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

**To be held at 0930 on Wednesday 02 November 2022**

**V = Verbal D = Document P = Presentation**

| Ref No. | Agenda Item | FOI exempt | Lead | Time |
|---|---|---|---|---|
| **PRELIMINARY BUSINESS** | | | | ***0930*** |
| **SO197/22 (P)** | **Patient Story**<br>*Purpose: To **receive** the patient story* | *No* | *L Barnes* | 15 mins |
| **SO198/22 (V)** | **Chair's welcome and note of apologies**<br>*Purpose: To **record** apologies for absence and confirm the meeting is quorate.* | *No* | *Chair* | |
| **SO199/22 (D)** | **Declaration of interests**<br>*Purpose: To **record** any Declarations of Interest relating to items on the agenda.* | *No* | *Chair* | |
| **SO200/22 (D)** | **Minutes of the previous meeting**<br>*Purpose: To **approve** the minutes of the meeting held on 5 October 2022.* | No | *Chair* | 10 mins |
| **SO201/22 (D)** | **Matters Arising and Action Log**<br>*Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions.* | *No* | *Chair* | |
| **STRATEGIC AND GOVERNANCE** | | | | **0955** |
| **SO202/22 (D)** | **Audit Committee AAA Highlight Report**<br>*Purpose: To **receive** the Audit Committee AAA Highlight Report from the meeting held on 19 October 2022* | *No* | *G Brown* | 10 mins |
| **SO203/22 (D)** | **2022/23 Trust Objectives – Mid Year Review**<br>*Purpose: To **receive** the Trust Objectives Mid-Year Review for assurance* | *Yes* | *AM Stretch* | 10 mins |
| **INTEGRATED PERFORMANCE REPORT** | | | | **1015** |
| **SO204/22 (D)** | **Integrated Performance Report (IPR)**<br>a) Quality and Safety | *No* | *L Barnes*<br>*K Clark* | 20 mins |

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|---|---|---|---|---|
| | b) Operations<br>c) Finance<br>d) Workforce | | *L Neary*<br>*J McLuckie*<br>*J Royds* | |
| | *Purpose: To **receive and note** the IPR for assurance.* | | | |
| **QUALITY & SAFETY** | | | | **1035** |
| **SO205/22 (D)** | **Quality and Safety Committee AAA Highlight Report**<br>*Purpose: To **receive** the Quality and Safety AAA Highlight report* | *No* | *G Brown* | 10 Mins |
| **WORKFORCE** | | | | **1045** |
| **SO206/22 (D)** | **Workforce Reports**<br>a) Committee AAA Highlight Report<br>b) People Plan Update<br>*Purpose: To **receive** the Workforce reports* | *No*<br>*No* | *L Knight*<br>*J Royds* | 20 Mins |
| **FINANCE, OPERATIONS AND INVESTMENT** | | | | **1105** |
| **SO207/22 (D)** | **Finance, Performance and Investment Reports**<br>a) Committee AAA Highlight Report<br>*Purpose: To **receive** the Finance, Performance and Investment Reports* | *No* | *J Kozer* | 10 mins |
| **SO208/22 (D)** | **Emergency Planning Reports**<br>a) Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment<br>*Purpose: To **approve** the EPRR Core Standards Self-Assessment* | *No* | *L Neary* | 10 mins |
| **CORPORATE** | | | | **1125** |
| **SO209/22 (D)** | **Executive Committee AAA Highlight Report**<br>*Purpose: To **receive** the Executive Committee AAA Highlight Report* | *No* | *AM Stretch* | 10 Mins |
| **CONCLUDING BUSINESS** | | | | **1135** |
| **SO210/22 (V)** | **Questions from Members of the Public**<br>*Purpose: To **respond** to questions from members of the public received in advance of the meeting.* | | *Chair* | *5 mins* |

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| **SO211/22 (V)** | **Any Other Business**<br>*Purpose: To **receive** any urgent business not included on the agenda* | *Chair* | *5 mins* |
| | **Date and time of next meeting:**<br>0930 Wednesday 07 December 2022 | | ***1145 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 05 October 2022**
(Approved by the Strategy and Operations Committee on 02 November 2022)

**Present**

| Name | Initials | Title |
|---|---|---|
| Richard Fraser | RF | Chair, STHK |
| Ann Marr | AM | Chief Executive |
| Anne-Marie Stretch | AMS | Managing Director |
| Geoffrey Appleton | GA | Non-Executive Director, STHK |
| Gill Brown | GB | Non-Executive Director, STHK & S&O |
| Nicola Bunce | NB | Director of Corporate Services |
| Kate Clark | KC | Medical Director |
| Ian Clayton | IC | Non-Executive Director, STHK & S&O |
| Rob Cooper | RC | Director of Operations and Performance, STHK |
| Lisa Knight | LK | Associate Non-Executive Director, 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 |
| Peter Williams | PW | Medical Director, STHK |

**In Attendance**

| Name | Initials | Title |
|---|---|---|
| Martin Abrams | MA | Hospital Spiritual Care and Chaplaincy Service *(Item SO169/22 only)* |
| Sonya Clarkson | SC | Deputy Director of HR and OD |
| Jan Fraser | JF | Hospital Spiritual Care and Chaplaincy Service *(Item SO169/22 only)* |
| Kate Greaves | KG | Student Minister on Placement *(Item SO169/22 only)* |
| Brendan Prescott | BP | Deputy Director of Quality, Risk and Assurance |
| Juanita Wallace | JW | Assistant to ADCG (minute taker) |
| Richard Weeks | RW | Corporate Governance Manager |

**Apologies**

| Name | Initials | Title |
|---|---|---|
| Lynne Barnes | LB | Director of Nursing, Midwifery and Therapies |
| Paul Growney | PG | Non-Executive Director, STHK |
| Jane Royds | JR | Director of HR and OD |

| AGENDA ITEM | DESCRIPTION | Action Lead |
|---|---|---|
| **PRELIMINARY BUSINESS** | | |
| **SO169/22** | **Patient Story**<br>MA introduced KG, Student Minister on Placement who had asked to observe today's patient story video and Committee discussion. | |

MA introduced the patient story video in which Joanna, who had been diagnosed with stage 4 cancer five years ago, shared her story about the care that she had received from the Trust, Clatterbridge Cancer Centre and Queens Court Hospice, and the support that she received from the spiritual care and chaplaincy service. She shared the positive impact that this had on both her and her husband and reflected that a person did not need to have specific religious beliefs to benefit from their support.

AM reflected on the importance of spiritual care and the need to support all faiths and forms of spirituality and asked if all patients had access to the service. MA assured the Committee that a significant number of patients were being referred to the service but noted that occasionally staff were cautious about asking a patient if they wanted to see a chaplain. MA noted that it was important to frame the question in the right way and that spiritual needs should be continuously re-evaluated throughout a patient's care. Additionally, spiritual care champions were being appointed and there was an objective to have a champion for every ward. JF reflected on the impact of champions, as she knew of one ward where the champion had explained the service to each patient, and this had resulted in six referrals.

IC reflected on his personal cancer journey and commented that a person was not always aware that they needed emotional and psychological support. Additionally, it was important to make patients aware of the support that was available. MA commented that being visible on both hospital sites and making staff aware of the resources available was important and reflected on the number of informal "corridor conversations" that he had with people.

BP expressed both his and LB's gratitude to the Hospital Spiritual Care and Chaplaincy Service for the support that they provided to patients and staff members.

RF reflected on the emotional story and asked for the Committee's thanks to be passed to the patient for sharing her story which he had found inspiring. Additionally, he thanked the Spiritual Care and Chaplaincy Service for everything that they did.

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

**SO170/22 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:

- Consultant Obstetrician and Gynaecologist, Dr Jayashree Srinivasan (Jay), had a poster accepted for the 18th World Congress on Menopause in Lisbon, taking place in October.
- Sexual Health Advisor, Eileen Cockwill has successfully completed a Level 7 accredited Professional Nurse Advocate Training Programme.
- Erica Isherwood was nominated for the RCN Northwest Award for Outstanding Contribution to Equality, Diversity, and Inclusion

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

**SO171/22 Declaration of interests**

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

**SO172/22 Minutes of the previous meetings**

The Committee reviewed the minutes of the previous meeting held on 07 September 2022 and approved them as a correct and accurate record of proceedings subject to the following amendments:

- SO153/22 Overdue Incident Actions to be amended to read *'Overdue Incident Actions – The Committee had requested the Scrutiny and Assurance Group ensure that there was appropriate attendance to have oversight of all incident action plans. An update on progress in closing the overdue incident actions had been requested for the September meeting.'*
- Strategy and Operations Committee Attendance 2022/23 (page 17) to be updated to note PW's attendance.

**RESOLVED:**
The Strategy and Operations Committee **approved** the minutes from the meeting held 07 September 2022

**SO173/22 Matters Arising and Action Logs**

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

It was noted that the Trust had agreed an extension with NSHE to the submission deadline of 31 October of Agenda Item SO186/22 Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment and this item had been deferred to the meeting scheduled for 02 November 2022.

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

## STRATEGIC AND GOVERNANCE

**SO174/22 Charitable Funds Committee AAA Highlight Report**

JMcL presented the AAA Highlight Report from the meeting held on 20 September 2022 and alerted the Committee to the following:

- The portfolio valuation achieved a return of -4.3% over the preceding 12 months, however, the Committee had agreed to continue with the existing investment strategy.
- The Committee had requested that the option of purchasing a hybrid minibus for the spinal unit be investigated. JMcL noted that this action had been completed and at the moment there was not an electric vehicle on the market that would meet the needs of the spinal unit, within the proposed price range.

JMcL advised the Committee of the following:

- The Charitable Funds Committee had agreed to liquidate £50k of the investment portfolio in order to release cash to pay outstanding invoices.

Assurance was provided that:

- The wellbeing garden scheme had been completed
- There had been agreement to create a staff panel to review bids to charitable funds in the first step of the approval process, to encourage greater involvement in decision making about the use of these funds.
- The Committee had approved the engagement of Mazars to audit the Charitable Funds 2021/22 accounts and annual report.

**RESOLVED:**
The Strategy and Operations Committee **received** the Charitable Funds Committee AAA Highlight Report

**SO175/22 Board Assurance Framework**

NB presented the Board Assurance Framework (BAF) report which provided an update on the proposed changes to the BAF and noted that good progress had been made in delivering the mitigating actions. Due to continued challenges in the NHS, it was not proposed that the risk scores were changed at this time. The amendments to the BAF had been reviewed by the assurance committees.

GB commented that it appeared that SO2b had not been updated since the last submission and requested that additional information about the mitigations be included. NB advised that SO2b was raised for the first time following Audit Committee and the Finance, Performance, and Investment Committee (FP&I) in July 2022. It was therefore the first time SO2b was presented as part of the full BAF review.

IC reflected on the improvements since the previous quarter and asked about the delay in the implementation of the Intrusion Prevention System (IPS) and wondered if this had been affected by the resignation of the Associate Director of Digital. JMcL advised that this had been resolved following the submission of papers for the Committee and the work was now completed, so this action would be shown as closed in the next update.

**RESOLVED:**
The Strategy and Operations Committee **approved** the proposed changes to the Board Assurance Framework

**SO176/22 Corporate Risk Register**

KC presented the Corporate Risk Register report which provided an update on the open risks and advised that work had been undertaken to improve the quality of the information and mitigations. KC advised that Risk 2168 (Cyber Security – unsupported systems) had been added to the Risk Register. Additionally, the risk score for Risk 1528 (Electronic Prescribing and Administration of Medicines (EPMA) system had been increased due to the delay in the implementation of the system.

The Scrutiny and Assurance Group was supporting work to ensure that the consolidated actions were applicable to various risks and progress in delivering these actions was tracked.

IC commented that he could see that the introduction of the Risk Management Framework (RMF) and training had started to make an impact. IC reflected on a recent Health Services Journal (HSJ) article about the increase of legionnaires disease and asked if the Trust had reviewed this risk. KC advised that the Trust had a Water Systems Group which ensured that the Trust was compliant with the relevant legislation and best practice guidance. An incidence of legionella had been detected in one of the standpipes, and actions had been taken to eliminate this from the hospital systems. As DIPC KC confirmed that she was assured that all the appropriate actions had been taken and the issue had been resolved.

RT commented on Risk 2019 relating to a risk of poor outcomes for patients admitted with spinal fractures and asked if this was a new or existing risk as it had not been presented to the Quality and Safety Committee. KC advised new actions had been added to an existing risk as a result of an incident referenced in the Learning from Deaths report.

GB commented on the 11 overdue risks and asked if these had been reviewed. KC advised that the risks were reviewed monthly before the Risk and Compliance Group meeting, however, there was occasionally a delay in

updating the risk register to reflect this and work was ongoing with Clinical Business Units (CBUs) to improve the timeliness of reporting.

**RESOLVED:**
The Strategy and Operations Committee **received** the Corporate Risk Register

**SO177/22** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaboration**

a) Working Arrangements

NB presented the Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaboration report and advised that the Cheshire and Merseyside (C&M) acute and specialist providers had come together to develop proposals for joint decision making on matters that could be best progressed and responded to at scale. The mechanism to achieve this was the creation of a committee in common between the member trusts, which would enable representatives of the Board (usually the CEO) to make collective decisions on specific issues.

AM advised that CMAST was required to define the process of collective decision making and that these working arrangements were the start of the formal process. CMAST was overseen by a leadership board incorporating the Chief Executive Officers (CEO) of the 12 member trusts.

JK asked what the consequence would be if a Trust did not agree these proposals and AM advised currently decisions were made collectively and this was the next stage in developing a mature collaborative system.

RF reflected on the importance of collaboration and accountability and remarked that these proposals move forward the framework to establish true partnership working in the health service.

**RESOLVED:**
The Strategy and Operations Committee **approved** the CMAST work plan and committee in common Terms of Reference

## INTEGRATED PERFORMANCE REPORT

**SO178/22** 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 August 2022.

**a) Quality and Safety Performance Report**

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

- Staffing rates had continued to improve and there had also been a decrease in the number of registered nurses' vacancies.
- The number of Hospital Acquired Pressure Ulcers (HAPU) category 3 pressure ulcers had remained above target and three main themes had been identified. A Lead Tissue Viability Nurse had now taken up post and would focus on the education of staff and the development of a wound passport.
- Three falls that resulted in moderate or severe harm had been reported in August 2022 and work was ongoing to improve this. The Falls Lead had undertaken a re-assessment of equipment on the wards and would be providing staff training on individual wards. The Trust had taken part in the National Falls Prevention week in September.
- The Patient Friends and Family Test approval rate had decreased to 86.7% in August, from 87.8% in July and this was mainly due to the ongoing challenges in the Emergency Department (ED). The presence of a Patient Advice and Liaison Services (PALS) officer in the ED had been positively received and was able to address many issues before they progressed to a formal complaint.

KC highlighted the following:

- Five Clostridioides Difficile (C.diff) cases had been reported in August 2022, four of which were assessed as being hospital-acquired. The Infection Prevention and Control (IPC) team was providing additional support to the RCA process.
- There had been an increase in the number of Escherichia coli (E. coli) cases, and this reflected the regional and national position and had been raised at the recent North West Infection and Prevention meeting. It was noted that no lapses in care had been identified.

RF requested that for future reports the narrative be updated to reflect the target/trajectories for ease of reference.

GB reflected on her staff engagement visit to Ward 14a where staff had suggested that access to more low-rise beds would help to prevent falls. BP advised that proposals were being developed for a total bed management solution which would make more low-rise beds available when requested. AMS confirmed that a review of the bed stock was being undertaken against demand to assess how many would be needed.

SR asked if pressure relieving mattresses were being used for patients on trolleys in ED as this might help reduce pressure ulcers. BP advised that the newly appointed Tissue Viability Lead Nurse had discussed the mattresses in ED with her STHK peers and was raising awareness and providing training for staff in ED.

**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 73.7%.
- Bed occupancy levels remained above 100% and this had contributed to a slight increase in 12-hour breaches in ED (14%).
- The average length of stay (LOS) had increased and there were now between 50 and 60 patients in the Trust each day who were ready for discharge.
- Overall elective recovery (ERF) was 95.4% of plan and 100% of 2019/20 levels. The Trust was the fourth best performing Trust in the C&M region.
- Ambulance handover performance remained challenged with delays in offloading as well as the inconsistent application of the North West Ambulance Service NHS Trust (NWAS) handover checklist.
- The Emergency Care Improvement Support Team (ECIST) bed modelling work had identified that the Trust had a deficit of 40 beds.
- Cancer access performance remained challenged but there has been an improvement in 62-day performance to 64.9%. It was noted that the 62-day referrals had grown across the C&M region by 14% and nationally by 18%, however the Trust had reflected a drop of -3%.
- The Trust had no104-week waiters.
- The Trust was the top performing Trust across C&M for both 52 week and 78 week waits.
- Diagnostic activity was above 2019/20 levels, however, there remained challenges with waiting times across several modalities. There had been an improvement in Computerised Tomography (CT) access, and it was expected that this would continue. It was noted that if the recent capital bids were successful this would help address the long waits and increase capacity.

**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 an £8m deficit at month 5 in line with the 2022/23 Plan.

JMcL highlighted the following:

- The Trust forecast continued to assume 100% of the Elective Recovery Fund (ERF) would be paid based on full allocations paid to trusts to date, however, the calculation of ERF performance was pending confirmation for the remainder of the year.
- The continued need for the escalation wards as a result of operational pressures experienced into 2022/23 was creating a cost pressure.
- The Better Payment Practice Code (BPPC) overall target of 95% had been achieved.
- Capital performance was ahead of the year-to-date budget and the order for the new CT scanner had been placed.

**RESOLVED**

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

**d) Workforce Performance Report**

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

- Performance Development Review (PDR) completion compliance had increased to 76.3% in August against the target of 85%
- The 90% stretch target for mandatory training had been implemented from June 2022 and performance was slightly below target at 88.9%
- Sickness absence had decreased from 8% in July to 6.1% in August.

**RESOLVED**

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

## QUALITY AND SAFETY

**SO179/22 Quality and Safety Report**

**a) Quality and Safety Committee AAA Highlight Report**

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

- The Executive Committee had been asked to review the Essential Skills Training and identify any improvements to be made, specifically to maintain resuscitation skills
- The S&O Clinical Assessment and Accreditation Scheme (SOCASS) and Ward Dashboards had reflected common areas of lower compliance (safety culture, medicines management and nutrition) and the Committee had requested additional information about the work being undertaken to improve in these areas.

GB provided an update on the alerts that had been presented at SOC in July 2022:

- The Executive Committee was currently reviewing options for the refurbishment of Ward 9a.
- Funding had been secured for the network upgrade and this would include the phone lines. It was noted that the disruption to phone lines was impacting clinical teams.

AMS advised that several issues impacting the refurbishment of Ward 9a had been discussed at Executive Committee. It was noted that due to current pressures and the use of the decant ward as an escalation area, the work would need to be carried out with the patients in situ as far as possible and it was recognised that this would take longer and increase costs.

AMS advised that CW would be assisting S&O with the IT infrastructure issues and CW advised that the disruption to the phone lines was due to network issues and a plan to introduce a new system would be submitted to the Executive Committee.

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

**SO180/22 Learning from Deaths Report (Quarter 1)**

KC presented the Learning from Deaths Report (Quarter 1) and clarified that the report related to reviews completed in the period rather than the period in which the death occurred.

KC highlighted the following:

- There were no deaths identified as avoidable.
- One death was identified with learning where avoidability could not be fully determined.

The following themes had been identified from the structured judgement reviews

- Nutrition and Hydration
- End of Life Care
- Cardiac Arrest
- Communication

It was noted that the Medical Examiners (ME) office had seen an improvement in the quality of documentation.

IC asked if the poor compliance with resuscitation training was linked to the learning identified in this report. KC advised that there were multiple aspects to resuscitation training, and this would be dependent on the individual's role within the Trust. All employees received basic resuscitation training and all team leaders should attend Advanced Life Support courses which required their release from normal duties. This was refresher training building on the clinicians professional training. It was noted that all national courses had been paused during Covid-19 and staff members had been automatically reaccredited.

PW asked for clarity about the structured judgement reviews (SJR) and how patients were identified for them. KC advised that these were completed if identified by the Medical Examiner's office and due to the increased resource in the team SJR were now at 100% compliance for mortality reviews. PW asked if all patients were screened and if necessary, referred for a SJR. KC confirmed that this was the process and that any cases requiring a SJR were highlighted during the screening process. Additionally, if relatives raised any concerns notes would be reviewed and if appropriate the case referred for a SJR and the families would be advised.

**RESOLVED:**
The Strategy and Operations Committee **received** the Learning from Deaths Report (Quarter 1) for assurance

## WORKFORCE

**SO181/22 Workforce Report**

**a) Workforce Committee AAA Highlight Report**

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

- The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports reflected an increase in the percentage of staff who had experienced bullying and harassment. This prompted an increased focus on civility and respect training and creating safe conversations.
- The Guardian of Safe Working post remained unfilled.

LK advised the following:

- A bespoke induction, and cohort recruitment and support had been introduced to reduce the high level of turnover of Healthcare Assistants (HCA) in the first 12 months of employment.
- Funding had been lost from the apprenticeship levy as it has not been fully utilised. To address this there was a shift in emphasis from using the levy to support in-role development and toward roles to 'grow our

own' staff. It was noted that an Apprenticeship and Work Experience Lead was being recruited.

The Workforce Committee received the Library and Knowledge Services strategy presentation which demonstrated the positive impact on clinical and non-clinical outcomes, and it was aligned to other Trust strategies such as health and wellbeing, quality improvement and cost improvement.

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

**SO182/22 Workforce Reports**

a) Workforce Race Equality Standard Report (WRES) (including action plan)

SC presented the Workforce Race Equality Standard Report (WRES) and action plan and highlighted the following:

- an increase in Black and Minority Ethnic (BME) staff across clinical and non-clinical bands,
- 6.1% increase in the number of BME staff experiencing harassment, bullying or abuse from patients or relatives
- 0.2% increase in BME staff experiencing harassment, bullying or abuse from colleagues
- 1.8% increase in BME staff experiencing discrimination at work.

b) Workforce Disability Equality Standard Report (WDES) (including action plan)

SC presented the Workforce Disability Equality Standard Report (WDES) and action plan and highlighted the following:

- The Trust's 2021/22 Electronic Staff Records (ESR) indicated that 3.28% of staff had noted a disability
- 11% increase in disabled staff experiencing harassment, bullying or abuse from patients, relatives, or the public
- 7.1% increase in disabled staff experiencing harassment, bullying or abuse from managers
- 8.5% increase in disabled staff experiencing harassment, bullying or abuse from other colleagues

It was noted that the action plans to address the WRES and WDES had been aligned to the overarching 'Equality Diversity and Inclusion (EDI) / Sense of Belonging' Plan which formed one of the pillars of the Trust's 'Our People Plan' with JMcL as the Executive sponsor.

**RESOLVED:**

The Strategy and Operations Committee **received** the WRES and WDES Reports and **approved** the action plans

**SO183/22 Nursing and Midwifery Strategy**

BP presented the Nursing and Midwifery Strategy which set out the strategic aims and objectives for the Nursing and Midwifery Teams to continue to deliver and maintain outstanding care for patients and a positive working environment for staff. The strategy was aligned with the national picture set out by both the Chief Nursing Officer (CNO) and Chief Midwifery Officer (CMO), the findings of the Ockenden report 2022 and reflected the Nursing and Midwifery Strategy for Cheshire & Merseyside. It was noted that the specific strategy for Allied Health Professionals was also being developed.

BP advised that this was a three-year strategy that had been aligned with STHK's strategy and set out the aims to develop staff and ensure that the right models of care were in place.

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 Nursing and Midwifery Strategy

**SO184/22 Guardian of Safe Working Report**

*(GA left the meeting)*

KC presented the Guardian of Safe Working (GoSW) report for the period 01 April to 30 June 2022 which provided an update on issues related to the Guardian of Safe Working. It was noted that the Guardian role remained unfilled and that the Trust had now gone out three times for expressions of interest. To mitigate the risk of the role being unfilled support had been received from the previous GoSW, as well as the STKH GoSW. KC advised that currently the process was being managed jointly between her, the Head of Resourcing, and the Director of Medical Education.

KC highlighted the following:

- Trainees were more engaged with the Exception Report system overall.
- Meetings with Education Supervisors were not being recorded on the system and this was noted as a recurring theme.
- All rotas were now compliant with the 2016 Junior Doctor Contract rule.

GB noted that the scheme to create a larger sleeping area and non-gendered bathrooms at the Southport site had not been progressed. KC advised that progress had been delayed because a scheme could not be agreed within the available budget however, work was progressing to upgrade areas of the Clinical Education Centre (CEC) and discussions were taking place to agree a realistic scheme. GB asked if there were sufficient sleep areas and KC advised that sleeping areas were available for a small number of doctors but noted that most Trainees who worked shifts could use the doctors' mess which had recently been outfitted with new sofas and chairs. Additionally, accommodation for doctors who were too tired to drive after completing a night shift was available via the accommodation officers.

RT reflected on the importance of teaching and protected time and asked if the cancellation of teaching was an issue. KC advised, that despite current pressure, no teaching sessions had been cancelled, however, there had been missed education opportunities which included missed opportunities to attend clinics.

**RESOLVED:**
The Strategy and Operations Committee **received** the Guardian of Safe Working Report

## FINANCE, OPERATIONS AND INVESTMENT

**SO185/22 Finance, Performance, and Investment Committee Reports**

a) Finance, Performance, and Investment Committee AAA Highlight Report

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

- The Trust continued to experience performance issues with the telephony network.
- The Trust reported an £8m deficit at month 5, which was in line with the financial plan. The Cost Improvement Programme (CIP) target was RAG rated as green and at month 5 the Trust was delivering to plan. The other main risk to delivering the plan was the continued non-elective pressures, which meant that the winter escalation wards were still open.
- The cash balance at the end of August was £6.1m

JK advised the following:

- Action had been taken by the Executive Committee to condense the network remediation programme, to improve system resilience.
- As part of the frontline digitisation initiative a three-year investment bid has been submitted to the ICB and the Trust was awaiting confirmation of £21m of funding.

- Rheumatology collaboration with STHK was due to commence in October which would result in additional direct clinical sessions and support to complete a service review.

Assurance was provided that:

- The theatre fire storage work at Ormskirk Hospital had been completed.
- The second temporary backup generator had been decommissioned and removed from site.
- The new laundry service had gone live on 01 October
- The Medicine and Emergency CBU presented on CIP achievement against the business unit target.
- The North Mersey Stroke Pathway went live on 19 September 2022.

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

**SO186/22 Emergency Planning Reports**

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

**RESOLVED:**
The Strategy and Operations Committee **noted** that the EPRR Core Standards Self-Assessment paper had been deferred to 02 November 2022

## CORPORATE GOVERNANCE

**SO187/22 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 Committee received an update on the potential for industrial action to be taken by NHS staff as well as the preparatory actions required.
- An update following the network outage on 08 September had been received and the Committee had reviewed the recommended short-term mitigation measures and the proposed actions to improve network resilience. The ongoing issues with the telephone system were also discussed.

AMS advised that the repurposing of Ward 11a Escalation Ward into a Ready for Discharge Ward had been discussed and it was noted that the Kendall Bluck report had identified that the Trust had a 40-bed deficit.

CW advised that there was a plan in place to bring forward the timescales for the network remediations and that following another outage at the start of October 2022 an upgrade had been scheduled to take place on 05 October which was expected to provide more resilience to the network.

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

## CONCLUDING BUSINESS

**SO188/22 Questions from Members of the Public**

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

**SO189/22 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 02 November 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 | | ✓ | ✓ | | | | | |
| Gill Brown | ✓ | A | ✓ | A | | ✓ | ✓ | | | | | |
| Nicola Bunce | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | | | | |
| Ian Clayton | ✓ | ✓ | ✓ | A | | ✓ | ✓ | | | | | |
| Rob Cooper | ✓ | ✓ | A | ✓ | | ✓ | ✓ | | | | | |
| Paul Growney | A | A | A | A | | A | A | | | | | |
| Lisa Knight | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | | | | |
| Jeff Kozer | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | | | | |
| Gareth Lawrence | A | ✓ | A | ✓ | | ✓ | ✓ | | | | | |
| Rowan Pritchard Jones | A | ✓ | ✓ | | | | | | | | | |
| Sue Redfern | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | | | | |
| Alan Sharples | ✓ | ✓ | ✓ | | | | | | | | | |
| Rani Thind | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | | | | | |
| Peter Williams | | | | ✓ | | ✓ | ✓ | | | | | |
| 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 | | | | | |
| Nina Russell | ✓ | ✓ | A | ✓ | | ✓ | ✓ | | | | | |
| Richard Weeks | | | | | | ✓ | ✓ | | | | | |
| ✓ = In attendance A = Apologies | | | | | | | | | | | | |

Strategy and Operations Committee (Part 1)

Matters Arising Action Log

Action Log updated 28 October 2022

Southport and Ormskirk Hospital NHS Trust

| Status | |
|---|---|
| Red | Significantly delayed and/or of high risk |
| Amber | Slightly delayed and/or of low risk |
| Green | Progressing on schedule |
| Yellow | Included on Agenda |
| Blue | Completed |

| Agenda Ref | Meeting Date | Agenda Item | | Agreed Action | Lead | Original Deadline | Forecast Completion | Status Outcomes | BRAG Status |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

COMPLETED ACTIONS

| Agenda Ref | Meeting Date | Agenda Item | Agreed Action | Lead | Original Deadline | Forecast Completion | Status Outcomes | Status |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

# ALERT | ADVISE | ASSURE (AAA)
# HIGHLIGHT REPORT

| | |
|---|---|
| **COMMITTEE/GROUP:** | AUDIT COMMITTEE |
| **MEETINGS HELD:** | 19 October 2022 |
| **LEAD:** | David Bricknell on behalf of Ian Clayton |

**KEY ITEMS DISCUSSED AT THE MEETING**

## ALERT

- **Board Assurance Framework (BAF)** – Committee were not clear whether the identified actions to reduce the gaps in assurance or reduce the gaps in control were sufficient to reduce the current level of risk to the target level in an acceptable timescale was raised. Assurance was provided that the proposed actions were discussed and challenged at each of the assurance committees, with members of these committees also on the Audit Committee. The document was also presented to the Executive Committee where the impact of the actions was challenged. It was noted that the BAF had shown a significant improvement in recent months and was now a live record of the issues facing the organisation.

## ADVISE

- **Internal Audit Progress Report** - a request to update the 2022/23 workplan to include a review of the Emergency Planning Business Continuity Plans (BCP) was approved. It was noted that this request was because of a new requirement following the Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment. To accommodate this request the requested Clinical Business Units (CBUs) Governance review would be deferred to 2023/24.
- **The Internal Audit Follow Up -** indicated that the Appraisals review (2020/21) had received limited assurance and some of the management actions remained outstanding. The Audit Committee requested that the Workforce Committee seek assurance on these actions so that they can be closed ahead of the next Audit Committee meeting in January 2023.
- **Anti-Fraud Progress Report** – it was noted that work on the fraud risk assessment was ongoing and that this was being mapped to the Trust risk register.
- The Anti-Fraud Specialist (AFS) had met with the Head of Education, Training and OD to discuss fraud awareness as part of the induction and mandatory training offer.

## ASSURE

- The Committee received the Internal Audit Charter which confirmed MIAA's ongoing compliance with the Public Sector Internal Audit Standards.
- The External Audit Update Report noted that there were no issues to raise and that the Charitable Funds audit was ongoing.
- Proposals were presented to improve the Declarations of Interest Process following a recent internal audit review and the proposed use of the Electronic Staff Records (ESR) system for budget holders and decision makers future reporting was noted. The importance of communicating clearly with staff about who needed to complete a declaration was also noted.
- **Register of Trust Sealings** – The Committee received the report which noted that there were four uses of the Trust's seal between 01 April and 30 September 2022
- **Aged Debt Analysis** – it was noted that the over 90-day balance had improved since June 2022 and work was ongoing to pursue any outstanding balances.

| | |
|---|---|
| • The Tenders and Quotations Waivers report was noted. | |
| **New Risks identified at the meeting** | None |
| **Review of the Risk Register?** No | |

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Southport and Ormskirk Hospital
NHS Trust

| | | | |
|---|---|---|---|
| **Title of Meeting** | **STRATEGY AND OPERATIONS COMMITTEE** | **Date** | **02 November 2022** |
| **Agenda Item** | **SO203/22** | **FOI Exempt** | **YES** |
| **Report Title** | **2022/23 TRUST OBJECTIVES – MID YEAR REVIEW** | | |
| **Executive Lead** | Nicola Bunce, Director of Corporate Governance | | |
| **Lead Officer** | Richard Weeks, Corporate Governance Manager | | |
| **Action Required** | ☐ **To Approve**<br>☐ **To Assure** | ☐ **To Note**<br>✓ **To Receive** | |

**Purpose**

To summarise progress to date against the Trust objectives for 2022/23.

**Executive Summary**

Overall progress against the Trust objectives is positive, with 92% of outcome measures making significant progress towards delivery by 31st March 2023. The objectives with the highest level of assurance are:

- Objective 1 – Improve clinical outcomes and patient safety to ensure we deliver high quality services
- Objective 4 – Develop a flexible responsive workforce of the right size and with the right skills who feel valued and motivated
- Objective 6 – Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby, and West Lancashire

Within the context of remaining one of the better performing trusts in Cheshire & Mersey, there remains challenges to full achievement of Objective 2

The below table summarises the RAG ratings for all the identified outcome measures:

| Progress | RAG | Count | Percentage |
|---|---|---|---|
| Fully achieved | Blue | 0 | 0% |
| Good progress made and confident that it will be fully delivered by 31st March 2023 | Green | 12 | 46% |
| Progress made but may not be fully delivered by 31st March 2023 | Amber | 13 | 50% |
| Behind plan and at risk of not being delivered | Red | 1 | 4% |

**Recommendations**

The Strategy and Operations Committee is asked to receive the 2022/23 Trust Objectives – Mid-Year Review.

**Previously Considered By:**

| | |
|---|---|
| ☐ **Strategy and Operations Committee** | ✓ **Executive Committee** |

| | |
|---|---|
| ☐ **Finance, Performance & Investment Committee**<br>☐ **Remuneration & Nominations Committee**<br>☐ **Charitable Funds Committee** | ☐ **Quality & Safety Committee**<br>☐ **Workforce Committee**<br>☐ **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:** |
|---|---|
| Richard Weeks, Corporate Governance Manager | Nicola Bunce, Director of Corporate Services |

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Southport and Ormskirk Hospital NHS Trust

# Southport and Ormskirk Hospital NHST - Trust Objectives 2022/23

| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| **1. Strategic Objective 1 – Improve clinical outcomes and patient safety to ensure we deliver high quality services** | | | | | |
| 1.1 Reduce number of falls and hospital acquired pressure ulcers | DoN | • Reduce all falls by at least 10% and falls resulting in harm by at least 20% compared to 2021/22<br>• Reduce number hospital acquired pressure ulcers with lapses in care by 10% compared to 2021/22<br>• Ensure all patient harm incidents are reported and investigated | Quality and Safety Committee | • A Falls and Tissue Viability Lead are now in post as subject matter experts<br>• Reporting accuracy and validation work ongoing<br>• Investigations and learning robust but need embedding<br>• Investigations for both falls and HAPUs are being presented at Harm free care panel which meets weekly with oversight from Fall and TVN Leads<br>• Pressure Ulcers (PU) improvement work continues with targeted education of staff, cross working with StHK experts and a PU QI event 'Stop the Pressure' is scheduled for Nov 22.<br>• Falls workstreams include the review of relevant policies, training, ward champions and appropriate kit | |
| 1.2 Improve the early detection of deteriorating patients. | DoN/MD | • Achieve compliance with AQUA Acquired Kidney Injury (AKI) standard for US within 24hrs and urinalysis.<br>• Reduce Hospital Acquired AKI compared to the 2021/22 baseline | Quality and Safety Committee | • We continue to participate in AQUA AKI pathway and we are currently on trajectory for achieving all targets set by | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| | | | |  <br>• A deep dive was agreed to better understand the reasons for current number of hospital acquired AKIs<br>• We continue to work with colleagues at StHK & Aintree to share best practice from QI | |
| | | • Implement and report hydration and nutrition performance metrics | | • QI work is ongoing to embed and sustain a change in practice to ensure that all direct admissions to clinical areas have a MUST completed on admission together with their first set of observations with the focus on Ward 9B (AMU) and Ward 10B (Surgical Assessment Unit)<br>• Referrals for patients with a MUST score of 2+ are now electronic, Q2 data indicates an improvement with 62% referred within 55% target, the highest the Trust has achieved in last 12 months | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| | | • Undertake NEWS2 observations at the correct intervals 95% of the time | | • At September 2022 we achieved 88% NEWS 2 Observations on time for all patients. Training remains in place; the Critical Care Outreach Team (CCOT) are currently reviewing Track & Trigger training package and are developing an in house AIMS course. | |
| | | • Audit compliance with the sepsis bundle and reduce incidents related to late detection | | • We participate in AQ Sepsis benchmarking programme, we have identified areas requiring improvement including blood cultures, anti-biotics within the hour and senior review. QI work is co-ordinated via the relaunched Deteriorating Patient Group. | |
| | | • Achieve CQUIN standard for unexpected admissions to critical care | | • The Critical Care Team continue to follow excellent practice in relation to patient's needing to be escalated to Critical Care. Documentation has been improved and the Team continue to achieve 100% compliance with the CQUIN. | |
| 1.3 Improve the quality of end of life care | DoN/MD | • Improve DNACPR documentation with additional training, awareness raising and regular audits | Quality and Safety Committee | • Compliance with DNACPR questions within monthly Clinical Standard has improved since August (95%) achieving 100% September. The Resuscitation Team will be completing a bi-annual Trust | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| | | | | wide DNACPR / Documentation Audit in November 2022<br>• A training package has been developed and introduced for all clinicians and senior clinical decision makers to improve confidence in conversations and decisions relating to treatment escalation planning, decisions about CPR and anticipatory clinical management planning. | |
| | | • Improve documentation pertaining to communication of diagnosis and end of life planning (documentation audit) | | • The relaunch of the Treatment Escalation Plan (TEP) will support improving discussion with patient and families regarding escalation of care and DNACPR decisions, this is being incorporated into the medical clerking document<br>• In collaboration with Queens Court Hospice, an audit is being undertaken reviewing the data from the individual plans for care of those thought likely to be dying and the documentation of the recognition of dying. Trend analysis is expected in Quarter 3 | |
| | | • Recognition of patients approaching end of life with application of advanced management and treatment plans | | • Further work ongoing to include TEP withing standard medical clerking proforma | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| | | with clear levels of escalation (NACEL audit) | | | |
| | | • Improve feedback from patients and relatives evaluated via PALs/Complaints/patient survey results | | • The End of Life (EoL) strategy is under development which will propose a requirement to support advanced communication training to senior clinicians within the organisation as well as intermediate communications skills training available to all levels of staff<br>• The latest data demonstrates a reduction in the number of complaints. | |
| 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 | DoN/MD | • Complete SOCAAS evaluation for every ward<br>• Results of SOCAAS and delivery of the improvement plans to be reported as part of the CBU performance metrics | Quality and Safety Committee | • All in-patient wards evaluated, with plans in place to assess remaining specialist areas by the end of 2022/23<br>• Since ward accreditation was relaunched September 2021 37 assessments and reassessments have been undertaken and improvements have been demonstrated across all areas of the organisation<br>• Between April – September 2022, the following ratings have been awarded<br>o 8 Golds<br>o 9 Silvers<br>o 3 Bronze | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| 1.5 Improve Patient Experience and reduce complaints | DoN/MD | • Learning from complaints and focussing on improving communication between staff, patients and their relatives<br>• Reporting and learning from incidents with SMART actions<br>• Increase in FFT response rates in areas that aren't meeting the expected number<br>• Increase in FFT scores for patients having a positive experience<br>• Reduction in patient complaints<br>• Increase in complaint case resolution. | Quality and Safety Committee | • The Compliments, Concerns and Complaints Policy has been updated and currently in approval process. A response letter template and action plan template has also been developed<br>• FFT response rates have improved, however we have seen a deterioration in scores due to pressures and waiting times in A&E | |
| 1.6 Implement the recommendations of the Ockenden report into the safety of maternity services | DoN | • Delivery of the recommendations of the second Ockenden Report<br>• Achievement of the CNST maternity safety bundle for 2022/23 | Quality and Safety Committee | • Ockenden 1 – we are fully complaint with all recommendations<br>• Ockenden 2 – currently working with colleagues from StHK to facilitate areas noted for improvement. Support and regional direction has also been requested from the LMNS<br>• An audit from MIAA (October 2022) in relation to compliance against Ockenden 1 recommendations concluded 'Substantial Assurance'<br>• Further roll out of Continuity of Carer is currently paused. | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| 1.7 Improve Same Day Emergency Care Services to avoid unnecessary hospital admission | COO | • Increase 0 and 1 day LOS<br>• Reduce conversion to admissions 1+ day LOS<br>• Reduced number of patient ward moves<br>• Implement direct to specialty pathways | Finance, Performance and Investment Committee | • Kendal Bluck review completed and presented to ETM and MEC leadership team with opportunities for developing SDEC model further<br>• Meeting with C&M lead (PW from STHK) for SDEC to review further opportunities<br>• ECIST bed modelling included further SDEC opportunities<br>• Operational planning session to agree additional pathways for SDEC for winter 2022<br>• MEC and Planned Care CBU winter plans for additional pathways for SDEC under development<br>• | |
| 1.8 Improve frailty services to avoid unnecessary admissions for 65+ patients | COO | • Increase 0 and 1 day LOS for age 65+ patients<br>• Reduce average LOS for age 65+ patients | Finance, Performance and Investment Committee | • Kendal Bluck review completed and presented to ETM and MEC leadership team with opportunities for improving frailty pathway and offer for winter 2022<br>• Operational planning session to agree SDEC plans for winter 2022 included frailty<br>• £960k funding awarded for 14 beds at Chase Heys | |
| **2. Strategic Objective 2 – Deliver services that meet NHS constitutional and regulatory standards** | | | | | |
| 2.1 Elective Restoration - to deliver against elective levels in line with 2022/23 operating plan | COO | • Deliver 104% 2019/2020 elective activity levels | Finance, Performance | • Weekly extraordinary PTL meetings in place chaired by COO | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| | | • Deliver 120% 2019/20 diagnostic activity levels<br>• Improve theatre utilisation to pre COVID levels<br>• Improve cancer performance to meet national standards<br>• Improve endoscopy productivity and performance<br>• Reduce long waiters in line with the elective recovery plan targets | and Investment Committee | to manage elective activity and long waiters.<br>• Improving position at 93.7% of elective activity from 19/20. In line with C&M position however delivery of 104% target is a challenge for all NHS providers.<br>• Overall delivering 104% 19/20 diagnostic activity, supported by 122% of 19/20 scope activity<br>• Best acute trust position for 52+ week and 78+ weeks and 0 104+ week breaches<br>• Theatre review undertaken by STHK and findings shared with ETM<br>• Theatre improvement plan has been developed and will be monitored via theatre improvement group<br>• Cancer improvement plan developed and weekly monitoring in place by COO<br>• Significant improvement seen in cancer performance; further improvement planned by March 23<br>• Endoscopy improvement plan in place, significant improvements in endoscopy productivity and activity<br>• Successful achievement of TIF bid £5.9m to support JAG accreditation | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| | | | | | |
| 2.2 Improve the effectiveness of discharge processes | COO/DoN/ MD | • Release the maximum number of beds. As a minimum this should be half the current delayed discharges<br>• Ensure sufficient and appropriate information is provided to all patients on discharge<br>• Improve Inpatient Survey satisfaction rates for receiving discharge information<br>• Achievement of 30% target for patients discharged before noon during the week and 85% of the weekday average discharges to be achieved before noon at the weekends consistently across all wards.at weekends<br>• Introduce criteria led discharge | Finance, Performance and Investment Committee | • Patient discharge leaflets provided upon admission<br>• New discharge lounge opened in July 2022.<br>• Increase in activity through discharge lounge.<br>• Challenges with RFD/NMC2R patients delaying discharge due to capacity in community<br>• System response to address challenges being progressed with new PLACE lead.<br>• £960k funding awarded for 14 beds at Chase Heys<br>• Review Ward 11a criteria for RFD patients | |
| 2.3 Delivery of the agreed Trust financial targets: outturn, cash balances and revised capital resource limits | DoF | • Achieve the approved financial plan for 2022/23 agreed under the new NHS financial regime | Finance, Performance and Investment Committee | • The Trust is in line with plan at M6 and forecasting delivery of the 2022/23 financial plan | |
| | | • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income | | • The Trust is achieving its cash balance and aged debt targets – having taken steps to secure planned ICB support funding in-year, whilst managing debt and maintaining Better Payment Practice Code (BPPC) performance | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| | | | | | |
| | | • Deliver the approached capital programme | | • The Trust is ahead of its original capital plan and has attracted significant further capital resources which are on track for delivery by the end of March 2023 | |
| 2.4 UEC Delivery – to deliver against UEC levels in line with 2022/23 operating plan | COO | • Improve 4 hour performance (vs TBC).<br>• Reduce 12 hour waits in ED (total).<br>• Minimise ambulance handover delays<br>  ○ Eliminate > 60 mins<br>  ○ 95% h/o < 30 mins<br>• 65% h/o < 15 mins. | Finance, Performance and Investment Committee | • Best performing acute trust in C&M for 4 hour performance and upper quartile nationally<br>• Kendal Bluck review completed and presented to ETM and MEC leadership team with further opportunities for SDEC which will support improvements in ED.<br>• Implemented NWAS ambulance handover checklist to improve ambulance handover delays<br>• Introduction of RATS (Rapid Assessment and Treatment model) to improve triage times and time to treatment October 2022<br>• Direct referral form NWAS into SDEC pathways from Primary Care commencing from November 22 | |
| 2.5 Transformation of diagnostics services by becoming a Community Diagnostic Hub (CDC) to maximise capacity, throughput and patient experience | COO | • Deliver 120% 2019/20 diagnostic activity levels<br>• Reduce waiting times in line with national standard | Finance, Performance and Investment Committee | • CDC bid for £4.9m submitted & approved<br>• Capital Programme Assurance Group (CPAG) established to manage programme of work | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| | | | | • 2nd CT scanner on order<br>• Scope equipment on order<br>• Overall delivering 104% 19/20 diagnostic activity, supported by 122% of 19/20 scope activity<br>• Diagnostic waiting times improved to 32.6%, narrowing gap to average England performance (31.4%) and average North-West performance (30.1%) | |
| **3. Strategic Objective 3 – Efficiently and productively provide care within agreed financial limits** | | | | | |
| 3.1 Reduction in the level of backlog maintenance across the Trust estate | DoF | • Development of a 3 year backlog maintenance strategy<br>• Reduction in backlog maintenance figures reported via ERIC submission 2022/23 by targeted capital investment<br>• Completion of all fire safety actions to achieve a fire safety certificate for both sites<br>• Wherever possible invest to improve the environment for patients and staff | Finance, Performance and Investment Committee | • £5.8m external investment received to reduce backlog maintenance<br>• The Estates Team are on track to ensure the work relating to the fire notice for Southport and Formby hospital will have been completed in 2022/23 and significant progress made on the fire safety work required at Ormskirk<br>• 3 year programme of work submitted but not granted in full. The Trust is in the process of identifying the priorities for backlog maintenance for 2023/24 to be in a position to negotiate the Trust's share of the ICB resource | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| 3.2 Improve the quality and resilience of Trust IT systems | DoI | • Reduce the number of system outages as a result of poor network resilience<br>• Reduce the cyber security risk across the network by replacing all network hardware with supported systems<br>• Improve the reliance and resilience of the network and therefore reduce the number of system outages | Finance, Performance and Investment Committee tee | • Technical work has taken place on existing network to reduce outages and improve performance. Feedback and monitoring have shown that the Telephony and Teams issues have been resolved<br>• The network refresh has started which will reduce the likelihood of failure due to ageing hardware. Expected completion due July 2023 but under review with the aim to bring forward completion to March/April 2023<br>• The Trust still have several end-of-life operating systems on the estate. However, this figure has reduced since April 2022. Progress in this area will be reviewed in November 2023, with the intention of producing a robust plan for when all the remaining systems will be appropriately supported | |
| 3.3 Further develop the use of electronic patient information to replace paper based medical records e.g. observation charts, nursing assessments and care plans, AHP assessments and inpatient clinical narrative | DoI | • Reduce the amount of paper in nursing documentation produced as part of the paper based medical record by 25%<br>• Reduce time spent by clinicians using paper-based processes by providing them access to a full and salient electronic documentation trail of a patient's care from wherever they need to access | Finance, Performance and Investment Committee | • Initial nursing documents built in test environment, awaiting access from system supplier to Clinical narrative to progress further. Due April 2023.<br>• Paper based process with scanning of paper giving electronic view of historic activity. Introduction of Clinical Narrative will enable the Trust to start to remove paper-based processes. | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| | | • Improve e-observations (NEWS2) to facilitate early identification of deterioration leading to earlier intervention<br>• Enabling speciality reviews of patient pathways resulting in the reduction in variation in patient care | | • Electronic observations live Trust wide (excluding Maternity). Upgrade due 02/23.<br>• Awaiting the delivery of Narrative from System C. | |
| 3.4 Maximise the productivity and effectiveness of clinical services using benchmarking and comparative data to reduce unwarranted variation | COO/DoT | • Named productivity programmes for 22/23 and action plan monitoring<br>• Continued participation in national GIRFT programme, including reviews and delivery of the resulting action plans | Finance, Performance and Investment Committee | • Submission of theatre data to C&M for regional benchmarking programme<br>• Benchmarking data used for theatre productivity and utilisation and developed action plan.<br>• Submission of O/P data to C&M for regional benchmarking, will be used to develop O/P improvement plans<br>• GIRFT review taking place aim of delivering service development programmes (DoT/MD)<br>• Trust involved in implementation of CMAST pathways | |
| 3.5 Implement robotic process automation within CBU's and corporate functions to automate manual tasks and release workforce | COO | • Reduction in delays with referrals due to having a 24-hour service that can process referrals across all specialties<br>• Reduction of spend on Agency and Bank staff as a % of these roles will be automated<br>• Better use of data across the departments, to include an increase | Finance, Performance and Investment Committee | • Robotic process automation software has been installed by IT and BI are progressing to testing routine processes for Workforce data<br>• Projects have been identified for implementation of the software | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| | | in real time reporting in order to improve decision making<br>• Increased capacity to manage the backlog of referrals in a time efficient manner due to robot workers available 24/7<br>• Improvements in quality of data integrity and reduce errors<br>• Improve DNA rates- Increased accuracy of patient demographics has a positive impact on DNA's and clinic utilisation which results in more patients being seen<br>• Improved patient safety as a result of reduced administrative processing errors and reducing the likelihood of these resulting in delays in the care process<br>• Increased efficiency of administrative processes, releasing time for more value-added activities | | | |
| **4. Strategic Objective 4 – Develop a flexible responsive workforce of the right size and with the right skills who feel valued and motivated** | | | | | |
| 4.1 Safe Staffing | DoN/HRD | • Real time staffing – Staffing against minimum compliance<br>• Continue international recruitment of nurses up to 160 WTE<br>• Reduce the number of HCA vacancies to below 20 WTE Real time staffing – Staffing against minimum compliance | Workforce Committee | • Significant work has been carried out to ensure that the staffing levels on the roster system provide an accurate picture of the wards.<br>• Work is ongoing to review bank and agency use to ensure it is aligned to current establishment | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| | | • Reduce the number of HCA vacancies | | • A further 6 nurses are due to join the Trust in November, and these are the final nurses from the projected 160.<br>• The Trust now has minimal band 5 vacancies and at present no further international nurse recruitment is planned<br>• Despite high volume recruitment of HCAs, the vacancy rate remains higher than expected.<br>• Regular, rolling recruitment events are scheduled to reduce the gap and ensure a steady pipeline of HCAs<br>• Equal emphasis in being placed on retention with the development of a bespoke induction, cohort recruitment to build peer support and nurturing talent through a 'new to care' programme giving dedicated in-house education support during first 6 months in post and completion of care certificate | |
| 4.2 Launch and embed the Trust's values known as SCOPE (Supportive Caring Open and Honest Professional Efficient) | HRD | • Formal launch of the Trust SCOPE values<br>• Specific focus on values and behaviours at Induction / Warm Welcome<br>• Evidence of regular, consistent reference to SCOPE values in | Workforce Committee | • SCOPE values re-branded and launched in line with You Matter to Us. Marketing items and posters shared widely across the Trust | |

| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| | | Trust meetings and staff engagement in sharing stories of living the values<br>• Increase in staff engagement score (Annual staff survey) at least in line with NHS average (6.8 in 2021)<br>• Positive impact on staff survey questions 'Recommend as place to work' and 'Standard of care at this organisation'<br>• Launch of Listening Plan including Exec Back to Floor building OD network and widening participation in Valuing Our People through Inclusion Group work streams<br>• Assurance staff are having at least annual career conversation with line manager (evidenced by >85% PDR compliance)<br>• Roots and branch review of recruitment and selection process with a view to introducing values based recruitment | | • Induction online module and Warm Welcome promotes SCOPE values throughout<br>• Board & Sub-Board Assurance Committees include staff & patient stories<br>• Awaiting results of 2022 Annual Staff Survey<br>• 2nd phase of Staff Voice Partnership taking place throughout October to December 2022<br>• NED Board to Wards up and running (4 visits to date)<br>• Slow improvement – PDR completion rate at 78.6% in September 2022.<br>• Targeted action to address high number of staff with no PDR in last 3 years<br>• Inclusion of statement on recruitment adverts to offer support to individuals to access & complete online applications via NHS Jobs<br>• Inclusion of Navajo & Disability Confident charter marks on recruitment materials<br>• Review of R&S training for managers<br>• Further work will be supported by new Staff Networks launched in October 2022 | |

| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| **5. Strategic Objective 5 – Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of Trust Values** | | | | | |
| 5.1 Embed just and learning (JLC) principles into people practices | HRD | • Mandated training for line managers<br>○ All Board/SOC members received JLC training by Dec 22<br>○ >30% completion of training for line managers in Year 1 | Workforce Committee | • To be launched late Autumn 2022 | |
| | | • Awareness of civility and respect behaviours across all employees<br>○ Civility and respect workshops delivered to >300 staff members in Year 1<br>○ Learning at workshops converted into behavioural objectives set in 2022/23 PDRs (evidenced by audit) | | • To be launched late Autumn 2022 | |
| | | • Increase in number of employee relations cases resolved informally and maintain level of formal cases <10 per month | | • At the end of August 2021, there were 10 ongoing employee relation cases, with no new cases (compared to 33 in March 2021). | |
| | | • Reduction in concerns raised by staff about their treatment at work | | • FTSU data shows a significant reduction in the number of cases referred to HR, from 13 cases in 2019/2020, 5 in 2020/2021, and no cases referred in 2021/2022 | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| 5.2 Promote a supportive and inclusive environment | HRD | • Redesigned core leadership and development programme incorporating compassionate leadership | Workforce Committee | • Leadership development programme scheduled Q1 2023 | |
| | | • Hold 6 weekly Schwartz Rounds | | • 5th Round took place in September with another planned in November. | |
| | | • 40 staff to have completed an individual restoration programme and returned to work | | • In excess of 30 staff referred to Restoration Programme | |
| | | • Improvements on staff survey themes linked to compassionate leadership / team / safe and healthy | | • Awaiting results of 2022 Annual Staff Survey | |
| | | • Promotion of flexible working practices (target of >200 staff with formal blended working arrangements in place) | | • Ongoing increase in recording staff working in agile manner. 170 flexible working applications submitted, with 81 accepted so far<br>• Will continue to use flexible working practices as an attraction/retention tool | |
| | | • Revised Health and Wellbeing strategy agreed by Workforce Committee by October 2022 | | • In development, to go to Workforce Committee Jan 2023 | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| **6. Strategic Objective 6 – Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire** | | | | | |
| 6.1 Work with local health care organisations, Place and Cheshire & Merseyside ICB to explore opportunities for collaboration to ensure future-proof services for the local population | DoT | • Implementation of North Mersey Stroke Pathways | Strategy and Operations Committee | • North Mersey Stroke Pathway went live on 19/09/2022 | |
| | | • Continue to build on the key relationship with Liverpool University Hospital Trusts for current hub & spoke models in Head & Neck and Vascular | | • Bi-monthly Partnership Board now in place. Key focus areas of Vascular and Ophthalmology have been selected due to service fragility | |
| | | • Demonstration of on-going clinical collaboration with STHK | | • STHK clinical collaboration continues at pace within Ophthalmology Rheumatology, Therapies, Maternity, Spinal Psychological services, cancer services and theatres | |
| | | • Influence the ICB collaboration areas for focus to achieve maximum impact on fragile clinical pathways at S&O | | • DoT is now a member of the ICB Clinical Pathway working group, two of the three areas selected are fragile services for S&O (ENT & Dermatology) | |
| | | • Development of business cases/cases for change relating to service development and sustainability | | • Trust continues to develop business cases/cases for change and have successfully secure over £40m of capital over next 3 years | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| | | • Clear alignment to Place/Commissioning and ICB priorities | | • Trust continues to align with emerging ICB and Place priorities | |
| 6.2 Continue to address service fragility to ensure we maintain oversight of the risks and opportunities going forward | DoT | • Continued update of service assessment and monitoring of identified key drivers of fragility and work with partners to develop long term plans to meet the health needs of the population | Strategy and Operations Committee | • Continue to monitor services and key drivers of fragility. Escalating as appropriate with key partners | |
| | | • Reduce the number of services assessed as being 'fragile' | | • Trust has now de-escalated 4 clinical services from the fragile list of 18 with working continuing in other service areas | |
| | | • Reduction in number of services requiring medium-term transformation input to support sustainability and returned to BAU governance processes | | • The above 4 services are now being managed with CBU business as usual processes | |
| 6.3 Work with partners across the local health system to implement Place Based Partnership Boards to improve the health of the local population | DoT | • Be a member of each PBPB in each Place<br>• Continue to be an equal partner in the Shaping Care Together (SCT) Programme to develop a long term plan for the future clinical and financial sustainability of services | Strategy and Operations Committee | • Trust is a member of PBPB<br>• SCT Programme continues, and the Trust remains an equal partner with a focus of the required future clinical reconfiguration to achieve sustainable service. SCT programme has experienced some delays due to ICB/Place changes | |

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| Objective | Lead Director | Outcomes Measures | Governance Route | Mid-Year Progress | RAG |
|---|---|---|---|---|---|
| 6.4 Continue to work with STHK to deliver the objectives of the Agreement for Long Term Collaboration | All | • Deliver the agreed milestones to improve services for patients | Strategy and Operations Committee | • S&O and STHK continue to deliver the agreed milestones to support service improvement | |

**ENDS**

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Southport and Ormskirk Hospital NHS Trust

| | | | |
|---|---|---|---|
| **Title of Meeting** | **STRATEGY AND OPERATIONS (S&O) COMMITTEE** | **Date** | **02 November 2022** |
| **Agenda Item** | **SO204/22** | **FOI Exempt** | **NO** |
| **Report Title** | **INTEGRATED PERFORMANCE REPORT (IPR)** | | |
| **Executive Lead** | Executive Management Team | | |
| **Lead Officer** | Michael Lightfoot, Head of Information<br>Katharine Martin, Performance & Delivery Manager | | |
| **Action Required** | ☐ **To Approve**<br>☐ **To Assure** | ☐ **To Note**<br>✓ **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 22/23 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 is asked to receive the Integrated Performance Report detailing Trust performance in September 2022, 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

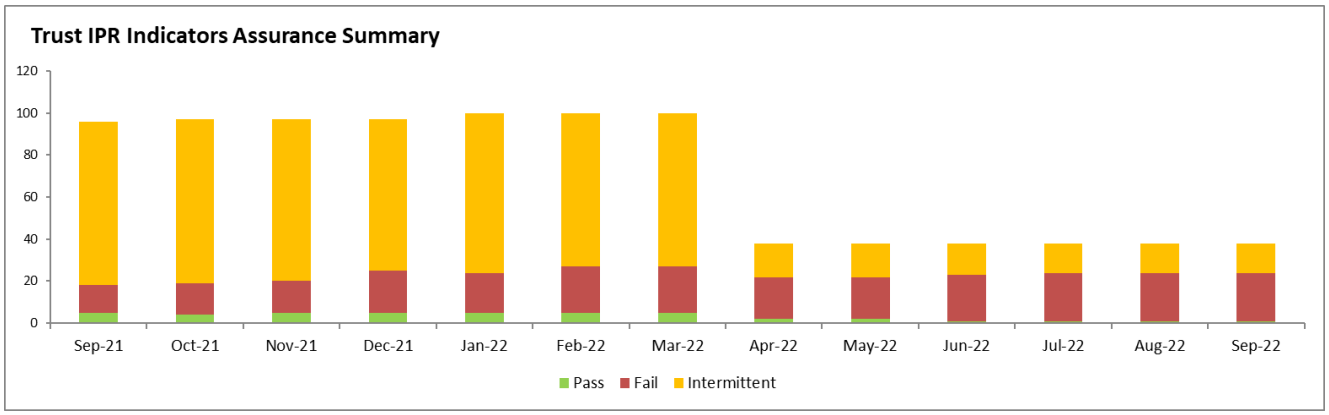
**Operations** - Trust Objective – Service

**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.

The control limits have been adjusted this month to show three time periods: pre-Covid period, Covid period and 'living with Covid'.



**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 September 2022 (2022/23 YTD = 1).
There were no cases of MRSA in September. (2022/23 YTD = 0).
There were five C. Difficile (CDI) positive cases reported in September 2022 (2022/23 YTD = 27).
The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for September 2022 was 97.7%. This is based on 100.75% for Registered Nurses and 94.2% for Un-Registered Nurses.
There were three category 3 hospital acquired pressure ulcer reported in September (2022/23 YTD = 17).
There were 49 patient falls in September of which two resulted in moderate harm (2022/23 11 Falls with Harm). All pressure ulcers and falls with harm are managed through the Harm Free Care panel.
The Patient Friends & Family Test - % that rate the Trust as 'Very Good or Good' (Trust overall) decreased to 85.8% in September, from 86.7% in August.
The % of complaints responded to within timescales has achieved 55.6% in September against the 80% target.
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 September 2022 was 72.3% (Adults ED 44.75%, Paeds ED 97.38% in September). This compares favourably with peers, with an England average of 69.1%, Northwest 67.2% and Cheshire & Mersey 71.2% (NHS Trusts only). Combined attendances for SDGH and ODGH were 7037 in September compared to 6943 in August. 41.1% of Ambulance Handovers occurred within 15mins, a small increase on August (38.3%) but behind the 65% target. 69.5% of Ambulance Handovers were within 30mins, compared to 66.1% in August and short of the 95% target. 62 Ambulance Handovers breached 60mins in September, a reduction on the 93 reported in August.

Performance against the 14-day GP referral to Outpatients improved to 78.3% in August 2022 (latest data month), from 71.2% in July, this is against an average of 75.4% for England, 72.1% North West and 74% for Cheshire & Mersey. The 28 Day Faster Diagnosis Standard achieved 63.1% in August (July 65.4%) against the 75% target. The 62-day cancer standard was below the target of 85.0% in month (August 2022) at 55.6% (64.9% in July). The Trust is below the average for Cheshire & Mersey (67%), England (61.8%) and Northwest (60.7%) (NHS Trusts only). The Trust failed to achieve the 96% target for the 31-day target in August 2022 with 87.1% performance in month (July 92.5%). By way of comparison, in August, the England average was 92.1%, Northwest 93.1% and Cheshire & Mersey 94.9%.

**Operational Performance continued**

The average daily number of stranded patients in September 2022 increased to 213 (August 209). The number of super-stranded patients also continued the increasing trajectory, reporting the highest number for more than two years, from an average of 84 in August to 86 in September.

The Criteria to Reside metric is in excess of the 35 target, averaging 58 in September, a deterioration on the 55 reported in August. 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 September 2022 with 70.5% compliance, (72% in August), against the 92% target. The Trust continues to perform well in comparison to peers, for example the average for NHS Trusts in England was 60.3%, Northwest 55.2% and Cheshire & Mersey 57.4% (latest data August 2022).
There were 194 52+ week waiters at the end of September, a decrease on the 200 reported in August, with 12 patients waiting longer than 78 weeks, the target is to achieve 0 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 September 2022 with 32.6% patients waiting longer than 6 weeks, a significant improvement on the previous month (42.5%) against a target of 1%. This compares to and NHS Trust average of England 31.4%, North-West 30.1% and Cheshire & Mersey 24.8% (August 2022 data).

The Covid-19 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 £9.5m deficit at Month 6 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 M6 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 2022/23 Plan in view of continued escalation and operational pressures experienced into 2022/23, though noting improved performance in September.

The Trust is reporting delivery of CIP to M6 – with £8.1m schemes delivering, and 50% of the £3.0m Q4 system stretch target identified to-date.

Capital – Spending slightly ahead of plan at £6.5m compared to £6.2m plan. Note plan has increased from £15.8m to £17.1m driven by awards for the 2nd CT scanner (£0.8m), architect fees (£0.4m – TIF/CDC) and right of use assets (£0.1m).

**Workforce**

Personal Development Review compliance has decreased in September to 74.8% against the 85% target. Performance in August was 76.3%. The 90% stretch target for Mandatory Training was implemented from June 2022 and the indicator is marginally behind the target at 88% for September, a decrease on the previous month (88.9%).

In month overall sickness is below target, decreasing to 5.9% from 6.1% reported in August. The rolling 12-month figure remains 7.2%. This is against sickness targets for 2022/23 of 6% (5% non-Covid, 1% Covid). Non-Covid Sickness continued to be below target at 4.8% in September (4.9% in August).

The overall Trust vacancy rate has increased to 10.6% in September, from 9.7% in August, against the 7.4% target. In-month Staff turnover has decreased marginally to 1% in September from 1.2% in August (target 0.83%).

# Integrated Performance Report

# Strategy & Operations Committee Report

September 2022

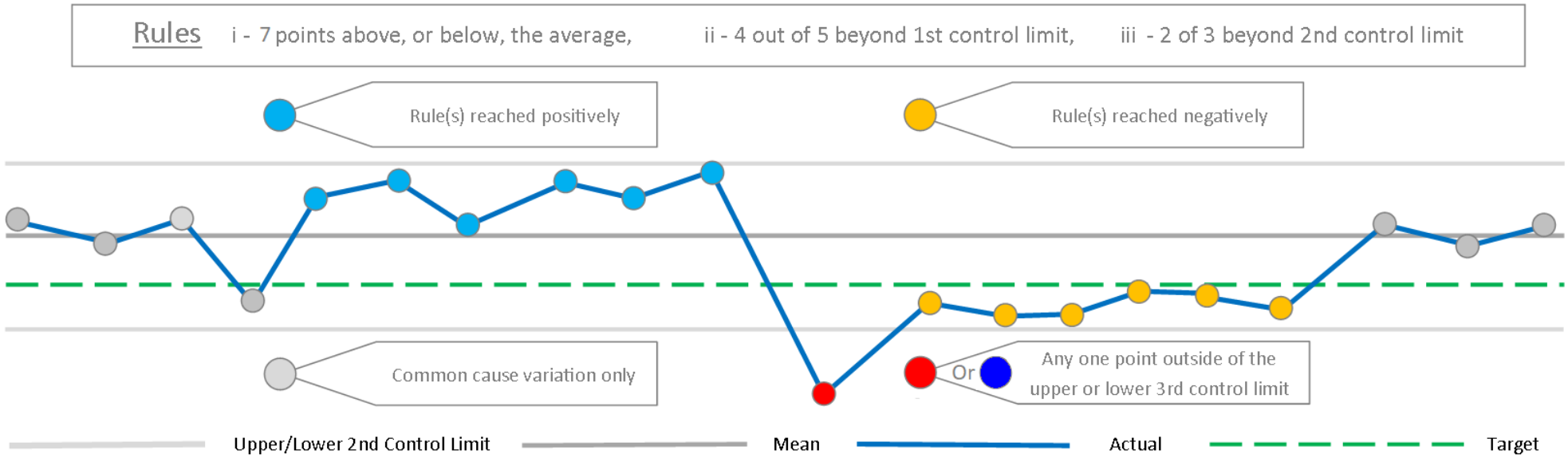
# Guide to Statistical Process Control

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

Accident & Emergency - 4 Hour compliance

Diagnostic waits

28 Day Faster Diagnosis Standard

62 day GP referral to treatment

Stranded Patients (>6 Days LOS) Super

Stranded Patients (>20 Days LOS)

# Quality

## Harm Free

Safe Staffing/Care Hours Per Patient Day

Issues
• The Safe Staffing indicator is showing special cause improvement and has been above target for eight consecutive months. Performance of 97.7% in September relates to 100.75% for Registered Nurses and 94.2% for Un-Registered Nurses.
• Care Hours Per Patient Day (CHPPD) continues to be assured.

Management Action
• Safe staffing remains above 95% due to the much-improved vacancy fill rate of registered staff, and additional support from NHSP to fill vacancies within unregistered staff rota.
• Work continues to support recruitment into these vacancies and reduce NSHP spend.
• CHPPD remains high due to the increased fill rate, however variances occur due to the fluctuating patient acuity experienced with in wards and departments.

Pressure Ulcers

Issues
• The category 3 and 4 indicator is performing statistically as expected.
• The number reported is higher than both the average and target in September.
• Numbers impacted by patients declining pressure relieving support.

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.
• 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

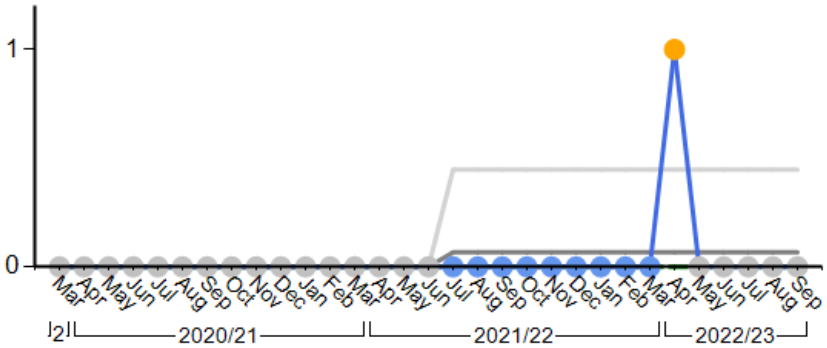
Issues
• Whilst the number of patient falls has fallen to the lowest since June 2020, performance is statistically as expected.
• Two falls resulting in moderate or above harm were reported in September, one less than the previous month. Whilst not statistically significant, this is above target.

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).

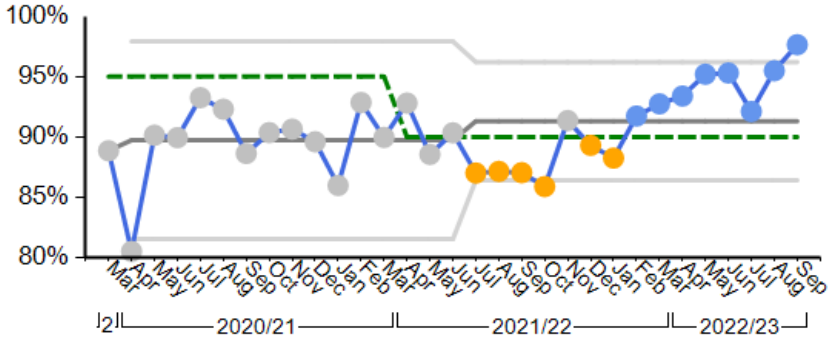
• Staff focus groups completed and issues raised to be fed back through falls group to add into trust wide action plan.
• Deconditioning project ongoing on 7b (pilot).
• Guidance for when and how to implement a low bed being written to support staff with the decision-making process.
• D&D team have produced 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.
• Producing post fall guidance (flowchart) including recommendations for manual handling methods to retrieve person from the floor (to be taken to next Falls Group for feedback).
• 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.
• Staff focus group completed which highlighted some key themes – information collated and to be fed back to falls group at the end of September.
• National Falls Prevention week starting 19th September. Information stand, as well as activities for patients and staff planned across both sites to increase knowledge and awareness of falls prevention.
• 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.

| | | Latest | | | | | Previous | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alert | Indicator | Plan | Actual | Patients | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| | Never Events | 0 | 0 | 0 | Sep 22 | | 0 | 0 | Aug 22 | 0 | 1 | |
| | Safe Staffing | 90% | 97.7% | N/A | Sep 22 | | 90% | 95.5% | Aug 22 | 90% | 94.9% | |
| | Hospital Pressure Ulcers - Grades 3 & 4 | 1 | 3 | 3 | Sep 22 | | 1 | 4 | Aug 22 | 12 | 17 | |
| | Patient Falls - Trust | 63 | 49 | 49 | Sep 22 | | 63 | 67 | Aug 22 | 756 | 400 | |
| | Falls - Moderate/Severe/Death | 1 | 2 | 2 | Sep 22 | | 1 | 3 | Aug 22 | 17 | 11 | |
| | Percentage of Patient Safety Incidents - Moderate/Major/Death (related) | 2.1% | 0.7% | 6 | Sep 22 | | 2.1% | 1.1% | Aug 22 | 2.1% | 0.7% | |

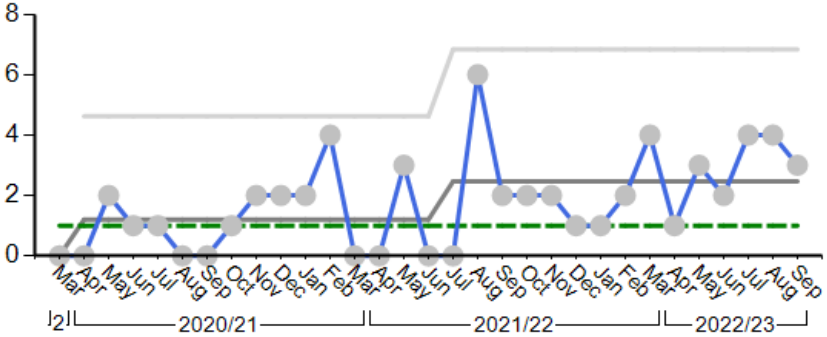
## Never Events



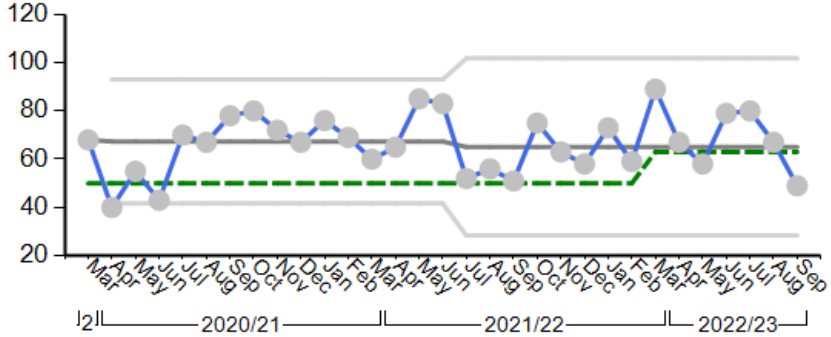

## Safe Staffing



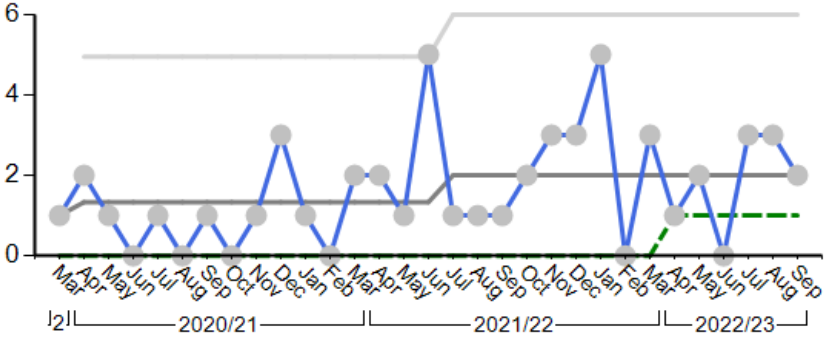

## Hospital Pressure Ulcers - Grades 3 & 4



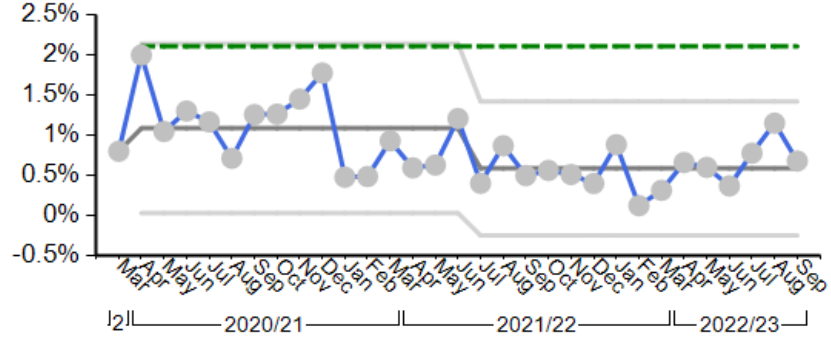

## Patient Falls - Trust




## Falls - Moderate/Severe/Death




## Percentage of Patient Safety Incidents - Moderate/Major/Death(related)



# Quality

## Infection Prevention and Control

C.Diff

Issues
• The indicator is performing statistically as expected.
• 5 reported cases in September, all Hospital Onset Hospital Acquired (HOHA), which is the same as the previous month and above 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 of the patients identified with a lapse in care due to stool sample not being taken promptly and no stool chart present. 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

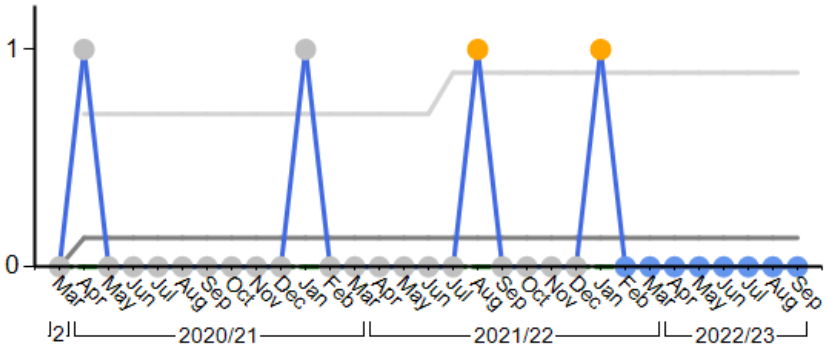
Issues
• The indicator is performing statistically as expected, with 5 (2 HOHA and 3 COHA) reported cases in September, this is a reduction on the 8 reported in August and whilst is above target is in-line with the average.
• The patients had multiple co-morbidities.

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.

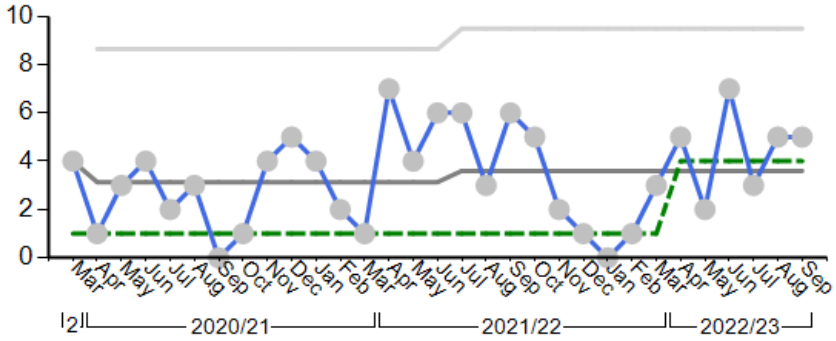
No MRSA cases were reported in September.

| | | Latest | | | | | Previous | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alert | Indicator | Plan | Actual | Patients | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| | MRSA | 0 | 0 | 0 | Sep 22 |  | 0 | 0 | Aug 22 | 0 | 0 |  |
| | C-Diff | 4 | 5 | 5 | Sep 22 |  | 4 | 5 | Aug 22 | 49 | 27 |  |
| | E. Coli | 4 | 5 | 5 | Sep 22 |  | 4 | 8 | Aug 22 | 51 | 28 |  |

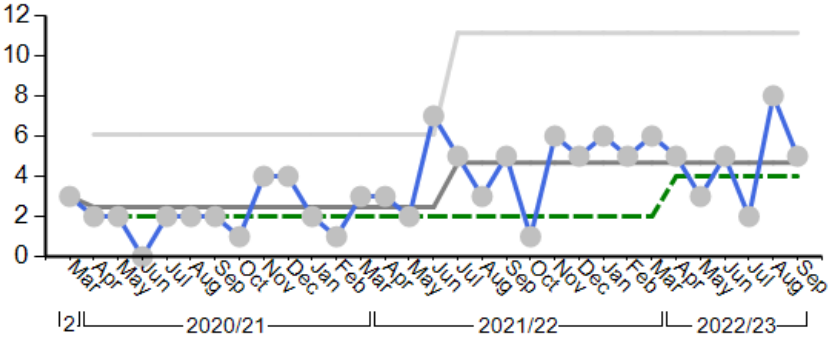
MRSA




C-Diff




E. Coli



# Quality

## Patient Experience

Complaints - % closed within 40 working days

Issues
• The indicator is failing assurance and performance in September remains consistent with the previous month.
• Compliance continues to be impacted by the ongoing closure of a backlog of overdue complaints.
• Impact of delays with quality assurance process and resource issues/competing priorities within the CBU's.

Management Action
• The CBUs are developing recovery plans.
• The majority of really old complaints have now been closed and there is a plan for each overdue complaint.
• The Complaints Team are now sending prompting reminders to the complaints handlers to ensure they are fully aware of their complaint and the response deadline.
• The Complaints Team are keeping in contact with the complainants at regular intervals to ensure they are aware of their complaint progress, this is to improve the complaint experience and to try and prevent complaints being re-opened in the future.

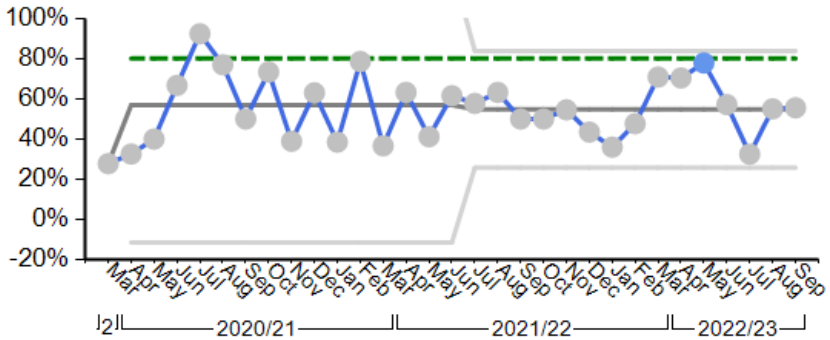
Friends and Family Test

Issues
• The Trust overall indicator continues to fail the assurance measure and is showing special cause concern with a 0.9% decline in September.
• Performance in September has been impacted by a deterioration in the Adults A&E percentage, with all other areas showing an increase.
• The score for Acute Inpatients has increased to 93.03% from 91.57%. This remains slightly below the internal indicator of 94% and August NHSE average of 94%. Themes alongside negative ratings are environment, staff attitude and implementation of care.
• A decreased score of 72.89% from 77.93% in Adult A+E (below August NHSE average of 77% and Trust target of 77.8%) and a slight decrease in score to 93.95% from 94.03% in Paediatric A+E.
• The experience of long waiting times in the adult A&E department continues to cause a higher number of negative responses and comments.
• Outpatients - An increased score of 94.6% when compared to previous month of 93.3%. This is above the August NHSE average of 93% and internal target of 92.8%.
• Labour Ward - Increase in overall score to 95.6% from 90.7%, this is above the August NHSE average of 93% and internal indicator of 94%.
• Postnatal Ward - An increase in performance from 81.3% to 95.7%, this is above the August NHSE average of 91% and Trust target of 92%

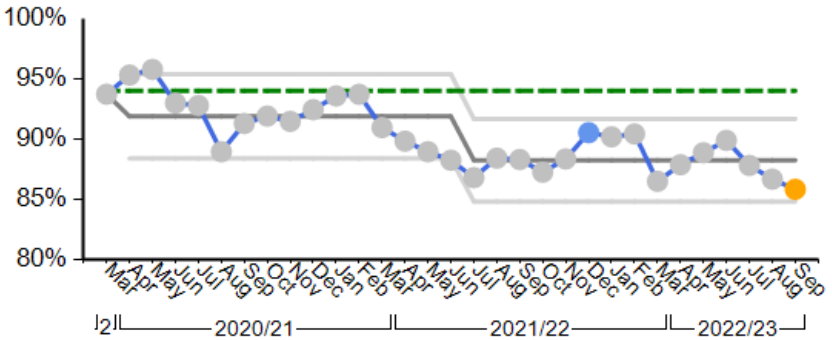
Management Action
• The profile of FFT continues to be raised as a valuable mechanism for receiving up-to-date patient feedback which is demonstrated via a 'You said, we did' approach on ward/dept quality boards.
• Monthly FFT summaries are shared with CBU's and are monitored through the Patient Experience 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.
• Interim results from the 2021 National Inpatient Survey received, Trust action plan is agreed and will be monitored via the Trust Patient Experience and Community Engagement group.
• Actions taken to improve the experience in Adults A&E include an enhanced PALS officer role in Adult A+E, volunteer recruitment and redeploying additional staff to support flow at peak times.
• 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% | 55.6% | N/A | Sep 22 | | 80% | 55% | Aug 22 | 80% | 53.5% | F |
| | Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall | 94% | 85.8% | N/A | Sep 22 | L | 94% | 86.7% | Aug 22 | 94% | 87.9% | F |

Complaints - % closed within 40 working days




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



# 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 with performance in September 0.4% worse than August.
• The Trust remains in the top quartile nationally for ED performance, achieving 72.3% in September for the 4-hour standard. Significant pressures in relation to staff sickness, skill mix, patient acuity and limited discharges continues to affect performance in September 22. The Trust performed ahead of the National average (69.1%), Northwest (67.2%) and Cheshire & Mersey (71.2%) (NHS Trusts only).
• 14.3% of patients spent longer than 12 hours in the department (1004 patients), this is the same percentage as 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.
• The Trust enacted full to capacity protocol the 2nd week in September due to unprecedented demand and minimal discharges.

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.
• Relaunch of discharge checklist to ensure TTOS and ambulance bookings are ordered in a timely manner.

Ambulance Turnaround Times

Issues
• All metrics failing their assurance measure but performance in September is statistically as expected and all indicators have improved on the previous month.
• 10% 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 November.
• 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 1.5% deterioration in September.
• The number of 52-week waits is above the trajectory but is on an improving trajectory.
• The Trust continues to perform well in comparison to peers, for example the average for NHS Trusts in England was 60.3%, Northwest 55.2% and Cheshire & Mersey 57.4% (latest data August 2022).
• There were 12 78-week waits at the end of September.
• Overall elective admitted activity achieved 80% of plan in September, a 2% improvement on the previous month.
• Issues identified in Pain service due to Anaesthetic shortages, Clinical Haematology due to reduction in venesection activity impacting day case figures and Gynaecology, where backlog of overdue follow-up patients continues to impact on throughput of new patient activity.

Management Action
• Continued risk stratification of the waiting list.
• Trust is part of the Cheshire & Mersey wider elective restoration group.
• Ophthalmology - Working with finance to convert vacancy monies to new Consultant and specialist posts to improve skill mix in specialty. Agency doctor commencing in October 2022 to support oculoplastics.
• Pain - Review of budget commenced to support reallocation of funding to provide increase in pain specialists and support increase in capacity.
• Clinical Haematology - STHK providing 3 x sessions per week which will improve performance.
• Gynaecology - New consultant commenced post on 21st September 2022. Increase of activity and improvement in performance expected from October 2022.

Diagnostics

Issues
• The Diagnostic Waits indicator is failing assurance and showing special cause concern.
• Performance against the 1% target has improved by almost 10% in September to 32.6%.
• The Trust's performance in September is more in line with peers, with performance for NHS Trusts in August of England 31.4%, North-West 30.1% and Cheshire & Mersey 24.8%.
• Diagnostic scopes over-performed in September, delivering 101.7% against the plan.
• Scans underperformed in September, delivering 93% of the plan.
• 166 Endoscopy patients waiting longer than 13 weeks for procedure, but reduction compared to August.
• Mutual aid with Walton Centre for CT halted during summer holidays, impacting activity.
• Workforce pressures in ECG and non-obstetric ultrasound impacting activity.

Management Action
• Further Endoscopy insourcing commenced with Your Medical to increase performance and maintain activity levels.
• Walton Centre CT lists reinstated September 2022, improvement expected from October 2022.
• Mutual aid agreed with STHK for ECG to commence November 2022.
• Vacancy in non-obstetric ultrasound filled, improvement expected October 2022.

Stroke

Issues
• Performance against the 90% stay on a Stroke ward continues to be challenged but has increased from 47.1% in June to 60.9% in July.
• Compliance in July 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 at least 1 ringfenced Stroke bed. Also impacted by Stroke patients testing COVID positive and so being unable to admit directly to Stroke ward if no available side room.
• Compliance has been challenged by late referrals to the Stroke team and late diagnosis. These accounted for 3 of the 9 breaches. 2 of these were avoidable.
• 1 of 9 breaches were a fast track discharge from CDU and were never admitted to an inpatient ward.
• 1 of 9 breaches was COVID positive and was not admitted to the Stroke ward.

Management Action
• The Stroke Operational Group continues to focus on quality and pathway improvements
• Collaborative work with LUFT continues as part of the 'North Mersey Stroke Transformation' pathway. Now implemented as of 19th September.

• In the interim 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.

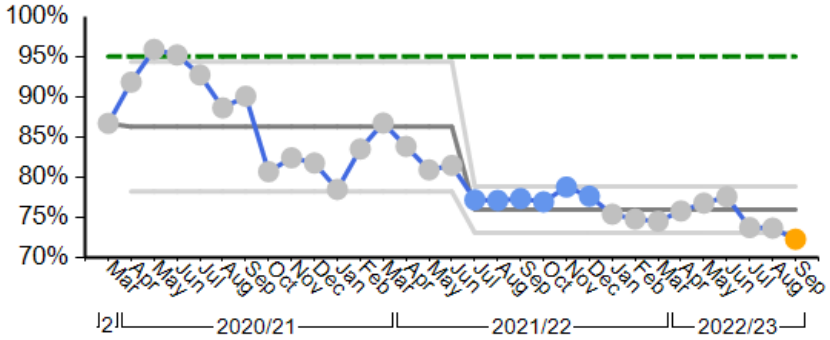
Discharge Communications

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

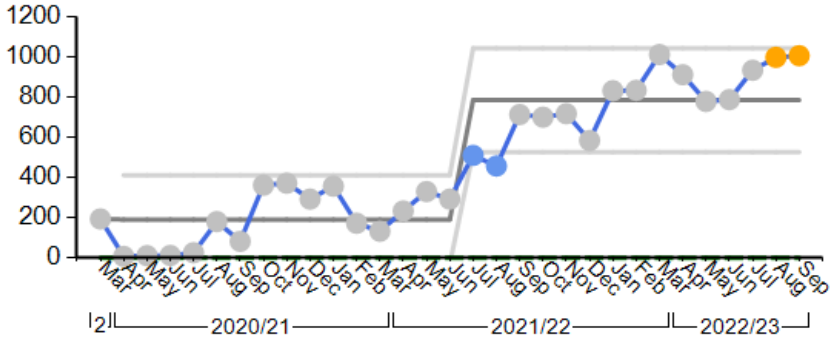
Management Action
• Meeting held with Pharmacy to understand the issues affecting E-Discharge compliance.
• Focus on wards using pink TTO's, identification of wards with lower compliance and targeted training.

| | | Latest | | | | | Previous | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alert | Indicator | Plan | Actual | Patients | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| ! | Accident & Emergency - 4 Hour compliance | 95% | 72.3% | 2671 | Sep 22 | L | 95% | 73.7% | Aug 22 | 95% | 75% | F |
| | Number of Patients spending 12+ Hours in ED - Trust | 0 | 1004 | N/A | Sep 22 | H | 0 | 996 | Aug 22 | 0 | 5405 | F |
| | % of Patients spending 12+ Hours in ED - Trust | 2% | 14.3% | N/A | Sep 22 | H | 2% | 14.3% | Aug 22 | 2% | 12% | F |
| | Ambulance Handovers - % within 15 Mins | 65% | 41.1% | 694 | Sep 22 | | 65% | 38.3% | Aug 22 | 65% | 41.9% | F |
| | Ambulance Handovers - % within 30 Mins | 95% | 69.5% | 360 | Sep 22 | | 95% | 66.1% | Aug 22 | | 69.1% | F |
| | Ambulance Handover Over 60 Mins | 0 | 62 | 62 | Sep 22 | | 0 | 93 | Aug 22 | 0 | 450 | F |
| ! | Diagnostic waits | 1% | 32.6% | 1925 | Sep 22 | H | 1% | 42.5% | Aug 22 | 1% | 42.7% | F |
| | Referral to treatment: on-going | 92% | 70.5% | 4497 | Sep 22 | L | 92% | 72% | Aug 22 | 92% | 73.2% | F |
| | 52 Week Waits | 56 | 194 | 194 | Sep 22 | H | 68 | 200 | Aug 22 | 0 | 242 | F |
| | Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month | 1% | 0.7% | 16 | Aug 22 | | 1% | 1.3% | Jul 22 | 1% | 1% | ? |
| | Stroke - 90% Stay on Stroke Ward | 80% | 60.9% | 9 | Jul 22 | | 80% | 47.1% | Jun 22 | 80% | 48.7% | F |
| | TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care | 60% | 83.3% | 2 | Aug 22 | H | 60% | 80% | Jul 22 | 60% | 83.6% | ? |
| | Outpatient Letters to GP's within 7 Days | 85% | 78% | 2240 | Aug 22 | | 85% | 66.3% | Jul 22 | 85% | 70.5% | F |
| | E-Discharges within 24hrs | 85% | 81% | 266 | Sep 22 | H | 85% | 83.8% | Aug 22 | | 77.1% | F |

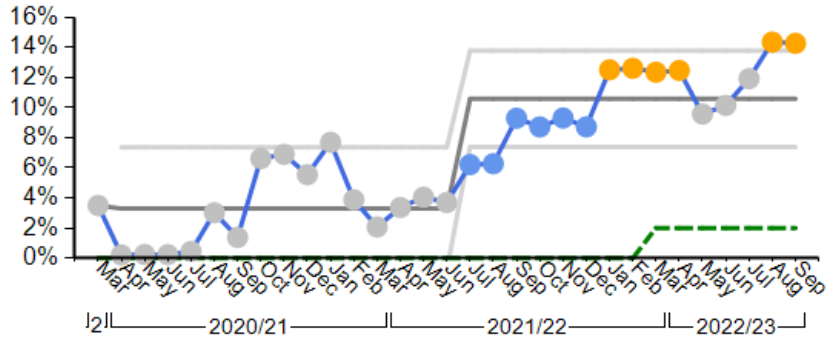
Accident & Emergency - 4 Hour compliance



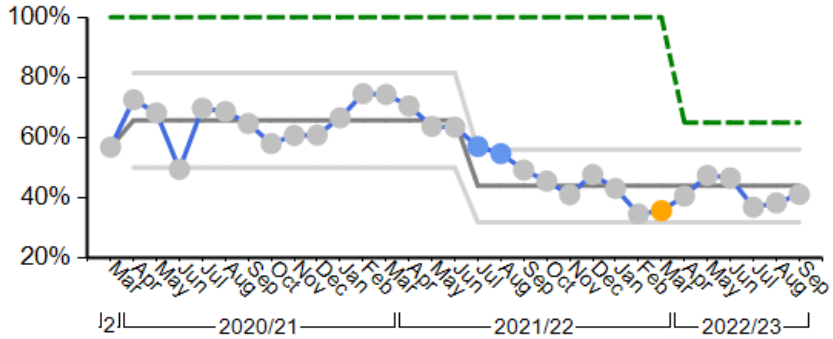

Number of Patients spending 12+ Hours in ED - Trust



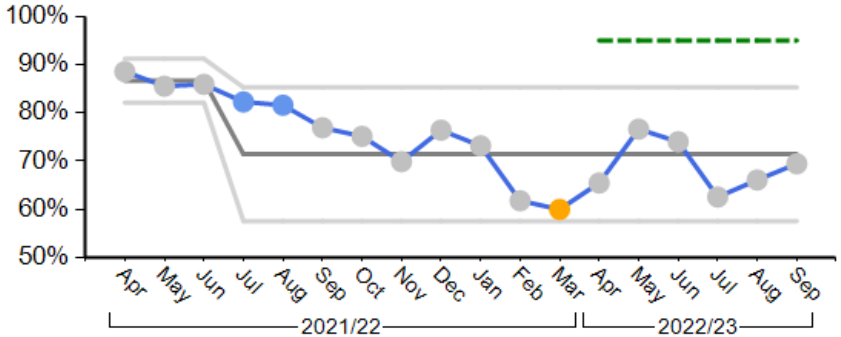

% of Patients spending 12+ Hours in ED - Trust



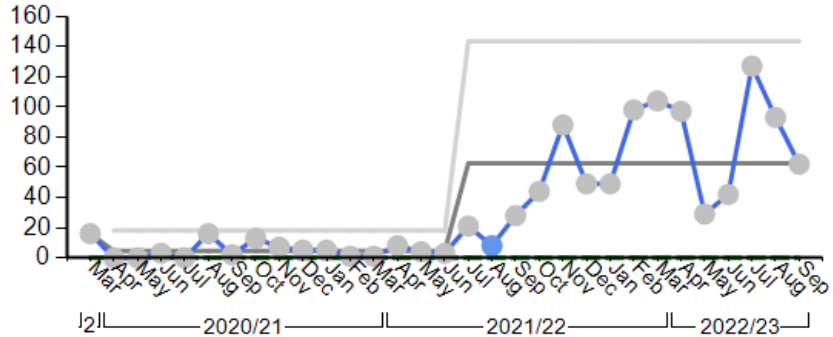

Ambulance Handovers - % within 15 Mins



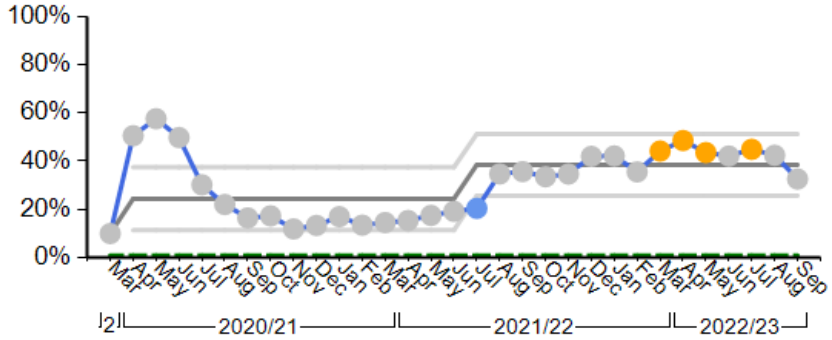

Ambulance Handovers - % within 30 Mins



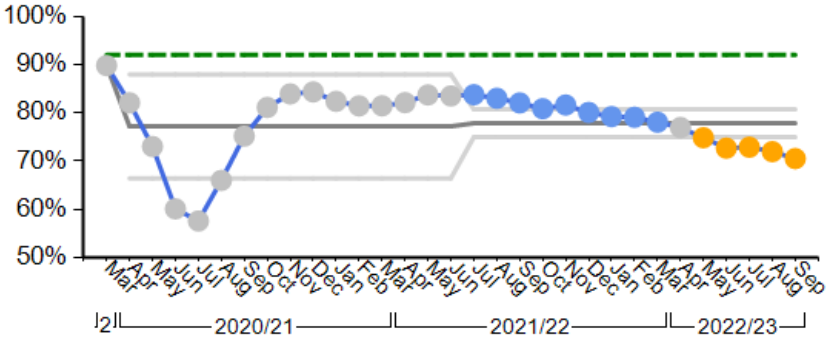

Ambulance Handover Over 60 Mins



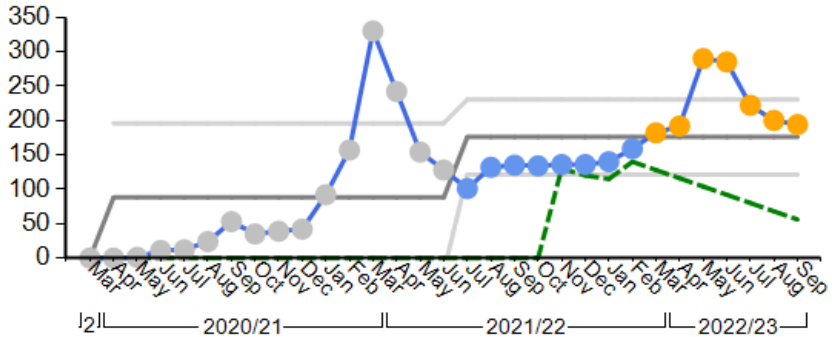
Diagnostic waits



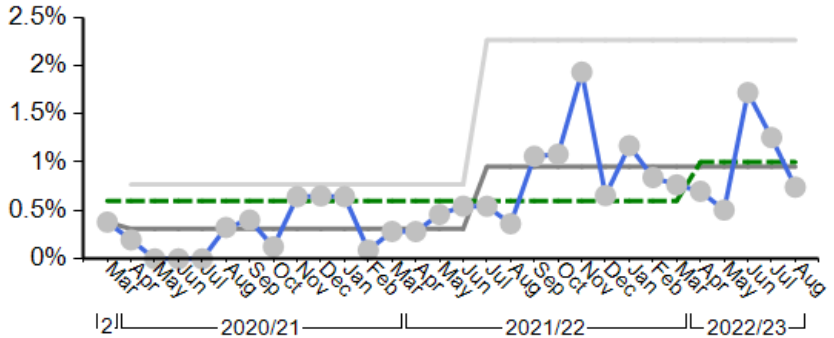

Referral to treatment: on-going



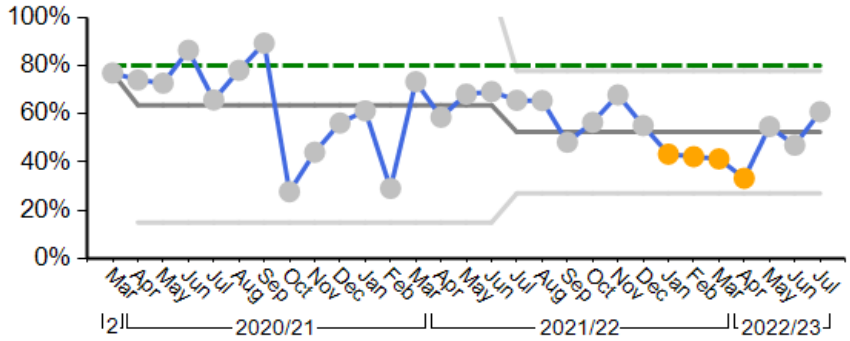

52 Week Waits



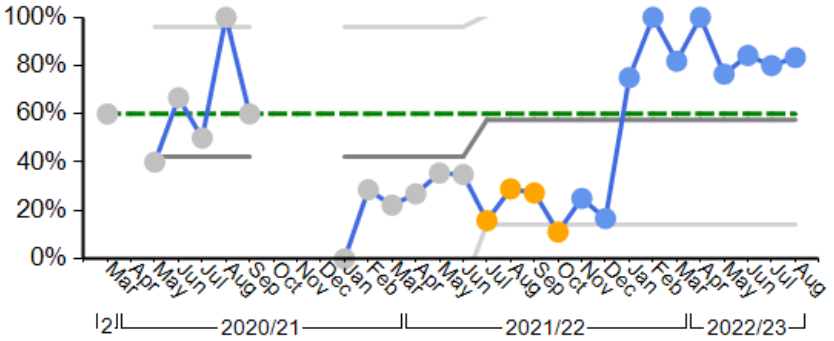

Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month



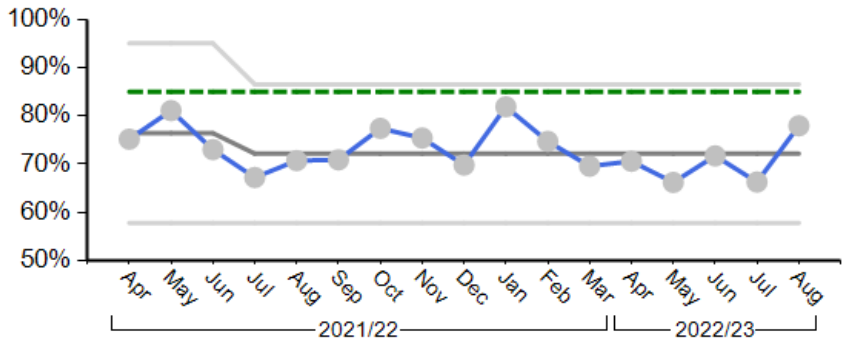

Stroke - 90% Stay on Stroke Ward



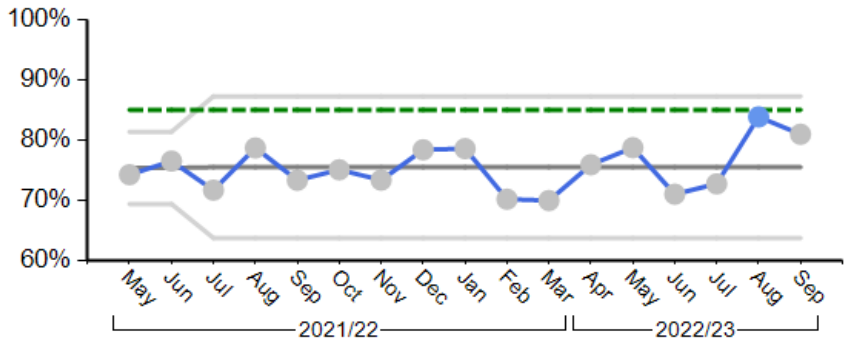

TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care



Outpatient Letters to GP's within 7 Days




E-Discharges within 24hrs



# Operations

## Cancer

Issues

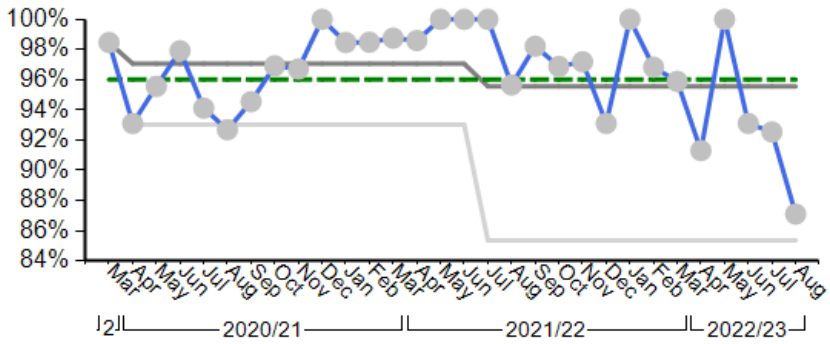
• The 31-day target, although performing statistically as expected, has declined in August to 87.1% against the 96% target. The England average was 92.1%, Northwest 93.1% and Cheshire & Mersey 94.9%.
• The 62-day GP referral to treatment is failing the assurance measure and has declined in August, achieving 55.6% against the 85% target. This is below the NHS Trust average for Cheshire & Mersey (67%), England (61.8%) and Northwest (60.7%). The only tumour group meeting this standard is Skin.
• There are currently 7.5 104+ day breaches, this is an increase of 1 patient compared to last month. The breaches are in the following tumour groups, Gynaecology (0.5), Lower GI (2.5), Head & Neck (1), Lung (1.5), Skin (1) & Urology (1).
• Issues with the High Risk FIT programme that went live in April.
• Histology challenges and diagnostic capacity.

Management Action

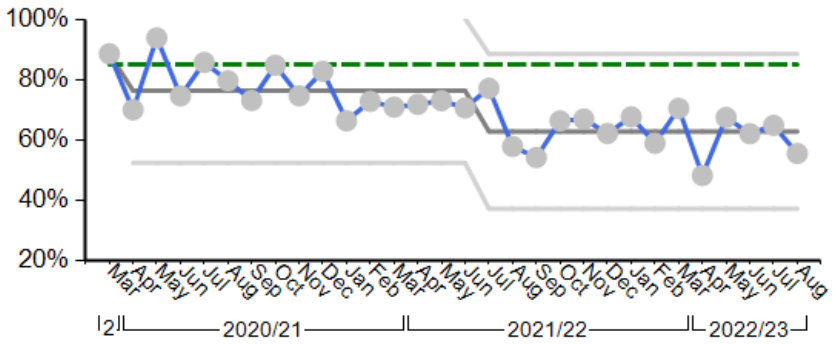
• Weekly PTL reporting with COO oversight, detailed improvement plans for all tumour groups weekly reporting at Cancer Improvement Meeting.
• An interim cancer manager has been recruited and started in September. Fixed-term DM recruited and due to start November.
• RCA process to be followed with breaches highlighted weekly and discussed with Data & Performance Manager and Directorate Manager. Now that the resource is in place, RCAs are beginning to be completed in a timely manner.
• Fortnightly steering group to escalate High Risk FIT issues and update on wait times.
• Assurance given to steering group at October meeting, meeting to now take place fortnightly with Colorectal Cancer lead in attendance.
• Cellular pathology manager attends the cancer performance meeting on a fortnightly basis to provide latest turnaround times. Process now in place following endoscopy to ensure patients who are no longer on pathway are not escalated inappropriately.
• Improvement plan submitted for radiology. Significant improvements have been made with CT. Continue to liaise with local partners for mutual aid.

| | | Latest | | | | | Previous | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alert | Indicator | Plan | Actual | Patients | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| | 31 day treatment | 96% | 87.1% | 8 | Aug 22 | | 96% | 92.5% | Jul 22 | 96% | 93.3% | ? |
| ! | 62 day GP referral to treatment | 85% | 55.6% | 32 | Aug 22 | | 85% | 64.9% | Jul 22 | 85% | 60% | F |
| ! | 28 Day Faster Diagnosis Standard | 75% | 63.1% | 439 | Aug 22 | | 75% | 65.4% | Jul 22 | | 64.7% | F |

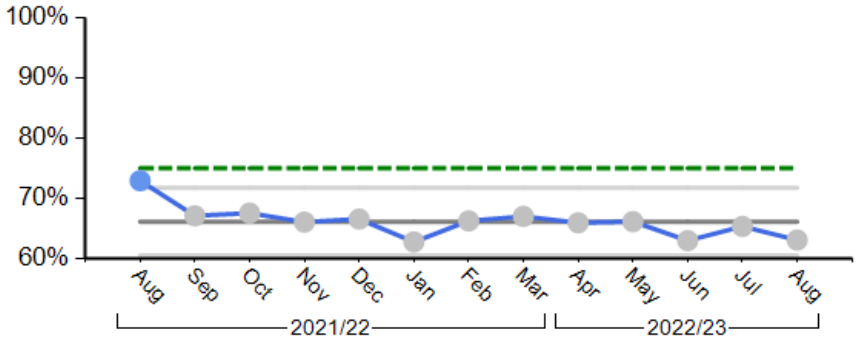
31 day treatment




62 day GP referral to treatment




28 Day Faster Diagnosis Standard



# Operations

## Productivity

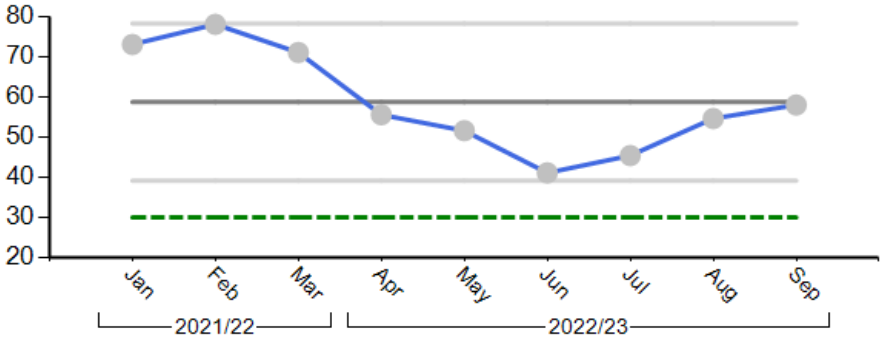
Stranded/Super Stranded Patients/Criteria to Reside

Issues
• Both indicators are failing their assurance measures and showing special cause concern with performance in excess of the target for the last 12 months.
• Both Stranded/Super-Stranded patients indicators have increased in September to the highest level for more than 2 years and have breached the 3rd upper control limit.
• The number of 'No Criteria to Reside' patients has deteriorated in the last three months.
• 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 September.
• Increase in acuity of patients.
• Capacity of community services, care homes and local authority to support patients.

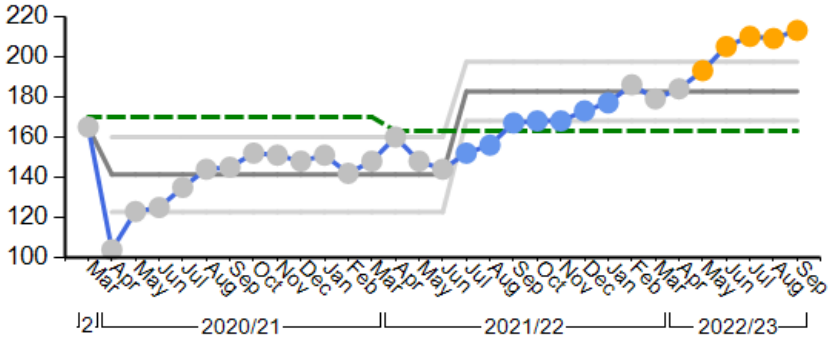
Management Action
• Focus on improvement of patients discharged by 5pm to ensure the trajectory is met.
• Ensuring patients are discharged home before lunchtime to enable early transfer of patients waiting to be admitted in ED.
• Discharge Improvement Group in place.

| | | 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 | 58 | 57.97 | Sep 22 | | 30 | 55 | Aug 22 | | | ? |
| ! | Stranded Patients (>6 Days LOS) | 163 | 213 | 213 | Sep 22 | H | 163 | 209 | Aug 22 | 163 | 1214 | F |
| ! | Super Stranded Patients (>20 Days LOS) | 53 | 86 | 86 | Sep 22 | H | 53 | 84 | Aug 22 | 53 | 460 | F |

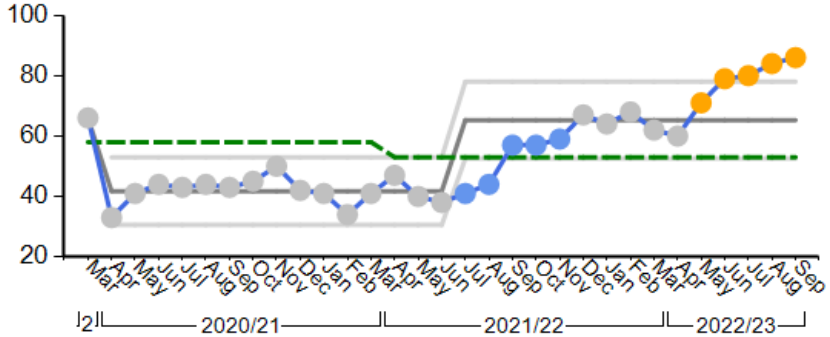
No Criteria to Reside - Avg No of Patients




Stranded Patients (>6 Days LOS)




Super Stranded Patients (>20 Days LOS)



# Workforce

## Organisational Development

Personal Development Reviews

Issues
• The indicator is failing the assurance measure and showing special cause concern and there has been a 1.5% decrease in September.

Management Action
• See action plan included.

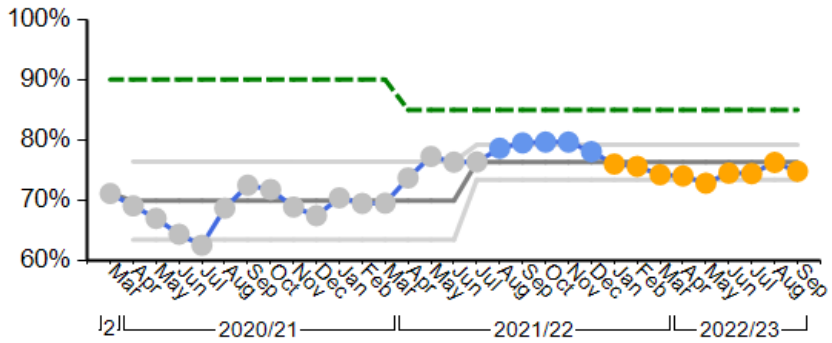
Mandatory Training

Issues
• The indicator is failing its assurance measure since the stretch target of 90% was implemented in June 2022.
• Compliance has declined marginally in September and the indicator is now 2% behind the stretch target.
• Conflict resolution remains an area of concern.

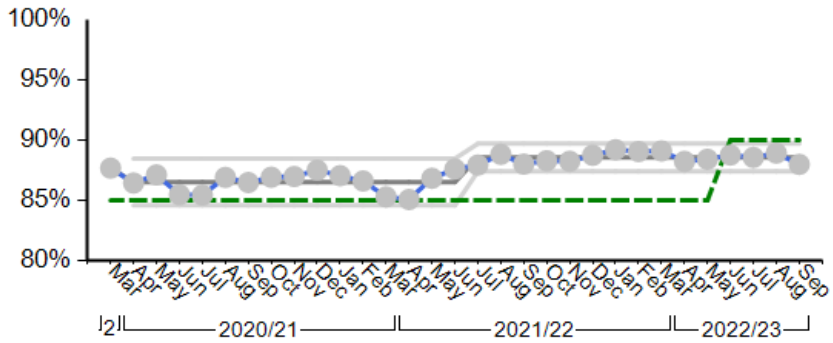
Management Action
• The Training Department is waiting for the revised training needs analysis to be completed by the Safeguarding Team which will incorporate the core skills framework (CSF) content alongside higher levels of face-to-face training, reflecting the StHK training model. The review should see the annual renewal date pushed back to three yearly in line with the CSF and see a significant improvement.

| | | Latest | | | | | Previous | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alert | Indicator | Plan | Actual | Patients | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| ! | Personal Development Review | 85% | 74.8% | N/A | Sep 22 | L | 85% | 76.3% | Aug 22 | 85% | 74.5% | F |
| | Mandatory Training | 90% | 88% | N/A | Sep 22 | | 90% | 88.9% | Aug 22 | 90% | 88.5% | F |

Personal Development Review



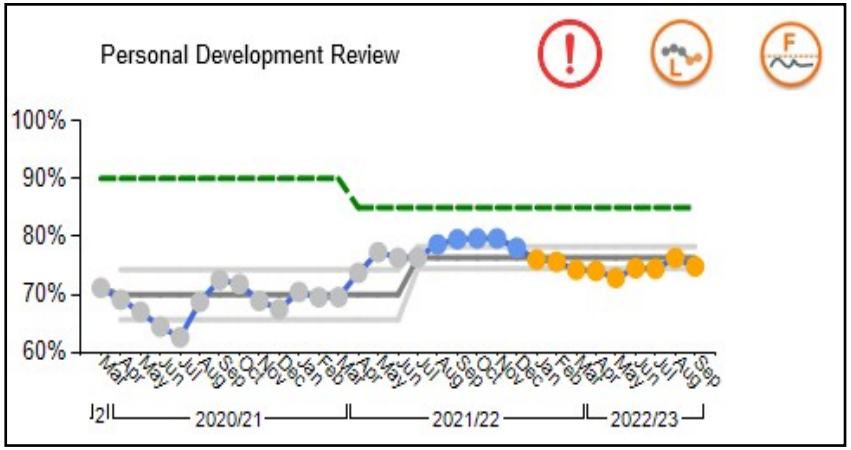

Mandatory Training



# Non Medical Appraisal/Personal Development Reviews

Southport and Ormskirk Hospital NHS Trust

| | | Latest | | | | | Previous | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alert | Indicator | Plan | Actual | Patients | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| ! | Personal Development Review | 85% | 74.8% | N/A | Sep 22 | L | 85% | 76.3% | Aug 22 | 85% | 74.5% | 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:** September has seen a decrease in PDR completion compliance of 1.5%. Capital and Estates have declined marginally to 83.3%. Corporate compliance has dropped significantly to 55.5% and will require some additional activity this month to show a required improvement by next month. CBU compliance rates vary between 69.23% and 79.59%, showing improvements in MEC and SS but PC has reduced marginally to 79.6%.

**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

Sickness in August has meant that more staff were returned to work and this may have resulted in a greater number of appraisals being completed.

**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**: Following the December to May decreases and the increase in compliance in August, it is disappointing to see a decrease in September compliance rates.

The hospitals have experienced an extremely busy and fraught Winter period. All colleagues are fatigued after the last two years of activity.

Exec intervention is required to push compliance locally in their areas of responsibility.

The review of the PDR documentation and process is underway – phase 2 of the action plan.

# Workforce

## Sickness, Vacancy and Turnover

### Sickness

Issues
• The in-month sickness rate is below target, at 5.9% against a 6% target.
• Non-Covid sickness is showing special cause improvement and for the second consecutive month is below target. This shows a positive impact from actions implemented to date.
• The rolling 12 month sickness rate continues to fail the assurance measure.
• Short term absence currently accounts for 55.90% of the overall absence percentage.
• Main reasons for absence are infectious diseases, gastrointestinal issues and cough/cold/flu.

Management Action
• Particular hotspots are A&E Nursing and Maternity, the HR advisory team are supporting the line managers in these areas with the management of the ongoing absence levels.
• Moving forward actions to support the workforce and attendance levels will be coaching and support to managers to support staff, management training, the winter wellness programme (including the vaccination programme) and flexible working options. There will also be a particular focus on supporting managers with managing the prevalence of short-term absence.

### Vacancies

Issues
• The Trust overall vacancy rate continues to fail its assurance measure and has increased by 0.9% in September.

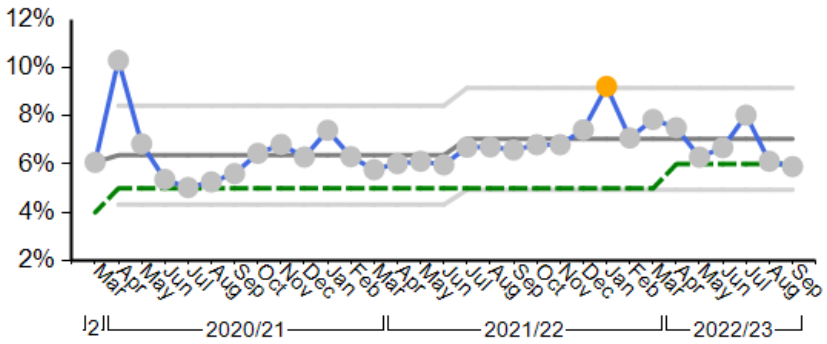
Management Action
• Whilst there has been a slight spike in the vacancy rate the Trust has 357.9 posts with active recruitment activity, 145.4 WTE of these are currently under offer.
• The recruitment team are working hard to ensure that all checks are progressed as quickly as possible to rapidly improve the staffing levels.
• There are 23 Medical posts under offer and already 4 medics have started in post in October.
• In terms of the nursing rate the main area for concern is HCAs, and the Trust has been running recruitment events to boost our number of HCAs. There are currently 68 HCA post under offer and 12 new starters so far this month alongside 13 staff nurses and midwives.
• The AHP rate is showing positive movement and we have a further nine start dates falling in October, which will again further boost the numbers. The Trust is collaborating with our colleagues in the region on the international recruitment for radiographers and OTs which will further increase numbers later in the year.

### Turnover

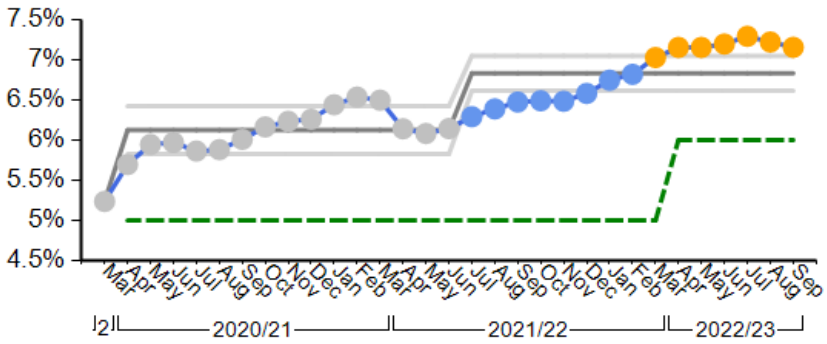
• Staff turnover is improving across all areas, and work is ongoing to improve the induction for some of our high turnover areas, in particular those who are new to care and coming into HCA roles. They are being provided with a 6-month induction programme and pastoral support to help their transition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

| | | Latest | | | | | Previous | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alert | Indicator | Plan | Actual | Patients | Period | Variation | Plan | Actual | Period | Plan | Actual | Assurance |
| | Sickness Rate | 6% | 5.9% | N/A | Sep 22 | | 6% | 6.1% | Aug 22 | 6% | 6.8% | ? |
| | Sickness Rate (Rolling 12 Month) | 6% | 7.2% | N/A | Sep 22 | H | 6% | 7.2% | Aug 22 | 6% | 7.2% | F |
| | Sickness Rate (not related to Covid 19) - Trust | 5% | 4.8% | N/A | Sep 22 | L | 5% | 4.9% | Aug 22 | 5% | 5.2% | F |
| | Trust Vacancy Rate – All Staff | 7.4% | 10.6% | N/A | Sep 22 | | 7.4% | 9.7% | Aug 22 | 7.4% | 10.1% | F |
| | Staff Turnover | 0.83% | 1% | N/A | Sep 22 | | 0.8% | 1.2% | Aug 22 | 9% | 6.8% | ? |

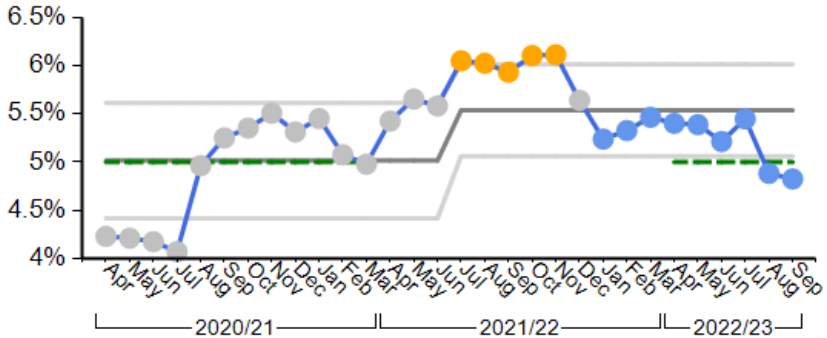
Sickness Rate



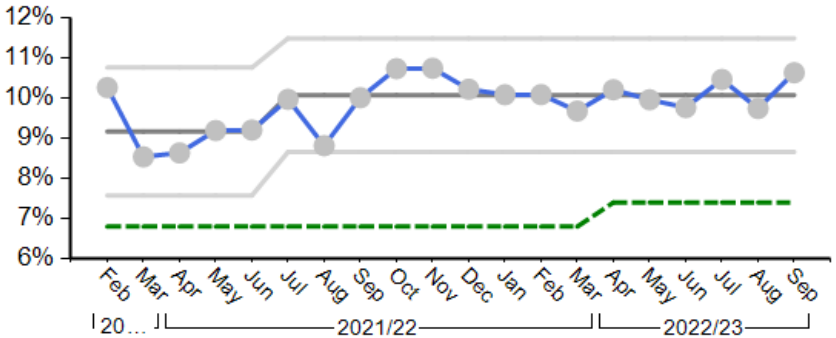

Sickness Rate (Rolling 12 Month)



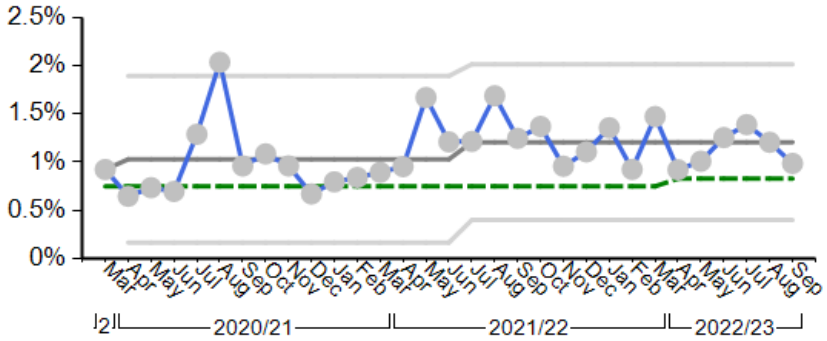

Sickness Rate (not related to Covid 19) - Trust




Trust Vacancy Rate – All Staff




Staff Turnover



# Finance

## Finance

The Trust is reporting a £9.5m deficit at Month 6 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 M6 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 2022/23 Plan in view of continued escalation and operational pressures experienced into 2022/23. The Trust currently has no flexibility for further winter provision, inflationary pressures, or addressing fragile services.

CIP - The Trust is reporting delivery of CIP to M6 – with £8.1m schemes delivering, and 50% of the £3.0m Q4 system stretch target identified to-date.

Cash  The cash balance at the end of September was £5.4m. A reduction of £0.7m from August's position. This was significantly better than last month's forecast of a £2m cash balance at the end of September. The drivers for this improvement in September were debt recoveries plus 2 VAT receipts (£1.2m in total) offset by £0.5m less outflows than expected.
Regional cash support of £2m has been received during October as planned (total requirement of £7m for the financial year as the Trust is operating with a planned £14.2m deficit in 2022/23).
Arrangements to secure cash support are in place with ICS – including contract payments being received on the 1st of each month.
Trust External Financing Limits (EFL) have been re-introduced and the year-end cash balance of £816k is the calculated figure that ensures that the Trust meets its EFL target.

Capital – Spending slightly ahead of plan at £6.5m compared to £6.2m plan. Note plan has increased from £15.8m to £17.1m driven by awards for the 2nd CT scanner (£0.8m), architect fees (£0.4m – TIF/CDC) and right of use assets (£0.1m).
Forecast outturn now includes TIF (£5.9m), CDC (£4.8m) and digital (£1.4m – note not yet confirmed). This brings the total to £28.9m which represents a substantial investment that will deliver improved facilities and services for patients and staff. Note spend will need to be £22m in the second half of the year compared to £6.5m in the first half to achieve the Trust's statutory Capital Resource Limit.

| | Latest | | | | Forecast | | | Year to Date | |
|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Plan** | **Actual** | **Period** | | **Plan** | **Actual** | | **Plan** | **Actual** |
| I&E surplus or deficit/total revenue | 6.6% | 6.8% | Sep 22 | | 6.0% | 6.0% | | 7.98% | 7.95% |
| Capital Spend | £1,800K | £1,800K | Sep 22 | | £17,100K | £29,700K | | £6,200K | £6,500K |
| Cash Balance | £2,000K | £5,400K | Sep 22 | | | | | | |

# ALERT | ADVISE | ASSURE (AAA)
# HIGHLIGHT REPORT

| | |
|---|---|
| **COMMITTEE/GROUP:** | QUALITY & SAFETY COMMITTEE (QSC) |
| **MEETING DATE:** | 24 October 2022 |
| **LEAD:** | Gill Brown |

**KEY ITEMS DISCUSSED AT THE MEETING**

## ALERT

**Alert Updates:**

- Increasing incidents of Violence and Aggression towards staff from patients and relatives – multifactorial action plan needed – Delegated to Executive Committee.
- Essential Skills Training – Delegated to Executive Committee.
- SOCAAS | Ward Dashboard – safety culture / red flags – Identified as compliance with IG metrics – Further detail in November CEC report.

**October Alerts:**

- Significant delays in Community Neurotherapy service across both ICBs causing delays and impact on Stroke rehabilitation. This has been escalated locally and regionally and will be followed up.
- Long term sickness in paediatric consultant workforce impacting on morale and performance indicators.
- Absence of Clinical Director (CD) in Obstetrics and Gynaecology resulting in no clinical attendance at Maternity & Neonatal Safety Champions meeting. An external clinician is doing a piece of medical engagement work supporting the Consultants with team working and individual responsibilities and to support four Consultants to cover the responsibilities of the CD role until this is filled.
- Deteriorating position in dermatology. Service is closed to referrals other than urgent or cancer. Processes are being reviewed to support the team to manage the workload.
- Delayed discharges from SIU impacting on ability to accept patients from tertiary centres.

## ADVISE

- **Patient Safety Report** - further information shared pertaining to bespoke human factors training nominated for HSJ Patient Safety Award

- **Integrated Performance Report (IPR)**
  - Discussion pertaining to falls prevention and the use of low-rise beds.
  - Validation of hospital acquired pressure ulcers discussed with further work anticipated with recruitment of new TVN lead.
  - Meeting with Sefton place quality lead re. maternity to provide assurance re. plans for leadership.
  - Thanks to Lynne Eastham for her contribution as Head of Midwifery.

- **Operational Performance Update** was received and noted
  - 72.3% 4hour standard (71.6% Cheshire and Merseyside (C&M) / 70.1% nationally).
  - two escalation wards remain open with increasing number of 'ready for discharge' and increased length of stay based on 2019/20 metrics.
  - Improving 52 and 78 week position with zero 104 weeks.
  - 91.6% of ERF plan and 93.7% of 2019/20 levels

## ASSURE

- IPR reviewed

| | |
|---|---|
| • AAA reports received from:<br>  o Clinical Effectiveness Committee.<br>  o Patient Safety Group. | |
| **New Risk identified at the meeting** | No new risks were identified at the meeting. |
| **Review of the Risk Register** | |

# ALERT | ADVISE | ASSURE (AAA)
# HIGHLIGHT REPORT

| | |
|---|---|
| **COMMITTEE/GROUP:** | Workforce Committee |
| **MEETING DATE:** | 25 October 2022 |
| **LEAD:** | Lisa Knight |

**RELATING TO KEY ITEMS DISCUSSED AT THE MEETING**

**ALERT**

- PDRs – continue to be below target with work plan ongoing to support services to improve.
- Guardian of Safe Working – position remains vacant, expressions of interest closed on 21 October 2022.

**ADVISE**

- Sickness absence presentation – proactive management in annual leave over the summer months and ongoing plan shared.
- Winter wellness plan for the Trust is going to continue again this year.
- Flexible working session being rolled out at ward level.
- Uniform policy - To go back to JNC for ratification and if no changes the Committee approved.

**ASSURE**

- 'Black History Month' - Sanjumol Yohannan and Onome Oyedokun joined the Committee and shared the positive experiences they both have had whilst working at S&O and explained the reason behind # my name is campaign.
- Sickness – reduction in month below 6% target.
- Time to hire – reduction in month despite absences in the Recruitment team
- AHP vacancy rates have reduced in month to the lowest level for 2 years.
- Healthcare Assistant recruitment events held – 68 posts out to offer and 12 new starters in month. Future events planned.
- The People Plan – progress again 19 key deliverable – 17 are green and 2 identified to be resolved.
- Flu and Covid-19 Vaccinations – on trajectory at 28% and expecting to hit 35% next week (flu). Covid-19 is at 27%
- Staff Network Sessions will commence in November.

**New Risks identified at the meeting:** None

**Review of the Risk Register:** Yes

Southport and Ormskirk Hospital NHS Trust

| | | | |
|---|---|---|---|
| **Title of Meeting** | **STRATEGY AND OPERATIONS (S&O) COMMITTEE** | **Date** | **02 November 2022** |
| **Agenda Item** | **SO206/22** | **FOI Exempt** | **NO** |
| **Report Title** | **OUR PEOPLE PLAN – QUARTERLY UPDATE** | | |
| **Executive Lead** | Jane Royds, Director of HR & OD | | |
| **Lead Officer** | Sonya Clarkson, Deputy Director of HR & OD | | |
| **Action Required** | ☐ **To Approve**<br>☐ **To Assure** | ✓ **To Note**<br>✓ **To Receive** | |

**Purpose**

This report provides the quarterly update on the progress against the Trust's *Our People Plan*

**Executive Summary**

Progress against the 19 key deliverables is as follows, 17 are in progress (green) and 2 have identified issues to be resolved (amber).

The People Plan Integrated Performance Report (IPR) measures the impact of *Our People Plan* programmes of work against the aspirational targets to be achieved by 2023 – ref Appendix 2.

The data shows there has been a disappointing decline to staff feedback across all the pulse survey indicators represented on the dashboard, although there are encouraging indicators for the employee relations activity, sickness absence, some recruitment activity, and an increase in flexible working requests.

**Recommendations**

The Strategy and Operations Committee is asked to receive the Our People Plan and note the progress being made to provide assurance on delivery of the Trust's *Our People Plan*.

**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: |
| --- | --- |
| Sonya Clarkson, Deputy Director of HR & OD | Jane Royds, Director of HR & OD |

## *Our People Plan* – Quarterly Progress Update

### 1. Purpose

This report provides the quarterly update on the progress against the key programmes of work identified in the Trust's *Our People Plan* and the key deliverables informed by the Staff Survey 2021.

### 2. Background

The results from the Annual Staff Survey are used to inform the annual key deliverables that support the Trust's *Our People Plan* and ensure action was taken from the feedback received from staff.

Following receipt of the 2021 Staff Survey results in March 2022, the key deliverables for 2022/23 were reviewed and refreshed by Valuing Our People through Inclusion group (VOPIG) – ref Appendix 1.

### 3. Our People Plan – Key Deliverables 2022/23

Progress against the 19 key deliverables is as follows, 17 are in progress (green), 2 have identified issues to be resolved (amber).

Since the last report, the following activity has taken place;

- Along with Sefton Place partners, the Trust held its fifth Schwartz Round in September 2022 and smaller 'Team Time' rounds have taken place in ITU.
- In excess of 30 staff have been referred to the individual restoration programme.
- A nursing and midwifery workforce plan was approved in September 2022, and an aligned medical workforce plan is under development. Consultation on an AHP workforce plan commenced on 14th October (AHP day).
- A nursing career pathway with associated leadership development offer was presented to WIG in October (which included introduction of reverse mentoring), receiving support to align to the overall leadership offer for staff.
- The Trust has been awarded the Navajo Charter Mark signifying good practice, commitment and knowledge of the specific needs, issues and barriers facing LGBTIQA+ people.
- Staff networks were launched in September, with 14 staff signed up to date and positive engagement at the recent 'pop up' stands raising awareness of the networks. First meeting of the staff networks scheduled for the end of November.
- Delivery of a suite of Equality, Diversity and Inclusion training commenced in October.
- The roots and branch review of recruitment and selection processes at the Trust has commenced, resulting so far in the development of a statement for inclusion on all recruitment adverts (offering support to individuals to access and complete online applications via NHS Jobs), as well as the inclusion of Navajo & Disability Confident charter marks on recruitment materials. Next steps are to review the R&S training for managers to improve recruiting manager practices at shortlisting and interviewing stages.

- The second programme of events under the Trust's Staff Voice Partnership engagement strategy commenced in September. The Executive Pop Ups are proving popular, and momentum is picking up with regular Board to Ward visits. Jane Royds has undertaken a shift in ITU as part of the 'Jobs for Jane' initiative. Feedback is collated and shared with Executive Directors with actions and responses communicated to staff via Team Brief every quarter.
- October is 'Speak up for civility' month driven by the FTSU team

The deliverables with identified issues/making slow progress are – roll out of training for the just and learning, and management essentials.

## 4. Our People Plan – Measures of Success

The quarterly People Plan Integrated Performance Report (IPR) (Appendix 2) aims to measure the impact of *Our People Plan* programmes of work against the aspirational targets to be achieved by 2023.

The data shows there has been a disappointing decline to staff feedback across all the pulse survey indicators represented on the dashboard, although there are encouraging indicators for the employee relations activity, sickness absence, some recruitment activity and an increase in flexible working requests.

## 5. Recommendations

The Strategy and Operations Committee is asked to note the progress being made to provide assurance on delivery of the Trust's *Our People Plan*.

**Appendix 1** ***Our People Plan*** **– Key Deliverables 2022/23**

| Key Areas of Focus | Key deliverables 2022/23 | Mar'22 progress rating (where applicable) | Jul'22 | Oct'22 |
|---|---|---|---|---|
| **Looking after our people** | 6 weekly Schwartz Rounds and introduce Team Talk | | Green | Green |
| | Develop an annual HR Policy Development framework (2021/22) | Amber | Amber | Green |
| | Launch Just and Learning / Civility and Respect training | | Green | Amber |
| | Develop Management Essentials training inc. flexible working requests | | Amber | Amber |
| | Staff Winter Wellness programme inc. Autumn vaccinations | | Green | Green |
| | >20 staff completed Individual Restoration programme | | Green | Green |
| | Revised Health and Wellbeing strategy | | Green | Green |
| **Belonging to the NHS** | Deliver suite of EDI training inc. Anti-Racism / Active Bystander training (2021/22) | Amber | Amber | Green |
| | Establish Staff Networks (2021/22) | Amber | Amber | Green |
| | Revise and align leadership development strategy and develop succession planning framework (2021/22) | Green | Amber | Green |
| | Introduce reverse mentoring (2021/22) | Amber | Amber | Green |
| | Launch Staff Voice Partnership | | Green | Green |
| | Roots and branch review of R&S Process | | Amber | Green |
| **New ways of working** | Increased oversight of flexible working requests | | Amber | Green |
| | Develop HR systems roadmap (2021/22) | Green | Green | Green |
| | Develop Trust Clinical Workforce Plan (2021/22) | Green | Green | Green |
| | Further roll out of STAR workforce planning methodology | | Green | Green |
| **Growing for the future** | Development of Advanced Clinical Practitioner roles | | Green | Green |
| | Maximise opportunities for SAS and Trust Grade doctors | | Green | Green |

## Appendix 2 People Plan IPR Dashboard

Southport and Ormskirk Hospital NHS Trust

# Integrated Performance Report

# People Plan

September 2022

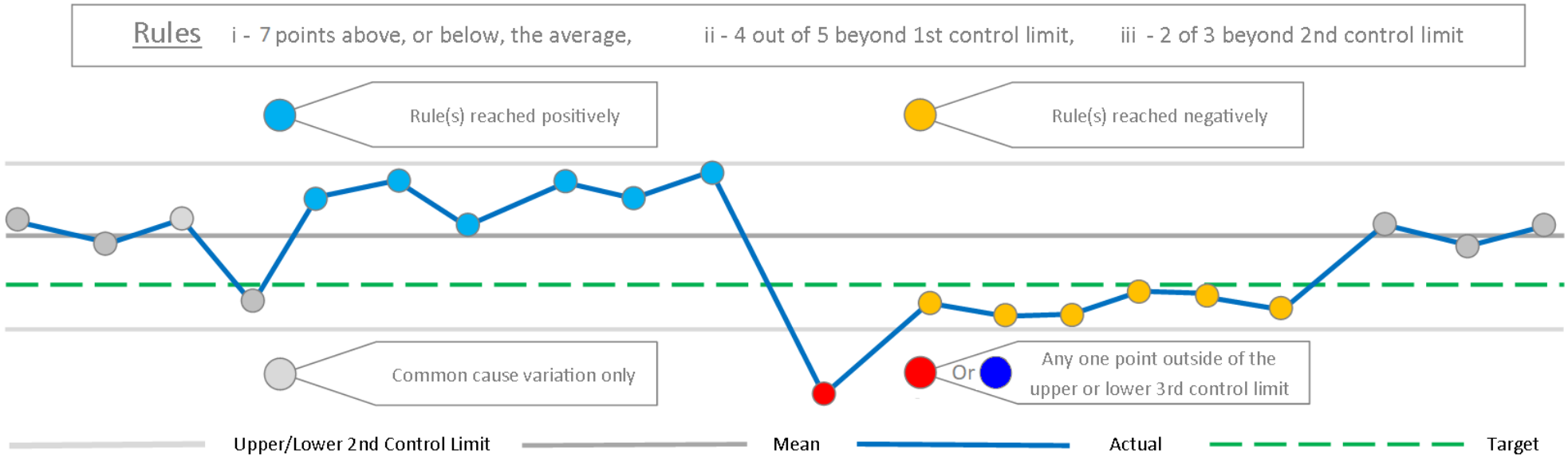
# Guide to Statistical Process Control

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

| | | Assurance | | | Variation | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | |  |  |  |  |  |  |  |  |
| People Plan | Looking after our people | 2 | 1 | 3 | 1 | 0 | 0 | 1 | 4 |
| | Belonging to the NHS | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 3 |
| | New ways of working and delivering care | 3 | 0 | 1 | 0 | 1 | 1 | 0 | 2 |
| | Growing for the future | 2 | 0 | 4 | 0 | 0 | 0 | 3 | 3 |
| | Staff Engagement | 3 | 0 | 1 | 0 | 0 | 0 | 0 | 4 |

## Assurance

Measures the likelyhood of targets being met for this indicator.

| | |
|---|---|
|  | Indicates that this indicator is inconsistently passing and falling short of the target. |
|  | Indicates that this indicator is consistently passing the target. |
|  | Indicates that this indicator is consistently falling short of the target. |

## Variation (Past 3 Months)

Whether SPC rules have been triggered positively or negatively overall for the past 3 months.

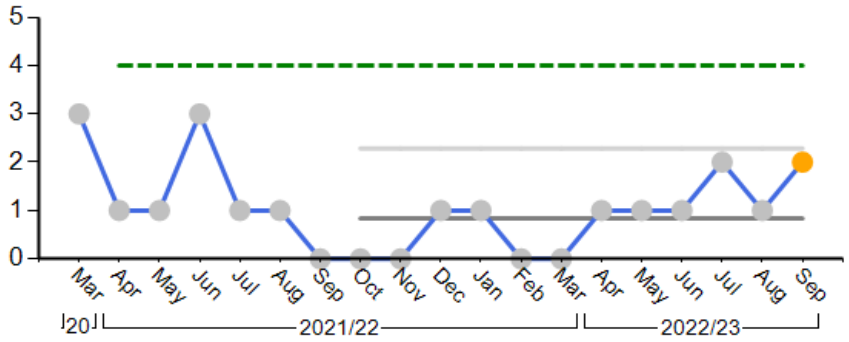
| | |
|---|---|
|  | Indicates that there is no significant variation recently for this indicator. |
|   | Indicates that there is positive variation recently for this indicator. |
|   | Indicates that there is negative variation recently for this indicator. |

# People Plan

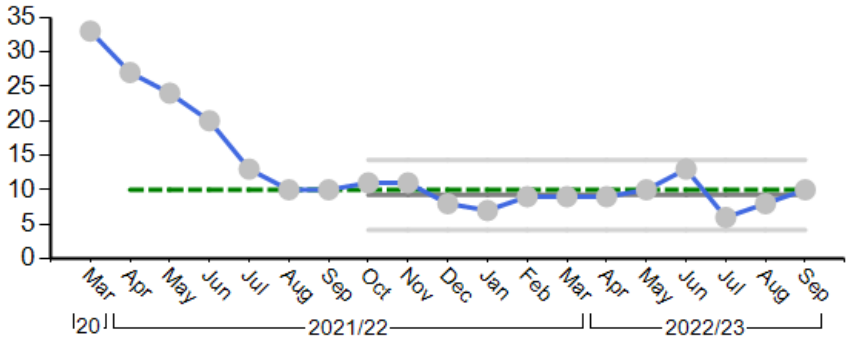
## Looking after our people

| | Latest | | | | Previous | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Plan** | **Actual** | **Period** | **Variation** | **Plan** | **Actual** | **Period** | **Plan** | **Actual** | **Assurance** |
| HR - Employee Relations - Number of new cases in month | 4 | 2 | Sep 22 |  | 4 | 1 | Aug 22 | 48 | 8 |  |
| HR - Employee Relations - Number of ongoing cases | 10 | 10 | Sep 22 |  | 10 | 8 | Aug 22 | 120 | 56 |  |
| HR - Employee Relations - Number of issues dealt with by JLC principles | 2 | 3 | Sep 22 |  | 2 | 1 | Aug 22 | 24 | 11 |  |
| Sickness Rate (not related to Covid 19) - Trust | 5% | 4.8% | Sep 22 |  | 5% | 4.9% | Aug 22 | 5% | 5.2% |  |
| HR - Sickness Absence Rate - % Long Term - Trust | 40% | 53.3% | Sep 22 |  | 40% | 66.4% | Aug 22 | 40% | |  |
| Staff Survey - My organisation takes positive action on health and well-being/Pulse Survey - My organisation is committed to looking after the people who work here | | 35.2% | Jul 22 |  | | 49.2% | Apr 22 | 57% | 41% |  |

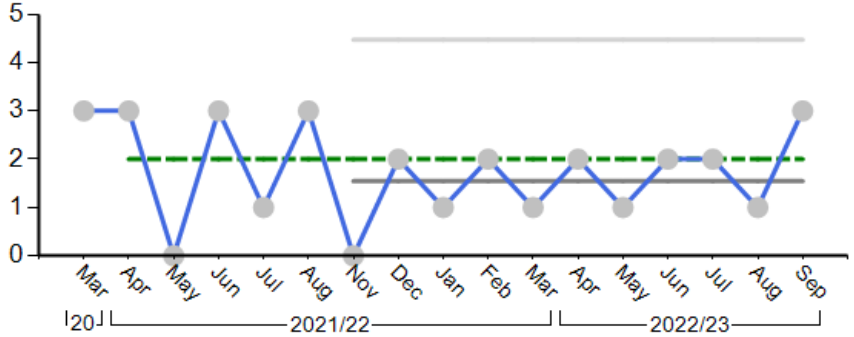
HR - Employee Relations - Number of new cases in month



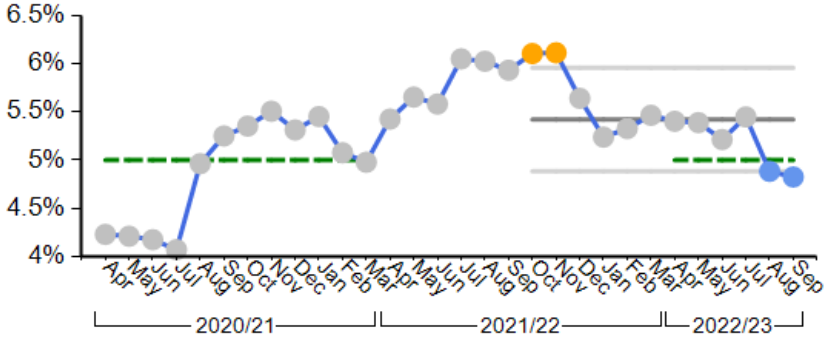

HR - Employee Relations - Number of ongoing cases



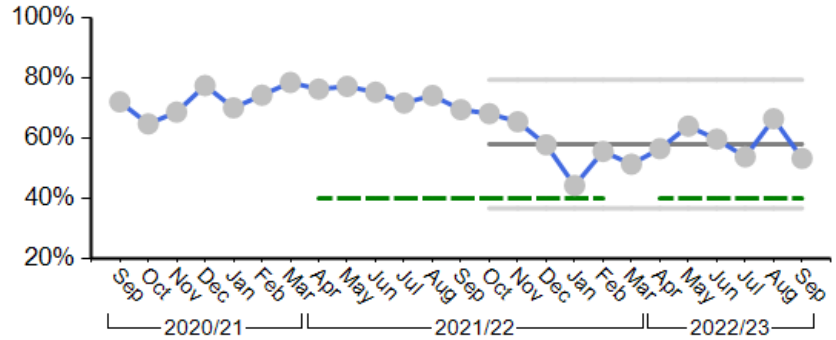

HR - Employee Relations - Number of issues dealt with by JLC principles



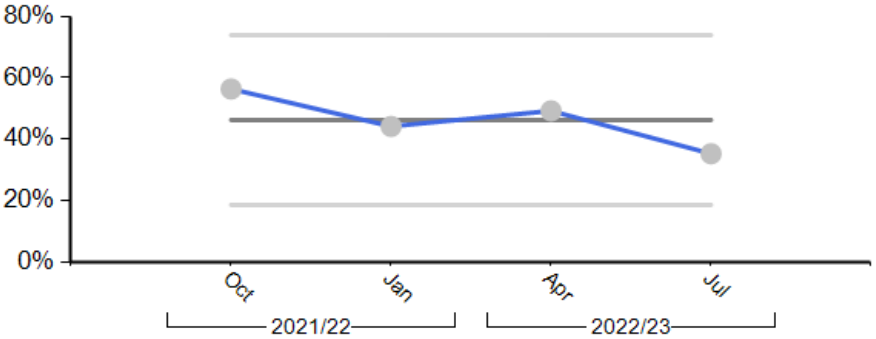

Sickness Rate (not related to Covid 19) - Trust




HR - Sickness Absence Rate - % Long Term - Trust

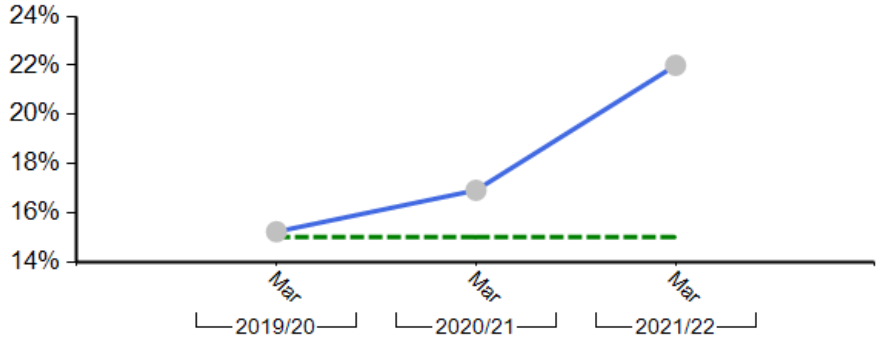



Staff Survey - My organisation takes positive action on health and well-being/Pulse Survey - My organisation is committed to looking after the people who work here

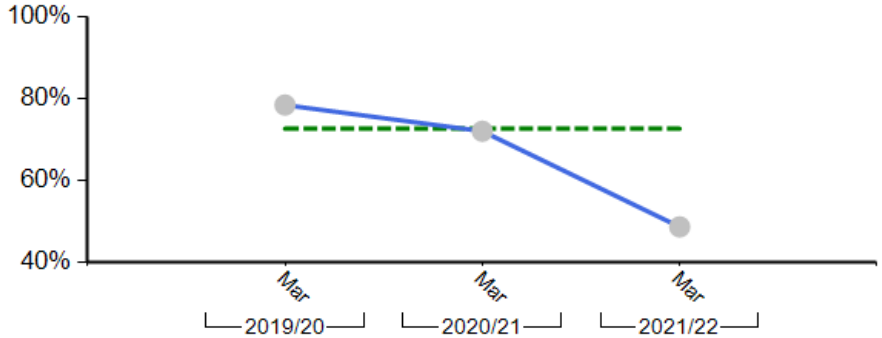


| | Latest | | | | Previous | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Plan** | **Actual** | **Period** | **Variation** | **Plan** | **Actual** | **Period** | **Plan** | **Actual** | **Assurance** |
| WRES - Recruitment - likelihood of appointing from shortlisting - BME | 15% | 22% | Mar 22 | | | 16.9% | Mar 21 | | 22% | |
| WRES - % of staff believing the Trust provides equal opportunities for career progression or promotion - BME | 72.5% | 48.5% | Mar 22 | | | 71.9% | Mar 21 | | 48.5% | |
| WDES - % of Disabled Staff who say employer made adequate adjustments | 70% | 74.5% | Mar 22 | | | 77.6% | Mar 21 | | 74.5% | |

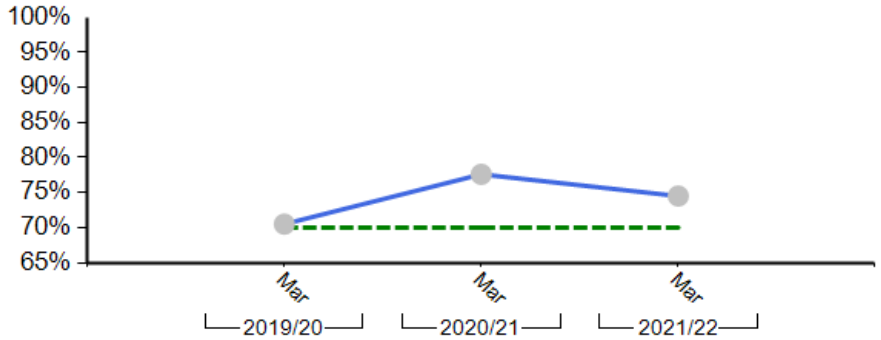
WRES - Recruitment - likelihood of appointing from shortlisting - BME




WRES - % of staff believing the Trust provides equal opportunities for career progression or promotion - BME



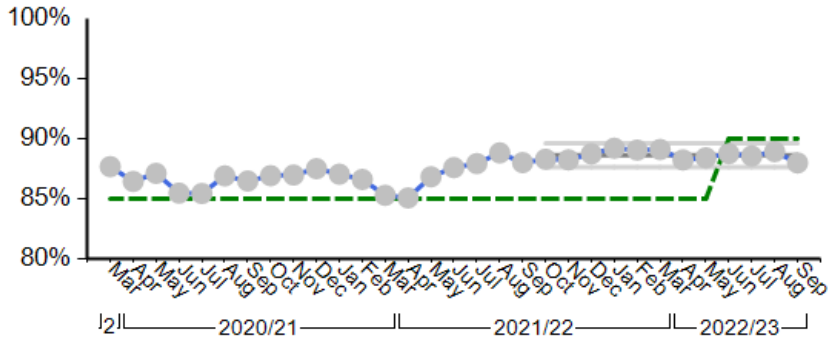

WDES - % of Disabled Staff who say employer made adequate adjustments



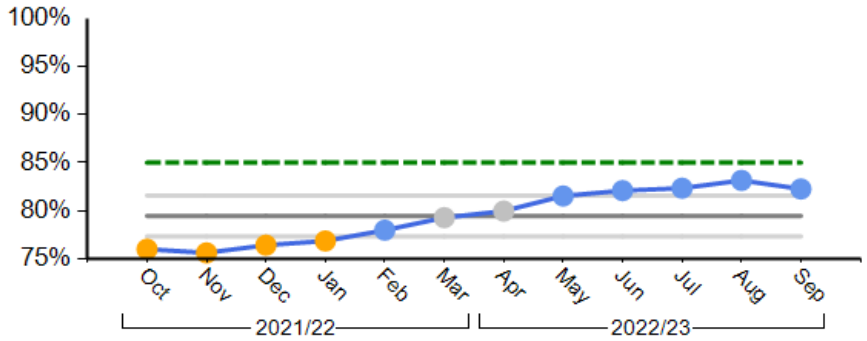
## New ways of working and delivering care

| | Latest | | | | Previous | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Plan** | **Actual** | **Period** | **Variation** | **Plan** | **Actual** | **Period** | **Plan** | **Actual** | **Assurance** |
| Mandatory Training | 90% | 88% | Sep 22 | | 90% | 88.9% | Aug 22 | 90% | 88.5% | F |
| Essential Skills Training - Trust | 85% | 82.3% | Sep 22 | H | 85% | 83.2% | Aug 22 | 85% | 82.3% | F |
| Personal Development Review | 85% | 74.8% | Sep 22 | L | 85% | 76.3% | Aug 22 | 85% | 74.5% | F |
| HR - Flexible Working Requests Submitted | 16 | 25 | Sep 22 | | 16 | 14 | Aug 22 | 200 | 18 | ? |

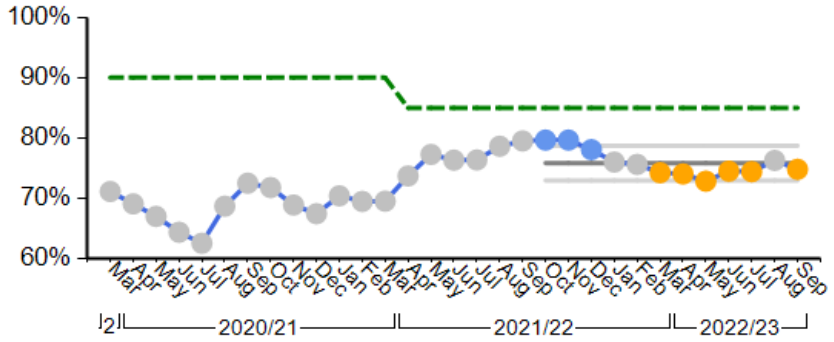
Mandatory Training



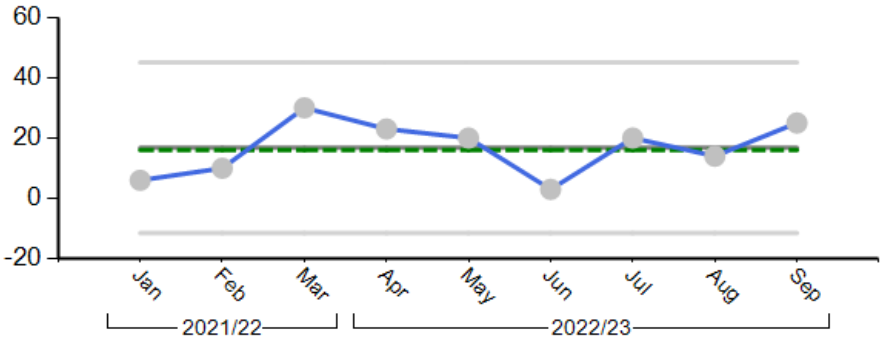

Essential Skills Training - Trust




Personal Development Review




HR - Flexible Working Requests Submitted

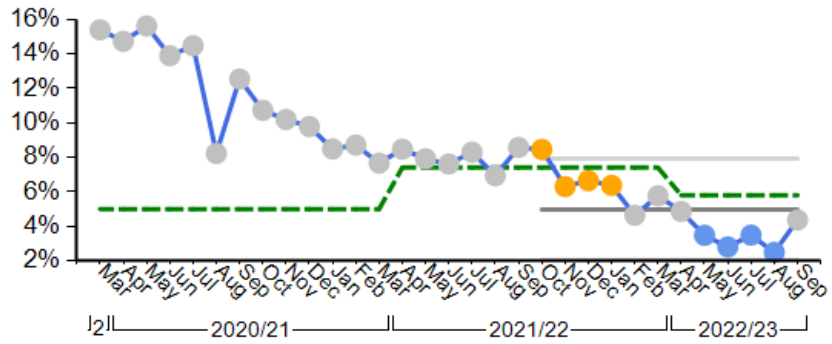


# People Plan

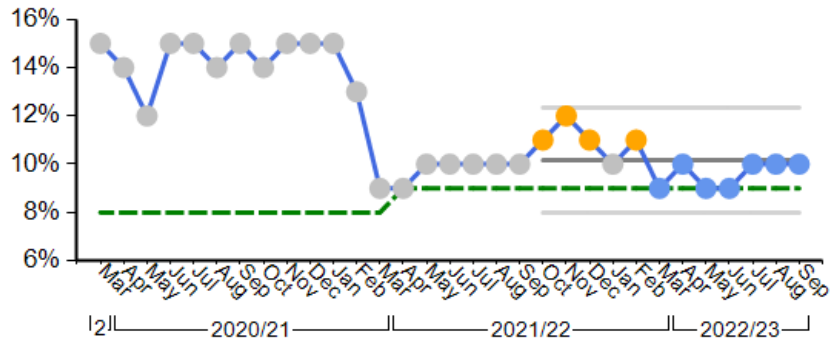
## Growing for the future

| | Latest | | | | Previous | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Plan** | **Actual** | **Period** | **Variation** | **Plan** | **Actual** | **Period** | **Plan** | **Actual** | **Assurance** |
| Vacancy Rate - Medical | 5.8% | 4.4% | Sep 22 |  | 5.8% | 2.5% | Aug 22 | 5.8% | |  |
| Vacancy Rate - Nursing | 9% | 10% | Sep 22 |  | 9% | 10% | Aug 22 | 9% | |  |
| % Agency Staff (cost) | 4.9% | 3.8% | Sep 22 |  | 5.6% | 4.4% | Aug 22 | 5.5% | 3.9% |  |
| Time to Recruit | 40 | 55 | Sep 22 |  | 40 | 58 | Aug 22 | 40 | 56 |  |
| Time to Recruit – Medical Staff | 50 | 96.4 | Sep 22 |  | 50 | 70 | Aug 22 | 50 | 88.2 |  |
| Time to Recruit – all staff excluding Medical | 30 | 49.4 | Sep 22 |  | 30 | 55.5 | Aug 22 | 30 | 52.5 |  |

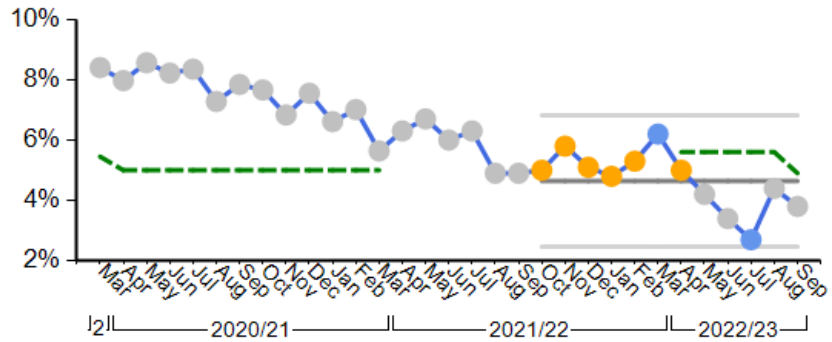
Vacancy Rate - Medical



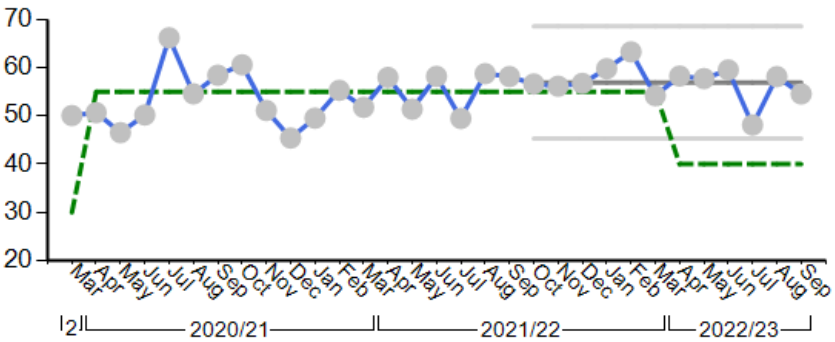

Vacancy Rate - Nursing



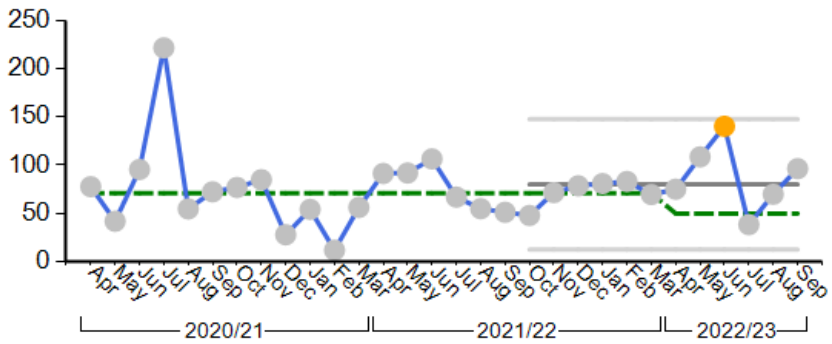

% Agency Staff (cost)



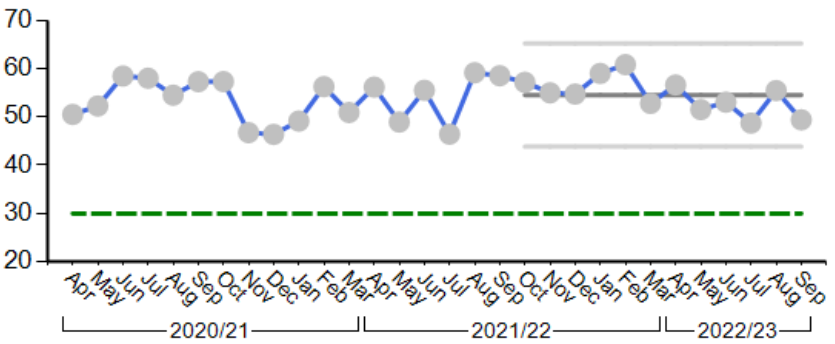

Time to Recruit




Time to Recruit – Medical Staff



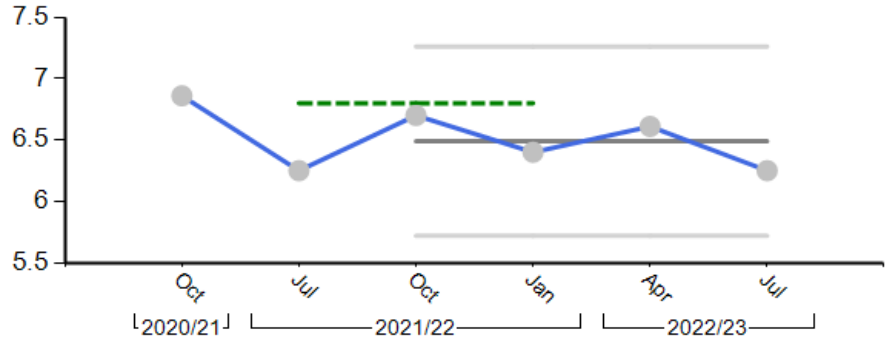

Time to Recruit – all staff excluding Medical



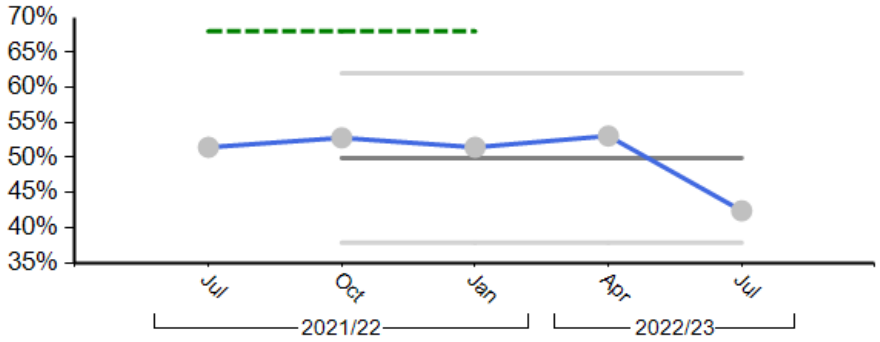
## Staff Engagement

| | Latest | | | | Previous | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Plan** | **Actual** | **Period** | **Variation** | **Plan** | **Actual** | **Period** | **Plan** | **Actual** | **Assurance** |
| Staff Survey - Staff Engagement Score | 6.8 | 6.3 | Jul 22 | | | 6.6 | Apr 22 | 6.8 | 6.7 | ? |
| Pulse Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation | 68% | 42.4% | Jul 22 | | | 53.1% | Apr 22 | 68% | 53.8% | F |
| Pulse Survey - I would recommend my organisation as a place to work | 59% | 45.2% | Jul 22 | | | 50% | Apr 22 | 59% | 53.9% | F |
| Pulse Survey - Care of patients / service users is my organisation's top priority | 75% | 57.6% | Jul 22 | | | 67% | Apr 22 | 75% | 68.4% | F |

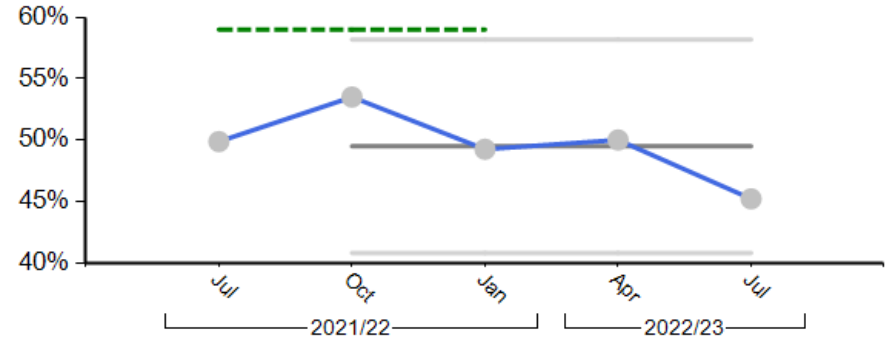
Staff Survey - Staff Engagement Score



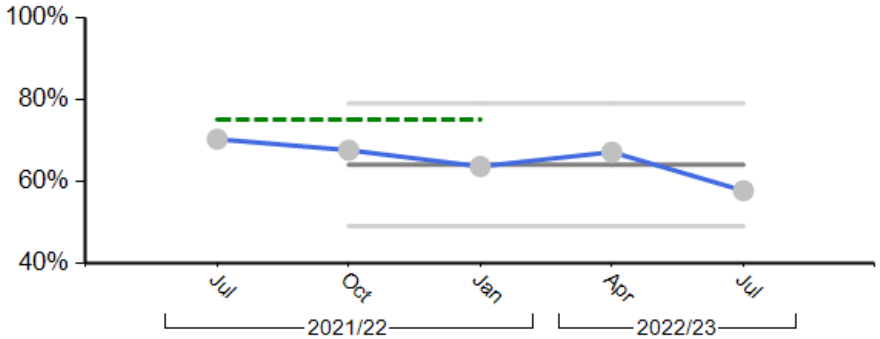

Pulse Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation




Pulse Survey - I would recommend my organisation as a place to work




Pulse Survey - Care of patients / service users is my organisation's top priority



# ALERT | ADVISE | ASSURE (AAA)
# HIGHLIGHT REPORT

| | |
|---|---|
| **COMMITTEE/GROUP:** | Finance, Performance, and Investment Committee |
| **MEETING DATE:** | 24 October 2022 |
| **LEAD:** | Jeff Kozer |

**RELATING TO KEY ITEMS DISCUSSED AT THE MEETING**

## ALERT

- The Trust is reporting a £9.5m deficit at month 6, which is in line with the financial plan. £8.1m of the Cost Improvement Target (CIP) target is RAG rated as green and at month 6 the Trust is delivering to plan. With regards to Elective Recovery Fund (ERF) the Trust has assumed payment in full up to month 6. September saw an improved performance against the elective targets. 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. The pressure relating to the pay award and non-pay inflation is being monitored.
- The cash balance at the end of September is £5.4m. The 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.
- Overall A&E performance in September 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 across the system.

## ADVISE

- The network remediation programme is making good progress across the Ormskirk site.
- As part of the loop protect work that was completed on the current IT network a significant amount of packet loss was rectified leading to improved performance including to the telephony system.
- STHK EPMA upgrade has taken place which enables the S&O implementation to commence.
- Trust continues to work with NHSE to transfer the remaining 90 orthodontic patients to alternative providers.
- The Committee received a paper from the Medical Director on feedback from the Kendall Bluck Review. The Medical Director is taking forward key recommendations and actions.
- Whilst still below the national standards, the Trust has seen improvements across all cancer metrics.

## ASSURE

- Cheshire and Merseyside Fire Brigade satisfied with the progress being made on compartmentation and the fire alarm system
- The new laundry service went live 01 October
- The Planned Care 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 5 is 95.5%, which is slightly above the 95% target.
- The capital programme spend at month 6 is slightly above the plan of £6.2m at £6.5m.
- North Mersey Stroke implementation continues to go well, and patients and staff feedback remains positive.

**New Risks identified at the meeting:** None

**Review of the Risk Register:** No action taken

Southport and Ormskirk Hospital NHS Trust

| | | | |
|---|---|---|---|
| **Title of Meeting** | **STRATEGY AND OPERATIONS (S&O) COMMITTEE** | **Date** | **02 November 2022** |
| **Agenda Item** | **SO208/22** | **FOI Exempt** | **NO** |
| **Report Title** | **STATEMENT OF COMPLIANCE 2022/23 CORE STANDARDS SELF-ASSESSMENT FOR EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)** | | |
| **Executive Lead** | Lesley Neary, Chief Operating Officer | | |
| **Lead Officer** | Chris Pilkington, EPRR Lead | | |
| **Action Required** | ✓ **To Approve**<br>☐ **To Assure** | ☐ **To Note**<br>☐ **To Receive** | |

**Purpose**

To approve the Trust's annual statement of compliance against EPRR national core standards prior to submission to the Integrated Care Board on 02 November 2022.

**Executive Summary**

NHS England has a statutory requirement to formally assure both itself and the NHS in England of Emergency Preparedness, Resilience and Response (EPRR readiness).

This is provided through the EPRR Core Standards self-assessment annual assurance process.

There is a requirement that this Statement of Compliance is agreed by the organisation's board/governing body.

Following a Trust self-assessment, and in line with the definitions of compliance, the organisation currently declares that out of 64 areas applicable to acute trusts, the Trust is complaint with 62. The Trust is therefore able to declare that it is **substantially complaint** against the EPRR Core Standards.

The full statement of compliance has been provided in Appendix A.

A summary of the Trust position against each standard is included in Appendix B.

An action plan to address the 2 areas of partial compliance is set out in Appendix C.

**Recommendations**

The Strategy and Operations Committee is asked to approve the statement of compliance stating **substantial compliance** noting immediate actions that will be taken to address the area of partial compliance in 2022/23.

**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:** |
| Chris Pilkington, EPRR Lead | Lesley Neary, Chief Operating Officer |

## 1. INTRODUCTION

The purpose of this report is to provide the Trust's self-assessment against the NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) for the period of 2022-23 for approval by the Strategy and Operations Committee (SOC) and set out the immediate actions to address areas of partial compliance.

## 2. CONTEXT

NHS England has a statutory requirement to formally assure both itself and the NHS in England of Emergency Preparedness, Resilience and Response (EPRR readiness). This is provided through the EPRR Core Standards self-assessment annual assurance process.

There is a requirement that this Statement of Compliance is agreed by the organisation's board/governing body.

Following the publication of new guidance relating to EPRR in July 2022, there are a total of 64 standards applicable to Acute Providers across a number of domains, set out below.

- Governance
- Duty to risk assess
- Duty to maintain plans
- Command and control
- Training and exercising
- Response
- Warning and informing
- Cooperation
- Business Continuity
- CBRN

The Trust took part in an ICB peer review of our self-assessment to review any areas of concern.

## 3. COMPLIANCE LEVEL

Following the Trust self-assessment, and in line with the definitions of compliance, the organisation currently declares that out of 64 areas applicable to acute trusts, the Trust is complaint with 62.

The Trust is therefore able to declare that it is **substantially complaint** against the EPRR Core Standards for 2022/23.

There are just two areas of partial compliance which are set out below.

***Reference 21: Command and Control***

***Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions.***

Following the peer review with C&M ICB it was agreed the Trust was partially compliant with this standard as not all Strategic and Tactical Commanders have completed the NEW NHSE 'Principles in Health Commander Training'.

There are currently 28 members of staff who cover a tactical commander on call role. Of these,

12 have already completed this training and 16 are booked onto dates in November 2022.

There are currently 14 members of staff who cover a strategic commander on call role. Of these, 9 have already completed the training and 5 will be booking on the training when NHSE release additional dates.

All staff regardless of being on a tactical or strategic on call rota have successfully undertaken Trust level training, the addition for 2022/23 is NEW NHSE training.

***Reference 51: Business Continuity***

***The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.***

The Trust's overall Business Continuity Plan (BCP) states that internal audit of Business Continuity Plans is in place. In order to meet full compliance however the Trust should have in place a regular internal audit of service/area level BCP's. Including BCP's on a Trust's internal audit plan would support full compliance of this standard.

An internal audit of BCP's is planned as part of Mersey Internal Audit Agency (MIAA) Internal Audit in quarter 3 2022/23.

The full statement of compliance and supporting documents are set out in appendices A and B.

The Trust level action plan to address the two areas of partial compliance are set out in appendix C.

## 4. RECOMMENDATIONS

The Strategy and Operations Committee (SOC) are asked to approve the statement of compliance for 2022/23 stating **substantial compliance** noting immediate actions that will be taken to address the area of partial compliance in 2022/23.

## Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
## Emergency Preparedness, Resilience and Response (EPRR) assurance 2022-2023

## STATEMENT OF COMPLIANCE

Southport and Ormskirk Hospital NHS Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Southport and Ormskirk Hospital NHS Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

| Overall EPRR assurance rating | Criteria |
|---|---|
| **Fully** | The organisation is 100% compliant with all core standards they are expected to achieve.<br><br>The organisation's Board has agreed with this position statement. |
| **Substantial** | The organisation is 89-99% compliant with the core standards they are expected to achieve.<br><br>For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. |
| **Partial** | The organisation is 77-88% compliant with the core standards they are expected to achieve.<br><br>For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. |
| **Non-compliant** | The organisation compliant with 76% or less of the core standards the organisation is expected to achieve.<br><br>For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.<br><br>The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance. |

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

_____

Date signed

| Date of Board/governing body meeting | Date presented at Public Board | Date published in organisations Annual Report |
|---|---|---|
| 2 November 2022 | | |

**Appendix B**

Please choose your: Acute Providers

| Domain | Total Applicable Standards | Fully Compliant | Partially Compliant | Not Compliant | Not Applicable |
|---|---|---|---|---|---|
| **Governance** | 6 | 6 | 0 | 0 | 0 |
| **Duty to risk assess** | 2 | 2 | 0 | 0 | 0 |
| **Duty to maintain plans** | 11 | 11 | 0 | 0 | 0 |
| **Command and control** | 2 | 1 | 1 | 0 | 0 |
| **Training and exercising** | 4 | 4 | 0 | 0 | 0 |
| **Response** | 7 | 7 | 0 | 0 | 0 |
| **Warning and informing** | 4 | 4 | 0 | 0 | 0 |
| **Cooperation** | 4 | 4 | 0 | 0 | 3 |
| **Business continuity** | 10 | 9 | 1 | 0 | 1 |
| **CBRN** | 14 | 14 | 0 | 0 | 0 |
| **Total** | **64** | **62** | **2** | **0** | **4** |

| Deep Dive | Total Applicable Standards | Fully Compliant | Partially Compliant | Non Compliant | Not Applicable |
|---|---|---|---|---|---|
| **Evacuation and Shelter** | 13 | 11 | 2 | 0 | 0 |
| **Total** | **13** | **11** | **2** | **0** | **0** |

| | |
|---|---|
| **Percentage Compliance** | 97% |
| **Overall Assessment** | **Substantially Compliant** |

**Assurance Rating Thresholds**
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

**Notes**

Please do not delete rows or columns from any sheet as this will stop the calculations

Please ensure you have the correct Organisation Type selected

The Overall Assessment excludes the Deep Dive questions

Please do not copy and paste into the Self Assessment Column (*Column T*)

| Ref | Domain | Standard name | Standard Detail | Supporting Information - including examples of evidence | Organisational Evidence | Self assessment RAG<br><br>Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.<br><br>Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.<br><br>Green (fully compliant) = Fully compliant with core standard. |
|---|---|---|---|---|---|---|
| 1 | Governance | Senior Leadership | The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio. | Evidence<br>• Name and role of appointed individual<br>• AEO responsibilities included in role/job description | Lesley Neary - AEO & COO | Fully Compliant |
| 2 | Governance | EPRR Policy Statement | The organisation has an overarching EPRR policy or statement of intent.<br><br>This should take into account the organisation's:<br>• Business objectives and processes<br>• Key suppliers and contractual arrangements<br>• Risk assessment(s)<br>• Functions and / or organisation, structural and staff changes. | The policy should:<br>• Have a review schedule and version control<br>• Use unambiguous terminology<br>• Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised<br>• Include references to other sources of information and supporting documentation.<br><br>Evidence<br>Up to date EPRR policy or statement of intent that includes:<br>• Resourcing commitment<br>• Access to funds<br>• Commitment to Emergency Planning, Business Continuity, Training, Exercising etc. | • Major Incident Plan V9 approved April 2022<br>• EPRR Policy Corp 61 Emergency Preparedness Resilience and Response approved March 2021<br>•Business Continuity Management Plan V8 approved April 2022<br>•EPRR Training and Exercising Programme<br>• Requests for funding for EPRR are generally allocated to the relevant CBUs however, if funds were required for specific items, assurance has been provided they would be made available. | Fully Compliant |
| 3 | Governance | EPRR board reports | The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually.<br><br>The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements | These reports should be taken to a public board, and as a minimum, include an overview on:<br>• training and exercises undertaken by the organisation<br>• summary of any business continuity, critical incidents and major incidents experienced by the organisation<br>• lessons identified and learning undertaken from incidents and exercises<br>• the organisation's compliance position in relation to the latest NHS England EPRR assurance process.<br><br>Evidence<br>• Public Board meeting minutes<br>• Evidence of presenting the results of the annual EPRR assurance process to the Public Board<br>• For those organisations that do not have a public board, a public statement of readiness and preparedness activitites. | EPRR Annual Report for 1/4/21 - 31/3/22 was approved at Risk and Compliance Group (RCG) on 14/06/22 and Executive committee on 04/07/22<br>Triple A from the Executive Committee was presented to SOC on 7/9/22 | Fully Compliant |
| 4 | Governance | EPRR work programme | The organisation has an annual EPRR work programme, informed by:<br>• current guidance and good practice<br>• lessons identified from incidents and exercises<br>• identified risks<br>• outcomes of any assurance and audit processes<br><br>The work programme should be regularly reported upon and shared with partners where appropriate. | Evidence<br>• Reporting process explicitly described within the EPRR policy statement<br>• Annual work plan | EPPR Workplan is updated monthly and monitored by the Resilience Group Resilience Group minutes are available as evidence | Fully Compliant |
| 5 | Governance | EPRR Resource | The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties. | Evidence<br>• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board<br>• Assessment of role / resources<br>• Role description of EPRR Staff/ staff who undertake the EPRR responsibilities<br>• Organisation structure chart<br>• Internal Governance process chart including EPRR group | •EPRR Policy CORP 61 V3.0.0 updated in March 2021 and approved at Trust Board in May 2021.<br>•The Major Incident Plan V9, updated April 2022, contains details for the organisational structure and describes roles and duties for staff.<br>•The MIP also shows the governance reporting structure for EPRR<br>• Succession Planning has been established through the PAG process | Fully Compliant |
| 6 | Governance | Continuous improvement | The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements. | Evidence<br>• Process explicitly described within the EPRR policy statement<br>• Reporting those lessons to the Board/ governing body and where the improvements to plans were made<br>• participation within a regional process for sharing lessons with partner organisations | • Incidents, Exercises and learning from these are captured through Resilience Group meetings.<br>• A Training and Exercising Programme is in place and tabled monthly at these meetings.<br>• Attendance at LHRP meetings<br>• EPRR Training & Exercising Programme | Fully Compliant |

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|---|---|---|---|---|---|---|
| **7** | **Duty to risk assess** | **Risk assessment** | The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers. | • Evidence that EPRR risks are regularly considered and recorded<br>• Evidence that EPRR risks are represented and recorded on the organisations corporate risk register<br>• Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather | The EPRR Risk Register is a standard item on the monthly Resilience Group agenda.<br>NHS England represent Health at the Local Resilience Forum (LRF) and report risks from the Community Risk Register at the Local Health Resilience Partnership (LHRP) meetings. | Fully Compliant |
| **8** | **Duty to risk assess** | **Risk Management** | The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally | Evidence<br>• EPRR risks are considered in the organisation's risk management policy<br>• Reference to EPRR risk management in the organisation's EPRR policy document | • Risks relating to EPRR are added to the Trust Risk Register.<br>• EPRR risks are reviewed at the monthly Resilience Group meetings.<br>• The Trust use the triple A system to Alert Advise Assure and this report is sent to the Risk and Compliance Group on a monthly basis. | Fully Compliant |
| **9** | **Duty to maintain plans** | **Collaborative planning** | Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered. | Partner organisations collaborated with as part of the planning process are in planning arrangements<br><br>Evidence<br>• Consultation process in place for plans and arrangements<br>• Changes to arrangements as a result of consultation are recorded | • Major Incident Plan shared with partner agencies including NHS England.<br>• Other plans are shared with appropriate colleagues including NWAS, Lancashire Fire and Rescue Service and Merseyside Fire and Rescue Service.<br>• Plans include 'Version Control and Document Management' together with an 'Amendments Log'<br>• Evacuation Exercise included partner agencies such as Fire Service, Local Authority, NWAS, STHK, NHSE/I | Fully Compliant |
| **10** | **Duty to maintain plans** | **Incident Response** | In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework. | Arrangements should be:<br>• current (reviewed in the last 12 months)<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | • Major Incident Plan V9 updated in April 2022.<br>• Appendix K - Critical Incident in the MIP was updated 15.08.2022 as we can no longer refer to an 'Internal' Critical Incident as this no longer forms part of the EPRR Framework | Fully Compliant |
| **11** | **Duty to maintain plans** | **Adverse Weather** | In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events. | Arrangements should be:<br>• current<br>• in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required<br>• reflective of climate change risk assessments<br>• cognisant of extreme events e.g. drought, storms (including dust storms), wildfire. | Trust Heatwave Plan V6.2 published August 2022.<br><br>The updated Flood Plan V4 is awaiting approval at the Risk and Compliance Group on 13 September 2022.<br><br>Thermal Comfort Policy<br><br>Bottled water and ice lollies made available to staff on both sites | Fully Compliant |

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|---|---|---|---|---|---|---|
| **12** | **Duty to maintain plans** | **Infectious disease** | In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases. | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required<br><br>Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. | IPC Outbreak Plan is incorporated in the IPC Operational manual which is part of the IPC policy. There are also other Key documents such as the isolation policy, Gastroenteritis policy, Influenza policy and Covid policy and SOPs to aid decision making such as for Monkeypox – these are available on the Trust Intranet site.<br>Polices are in review in light of the National IPC Manual, however as national guidance is updated the Trust socialises these changes through Team Brief Live, Trust News, The Meeting Place and will also disperse written updates throughout the wards and departments.<br>There is a mechanism of audits to verify compliance with trust policies and these are fed back through IPC Operational and Assurance meetings and monthly reports.<br>Training is provided remotely as well as face to face – there is obviously some training that requires practicum as well as theoretical training. FFP3 training is provided through the clinical business units and includes objective testing using an analytical machine to measure accurate fit. Electronic records are maintained identifying the staff member | Fully Compliant |
| **13** | **Duty to maintain plans** | **New and emerging pandemics** | In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | The Trust has an Influenza Pandemic plan that was recently reviewed and updated in response to lessons learned with respect to COVID; even though the title relates to influenza it was agreed and described in the text that the plan should be a template for other future pandemics irrespective of the disease involved. The plan has been through the Trust process of validation and ratification.<br>The Trust has a standing Resilience Group which meets at scheduled intervals throughout the year and identifies emergency planning exercises, hence pandemic response will be considered as an exercise for this coming year.<br>The Resilience group has been involved in emergency planning including equipment use, FFP3 respiratory training and fitting and PPE training throughout the COVID pandemic. The group also identifies training and resource needs.<br>(Received from Andrew Chalmers) | Fully Compliant |

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|---|---|---|---|---|---|---|
| **14** | **Duty to maintain plans** | **Countermeasures** | In line with current guidance and legislation, the organisation has arrangements in place<br>to support an incident requiring countermeasures or a mass countermeasure deployment | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required<br><br>Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination.<br><br>There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements.<br><br>Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident. | Our Pharmacy Team have been able to provide COVID vaccinations to staff at short notice and have yet to be asked to provide vaccinations for Monkeypox, due to the shortage of vaccine, with a number of major hospitals already taking this on.<br>We have a minus 70 degrees freezer and a spare fridge ready to deploy to store vaccines.<br>The team would step down other clinical activities to deploy vaccinations as they have done with the COVID vaccine.<br>Consideration would be required from a Trust operational perspective on the issue how to support Health and Wellbeing, if it involved vaccination of staff, and further consideration if patient cohorts required treatment.<br>(Received from John Williams)<br>Due to a limited number of vaccinators, re-deployment of staff would have to be considered, to support any mass vaccination programme<br>(Update from Linda Lewis)<br>Any issues can be highlighted at the Resilience Group meetings as area updates form the standard agenda | Fully Compliant |
| **15** | **Duty to maintain plans** | **Mass Casualty** | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties. | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required<br><br>Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary. | Local Resilience Forum Mass Casualty Plan and Cheshire & Merseyside Mass Casualty Planning Matrix are in place.<br>As shown in the response to COVID-19, we have the ability to go to 18 ITU beds if required however, this would mean we dropped all but emergency theatre activity as per the COVID Plan.<br>Process in place in ED to book in unknown patients<br>Daily Mortuary reporting system in place | Fully Compliant |
| **16** | **Duty to maintain plans** | **Evacuation and shelter** | In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors. | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Current Trust Evacuation Plan V3.1 updated December 2021.<br>This was updated following the learning and actions from the Table Top Evacuation Exercise in September 2021. | Fully Compliant |
| **17** | **Duty to maintain plans** | **Lockdown** | In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident. | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | The Trust Access and Lockdown Plan V2.2 updated July 2021 provides guidance for the arrangement in the event the Trust is required to initiate a lockdown.<br>Since COVID, ward areas can only be accessed using card/keycode access><br>Trust is 'locked down' effectively every night to provide restricted access out of hours.<br>During the Liverpool Women's incident in November 2021, the Trust were able to 'Lockdown' the Ormskirk site.<br>The Counter Terorism Agency have conducted a walkaround of the hospital and submitted their recommendations to the H&S Lead | Fully Compliant |

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|---|---|---|---|---|---|---|
| **18** | **Duty to maintain plans** | **Protected individuals** | In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site. | Arrangements should be:<br>• current<br>• in line with current national guidance<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | Details around VIPs are contained in the Trust Major Incident Plan V9 and the Trust Media Handling Policy CORP 03. | Fully Compliant |
| **19** | **Duty to maintain plans** | **Excess fatalities** | The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events. | Arrangements should be:<br>• current<br>• in line with current national guidance<br>in line with DVI processes<br>• in line with risk assessment<br>• tested regularly<br>• signed off by the appropriate mechanism<br>• shared appropriately with those required to use them<br>• outline any equipment requirements<br>• outline any staff training required | The Trust are required to submit Mortuary figures on a daily basis.<br>If the SDGH Mortuary (62 capacity) was full, the Mortuary at ODGH (24 capacity) could be used. In the event of Mass fatalities, the Trust has an arrangement to utilise Whiston Hospital mortuary facilities. | Fully Compliant |
| **20** | **Command and control** | **On-call mechanism** | The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level. | • Process explicitly described within the EPRR policy statement<br>• On call Standards and expectations are set out<br>• Add on call processes/handbook available to staff on call<br>• Include 24 hour arrangements for alerting managers and other key staff.<br>• CSUs where they are delivering OOHs business critical services for providers and commissioners | The Senior Manager On-Call Rota includes General Manager and Executive Manager On Call 24/7.<br>There is a clear process and guidance in place so staff feel supported and are able to escalate to Executive level if necessary.<br><br>On Call Policy currently under review. | Fully Compliant |
| **21** | **Command and control** | **Trained on-call staff** | Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions | • Process explicitly described within the EPRR policy or statement of intent<br><br>The identified individual:<br>• Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards)<br>• Has a specific process to adopt during the decision making<br>• Is aware who should be consulted and informed during decision making<br>• Should ensure appropriate records are maintained throughout.<br>• Trained in accordance with the TNA identified frequency. | • Training for 'Principles of Health Command courses - Tactical and Strategic' are ongoing for On Call General Managers and Executive Manager. This training is delivered by NHS England and meets the NMOS. Managers are required to keep their own training portfolio updated.<br>• Earlier this year, the Trust commissioned an external trainer to provided Command and Control Training to members of the Executive On Call rota | Partially Compliant |
| **22** | **Training and exercising** | **EPRR Training** | The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role. | Evidence<br>• Process explicitly described within the EPRR policy or statement of intent<br>• Evidence of a training needs analysis<br>• Training records for all staff on call and those performing a role within the ICC<br>• Training materials<br>• Evidence of personal training and exercising portfolios for key staff | • Details of the Trust EPRR Training Needs Analysis (TNA) can be found in the Major Incident Plan.<br>• Staff are required to maintain their own training portfolios.<br>• In-house PRPS trainers<br>• In-house Loggist trainers<br>• ERPP awareness training delivered to Bed Managers / Bleep Holders | Fully Compliant |

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|---|---|---|---|---|---|---|
| **23** | **Training and exercising** | **EPRR exercising and testing programme** | In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care) | Organisations should meet the following exercising and testing requirements:<br>• a six-monthly communications test<br>• annual table top exercise<br>• live exercise at least once every three years<br>• command post exercise every three years.<br><br>The exercising programme must:<br>• identify exercises relevant to local risks<br>• meet the needs of the organisation type and stakeholders<br>• ensure warning and informing arrangements are effective.<br><br>Lessons identified must be captured, recorded and acted upon as part of continuous improvement.<br><br><u>Evidence</u><br>• Exercising Schedule which includes as a minimum one Business Continuity exercise<br>• Post exercise reports and embedding learning | There is an EPRR Training and Exercise Programme in place that is developed by the EPRR Manager and the MI Lead for A&E. Once produced, the programme is review and updated to capture ideas and suggestions for members other Resilience Group. This is an Agenda item on the monthly Resilience Group meetings. Following each exercise, Exercise Reports are completed and post exercise action plans are produced to embed learning. | Fully Compliant |
| **24** | **Training and exercising** | **Responder training** | The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards.<br><br>Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role | <u>Evidence</u><br>• Training records<br>• Evidence of personal training and exercising portfolios for key staff | • Individuals is responsible for managing their own training portfolio.<br>• Line managers are responsible for individual training requirements. | Fully Compliant |
| **25** | **Training and exercising** | **Staff Awareness & Training** | There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department. | As part of mandatory training<br>Exercise and Training attendance records reported to Board | • As part of the Trust 'Warm Welcome' Induction, EPRR awareness is available to all new starters.<br>• Mandatory Training is reported to the Board via the Training & Development Team | Fully Compliant |
| **26** | **Response** | **Incident Co-ordination Centre (ICC)** | The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required.<br><br>An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards.<br><br>ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness.<br><br>Arrangements should be supported with access to documentation for its activation and operation. | • Documented processes for identifying the location and establishing an ICC<br>• Maps and diagrams<br>• A testing schedule<br>• A training schedule<br>• Pre identified roles and responsibilities, with action cards<br>• Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards<br>• Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions. | There is a designated Incident Control Room available at both hospital sites. They are equipped appropriately with relevant information i.e. Action Cards, Contacts, Log Books, copies of relevant Plans etc. As we have two sites, if one site is compromised, the ICR on the alternative site can used as a contingency.<br>The Incident Control Room is used on a daily basis by key staff including the EPRR Manager, so equipment is already in use.<br>There is an identified room within Ormskirk Hospital in the event a Control Room was required on that site | Fully Compliant |
| **27** | **Response** | **Access to planning arrangements** | Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible. | Planning arrangements are easily accessible - both electronically and local copies | Electronic copies of emergency plans available on intranet and hard copies available within the Incident Control Room on both hospital sites. | Fully Compliant |

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|---|---|---|---|---|---|---|
| **28** | **Response** | **Management of business continuity incidents** | In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework). | • Business Continuity Response plans<br>• Arrangements in place that mitigate escalation to business continuity incident<br>• Escalation processes | • The Trust Business Continuity Management Plan V8 was updated April 2022.<br>• Departmental Business Continuity Plans (BCPs) are updated on an annual basis.<br>• Hard copies of the above, are kept in Major Incident cupboard in the Incident Control Room and electronic copies are available in the On Call Shared Folder that all On Call staff can access. | Fully Compliant |
| **29** | **Response** | **Decision Logging** | To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure:<br>1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy.<br>2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker | • Documented processes for accessing and utilising loggists<br>• Training records | • An up to date list of Logists is held by EPRR manager.<br>• Logists have their own action card within the Major Incident Plan and have access to refresher training when provided.<br>• The Trust have Loggist 'Train the Trainers' which means 'in house' training can be provided. | Fully Compliant |
| **30** | **Response** | **Situation Reports** | The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats. | • Documented processes for completing, quality assuring, signing off and submitting SitReps<br>• Evidence of testing and exercising<br>• The organisation has access to the standard SitRep Template | • The BI Team are responsible for receiving, completing and submitting any sitreps when required.<br>• The Trust has a designated EPRR mailbox to receive notifications and briefings. This is monitored on a regular basis. | Fully Compliant |
| **31** | **Response** | **Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'** | Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook. | Guidance is available to appropriate staff either electronically or hard copies | ED consultants have access to 'Clinical Guidelines for Major Incidents and Mass Casualty events' electronically and there is a hard copy in the ED office Guidance available on Trust Intranet. | Fully Compliant |
| **32** | **Response** | **Access to 'CBRN incident: Clinical Management and health protection'** | Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE) | Guidance is available to appropriate staff either electronically or hard copies | • All staff can access the CBRNe/HAZMAT Plan as it is available on the Emergency Planning pages of the Trust Intranet.<br>• A hard copy is stored in the Incident Control Room.<br>• Additionally, an electronic copy is stored in the On Call Shared folder which all on-call staff can access. | Fully Compliant |
| **33** | **Warning and informing** | **Warning and informing** | The organisation aligns communications planning and activity with the organisation's EPRR planning and activity. | • Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents.<br>• Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework.<br>• Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements.<br>• Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry. | • The Trust Website provides us with digital resilience where messages to the public can be advertised instantly.<br>• The event of an incident, the Comms Team would be contacted to support senior leaders, and record any requests/decisions that are made.<br>• Throughout the Pandemic the Trust used MS Teams to deliver Staff and entire Trust Briefings.<br>• Alternative communication methods include Facebook 'Meeting place' and S&O Twitter account. | Fully Compliant |

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| **34** | **Warning and informing** | **Incident Communication Plan** | The organisation has a plan in place for communicating during an incident which can be enacted. | • An incident communications plan has been developed and is available to on call communications staff<br>• The incident communications plan has been tested both in and out of hours<br>• Action cards have been developed for communications roles<br>• A requirement for briefing NHS England regional communications team has been established<br>• The plan has been tested, both in and out of hours as part of an exercise.<br>• Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate). | The PR and Communications Team have a respective action card in the Major Incident Plan, detailing their roles and responsibilities.<br>They would also form part of the regional Communications Cell.<br>(Received from Tony Ellis) | Fully Compliant |
| **35** | **Warning and informing** | **Communication with partners and stakeholders** | The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident. | • Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications<br>• A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level.<br>• A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident<br>• Appropriate channels for communicating with members of the public that can be used 24/7 if required<br>• Identified sites within the organisation for displaying of important public information (such as main points of access)<br>• Have in place a means of communicating with patients who have appointments booked or are receiving treatment.<br>• Have in place a plan to communicate with inpatients and their families or care givers.<br>• The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements | The Communications Policy and Stakeholder list is refreshed periodically to reflect changes in the Trust and healthcare environment.<br>(Received from Tony Ellis) | Fully Compliant |
| **36** | **Warning and informing** | **Media strategy** | The organisation has arrangements in place to enable rapid and structured communication via the media and social media | • Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media<br>• Develop a pool of media spokespeople able to represent the organisation to the media at all times.<br>• Social Media policy and monitoring in place to identify and track information on social media relating to incidents.<br>• Setting up protocols for using social media to warn and inform<br>• Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response | The Trust have in place the following policies :-<br>• Corp 03 Media Handling Policy<br>• CORP 108 Social Network and Social Media Policy<br>(Received from Tony Ellis) | Fully Compliant |
| **37** | **Cooperation** | **LHRP Engagement** | The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings. | • Minutes of meetings<br>• Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities. | Practitioner and Strategic LHRP meetings are attended by EPRR manager and AEO. Minutes of meetings are provided by the LHRP Secretariat, following each meeting. | Fully Compliant |
| **38** | **Cooperation** | **LRF / BRF Engagement** | The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders. | • Minutes of meetings<br>• A governance agreement is in place if the organisation is represented and feeds back across the system | We are represented at the Local Resilience Forum (LRF) by NHS England. Outcomes are fed back via LHRP meetings. | Fully Compliant |
| **39** | **Cooperation** | **Mutual aid arrangements** | The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies.<br><br>In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England. | • Detailed documentation on the process for requesting, receiving and managing mutual aid requests<br>• Templates and other required documentation is available in ICC or as appendices to IRP<br>• Signed mutual aid agreements where appropriate | Mutual Aid is referenced in the Major Incident Plan V9 and if we needed to request Mutual Aid, the Trust would liaise with NHS England.<br>We have a Memorandum of Understanding (MOU) with partner agencies such as Merseyside Fire and Rescue Service, North West Ambulance Service, Northwest 4 X 4. | Fully Compliant |
| **43** | **Cooperation** | **Information sharing** | The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents. | • Documented and signed information sharing protocol<br>• Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004 | There is a signed protocol that covers a commitment to share appropriate information with organisations across Cheshire and Merseyside.<br>Each instance of information sharing with external partners is judged on its own merits and individually signed off by John McLuckie as SIRO.<br>The use of agreements are covered in the Information Governance Handbook - CORP 125.<br>(Received from Stephen Brooks) | Fully Compliant |

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| **44** | **Business Continuity** | **BC policy statement** | The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301. | The organisation has in place a policy which includes intentions and direction as formally expressed by its top management.<br>The BC Policy should:<br>• Provide the strategic direction from which the business continuity programme is delivered.<br>• Define the way in which the organisation will approach business continuity.<br>• Show evidence of being supported, approved and owned by top management.<br>• Be reflective of the organisation in terms of size, complexity and type of organisation.<br>• Document any standards or guidelines that are used as a benchmark for the BC programme.<br>• Consider short term and long term impacts on the organisation including climate change adaption planning | The Trust Business Continuity Management Plan V8 is in place. This was updated and approved in April 2022 | Fully Compliant |
| **45** | **Business Continuity** | **Business Continuity Management Systems (BCMS) scope and objectives** | The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.<br><br>A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme. | BCMS should detail:<br>• Scope e.g. key products and services within the scope and exclusions from the scope<br>• Objectives of the system<br>• The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties<br>• Specific roles within the BCMS including responsibilities, competencies and authorities.<br>• The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process<br>• Resource requirements<br>• Communications strategy with all staff to ensure they are aware of their roles<br>• alignment to the organisations strategy, objectives, operating environment and approach to risk.<br>• the outsourced activities and suppliers of products and suppliers.<br>• how the understanding of BC will be increased in the organisation | • The Trust Business Continuity Management Plan V8 is in place and was updated and approved in April 2022.<br>• Department BCP's will support this overarching plan. | Fully Compliant |
| **46** | **Business Continuity** | **Business Impact Analysis/Assessment (BIA)** | The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es). | The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme.<br><br>Documented process on how BIA will be conducted, including:<br>• the method to be used<br>• the frequency of review<br>• how the information will be used to inform planning<br>• how RA is used to support.<br><br>The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA:<br>• Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption.<br>• A consistent approach to performing the BIA should be used throughout the organisation.<br>• BIA method used should be robust enough to ensure the information is collected consistently and impartially. | Each department business continuity plan is formulated using a Business Impact Analysis/Assessment which includes a Risk Assessment. Business Impact Analysis is carried out using a standardised methodology across the organisation, and includes Recovery Time Objectives (RTO) & Maximum Tolerable Period of Disruption (MTPD). | Fully Compliant |
| **47** | **Business Continuity** | **Business Continuity Plans (BCP)** | The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to:<br>• people<br>• information and data<br>• premises<br>• suppliers and contractors<br>• IT and infrastructure | Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation.<br><br>Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following:<br>• Purpose and Scope<br>• Objectives and assumptions<br>• Escalation & Response Structure which is specific to your organisation.<br>• Plan activation criteria, procedures and authorisation.<br>• Response teams roles and responsibilities.<br>• Individual responsibilities and authorities of team members.<br>• Prompts for immediate action and any specific decisions the team may need to make.<br>• Communication requirements and procedures with relevant interested parties.<br>• Internal and external interdependencies.<br>• Summary Information of the organisations prioritised activities.<br>• Decision support checklists<br>• Details of meeting locations<br>• Appendix/Appendices | Departments/Ward areas are responsible for reviewing and updating their BCP's. These BCP's contain Recovery Time Objectives (RTOs) and Maximum Tolerable Period of Disruption (MTPD). | Fully Compliant |
| **48** | **Business Continuity** | **Testing and Exercising** | The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents. | Confirm the type of exercise the organisation has undertaken to meet this sub standard:<br>• Discussion based exercise<br>• Scenario Exercises<br>• Simulation Exercises<br>• Live exercise<br>• Test<br>• Undertake a debrief<br><br>Evidence<br>Post exercise/ testing reports and action plans | The Trust has an annual EPRR Training and Exercising Programme which features areas to be tested, based on agreement with the EPRR Manager, ED MI Lead and members of the Resilience Group. BCPs are tested on a regular basis through day-to-day incidents involving loss of utilities / network / staff shortages, etc. | Fully Compliant |

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| **49** | **Business Continuity** | **Data Protection and Security Toolkit** | Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis. | Evidence<br>• Statement of compliance<br>• Action plan to obtain compliance if not achieved | In 21/22 the Trust's received a 'standards met' rating for it's DSPT submission with the Trust's independent auditors (Merseyside Internal Audit) giving the Trust a 'substantial assurance' rating against the DSPT evidence that was audited.<br>(Received from Stephen Brooks) | Fully Compliant |
| **50** | **Business Continuity** | **BCMS monitoring and evaluation** | The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board. | • Business continuity policy<br>• BCMS<br>• performance reporting<br>• Board papers | • BCM plan in place with departmental business continuity plans in place to support this plan.<br>• Business Continuity incidents are reported through the CBU updates at the monthly Resilience Group meetings and escalated, when required, via the AAA Reporting structure to the Risk and Compliance Group, which reports to Executive Committee and SOC. | Fully Compliant |
| **51** | **Business Continuity** | **BC audit** | The organisation has a process for internal audit, and outcomes are included in the report to the board.<br><br>The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme. | • process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation<br>• Board papers<br>• Audit reports<br>• Remedial action plan that is agreed by top management.<br>• An independent business continuity management audit report.<br>• Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle.<br>• External audits should be undertaken in alignment with the organisations audit programme | Historically, MIAA have completed internal audits. It has been agreed through our Audit Committee, that MIAA will be requested to undertake an audit of our BCPs during quarter 3 or 4 of 2022/23 | Partially Compliant |
| **52** | **Business Continuity** | **BCMS continuous improvement process** | There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS. | • process documented in the EPRR policy/Business continuity policy or BCMS<br>• Board papers showing evidence of improvement<br>• Action plans following exercising, training and incidents<br>• Improvement plans following internal or external auditing<br>•Changes to suppliers or contracts following assessment of suitability<br><br>Continuous Improvement can be identified via the following routes:<br>• Lessons learned through exercising.<br>• Changes to the organisations structure, products and services, infrastructure, processes or activities.<br>• Changes to the environment in which the organisation operates.<br>• A review or audit.<br>• Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions.<br>• Self assessment<br>• Quality assurance<br>• Performance appraisal<br>• Supplier performance<br>• Management review<br>• Debriefs<br>• After action reviews<br>• Lessons learned through exercising or live incidents | • The Resilience Group Work Plan monitors the annual review of the departmental BCPs.<br>• BCPs are put to the test on a regular basis through unexpected business continuity incidents.<br>• Lessons learned are incorporated into revised plans.<br>• The Business Continuity Management Plan is reviewed by the Resilience Group and ratified by the Risk and Compliance Group which is a sub-committee of the Strategy and Operations Committee (SOC). | Fully Compliant |
| **53** | **Business Continuity** | **Assurance of commissioned providers / suppliers BCPs** | The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own. | • EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance<br>• Provider/supplier assurance framework<br>• Provider/supplier business continuity arrangements<br><br>This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers | Our Procurement Department request specific BCPs for key providers and hold the BCPs for our major suppliers of everyday goods.<br>E.g. Supply Chain, BOC . | Fully Compliant |
| **55** | **CBRN** | **Telephony advice for CBRN exposure** | Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents. | Staff are aware of the number / process to gain access to advice through appropriate planning arrangements | The contact details for advice from UK Health Security Agency is displayed in A&E for staff to access. | Fully Compliant |

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| **56** | **CBRN** | **HAZMAT / CBRN planning arrangement** | There are documented organisation specific HAZMAT/ CBRN response arrangements. | Evidence of:<br>• command and control structures<br>• procedures for activating staff and equipment<br>• pre-determined decontamination locations and access to facilities<br>• management and decontamination processes for contaminated patients and fatalities in line with the latest guidance<br>• interoperability with other relevant agencies<br>• plan to maintain a cordon / access control<br>• arrangements for staff contamination<br>• plans for the management of hazardous waste<br>• stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes<br>• contact details of key personnel and relevant partner agencies | • The Trust CBRN Plan V6.1 was reviewed in September 2021.<br>• The plan was shared with partner agencies for comments - Merseyside Fire and Rescue Service, Lancashire Fire Service and NWAS, which were incorporated into the plan and agreed by the members of the Resilience Group. | Fully Compliant |
| **57** | **CBRN** | **HAZMAT / CBRN risk assessments** | HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation.<br><br>This includes:<br>• Documented systems of work<br>• List of required competencies<br>• Arrangements for the management of hazardous waste. | • Impact assessment of CBRN decontamination on other key facilities | • CBRN Plan in place.<br>• MOU with NWAS for Disposal of Contaminated Material following Decontamination of Self Presenting Casualties - 5 December 2016 (still valid).<br>• MOU with Merseyside Fire and Rescue Service for Decontamination of Self Presenters at Southport Hospital - September 2021.<br>· Our CBRN Plan includes an action card for the Estates On Call to risk assess ED to check if the main air intakes need to be shut down and the ED Coordinator is asked to do a risk assessment if PRPS is needed when patients self present in ED. | Fully Compliant |
| **58** | **CBRN** | **Decontamination capability availability 24 /7** | The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week. | Rotas of appropriately trained staff availability 24 /7 | • A register is available to all those covering on-call and ED staff of those members of staff who are trained to wear the Powered Respirator Protective Suits (PRPS) and to erect the decontamination tent.<br>• Documented training records are available.<br>•Training in both of these elements is ongoing, to increase numbers in the CBRN Response Team. | Fully Compliant |
| **59** | **CBRN** | **Equipment and supplies** | The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients.<br><br>• Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/<br>• Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf<br>• Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ | Completed equipment inventories; including completion date | • The Trust holds appropriate equipment to ensure safe decontamination of patients and protection of staff.<br>• Equipment checklist is completed annually as a minimum. | Fully Compliant |
| **60** | **CBRN** | **PRPS availability** | The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment.<br><br>There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date. | Completed equipment inventories; including completion date | The organisation has the required number of PRPS equipment available for immediate deployment. These were serviced by Respirex in September 2022 as part of the annual service contract. Finance is available to cover revalidation and replacement, as required. | Fully Compliant |

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| **61** | **CBRN** | **Equipment checks** | There are routine checks carried out on the decontamination equipment including:<br>• PRPS Suits<br>• Decontamination structures<br>• Disrobe and rerobe structures<br>• Shower tray pump<br>• RAM GENE (radiation monitor)<br>• Other decontamination equipment.<br><br>There is a named individual responsible for completing these checks | Record of equipment checks, including date completed and by whom. | A Preventative Programme of Maintenance (PPM) is in place and is held by the Emergency Preparedness Manager which records dates of equipment checks and any maintenance/replacements required. This document can be located on the network drive under \\odgh-dfs\fs\Shared Files\Emergency Planning\CBRN\2022 | Fully Compliant |
| **62** | **CBRN** | **Equipment Preventative Programme of Maintenance** | There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for:<br>• PRPS Suits<br>• Decontamination structures<br>• Disrobe and rerobe structures<br>• Shower tray pump<br>• RAM GENE (radiation monitor)<br>• Other equipment | Completed PPM, including date completed, and by whom | • PPM at Southport took place on 16 Aug 2022<br>• PPM at Ormskirk took place on 16 Aug 2022<br>• The PPM was carried out by the Emergency Preparedness Manager and CBRN Lead from ED<br>• The Ram Gene monitors for part of the EBME audit checklist and are calibrated annually.<br>• The PRPS on both sites are serviced annually by Respirex | Fully Compliant |
| **63** | **CBRN** | **PPE disposal arrangements** | There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance. | Organisational policy | We dispose of PPE when no longer required using the Trust waste disposal contract, following the correct procedure as advised by Respirex.<br>Refer to Respirex document 'Instructions for use of Powered Respirator Protective Suit PRPS'.<br>If requested, we can transfer equipment to partner organisations for them to use for training purposes providing we inform Respirex. | Fully Compliant |
| **64** | **CBRN** | **HAZMAT / CBRN training lead** | The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training | Maintenance of CPD records | We currently have 2 members of staff who completed the NARU PRPS training course in April 2019. They both attended NARU refresher training in May 2022 and can provide training to staff across the organisation. | Fully Compliant |
| **65** | **CBRN** | **Training programme** | Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination. | Evidence training utilises advice within:<br>• Primary Care HAZMAT/ CBRN guidance<br>• Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/<br><br>• A range of staff roles are trained in decontamination techniques<br>• Lead identified for training<br>• Established system for refresher training | Relevant CBRN Training materials have been developed by the Emergency Preparedness Manager. Initial Operational Response (IOR) "Remove, Remove, Remove" equipment available in the ED Receptions on both sites and reception staff are briefed on the procedure to follow should a patient self-present with a suspected chemical exposure. | Fully Compliant |

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| **66** | **CBRN** | **HAZMAT / CBRN trained trainers** | The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme. | Maintenance of CPD records | We currently have 2 members of staff who completed the NARU PRPS training course in April 2019. They both attended NARU refresher training in May 2022 and can provide training to staff across the organisation. | Fully Compliant |
| **67** | **CBRN** | **Staff training - decontamination** | Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant. | Evidence training utilises advice within:<br>• Primary Care HAZMAT/ CBRN guidance<br>• Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/<br>• Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf<br>• A range of staff roles are trained in decontamination technique | • The Reception staff line managers holds responsibility for ensuring the reception staff are briefed on Remove Remove Remove, and their staff maintain suitable levels of training in IOR, including new staff members.<br>• All staff have the opportunity to view the IOR video which is located via the Emergency Planning page on the Trust Intranet. | Fully Compliant |
| **68** | **CBRN** | **FFP3 access** | Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7. | | FFP3 (or equivalent) masks are available for staff for their protection against infectious respiratory viruses.<br>During COVID-9 a database was established to hold the model of mask that the clinical staff has been fit tested to use. | Fully Compliant |

Southport and Ormskirk Hospital NHS Trust

**EPRR Work Plan 2022/23**

| TASK NAME | RELATED CORE STANDARDS | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trained and up-to-date staff available 24/7 to manage escalations, make decision and identify key actions. | 21 | START | | END | | | | | | | | | | Principles of Health Command training to be completed by Tactical and Strategic Commanders by January 2023. |
| Mersey Internal Audit Authority (MIAA) to complete internal audit of BCPs in Quarter 3 2022/23. | 51 | START | | END | | | | | | | | | | Internal audit to be completed. |

# ALERT | ADVISE | ASSURE (AAA)
# HIGHLIGHT REPORT

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| **COMMITTEE/GROUP:** | Executive Committee |
| **MEETINGS HELD:** | October 2022 |
| **LEAD:** | Anne-Marie Stretch |

**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. The outcome of ballots will be known in the coming weeks, and it is anticipated that action could be taken from November onwards.

## ADVISE

Maternity Services Update (25/10/2022)
The Committee discussed the letter received from the Chair of the Cheshire & Merseyside Quality and Safety Surveillance Group in relation to Quality Assurance for Maternity services and it was noted that a meeting had been arranged to discuss the concerns raised.

Overtime Pay and Payments during Annual Leave (03/10/2022)
The Committee discussed the proposed policy on Overtime Pay and Payments during Annual Leave and noted that this was a national issue. It was agreed that additional information would be provided before a decision would be made.

Maternity Action Plan Update (standing item)
The Executive Committee received an update on the progress of implementing and embedding the plan. It was agreed that progress reporting would now reduce to every other week.

System Responses (standing item)
Engagement with system partners was discussed with a view to forging improved working relationships and ensuring that S&O is represented in Sefton and Lancashire Place meetings.

Medical Day Unit (MDU) Update (03/10/2022)
The Committee received an update on the relocation of the Medical Day Unit (MDU) back to the Southport site and it was agreed that due to the current increasing Covid-19 infection rates in the hospital and community it remained safest for the service to remain at the Ormskirk site and that this decision would be periodically reviewed.

Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment (03/10/2022)
The Committee received the Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment. It was agreed that the Trust's Internal Auditors would be requested to complete an audit of the Trust's Business Continuity Plans to ensure full compliance with this requirement.

Kendall Bluck Workforce Review (03/10/2022)
The Committee reviewed the final report and recommendations and agreed that further work was now required to plan for how these would be implemented.

Declaration of Interest Process Review (10/10/2022)
The Committee received the report which responded to a recent internal audit finding and outlined the current paper based process as well as three proposed options to improve the Trust's compliance with the completion of Declarations of Interest. It was noted that the Trust had achieved 100% compliance at Board level. The Committee supported the recommendation to adopt the adoption of the Electronic Staff Records (ESR) software for the completion of declarations going forward. The report was to be presented at the Audit Committee.

Risk and Compliance Group AAA Report (September 2022) (10/10/2022)
The report had noted that the following risks had been discussed and the risk score had decreased:

- Risk 2471 related to increase demand at paediatric ED. The risk score has been reduced following changes to the staffing roster.
- Risk 2301 related to Radiographers/Sonographers staffing. The risk score has been reduced following a successful system wide recruitment drive.

It was noted that a new risk around site security had been added to the Risk Register with a risk score of 16. It was agreed that a full risk assessment would be completed, and priority areas highlighted.

Policy Management Update (10/10/2022)
The report provided an update on the management of Trust policies and provided assurance that work was currently being undertaken to ensure all policies were current and compliant with the standard corporate template. The Committee had approved an extension to review dates for several policies that were legally compliant but only needed to be updated to reflect the Trust's just and learning culture.

Internal Audit Plan (10/10/2022)
The Committee considered a proposal that the Internal Audit Plan, which included an amendment to undertake an audit of the Trust's Business Continuity Plans (BCP). The need for this had been highlighted following the presentation of the Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment at the Executive Committee on 03 October 2022. It was agreed that the updated Internal Audit Plan would be presented at the Audit Committee on 19 October for approval.

Patient Safety Incident Response Framework (17/10/2022)
The Committee received an update on the Patient Safety Incident Response Framework (PSIRF) which highlighted the significant changes to the approach being taken by the NHS in response to patient safety incidents and was intended to improve the quality of investigations and deliver a sustained reduction in risk as well as providing assurance to Board members about lessons learnt from incidents.

On Call Policy (17/10/2022)
The Committee reviewed the On Call policy and agreed that a further version be submitted to the Executive Committee.

Repurposing of Ward 11a Escalation Ward into a Ready for Discharge Ward – Update (17/10/2022)
The Committee received an update about the costs to change the function of the ward to a ready for discharge ward. The skill mix required was also discussed.

Ward 9a Refurbishment (17/10/2022)
The Committee discussed the options presented to decant the ward during the refurbishment and it was agreed that due to operational pressures this would be put on

hold to a future date. It was acknowledged that the work carried out to date had resulted in improved infection and control provision.

Pension Recycling Scheme (17/10/2022)
The Committee discussed the options for a Pension Recycling Scheme that could be put in place for staff impacted by the pension tax thresholds, and it was agreed that a proposal would be made to the Remuneration Committee for consideration.

Digital Maternity Strategy (25/10/2022)
The Committee endorsed the Digital Maternity Strategy which is a key component to meet the Clinical Negligence Scheme for Trusts (CNST) standards and had to be submitted to the Local Maternity and Neonatal System (LMNS) by 31 October.

Monthly Staffing Report (25/10/2022)
The Committee received an update on the monthly staffing, vacancy rates, recruitment, and establishment reviews. Further work was required to align establishments.

Winter Plan (25/10/2022)
The Committee discussed the various schemes proposed by the Clinical Business Units and it was agreed that the next step would be to draw up a list of priorities.

Resus Essential Skills Training (25/10/2022)
The Committee reviewed the Resus Essentials Skills Training, and it was noted that focussed work had taken place in some areas resulting in improved compliance. The focussed work continues and there will be a regular report to future Executive Committee meetings for monitoring.

Repurposing and Staffing of Ward 11a (25/10/2022)
The Committee reviewed the updated proposal, which included a skill mix review and approved the repurposing of Ward 11a into a Nurse Led Unit.

Volunteer Mileage Rate (25/10/2022)
The Committee approved a change in the volunteer mileage rate based on HMRC rates.

**ASSURE**

Health Education England Provider Self-Assessment Report (03/10/2022)
The Committee approved the Health Education England Provider Self-Assessment Report subject to minor amendments ahead of the report being submitted to Health Education England.

Health Financial Management Association (HFMA) Finance Checklist (03/10/2022)
The Committee received the Health Financial Management Association (HFMA) Finance Checklist which provided an overview of the improvements made to date as well as planned developments. The Committee agreed that the outcome of the self-assessment had reflected the Trust's improvement journey whilst recognising the work still to be done.

2021 Cancer Patient Experience Survey (03/10/2022)
The Committee received the results of the 2021 Cancer Patient Experience Survey and discussed the action plan that had been developed to support improvement in certain areas.

Cost Improvement Programme (CIP) Update (17/10/2022)
CIP had been delivered to plan and most of the Quality Impact Assessments (QIA) had been completed covering £7.5m of schemes for submission to the QIA Panel.

Trust Objectives 2022/23 Mid-Year Review (25/10/2022)

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| The Committee reviewed the progress to date against the Trust's objectives for 2022/23 and significant progress was noted against all objectives except for Objective 2 (elective restoration, improving discharge processes and delivery of Urgent and Emergency Care (UEC) standards) which reflected the operational pressures on the Trust.<br><br>Maternity Services Update (25/10/2022)<br>The Committee 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.<br><br>Capital Planning Assurance Group Weekly Update (25/10/2022)<br>The Committee received the Capital Planning Assurance Group Weekly update and were assured by the progress being made in all workstreams. | |
| **New Risk identified at the meeting** | None |
| **Review of the Risk Register** | |