonstrating how the library will support those higher-level goals.

The strategic themes reflect the vision of delivering the right knowledge and evidence at the right time in the right place, enabling high quality decision making, learning, research, and innovation to achieve excellent healthcare and health improvement as per Knowledge for Healthcare. The purpose of this strategy is to align the Southport & Ormskirk Library and Knowledge Service with the Trust's values and objectives including Our People Plan, Nursing and Midwifery Strategy, and Medical Education Strategy.

We aim to ensure that the library has the staff, accommodation, resources, and facilities to respond appropriately to changes and developments within the NHS and healthcare. Success, progress, and impact will be measured by the following: Annual Report/Strategic Implementation Plan/KPIs/Health Education England Quality and Improvement Outcomes Framework.

Recommendations

The Strategy and Operations Committee is asked to approve the Library & Knowledge Service Strategy 2023-26.

Previously Considered By:

☐ Strategy and Operations Committee	☐ Executive Committee
☐ Finance, Performance & Investment Committee	☐ Quality & Safety Committee
☐ Remuneration & Nominations Committee	✓ Workforce Committee
☐ Charitable Funds Committee	☐ Audit Committee

Strategic Objectives

✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services

✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards

✓ **SO3** Efficiently and productively provide care within agreed financial limits	
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Margaret-Mary O'Mahony, Library & Knowledge Service Manager	Jane Royds, Director of HR & OD

LIBRARY & KNOWLEDGE SERVICE

STRATEGY

2023 - 2026

WWW.SONHSLKS.COM

Our Vision

To provide an integrated, dynamic, cost-effective, and responsive library and knowledge service for the clinical decision making, education, and research needs of all involved in patient care and hospital services across the organisation.

Our Mission

To facilitate timely access to relevant, evidence-based information, by providing; high quality resources, education, knowledge mobilisation, and information consultancy to deliver continuous service improvements and excellent patient care.

Introduction

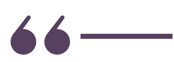
This document defines the strategic direction for Southport & Ormskirk Library & Knowledge Service from 2023 to 2026. It outlines the Vision, Aims and Objectives for delivering high quality evidence, discovery, and knowledge services. It also responds to the national and local NHS drivers, demonstrating how the library will support those higher-level goals.

Our mission and its objectives are driven by NHS strategies set out in both the NHS Education Contract[1], and the NHS People Plan[2]. Southport & Ormskirk Library & Knowledge Service objectives are further directed by the guidance set out in the Quality and Improvement Outcomes Framework[3] and Knowledge for Healthcare: a development framework for NHS library and knowledge services in England [4] which identify key priorities for NHS library services.

We aim to ensure that the library has the staff, accommodation, and facilities to respond appropriately to changes and developments within the NHS and healthcare. Success, progress, and impact will be measured by the following: Annual Report/strategic implementation plan/statistics/Health Education England Quality and Improvement Outcomes Framework.

The strategic themes reflect the vision of delivering the right knowledge and evidence at the right time in the right place, enabling high quality decision making, learning, research, and innovation to achieve excellent healthcare and health improvement as per Knowledge for Healthcare.

The purpose of this strategy is to align the Southport & Ormskirk Library and Knowledge Service with the Trust's values and objectives[5] including Our People Plan[6], Nursing and Midwifery Strategy, and Medical Education Strategy.



Evidence does not speak for itself but needs to be mobilised at the right time, and through the right people, to make a difference in decision making.

NIHR Health Services and Delivery Research, 2012

1. **NHS Education Contract - April 2021-March 2024.pdf (hee.nhs.uk)**
2. **NHS England » Online version of the People Plan for 2020/2021**
3. **HEE Quality and Improvement Outcomes Framework.pdf**
4. **Knowledge for Healthcare - Mobilising evidence; sharing knowledge; improving outcomes (hee.nhs.uk)**
5. **Trust Objectives 2022 (mcusercontent.com)**
6. **Our People Plan**

Evidence

Ensure that the right knowledge and evidence is available, at the right time, in the right place, enabling high quality decision-making, learning, research and innovation, to achieve excellent healthcare and health improvement.

Awareness and Access

Apply best practice in management of assets and resources, ensuring they are contextually relevant to our specialist audiences, promote access through marketing and engagement activities and enable improved access through physical and digital means.

Research and Knowledge

Support and actively promote sharing and dissemination of knowledge and learning to improve collaboration and research outputs.

Skills Development

Encourage the development of users' digital and information literacy

Leadership and Organisational Development

Provide resources to support the organisation in developing and supporting its staff.

Investment and Growth

Identify and capitalise on opportunities for investment and growth of the service.

Strategic Themes

The following key themes mirror the Knowledge for Healthcare Framework and works to support Southport & Ormskirk's Trust Objectives

Mobilising evidence and knowledge to deliver outstanding care

Supporting S&O staff and stakeholders to mobilise evidence, learning, knowledge and 'know how' to enable evidence based policy and practice.

- Identify and respond to information needs
- Promoting evidence into practice
- Contributing to organisational knowledge management
- Deliver services at the point of need
- Ensure awareness and use of services and resources
- Promote research and education / Pathway to publication
- Provide appropriate library spaces 24/7, including "quiet zones", IT suite and group study spaces to encourage learning and innovation

Quality and impact to achieve best patient outcomes

- Ensure S&O staff and stakeholders receive quality assured, business critical library and knowledge services.
- Participate in the Quality and Improvement Outcomes Framework, using it to identify areas of best practice as well as areas where more work can be undertaken to improve the quality of library provision.
- Evaluate the delivery of mediated services including information skills training, evidence searching and information consultancy.
- Implement impact assessment tools to gather evidence of the effect of library and knowledge services including outreach and mediated searching.
- Share best practice both within and outside of the Trust.
- Improve engagement with senior stakeholders across the Trust.

Strategic Themes

Improve health literacy

- Identify and improve core health and digital literacy skills of staff and learners.
- Provide guidance on accessing and developing quality patient information.
- Work with departments to offer resources and services to support patients i.e. the ICU knowledge website.
- Support staff wellbeing by providing relevant wellbeing resources and by promoting the library spaces as a wellbeing hubs.

Strong system leadership

- Provide evidence and resources to support change management including support with service redesign, partnership working, quality assurance, and wider NHS/ICB.
- Support education, learning and organisational development teams in the development of a strong coaching culture across the Trust.
- Support clinical and non-clinical managers to make evidence-based decisions, by the provision of evidence reviews, information consultancy, current awareness alerts, point of care resources, and knowledge sharing activities.

Deliver sustainable healthcare to meet people's needs

- Deliver a cost-effective library and knowledge service, evaluating subscriptions annually and liaising with the stakeholders to ensure the provision of resources that meet the needs of the workforce.
- Collaborate with other NHS LKS on consortia purchases and reciprocal sharing of resources.
- Provide evidence-based information on care and treatment options, to support cost efficiency and patient safety.

Applying knowledge into action is the currency of a successful healthcare organisation. Taking the 'heavy lifting' out of getting evidence into practice to improve the quality of care, NHS Knowledge and Library Service teams offer the 'gift of time' to healthcare professionals

Dr Navina Evans, Chief Executive, Health Education England

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ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Finance, Performance, and Investment Committee
MEETING DATE:	28 November 2022
LEAD:	Jeff Kozer

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The Trust is reporting a £10.9m deficit at month 7, which is in line with the financial plan. £9.3m of the Cost Improvement Target (CIP) target is RAG rated as green and at month 7 the Trust is delivering to plan. With regards to Elective Recovery Fund (ERF) the Trust has assumed payment in full up to month 7. The other main risk to delivering the plan is the continued non elective pressures, which has meant that the winter escalation wards are still open. A staffing model for 11a has been agreed which should see bank and agency spend reduce as recruitment takes place. The pressure relating to the pay award and non-pay inflation is being monitored.
- The cash balance at the end of October is £4.7m. The Integrated Care Board (ICB) finance team have made payments on the first of the month from August instead of 15th, and £2m additional support was provided in October, with a further £7m received in November. To note the £9m will be repayable by the end of March.
- A concern was raised with regards to the potential impact on patient safety of the new protocols put in place to cover a situation where either a Trust or ICB wishes to report a deterioration from the financial plan.
- Overall A&E performance in October 2022 compares positively to peers and top quartile nationally and best acute performer in C&M but below the national standard.
- Challenges with discharges due to capacity issues remain across the system.

ADVISE

- The network remediation programme is making good progress across the Ormskirk site.
- EPMA pilot in Spinal to take place in December.
- ERF activity at 92% for October 2022, in line with C&M position of 92.5%.

ASSURE

- Specialist Services CBU attended to present on progress with regards to CIP achievement and the alignment with their overall strategy.
- The Better Payment Practice Code (BPPC) performance at month 7 is 96%, which is slightly above the 95% target.
- The capital programme spend at month 7 is slightly below the plan of £8.8m at £8.6m.
- The Trust is 1 of only 2 trusts in the ICB to see a reduction in agency spend in year compared to 2021/22, with a 28% reduction.
- Endoscopy activity for October 2022 is reported at 141% of 2019/20 levels. At the start of April 2022, the number of patients on endoscopy waiting list was 2,229 it is now 666. The number of patients waiting over 13 weeks was 1,556 now 87.
- The Trust has seen improvements in cancer metrics and in September 2022 treated a record number of patients on a 2 week wait cancer pathway with the number of 104+ day breaches reducing from 109 in April 2022 to 25.

New Risks identified at the meeting: None

Review of the Risk Register: No action taken

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Executive Committee
MEETINGS HELD:	November 2022
LEAD:	Anne-Marie Stretch, Managing Director

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Preparation for Industrial Action
The Committee received an update on the potential for industrial action from several unions representing NHS staff and noted that the self-assessment checklist had been completed. The outcome of the RCN ballot for the Trust was that there was not a mandate to take strike action. The outcome of the Unison ballot and those of the other health unions will be received over the coming weeks.

ADVISE

Maternity Action Plan Update (bi-weekly standing item)
The Executive Committee received updates on the progress of implementing and embedding the plan and it was noted that all actions were now complete except for the capital scheme for the maternity theatre.

Essential Skills Training Update (October 2022) (01/11 and 14/11/2022)
The Essential Skills Training update was discussed, and it was agreed that the training for Board members would be reviewed with a view to arranging group training sessions. It was noted that, despite the Trust being close to capacity at times over the preceding month, essential skills training had not been cancelled and staff had been released to attend.

Tier 2 Self-Assessment Feedback (07/11/2022 and 21/11/2022)
The Committee received an update on the Tier 2 Self-Assessment feedback, including confirmation that the Trust had been stood down as a Tier 2 Trust with effect from 21 November 2022.

IT Investment Agreement (07/11/2022)
The Committee reviewed the draft NHS Digital IT Investment Agreement, and it was noted that the funding could be used for infrastructure projects or solutions to support infrastructure. The Committee approved the agreement for submission.

Protocol for Changes to In-Year Forecast (14/11/2022)
The meeting had reviewed the NHSE Protocol for Changes to In-Year forecasts which had also been discussed at the Finance, Performance, and Investment Committee.

JAG Accreditation Pre-Assessment (14/11/2022)
There had been pre-accreditation visit by a representative from the Endoscopy network. The representative had advised that with the developments planned the Trust would be able apply for JAG accreditation during 2023/24, when the capital works were completed.

Proposal for the Replacement of External Lighting (14/11/2022)
The Committee approved the capital scheme to replace and enhance external lighting at both the Southport and Ormskirk sites.

Monthly Nurse Staffing Report (21/11/2022)
The Committee received an update on the monthly nurse staffing, vacancy rates, recruitment, and establishment reviews and it was noted that the next nurse staffing review would include an update on the staffing needed to support the demand for supplementary care.

Model Hospital (29/11/2022)
The Committee received an update on possible future improvements to productivity and efficiency which included a focus on reducing length of stay.

Day Case Rates (29/11/2022)
The Committee was briefed on the opportunities to improve theatre day case rates and reduce bed requirements.

Winter Plan Update (29/11/2022)
The Committee received an update on the Winter Plans and were assured that no additional funding would be required to implement the plans.

National Standards of Cleanliness (29/11/2022)
The Committee agreed the Cleanliness Charter which is a requirement of the new NHS National Standards of Cleanliness.

ASSURE

System Responses (standing item)
Directors provided feedback from several external meetings and events with system partners where they had represented the Trust.

Cost Improvement Programme (CIP) Update (14/11/2022)
CIP had been delivered to plan and schemes were progressing through the weekly Quality Impact Assessments (QIA) Panels. The Committee was assured of the focus of the delivery of 2022/23 plans as well as the development of the 2023/24 plans.

Capital Planning Assurance Group Weekly Update (standing item)
The Committee received the Capital Planning Assurance Group weekly progress report and remain assured of the progress being made to deliver the Targeted Investment Fund (TiF) and Community Diagnostic Centre (CDC) developments, including the staffing.

Risk and Compliance Group AAA Highlight Report for November 2022 (21/11/2022)
The Committee received the report and noted that Risk 2201 (Covid-19 Workforce) had been closed and incorporated into the generic workforce risk.

The Committee received an update on Risk 1528 (Electronic Prescribing and Medicines Administration (EPMA)) which noted that the system implementation date for S&O had now been agreed.

Equality Delivery System 2022 (21/11/2022)
The Committee received an update of the Equality Delivery System 2022, and it was agreed that the Medical Director and the Director of Transformation would be the Executive Leads for Domain 3 (Inclusive Leadership).

Well Led Self-Assessment, Evidence Collection and Next Steps (29/11/2022)
The Committee received an update on the Well Led Self-Assessment, noted the gaps and actions highlighted and agreed on the next steps to be included in an improvement plan.

EPRR Assurance Cheshire and Merseyside Integrated Care Board Reporting (29/11/2022) The Committee received feedback that the Cheshire and Merseyside Integrated Care Board had signed off the Emergency Preparedness, Resilience and Response (EPRR) Compliance Statement and declared the Trust substantially compliant. HFMA Checklist Audit (29/11/2022) The Committee noted that the MIAA were currently concluding their review of the Trust's HFMA Checklist and noted that the scores previously reported across all domains remained unchanged.	
New Risk identified at the meeting	None
Review of the Risk Register	