Southport and Ormskirk Hospital NHS Trust

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

To be held at 0930 on Wednesday 05 October 2022

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0930***
SO169/22 (P)	**Patient Story** *Purpose: To **receive** the patient story*	*No*	*L Barnes*	15 mins
SO170/22 (V)	**Chair's welcome and note of apologies** *Purpose: To **record** apologies for absence and confirm the meeting is quorate.*	*No*	*Chair*	
SO171/22 (D)	**Declaration of interests** *Purpose: To **record** any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
SO172/22 (D)	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 07 September 2022.*	No	*Chair*	10 mins
SO173/22 (D)	**Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions.*	*No*	*Chair*	
STRATEGIC AND GOVERNANCE				**0955**
SO174/22 (D)	**Charitable Funds Committee AAA Highlight Report** *Purpose: To **receive** the Charitable Funds Committee AAA Highlight Report from the meeting held on 20 September 2022*	*No*	*J McLuckie*	10 mins
SO175/22 (D)	**Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework*	*Yes*	*N Bunce*	10 mins
SO176/22 (D)	**Corporate Risk Register** *Purpose: To **receive** the Corporate Risk Register*	*Yes*	*K Clark*	10 mins

SO177/22 (D)	**Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaboration** a) Working Arrangements *Purpose: To **approve** the CMAST Work Plan and Committee in common Terms of Reference*	*No*	*N Bunce*	10 mins
INTEGRATED PERFORMANCE REPORT				**1035**
SO178/22 (D)	**Integrated Performance Report (IPR)** a) Quality and Safety b) Operations c) Finance d) Workforce *Purpose: To **receive and note** the IPR for assurance.*	*No*	*B Prescott* *K Clark* *B Prescott* *L Neary* *J McLuckie* *S Clarkson*	20 mins
QUALITY & SAFETY				**1055**
SO179/22 (D)	**Quality and Safety Committee AAA Highlight Report** *Purpose: To **receive** the Quality and Safety AAA Highlight report*	*No*	*G Brown*	10 Mins
SO180/22	**Learning from Deaths Report (Quarter 1)** *Purpose: To **receive** the Learning from Deaths Report (Quarter 1) for assurance*	*No*	*K Clark*	10 mins
WORKFORCE				**1115**
SO181/22 (D)	**Workforce Committee AAA Highlight Report** *Purpose: To **receive** the Workforce reports*	*No*	*L Knight*	10 Mins
SO182/22 (D)	**Workforce Reports** a) Workforce Race Equality Standard Report (WRES) (including action plan) b) Workforce Disability Equality Standard Report (WDES) (including action plan) *Purpose: To **receive** the WRES and WDES Reports and **approve** the Action Plan*	*No*	*S Clarkson*	20 mins
SO183/22 (D)	**Nursing and Midwifery Strategy** *Purpose: To **approve** the Nursing and Midwifery Strategy*	*No*	*B Prescott*	10 mins
SO184/22	**Guardian of Safe Working Report**	*No*	*K Clark*	10 mins

	*Purpose: To **receive** the Guardian of Safe Working Report for assurance*			
FINANCE, OPERATIONS AND INVESTMENT				**1205**
SO185/22 (D)	**Finance, Performance and Investment Reports** a) Committee AAA Highlight Report *Purpose: To **receive** the Finance, Performance and Investment Reports*	*No*	*J Kozer*	10 mins
SO186/22 (P)	**Emergency Planning Reports** a) (Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment *Purpose: To **approve** the EPRR Core Standards Self-Assessment*	*No*	*L Neary*	10 mins
CORPORATE				**1220**
SO187/22 (D)	**Executive Committee AAA Highlight Report** *Purpose: To **receive** the Executive Committee AAA Highlight Report*	*No*	*AM Stretch*	10 Mins
CONCLUDING BUSINESS				**1230**
SO188/22 (V)	**Questions from Members of the Public** *Purpose: To **respond** to questions from members of the public received in advance of the meeting.*		*Chair*	*5 mins*
SO189/22 (V)	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*		*Chair*	*5 mins*
	Date and time of next meeting: 0930 Wednesday 02 November 2022			***1245 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

Approved Minutes of the Strategy and Operations Committee (Part 1)
Held on Microsoft Teams
Wednesday 07 September 2022
(Approved at the Strategy and Operations Committee on 05 October 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
Lynne Barnes	LB	Director of Nursing, Midwifery and Therapies
Gill Brown	GB	Non-Executive Director, STHK & S&O
Nicola Bunce	NB	Director of Corporate Services
Kate Clark	KC	Medical Director
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
Jane Royds	JR	Director of HR and OD
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
Lynne Eastham	LE	Associate Director of Midwifery, Nursing and Therapies, *(Item SO155/22)*
Linda Douglas	LD	Freedom to Speak Up Guardian *(Item SO157/22)*
Tony Ellis	TE	Communications and Marketing Manager *(Item SO146/22)*
Helen Hurst	HH	Associate Director of Nursing, Midwifery and Therapies, Planned Care *(Item SO146/22)*
Stephen Mellars	SM	Deputy Director of Nursing, Midwifery and Therapies
Penny Sinclair	PS	Matron Planned Care *(Item SO146/22)*
Juanita Wallace	JW	Assistant to ADCG (minute taker)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Paul Growney	PG	Non-Executive Director, STHK

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
SO14622	**Patient Story**	

LB introduced the patient story video in which Phil, who has received care from the orthopaedic trauma team at Southport for around 30 years due to brittle bone disease, told his story. He had been admitted most recently in June 2022 with a broken hip, and he spoke about why he preferred to be cared for at Southport, what changes he had seen over the years, as well as the experience of his recent surgery.

LB asked PS how she had felt hearing the patient say that nurses did not have time for pastoral care. PS reflected on her discussion with the patient and how hospital admissions had changed over the years, including a marked reduction in patients' length of stay. PS agreed that the nursing staff were busier now and therefore had less time for pastoral care, but that there were still opportunities to get to know patients whilst doing observations and medical rounds. She also advised that the video had been shared at various team meetings to stimulate discussion on the subject among staff. SR reflected on the importance of communication to ensure that patients felt listened to, but that modern healthcare sometimes meant the opportunities for informal discussions were less frequent.

PS also advised that there was a recruitment drive taking place and that Planned Care had several people interested in joining their team so was hopeful of filling the current vacancies.

GB asked if there was an opportunity to get more volunteers on the ward to support the informal interaction with patients. HH advised that as the restrictions on having volunteers in patient areas (as a result of Covid-19) were lifted the Trust was looking to increase recruitment. PS reported that the catering assistants on the orthopaedic ward always built a good rapport with patients.

LB advised that it was SM's last SOC meeting today as he would be retiring shortly and thanked him for his many years of work in the Trust and his support.

RF asked for thanks to be passed to the patient for allowing the SOC to hear his story and noted how valuable patient stories are.

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

SO147/22 Chair's Welcome and Note of Apologies

RF welcomed all to the meeting and in particular RW to his first meeting in his new role as Corporate Governance Manager.

RF advised that the Trust had been shortlisted for three Nursing Times Awards categories:

- Cancer Nursing - Spine mnemonic in the management of metastatic spinal cord compression
- Emergency and Critical Care - The personal touch in end-of-life care in critical care
- Managing Long Term Conditions - Acute Admiral Nurse Service

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

SO148/22 Declaration of interests

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

SO149/22 Minutes of the previous meetings

The Committee reviewed the minutes of the previous meeting held on 06 July 2022 and approved them as a correct and accurate record of proceedings.

RESOLVED:
The Strategy and Operations Committee **approved** the minutes from the meeting held 06 July 2022

SO150/22 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 agreed to close the following action:

- SO127/22 – LN advised that Histology reporting had continued to be an area of focus at pathology meetings. Both teams had reiterated the escalation process. STHK turnaround had improved and was less than 14 days with a few exceptional circumstances. There was a high volume of urgent requests, and these were linked to the high volume of urgent cancer referrals to S&O. Action closed

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

STRATEGIC AND GOVERNANCE

SO151/22 Audit Committee AAA Highlight Report

IC presented the AAA Highlight Report and alerted the Committee to the following:

- The external Audit Value for Money (VFM) report once again highlighted that the Trust did not meet the VFM criteria of financial sustainability.

The auditors had recognised that many other trusts across the country were in a similar position.

- The Committee noted that the narrative for the new Estates infrastructure Risk (SO2c) approved at the July SOC meeting needed to be developed to include further detail on the actions being planned to mitigate the risks.

IC advised that the Committee had been made aware of the increase in phishing and smishing attempts that targeted NHS staff, in some instances utilising compromised nhs.net accounts and asked for assurance that everything was being done to alert and protect staff. JMcL advised that a second phishing exercise had been conducted and that there had been an improved response from staff. Furthermore, additional support and training would be provided to those staff members who had responded to either of the phishing exercises.

AMS commented on the backlog maintenance capital and advised that the Trust was working with the Integrated Care Board (ICB) and that a site visit from the ICB Director of Finance was being arranged. AM noted that it was important to maintain the dialogue with the ICB and provide assurance that any capital allocated for backlog maintenance could be spent in year.

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

INTEGRATED PERFORMANCE REPORT

SO152/22 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 July 2022.

a) Quality and Safety Performance Report

LB and KC presented the report which provided an overview of performance against the quality and safety metrics. It was noted that:

- There had been an increase in the number of falls reported in July 2022 and a deep dive had been completed into the wards with high numbers of falls and actions had been implemented. The Dementia and Delirium team had produced new short-term sedation guidelines.
- There had been a decrease in the percentage of complaints closed within 40 working days and complaints training for the Clinical Business Units had taken place at the end of August 2022.
- The Friends and Family Test indicator continued to fail the assurance measure, and this had been impacted by a deterioration in performance in the Accident and Emergency (A&E) and Maternity areas.

KC advised that there had been three C.Difficile (C.Diff) cases reported in July 2022 and each had been reviewed by the Microbiologist and the clinical team.

KC advised that one never event had been reported in July and several changes to internal processes had been made as result to prevent a similar occurrence in the future.

GB asked whether the Covid-19 situation was impacting the ward refurbishment programme. LN advised that as the Trust was still using Ward 11a as an escalation ward as a result of the impact of both Covid-19 and non-elective pressures. Without decant capacity it was difficult to progress the refurbishment programme, however the Operations and Estates teams were working together to see what works could be progressed.

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 73.8%. This continued to compare well with other trusts in the Cheshire and Merseyside (C&M) region (71.1%) and nationally (71%).
- Bed occupancy levels remained high with occupancy levels above 100% and this contributed to an increase in 12hour breaches in the Emergency Department (ED) (11%).
- The average length of stay (LOS) had increased and there were now on average 50 patients in the Trust who were ready for discharge. The biggest challenge for many of these patients is being able to access packages of care in the community so they can be safely discharged.
- An average of 6% of beds were occupied by Covid-19 patients but this had increased to 18% at the end of July.
- The Trust would be launching a 'Home for Noon' campaign shortly and this would be supported by the Project Management Office and the Assistant Director of Communications, STHK
- As with other trusts across the C&M region, there had been a decrease in elective activity in July 2022 due to the impact of UEC performance and Covid-19, however, the Trust still compared well to peers.
- Referral to Treatment (RTT) performance was 72.7% of patients seen within 18 weeks which compared favourably to the C&M region (60.5%) and nationally (63.1%).

- A new extraordinary Patient Treatment List (PTL) meeting had been introduced in August 2022 to focus on longer waiters (74+ week waiters) and those cancer patients over 21 days with no treatment date.
- Cancer access performance remained challenged but there has been an improvement in 104-day breaches from 117 in April 2022 to 37 patients.

RF advised that, following the recent Northwest Region Chairs' Briefing, all trusts would be required to report type two ambulance performance for the organisation. NWAS performance was not currently reported in this way so RF had been in contact with the Chair of the NWAS to see how the information would be provided to trusts. AM advised that NWAS had changed the classification around the category of ambulances being rolled out and that this had resulted in an increase in those patients who required rapid assistance on arrival. LN advised that whilst the Trust endeavoured to offload patients as quickly as possible, the ED estate can prove restrictive due to overall capacity and lack of ALO space.

AM reflected on the Trust's recent successful bid for capital to increase bed capacity and commented that there might be another tranche of funding ahead of winter. LN advised that the additional funding of £800,000 had allowed for the purchase of just over 14 additional beds at Chase Hays to be run by the Trust.

RC reported that, the opening of the new Royal Liverpool hospital in October 2022 would result in a deficit of between 100 to 200 beds for the system which would impact on the flow of patients at both S&O and STHK. LN commented that LUHFT had made several requests for mutual aid for elective specialties and S&O would help where it was able, however the UEC impact was more difficult to predict and if significant could then threaten the elective programme.

LN also reported that the Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative was also seeking mutual aid between acute providers to ensure that all patients who had been waiting for more than 104 in the ICS were seen as soon as possible. PW also advised that work was being undertaken around admission avoidance such as Same Day Emergency Care Pathways and Virtual Wards. PW also highlighted the need for all trusts to maximise the effectiveness of these initiatives to reduce length of stay to increase system 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 a £6.6m deficit at month 4 in line with the 2022/23 Plan.

JMcL highlighted the following:

- Elective Recovery Fund (ERF) had been paid in full at the end of July 2022 and it was assumed that full payment would also be received at the end of the second quarter despite not achieving the elective recovery trajectories
- The escalation areas (wards 1 and 11a) had remained open and were expected to remain open for the remainder of the financial year, which had not been assumed in the original plan, which had factored in the costs for winter but not a full 12 months.
- Regional cash support would be required from October 2022 and JMcL reported that he was in discussion with the C&M ICB about this.
- Other pressures now included inflation which was above the 2.7% the NHS had been funded for. The Trust's fixed rate gas contract was due to end in March 2023, and this would be a pressure for 2023/24.
- The capital spend to date was £3.7m which was £242,000 ahead of plan and this was mainly due to the spend on theatre storage and fire compartmentation. It was also noted that the Trust has a fully developed capital programme to deliver the schemes recently approved by NHSE and was working with a strategic partner, VINCI Construction, to achieve these.
- The Trust was marginally below the 95% Better Payment Practice Code (BPPC) target; however, action had been taken to increase the frequency of the NHS payments runs.

RESOLVED

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

d) Workforce Performance Report

JR presented the Workforce Performance report and advised that:

- Performance Development Review (PDR) completion compliance was 74.4% in July against the target of 85%
- There had been a slight decrease in core mandatory training in July to 86.6% from 88.8% in June however, the stretch target had been increased to 90%
- Sickness absence had spiked in July to 8% and this was mainly due to an increase in Covid-19 related sickness.
- The Trust vacancy rate had increased to 10.5% in July and the in-month staff turnover rate was 1.4%, this was mainly driven by Health Care Assistant (HCA) vacancies, and recruitment plans had been put in place to try and address this.

IC reflected on the Statistical Performance Controls (SPC) charts and his discussion with LN. IC gave an example of the alert protocol which was not highlighting sickness absence this month. RF agreed with IC's comment and commented that there was a similar situation with the stranded patients' information.

LK responded that the control limit lines should move with the data under the SPC guidance and were not tied to a specific target. However, she agreed that in some cases this was counter intuitive to how the Trust was performance managed.

AMS commented that discussions were ongoing about developing the IPR jointly with STHK, so the reports looked the same for both trusts. It was critical that there was an agreed protocol for changing targets with the IPR.

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

QUALITY AND SAFETY

SO153/22 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 continued disruption to the telephone lines was impacting patient experience and accuracy of clinical discussions.

GB provided an update on the alert that had been presented at SOC in June 2022:

- 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

GB advised the Committee of the following:

- Maternity Report – the meeting had received an update on progress against the Ockenden recommendations, Maternity Self-Assessment Tool, CNST, Continuity of Carer, Maternity Quality & Safety (including the Elective Caesarean Theatre Pathway) and Mutual Aid working with STHK
- The maternity service had been awarded a Bronze accreditation as part of the S&O Clinical Assessment and Accreditation Scheme (SOCAAS).

The Committee had also received the Falls Prevention Update which has highlighted the importance of assessing the ward environment and providing feedback to the Ward Manager. There was a targeted improvement action plan that would be implemented, and its effectiveness monitored.

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

SO154/22 Safe Staffing and Midwifery Staffing Establishment Report

LB presented the Safe Staffing and Midwifery Staffing Establishment Report and highlighted the following:

- The RN staffing fill rate had continued to rise as the number of Band 5 vacancies had reduced and the Care Hours per patient per day (CHPPD) target had been met at 8.8CHPPD in June 2022.
- The Trust was not achieving the Health Care Assistant (HCA) workforce standard, and this was due to vacancies and staff retention. It was noted that this was a national issue. The Trust had hosted a 'new to care event' which was aimed at recruiting staff with the relevant personal skills and qualities to join the nursing teams as trainee Health Care Support Workers. The Trust had also designed a preceptor programme of education for newly appointed HCAs which was similar to the current nursing preceptorship programme.
- The Emergency Department (ED) and the Acute Medical Unit (AMU) had received funding for additional nursing staff and these posts had been successfully recruited to.

RF highlighted that the report had indicated that the report was for noting however, the agenda indicated that it was for approval. He stressed the importance of ensuring that this was correct from a governance perspective.

RESOLVED:
The Strategy and Operations Committee **approved** the plans to increase the recruitment of HCAs and noted the Safe Staffing and Midwifery Staffing Establishment Report

SO155/22 Quarterly Maternity Assurance Report

LE presented the Quarterly Maternity Services Assurance Report and highlighted the following:

- The Trust was now compliant with the Ockenden 1 report recommendations and work was ongoing to complete the actions

highlighted as part of the second Ockenden report. It was noted that S&O was working in partnership with STHK to achieve this.

- The regional Maternity Insight visit took place on 10 June 2022 and the Trust received positive feedback. A follow-up meeting had been scheduled for 27 July 2022 to review the elective caesarean section pathway and action plan that had been implemented in response to the serious incident in Maternity.
- Maternity Incentive scheme – this was launched in 2017/18 and the Year 4 (2022/23) safety actions had remained unchanged, however, there were several amendments to evidence that previous actions were fully embedded. Currently there were four actions rated as 'amber' and the maternity team was working through these with support from the Project Management Office to ensure all actions could be evidenced by the time the annual declaration was due.
- Continuity of Care – The Trust temporarily paused the rollout of the Continuity of Care programme in May 2022 until assurance around safe staffing levels had been achieved. The Trust had submitted plans to the Local Maternity and Neonatal System (LMNS) for the rollout of the Continuity of Care programme by March 2024.
- Maternity performance was monitored through local and regional maternity dashboards and any outliers were challenged by the LMNS and lessons learnt were shared.
- As a 'lessons learnt' from the serious incident, one of the actions from the Regional Quality Review Meeting was for all units to review the process for seeking mutual aid and in response to this daily 'sitreps' had been implemented between the S&O and STHK maternity teams.

GB asked if the maternity risk register had been reviewed as a result of the serious incident. LB confirmed that a review of the Risk Register had been undertaken following the serious incident in April and that the greatest risk was, capacity in theatres and the availability of scrub nurses. However, following the work undertaken in these areas, this risk score might be reduced at the next review. LB also advised that overall midwifery staffing, and the national review of neonatal unit provision had also been identified as a risk for the service.

RT requested confirmation that the Continuity of Care would not happen without safe levels of staffing. AM assured the committee that the Continuity of Care would not be implemented at either S&O or STHK until it was safe to do so.

RT also asked if the number of red flag incidents had changed as a result of the changes and LE responded that there had not been an increase in reported incidents.

RF, AMS and SR reflected on the amount of detailed information about maternity services that was now being presented to the Boards /the SOC and queried if this level of volume of detail supported effective governance or if there should be a summary of the performance with any areas of concern highlighted. RT commented that a similar discussion had taken place at the Maternity Champions meeting.

RESOLVED:
The Strategy and Operations Committee **noted** the Quarterly Maternity Assurance Report

WORKFORCE

SO156/22 Workforce Report

a) Workforce Committee AAA Highlight Report

LK presented the AAA Highlight report and advised that no alerts had been raised.

LK advised that the Committee had received the monthly Health and Wellbeing presentation and following a discussion the meeting acknowledged the hard work undertaken by staff and noted the importance of supporting staff with their health and wellbeing.

Assurance was provided that:

- There had been no increase in risk levels in month and that work was progressing positively with the four risks aligned to the committee.
- The bi-annual establishment reviews were being undertaken and that recruitment had been successful in reducing the number of band 5 nursing vacancies.

b) Gender Pay Gap Reporting 2021/22

JR presented the Gender Pay Gap Reporting 2021/22 which detailed the results and provided an update on the actions to eliminate the gender pay gap:

- The Trust workforce was 76.51% female and 23.49% male
- The medical and dental workforce was 66.8% male and 33.2% female
- The mean average gender pay gap was 21.67% with females earning £4.59 an hour less than males (compared to a current 2020/21 sector mean 22.8%)
- The Trust's mean hourly gender pay gap had reduced by 1.39% from 2020/21.
- A continued focus on the Staff Voice Partnership to help improve lived experiences in the working environment
- The removal of barriers to progression and promoting opportunities to a broader range of applicant

- Delivery of the Trust's Our People Plan with particular focus on the Trust's commitment to more agile working
- Continuing to support the development of women in the workplace, including targeted mentoring and coaching programmes, clear career pathways and establishing a 'women in leadership' staff network
- To deliver a programme of training that focussed on unconscious bias to prompt self-awareness and personal responsibility in helping to remove barriers for others

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

SO157/22 Freedom to Speak Up Report

LD presented the Freedom to Speak Up Quarter 1 report which provided assurance that staff members felt able to raise their concerns and that the appropriate systems and processes were in place for staff to do this safely and confidently, knowing that appropriate action would be taken. It was noted that 16 concerns had been raised during the period and covered the following themes:

- Infrastructure /Environment
- Leadership
- Senior Management Issue
- Patient Safety / Quality

LD advised that there were still concerns being raised anonymously, however following discussions most staff members were now confident to meet with a member of the Executive team to discuss their concerns. This reflected a confidence in the system.

There had been an increase in the number of concerns raised by the nursing and midwifery staff grouping and LD had discussed this with LB. LB commented that work had been undertaken to encourage nurses to raise concerns, so she regarded this increase positively.

The Trust had 26 active Freedom to Speak Up (FTSU) Champions and there was an ongoing recruitment programme in place to increase this number further.

Following a recent national FSUP Guardian survey in which the guardians had suggested a password protected area of the website a 'You said, we did: Guardian only' area had been set up and this provided support and information for the guardians.

The Freedom to Speak Up Policy had been updated to follow the new national guidance.

FTSU month would be taking place in October 2022 and LD had received a list of topics for each week. A programme of events had been drawn up and the FTSU Champions on both hospital sites would be involved.

GA reflected on the improvement that he has seen and commented that it was critical that staff were comfortable with coming forward and congratulated the FTSU on their achievements. PW commented that he was impressed with feedback received from staff members who had raised concerns as well as the outcomes.

LD thanked the Executive team and senior management for the positive response to concerns raised which is enabling a culture change to begin in the organisation.

RESOLVED:
The Strategy and Operations Committee **noted** Freedom to Speak Up Quarter 1 report

SO158/22 Medical Revalidation Annual Report and Declaration

KC presented the Medical Revalidation Annual Report and Declaration which provided assurance that the appropriate processes were in place to ensure that the Trust was compliant with its legal obligations under 'The Medical Profession (Responsible Officers) Regulations 2010' (amended 2013) and continued to provide a robust medical appraisal and revalidation system. She advised that as at the end of the appraisal cycle on 31 March 2022, the Trust was the 'designated body' for 235 doctors and that 78.7 % of the doctors had completed a medical appraisal in the required timescales in line with the General Medical Council (GMC) requirements.

KC confirmed that she had continued to act as the Responsible Officer (RO) for the Trust.

KC advised that two individuals had not completed their appraisals as there were ongoing issues for which they were receiving support and the individuals were helped to recognise that this would be the best option for them.

It was noted that the appraisees were still completing the shortened form of the appraisal and were able to bring additional documentation into the

appraisal with them. As part of the process, the appraisees were provided with copies of incidents, complaints, and compliments to reflect upon.

KC advised that an appraiser support group had been established and a random sample of appraisals would be reviewed for content and discussion.

S&O currently used a bespoke IT system for administering the process that was managed via SharePoint, however, this system was out of date. The Revalidation Officer was developing a business case and it was hoped that the Trust would be able to link with STHK's whose current system was also due for renewal in the near future. It was noted that the ICB had also discussed the possibility of a single system for the C&M region.

RESOLVED:
The Strategy and Operations Committee **approved** the Medical Revalidation Annual Report and Declaration

FINANCE, OPERATIONS AND INVESTMENT

SO159/22 Finance, Performance and Investment Committee Reports

a) Finance, Performance and Investment Committee AAA Highlight Report

JMcL and LN presented the AAA Highlight report and updated the committee on items that had not been reported elsewhere on the agenda.

LN advised that The North Mersey Stroke Pathway Full Business Case (FBC) had been approved and the new service was on schedule to start on 19 September as planned.

JMcL advised that a high-level plan for the network replacement (including the telephone system) had been received and commented that due to worldwide distribution delays this work would now run over into the first quarter of 2023/24.

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

CORPORATE GOVERNANCE

SO160/22 Executive Committee Report

AMS presented the AAA highlight report that detailed the activity and reports considered by the Executive Committee during July and August and advised that a number of items noted in the report had been addressed earlier in the meeting. AMS alerted the Committee to the following:

- Work was ongoing with the specialist commissioners to close the S&O Orthodontics service, however, there were concerns about the speed of case note reviews to allocate patients to an appropriate alternative pathway. Communication with the patient cohort continued to keep them informed of progress in identifying and transferring them to an alternative provider. NHSE had been informed of patients who had been waiting more than 78 weeks or were likely to breach shortly. There are currently six 78+ week breaches and seven 52+ week breaches for orthodontics

AMS advised that:

- S&O had closed to routine referrals for dermatology in April 2017 and since then, West Lancashire patients had been referred to Wigan, STHK and LUHFT. However, due to increased demand and capacity pressures these trusts had also closed to out of area referrals over time. Most recently LUHFT had closed to out of area referrals which had resulted in West Lancashire patients having no access to routine dermatology referrals. An agreement had been put in place with STHK to allow the re-opening of routine referrals for this population with outpatient appointments being delivered on the ODGH site by STHK for West Lancashire patients.
- The Executive Committee had reviewed the risk of Paediatric attendances outside of the current opening hours of the Paediatric Emergency Department. Arrangements to ensure patients who presented at other times were safely transferred to other services were being reviewed and this work was being led jointly by Medical and Emergency Care (MEC) and Specialist Services Clinical Business Units.
- Proposals to repurpose Ward 11a Escalation Ward into Ready for Discharge Ward as part of the winter plan had been discussed and approved subject to minor additions.

IC asked about the Health Inequalities Prevention Pledge and NR advised that this was the start of the process and that the pledge would take a period of time to implement. The C&M ICB were committed to addressing health inequalities.

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

CONCLUDING BUSINESS

SO161/22 Questions from Members of the Public

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

SO162/22 Any Other Business

In closing RF thanked SM for his service and wished him well with this retirement.

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12.03

The next meeting would be held on **Wednesday 05 October 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						
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	✓	✓	✓	✓		✓						
Kate Clark	✓	✓	A	✓		✓						
John McLuckie	✓	✓	✓	✓		✓						
Lesley Neary	✓	✓	✓	✓		✓						
Jane Royds	✓	✓	✓	✓		✓						
Nina Russell	✓	✓	A	✓		✓						
Richard Weeks						✓						
✓ = In attendance A = Apologies												

Strategy and Operations Committee (Part 1)

Matters Arising Action Log

Action Log updated 30 September 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
SO127/22	06/07/2022	**Integrated Performance Report** b) Operational Performance Report	RT asked if there had been any progress around the historic issues with Histology reporting. LN advised that this had been discussed at a recent Pathology Contract meeting and that the data around demand levels would be reviewed. LN undertook to provide an update at the next SOC meeting	L Neary	06/07/2022	Sep-22	**July Update:** LN to provide an update around Histology reporting at the SOC Meeting on 07 September 2022 **September Update:** This has continued to be an area of focus at pathology meetings and the last meeting took place on 12 August 2022. Both teams reiterated the escalation process (after 14 days) but STHK turnaround improved and less than 14 days with a few exceptional circumstances. High volume of urgent, linked to high volume of urgent cancer referrals to S&O. **Action closed**	**Completed**

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Charitable Fund Committee
MEETING DATE:	20 September 2022
LEAD:	Neil Mason, Chair

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The portfolio valuation stands at £815,913, which is a return of -4.3% over the last 12 months. Despite this the Committee agreed to continue with the existing investment strategy.
- Given the direction of travel with regard to types of fuel being utilised in vehicles in the future the Committee asked for the spinal minibus purchase of a van to be further investigated to see whether a hybrid model could be considered.

ADVISE

- The Committee agreed to liquidate £50k of the investment portfolio to provide short term cash support.
- A shopping list was presented as to how to utilise existing fund balances given some funds had not been accessed over the last 12 months. The list was welcomed and now requires some fine tuning before proceeding.

ASSURE

- The wellbeing garden scheme is now completed.
- It was agreed to include a panel as a first step ahead of the existing approval process in as part of ensuring there is greater involvement in decision making.
- The Committee approved the engagement of Mazars to undertake an independent review of the Charity's 2021/22 accounts and annual report at a cost of £1,850 plus VAT.
-

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**	**05 October 2022**
Agenda Item	**SO175/22**	**FOI Exempt**	**NO**
Report Title	**BOARD ASSURANCE FRAMEWORK – QUARTERLY REVIEW**		
Executive Lead	Nicola Bunce, Director of Corporate Services		
Lead Officer	Nicola Bunce, Director of Corporate Services		
Action Required	✓ **To Approve** ✓ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

Review the Board Assurance Framework (BAF) and approve the proposed changes.

Executive Summary

The BAF allows the Directors to understand how the controls put in place by the Trust provide assurance on the reduction of risk in relation to the delivery of its strategic objectives. The BAF report is designed to provide assurance on the extent to which the Trust has appropriate and robust controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls.

Since presentation at the July meeting, the BAF has been reviewed by the lead executive for each strategic risk and the individual risks have been presented to the relevant assurance committees.

Key to changes:

~~Scored through text~~ = deletions/completed
Blue text = additions/updates
Red Text = overdue actions

At this time, it is not proposed that the scores of any of the BAF risks are changed.

Recommendations

The Strategy and Operations Committee is asked to note the updates and approve the proposed changes to the BAF.

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:**
Nicola Bunce, Director of Corporate Services	Nicola Bunce, Director of Corporate Services

Strategic Objective 1: Improve clinical outcomes and patient safety to ensure we deliver high quality services

Assurance Committee: Quality & Safety Committee
Executive Lead: Director of Nursing / Medical Director

RISK ID	1	Risk Description	If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety

Inherent Risk			Risk as at Sept 2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	5	20	3	5	15	2	5	10

Risk Description: If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety **CAUSE** Immature governance and risk management processes; poor understanding of minimum standards; shortage of appropriately trained clinical staff in certain specialties and professions; lack of robust processes and management systems to provide evidence and assurance to regulatory agencies. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; inability to demonstrate that risks are managed in a timely way; learning and improvements are delayed; poor clinical outcomes; difficulty in recruiting to clinical vacancies; high use of agency and locum staff leading to increased costs; reduced patient experience feedback; enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.	1. Trust Governance Structures. 2. Trust policies and procedures. 3. Quality priorities programme encompassing five priority areas: • Falls • Pressure Ulcers • AKI: hydration & nutrition • Communication with families • Ockenden Compliance 4. Risk Management Strategy and escalation framework. 5. Quality impact assessments (QIAs) for all service changes that are considered. 6. Single accountability framework for reviewing CBU areas for development/strengths. 7. Application of clinical pathways and guidelines. 8. Programmes in place for clinical standards and professional practice. 9. Work plans for medical staff. 10. Clinical revalidation. 11. Ward/departments staffing position is controlled through: • 3 x daily at staffing huddle; • 7 day staffing matron in place for oversight and management; • Weekly staffing review and sign off; • Roster sign off meeting. 12. Training programme (mandatory and non-mandatory). 13. CQC actions from 2019 inspection complete. Continued oversight through Quality priorities 14. Supervision and education of clinical staff across all professions. 15. Application of Patient Safety and other safety alerts. 16. Patient Safety Specialists appointed. 17. Cycles of business for governance meetings 18. Use of temporary staffing arrangements to maintain Unify Fill-rates of above 90%. 19. Patient safety specialist roles 20. Medical examiners roles and fully established programme to review all deaths	1. Non-standardised Trust approach to quality improvement. 2. Clinical workforce strategy not fully developed. 3. Nursing, midwife, AHP and support staff recruitment and retention programme needs further development.	**LEVEL 1** (Operational Management) 1. Alert, Advise, Assure reports from Groups. • Harm free care panel • Serious Incident Review Group • Health and Safety Group • Risk and Compliance Group 2. Performance, Improvement, Delivery and Assurance (PIDA) with suite of measures. 3. Patient feedback (FFT/Patient Surveys) 4. Clinical audit reports 5. Mortality and SJR Process. 6. Review of documentation and quality indicators through use of tendable. 7. Health and Safety Inspection Programme 8. IPC Assurance Framework 9. Health and safety/fire risk assessment/audit programme. 10. Medical Examiners office/officers now set up and in practice. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Q&S Committee (monthly): ○ Mortality metrics ○ Never events ○ Incident data ○ Serious Incidents ○ CQUINS ○ Performance data ○ Complaints and compliments 2. HSMR/SHMI. 3. Quality Strategy metrics 4. Mandatory training 5. Monthly Safe Staffing Report 6. Nurse establishment reviews 7. SOCAAS ward accreditation programme 8. VitalPac deterioration measures 9. Freedom to speak up guardian 10. IPC BAF 11. Winter Staffing Assurance Framework Assessment **LEVEL 3** (Independent/Semi-Independent) 1. GMC / NMC Reports 2. Royal College Reports / Visits. 3. CQC inspection visits	1. CQC 'Must and should do' actions not addressed in full. 2. Gaps in evidencing that lessons are consistently learnt and changes in practice embedded following incidents, complaints, claims, inquests, and audit. 3. Guardian of safe working post vacant	1. Clinical workforce strategy to be completed – ~~by end of Jan 21.~~ **Revised to: Nov 22** **Sept 22 Update: Approach to medical & clinical workforce strategy presented using HEE STAR methodology, supplemented by external review by Kendall Bluck consulting.** ~~Outstanding CQC actions included in agreed quality priorities. Monitoried through SOCAAS and Reporting to QSC & SOC (monthly).~~ **CLOSE** 2. Enhance the sharing of lessons across the organisation and test that actions/changes are complete/ embedded into practice. **Sept 22 Update: Actions progressing. Included in PSIRF implementation and updated incident management framework.** 3. ~~Complete review of Risk Management Policies and Assistant Director of Integrated Governance now developing a framework with associated training to bridge the gap on Risk Management Training in the Trust and a clear process.~~ **Sept 22 Update: Risk management framework approved & launched. CLOSE** 4. Risk Management training launched September 2021 and being regularly reviewed and rolled out to staff across the Trust. **On-going – Dec 2022.** **Sept 22 Update: Training ongoing, aligned to new RMF** 5. Quality Improvement program board established. TOR include definition of QI methodology, training needs and project delivery. (Dec 2022). **Sept 22 Update: Monthly board in place reporting to QSC.** 6. Nursing, midwifery & AHP recruitment and retention strategy (Dec 2022). **Sept 22 Update: Nursing & Midwifery strategy tabled for EC on 05/09/22. AHP strategy in draft, further work**

		21. Full roll-out/reporting of Tendable app measures 22. Nursing, midwife, AHP and support staff recruitment and retention programme in place. 23. Regular risk management training taking place across the Trust and available to book onto for all Trust staff. Patient safety managers also holding risk management training within the CBU's and specialities. 24. Quality Improvement Plan goes through bi-monthly to QSC and is presented to the SOC 25. Incident reporting and investigation process 26. Ockenden 1 Action plan 27. Ockenden 2 gap analysis 28. Reporting of nosocomial infections and outbreaks 29. Corporate Objectives		4. CQC Insight Report, Outlier Alerts and engagement meetings 5. Healthwatch 6. Peer Reviews and accreditation. 7. Getting it right first time (GIRFT) programme. 8. NHSI/E oversight meetings 9. Quarterly and Annual Guardian of Safe Working Report. 10. CCG monthly quality and performance meetings 11. Internal/External Audit 12. Quality Account 13. Risk management deep dives and self-checks by the Integrated Governance team 14. Quality Improvement Plan goes through bi-monthly to QSC and is presented to the board.		**needed. Successful recruitment noted in nurse staffing reports** 7. Repeat MIAA audit of lessons learnt (Q1 2023/24) 8. Implementation of PSIRF and roll out of new Incident management framework (IMF) (April 2023) 9. Exception reporting reviewed by HR, Director of Medical Education and Medical Director. No internal applicants & STHK unable to support. Further expression of interest request to go external (Oct 2022)
	The Q&S Committee reviews key quality requirements, expectations and performance requesting remedial action plans where required using a systematic and robust methodology of review and challenge					

AMBITION: To improve clinical outcomes and patient safety to ensure we deliver high quality services

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	**The Trust is willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.**	Tending always towards exposure to only modest levels of risk to achieve acceptable, but possibly unambitious outcomes.	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

Risk Description: If the Trust cannot achieve its key performance targets it may lead of loss of services

Strategic Objective 2a: Deliver services that meet NHS constitutional and regulatory standards

Assurance Committee: Finance, Performance and Investment Committee
Executive Lead: Chief Operating Officer

RISK ID	2	Risk Description	**If the Trust cannot achieve its key performance targets it could lead to failure in delivering safe, high quality patient care and experience and failure to deliver contracts.**

Inherent Risk			Risk as at September 2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	4	4	16	2	4	8

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust cannot achieve its key performance targets it could lead to failure in delivering safe, high quality patient care and experience and failure to deliver contracts. **CAUSE** • COVID-19 causing delays in elective and diagnostic recovery, cancer pathways and patient discharge. • Continued rise in UEC demand and challenges with patient discharge due to insufficient/inconsistent alternative provisions across the system. • Reduction in the supply of suitably skilled and experienced staff across a number of services. • Ineffective use of resources to support improvements in productivity and improve clinical outcomes. • Failure in operational leadership **CONSEQUENCE** • Failure to deliver safe, high quality patient care • Reduced patient experience • Poor clinical outcomes • Over-reliance on temporary workforce due to current and	COVID-19 and Recovery • ~~Bronze, silver, gold command structure for oversight and decision making.~~ • ~~Frequency of gold/silver/bronze meetings revised based upon trigger alerts linked to COVID-19 admissions.~~ • In line with national guidance Living with Covid, oversight and decision making has been assigned as part of BAU process to ETM. Systems and processes remain valid and can be stood back up dependent upon prevalence. • Part of C&M hospital cell group monitoring COVID-19 recovery and supporting mutual aid discussions. • Single accountability framework for reviewing CBU areas for development/strengths. • RTT restoration plan being monitored on a ~~weekly~~ monthly basis and reported ~~to gold weekly and~~ to ETM & ~~monthly to~~ FP&I. • Non RTT trackers in place with planned programme of work • Directorate Manager role that is solely responsible for access - providing greater strengthen in governance and compliance. • Access policy for validation of all patients on waiting lists. • Clinical prioritisation of all patients. • Recruitment for dedicated DM, band 6 and band 5 for cancer services. UEC and Discharges • ED RCA process for breaches • Agreed in-hospital winter plan 2020/21. With plans for 2022/23 under development. • Agreed out of hospital (system) winter plan 2020/21. With plans for 2022/23 under development.	1. The expected outcomes and opportunities of partnership with STHK are still being explored across some services. 2. Need to identify other appropriate stakeholders for clinical services partnerships. 3. Shaping Care Together programme is yet to ~~define preferred option~~ to secure capital and define preferred option. ~~4. The workforce of the Trust does not have the mature level of expertise to ensure QI methodology can be applied.~~ 5. Lack of systematic capacity and demand modelling. ~~6. Sefton Brough is still developing plans for ICP from July 2022~~	**LEVEL 1** (Operational Management) 1. Quarterly Performance, Improvement, Delivery and Assurance (PIDA) Boards – CBU assurance 2. Monthly CBU FPI's in place from April 2022 – CBU assurance. 3. Number of improvement boards in place reporting in via PIDA ○ Theatre Utilisation Board ○ Urgent and Emergency Care Improvement Board ○ Endoscopy Improvement Board ○ Cancer Improvement Board 4. Review of CBU Risk Registers at Risk and Compliance Group. 5. CBU review at Clinical Effectiveness Committee. 6. CBU Governance Meetings in place. 7. Local IPRs in place to monitor performance which are presented at monthly CBU FP&I and quarterly Performance, Improvement, Delivery and Assurance (PIDA). 8. Extraordinary PTL for long waiters (including cancer) in place from Aug 22 chaired by COO **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 9. CEO's reports to Board 10. Integrated Performance Report (IPR) to SOC, FP&I, Q&S and Workforce Committee (monthly) to monitor any impacts on patients as a result of the risk including: ○ Mortality ○ Incident data ○ CQUINS ○ Operational performance data ○ Complaints and compliments ○ Financial position 11. Monthly reports on ~~Covid-19,~~ elective restoration, UEC performance (including Covid) to FP&I. 12. Monthly reports on cancer improvement to QSC 13. Quarterly Joint Performance Meeting (NHSE, STHK and S&O) . **LEVEL 3**	1. Constitutional standards are not routinely being met ~~2. Robust plans to deliver the 2022/23 operational plan~~ 3. ~~COVID-19 continues to impact elective recovery and discharge of patients~~ 4. Plans to deliver the 2022/23 operational plan in place, however impacted by covid. Awaiting NHSE requirement to develop plans for H2 2022/23 in light of current and potential impact of Covid-19 and further waves.	1. ~~Clinical workforce strategy to be completed~~ **~~Action picked up under SO1.~~** 2. ~~COVID-19 and recovery~~ Elective recovery plans in place. **Sep 22 Update: Monthly progress reporting to EC & FP&I. Trust participates in C&M elective restoration cell that meet weekly. New extraordinary weekly PTL meeting established, chaired by COO to focus on long waiters and clinically urgent patients. Trust part of Tier 2 reporting to NHSE on long waiters, 2nd best performing Trust across C&M. CDC and 2nd CT scanner bids approved - c£5m, implementation plans in place.** 3. Develop cancer improvement plan to address performance across all cancer metrics ~~by Dec 21~~ in line with plan for 2022/23. **Sep 22 Update: Continued focus on cancer. Weekly PTL meetings remain in place chaired by the ADO, weekly performance meeting in place, chaired by DCOO and extraordinary weekly PTL meetings in place chaired by COO with ADO attendance. Recently recruited to full capacity in tracker team, recruiting 2 x CNS colorectal and unsuccessful in recruitment for B5 and B6. STHK supporting. STHK review taken place, action plan developed to be reported via ETM in Sep 22.** 4. Develop Endoscopy Improvement Plan **Sep 22 Update: Endoscopy improvement group continues to meet monthly with COO & MD in attendance. Weekly and monthly data submissions to C&M. Best performer on points per list in C&M. TIF bid to support JAG accreditation national panel 3rd Oct 22.**

	projected workforce gaps leading to increasing costs and potential impact upon quality of patient care and experience. • Failure in delivery of national performance targets/plans which could lead to intervention by regulator(s)/ and/or commissioner(s) • Reputational damage and loss of public confidence. • Financial penalties and loss of services. • Loss of market share. • Reliance on other acute providers to support the delivery of clinical services • Loss of ERF funds.	• System wide capacity and flow meeting held twice weekly to review system discharge delivery. • 4 x daily bed capacity meetings to support daily planning. • ~~Additional funding to support UEC winter plans.~~ • Additional funding to support +14 beds at Chase Heys £840k for Sept 22-Mar 23 Workforce • Shaping care together programme. • Comprehensive trust service assessment completed to establish levels of fragility and core drivers Use of Resources • Use of Resources Programme established to support well led approach for clinical and corporate services. • Quality impact assessments (QIAs) for all service changes that are considered. • Use of Quality Improvement (QI) Methodology to ensure any service improvement becomes sustained and embedded. Operational leadership • Weekly Senior Operational Leadership (SOLT) Meetings • Monthly Senior Operational group (SOG) meetings with development plan in place • Essential skills and mandatory skills training programme		(Independent/Semi-Independent) 14. NHSI Single Oversight framework and monitoring arrangements 15. CCG monthly quality and performance meetings. 16. NHS benchmarking data including Model Hospital Dashboard and Dr Foster reporting 17. Getting it right first time (GIRFT) programme. 18. Cancer alliance oversee delivery and performance regarding cancer metrics. 19. NHS England / NHS Improvement 20. CQC 21. Internal Audit 22. External Audit.		5. Discharge planning: Improve the effectiveness of discharge processes to support 30% discharges before noon. **Sep 22 Update: Work in place with Sefton Place director to support discharges. Discharges workstream in place. Discharge campaign home before noon will be launched in Sep 22 with support from nursing and medical colleagues. DF and bed manager training planned Sep 22.** 6. ~~Working with ECIST to develop a capacity and demand model for UEC by August 2022~~ Capacity & Demand Modelling. **Sep 22 Update: ECIST Capacity and Demand model presented to ETM in Aug 22, deficit of 30-40 beds. Mitigation actions in place to reduce. Funding c£900k awarded for 14 beds in community. Next steps are for BI to work with CBU's using NHSE IST capacity and demand tool for elective to determine capacity required to deliver latter part of 2022/23 and 2023/24.** 7. Theatre Improvement ~~– Theatre Improvement and Productivity Group was relaunched in June 2002 and has identified key opportunities for improvement focusing initially on T&O, Ophthalmology and ENT. These specialty improvement plans will be implemented during 2022/23.~~ **Sep 22 Update: STHK review theatres presented to COO and MD, and then ETM. Theatre Recovery Plan under development which will be presented to ETM by end Sep 22. Redesigned theatre list planning meetings in line with STHK and COO in attendance on a weekly basis. Team visiting STHK for peer support. New theatre leadership team in place from 5th Sep 22.**
	The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To give every person the best care every time and deliver our operational performance standard

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks**.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

Risk Description: There is a risk around condition of estates and backlog maintenance issues

Strategic Objective 2b: Deliver services that meet NHS Constitutional and regulatory standards	**Assurance Committee: Finance Performance and Investment Committee** **Executive Lead:** Director of Finance

RISK ID	**2432**	**Risk Description**	**If the condition of the Trust estate is not improved then there is a risk to the delivery of high quality safe and effective services and to the experience of patients, visitors, and staff**

Inherent Risk			**Risk as at September 2022**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
5	5	**25**	4	5	**20**	1	5	5

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK There is a risk that essential hospital infrastructure could fail or not be fit for purpose to meet recognised H&S requirements or NHS HBN standards **CAUSE** Lack of capital investment to reduce CIR (Critical Infrastructure risk) backlog **Fire safety risk to life** as a result of lack of early warning (fire alarm) and ability to prevent spread of fire (compartmentation) **Failure of primary electrical systems (Southport)** which could result in loss of mains electricity to the site and loss of backup supply in the event of a power interruption **Failure of secondary electrical systems (Southport)** which result of loss on power through internal distribution network. Inability to effectively isolate areas **Inadequate ventilation (both sites)** resulting from insufficient air changes to meet HTM (Health Technical Memorandum) and infection control standards **Failure of nurse call system (both sites)** due to aging and obsolete parts causing rise to patient safety concerns and inability to care for patients safely **Failure of BMS (Building management System) (both sites)** resulting in inability to control critical systems that are linked to it such as heating, cooling, fire alarm systems **Failure CCTV and Access control systems (both sites)** resulting in lack of adequate security for both patients and staff **Failure lifts (both sites)** Impacting on the ability to transfer patients safely **Failure Mechanical/plumbing (water, oxygen, gas etc) (both sites)** due to ageing systems causing rise to patient safety concerns and inability to care for patients safely **Failure of autoclaves (Southport)** resulting in inability to deliver sterile services to the Trust, impacting on patient safety **SDGH (Southport District General Hospital)** Energy Centre plant and equipment.	1. Estate asset List & information in place 2. 6 Facet & Condition Surveys undertaken 3. Engineering Safety Systems Group has been established 4. Annual Capital Programme 5. Additional project management and construction capacity secured 6. Trust Green Plan 7. E&F Governance & performance management report 8. E&F Policies & SOP's	1. Gaps in asset information 2. Some assets awaiting surveys to be undertaken 3. Need for the development of an Estates Strategy that responds to the Shaping Care Together preferred service configuration option	**LEVEL 1** (Operational Management) 1. Planned Preventative Maintenance (PPM) Programme 2. Minor works response times 3. H&S Group 4. Water Safety Group 5. Engineering safety Group 6. E&F Governance Group **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Capital plan 2022 – identifies funding to continue with fire safety and nurse call projects 2. ERIC 21/22 Submission 3. Fire safety action plans for both sites which are monitored at the H&S Group **LEVEL 3** (Independent/Semi-Independent) 1. AE (Authorising Engineer) Appointments 2. AE (Authorising Engineer) Audits undertaken 3. Condition surveys	1. Current PPM Programme does not meet SFG20 - Standard maintenance specification for building engineering 2. Route to securing sufficient capital to address the serious backlog maintenance issues at the Trust	1. Current CAFM system does not have capabilities required for sufficient asset management or the ability to API link to SFG20 standards - Currently in Mobilisation phase site drawings are being uploaded and asset collection commenced in June – Moderate progress made – Target completion date December 2022 2. Trust has received £3.2m to tackle fire safety issues in 2022/23 and also a further £2.6m has been awarded which will be targeted against access control/CCTV at ODGH, electrical safety issues at SDGH & additional fire compartmentation works at ODGH to be completed in 2022/23. 3. Negotiations continue with C&M ICS to agree how the remaining gap will be addressed.

	CONSEQUENCE If our infrastructure fails or has issues there are several consequences which could potentially happen as a result, such as: • injury to patients, staff, visitors and contractors • Fines for non-compliant systems and support • Risk of fire • Death • Loss of trust assets • Public perception					

AMBITION: To provide sustainable ?					
Category	**AVERSE**	**CAUTIOUS**	**MODERATE**	**OPEN**	**HUNGRY**
	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	The Trust is eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

Strategic Objective 2c: Major and sustained failure of essential IT systems

Assurance Committee: Finance Performance and Investment Committee
Executive Lead: Director of Finance

RISK ID	2411	Risk Description	There is a risk of major and sustained failure of essential IT systems

Inherent Risk			Risk as at September 2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	5	4	20	4	2	8

Risk Description: There is a risk that major and sustained failure of essential IT systems

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK There is a risk of a major and sustained failure of essential IT infrastructure **CAUSE** • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Inadequate investment in systems and infrastructure **CONSEQUENCE** • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	1. IM& T Committee Oversight & IT Management Governance 2. Procurement Frameworks 3. Trust Digital Strategy 4. Performance framework and KPI's 5. Cyber Security Response Plan 6. Benchmarking 7. Workforce Development 8. Risk Register 9. Major Incident Reviews 10. Disaster Recovery Policy 11. Disaster Recovery Plan and restore procedures 12. Backup System in place and operational 13. Engagement with C&M Cyber Security Group 14. Cyber Associates Network Membership 15. Business Continuity Plans 16. Care Cert Response Process 17. Project Management framework 18. Change Advisory Board 19. Digital Design Authority 20. Information asset owner / administrator register 21. Cyber Security Provision provided by Mid-Mersey Digital Alliance (MMDA) 22. Monthly Patching Strategy in place 23. Microsoft Defender Anti-Virus in place and actively monitoring for malware, viruses and threats 24. All servers and PC's linked to Microsoft ATP\Defender 25. Regular Cyber Security Comms ~~26. Quarterly NHS Digital Simulated Phishing Attacks~~ 27. Backup System with backup schedule in place	1. Technical Development of Trust Staff	**LEVEL 1** (Operational Management) 1. IM&T Committee 2. Digital design Authority 3. IT On Call (including Network specific cover provided by MMDA) 4. Risk and Compliance Group 5. Information Governance Steering Group 6. Executive Management Committee 7. Information Asset Owner Framework 8. Benefits Realisation Framework monitoring 9. Cyber Security Action Plan 10. Monthly Cyber Security Assurance Group with MMDA **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Board and Committee Reports 2. Quarterly Digital Strategy Reviews 3. Monthly Cyber Security Reporting **LEVEL 3** (Independent/Semi-Independent) 1. Internal Audit reports 2. Annual Penetration Test and Report 3. Data Security Protection Toolkit Submission 4. Microsoft Unified Support Contract 5. Microsoft Server 2008 Extended Support 6. 24/7 Support Contracts in place for core systems such as EPR, Kainos, VMWare, Dell, etc. 7. Quarterly NHS Digital simulated phishing attack reports	1. Migration from end-of-life operating system ongoing and due to complete in 2022 2. Cyber Essential Certification / Accreditation	1. Implementation of Intrusion Prevention System (IPS) that detects cyber-attacks within the network. (Q2 22/23) 2. Network Remediation Rollout underway (Ongoing with completion now scheduled for Q4 22/23) This work has commenced with a current expected completion date of July 2023. A review is being undertaken to see whether with more resources the date can be brought forward. 3. Cisco Identity Services Engine Implementation (Now Scheduled for Q4 2022/23). 4. ~~Annual Penetration Test (June 2022)~~. **Completed** 5. PC Network Segregation (to be complete Q3 2022/23) 6. ~~Brocade Core Switch replacement (June 2022).~~ **Completed**. 7. ~~VPN Replacement (June 2022)~~ **Completed** 8. The AD for digital at S & O has now left the organisation and professional support is now being provided by the team from STHK while a proposal for the long-term arrangement sis being worked up and then agreed.

		28. Care Cert Response Process in Place 29. Role Based Access Control in place across domain and all clinical systems 30. Failover technology in place across Trust VMWare estate 31. Server Network Segregation in place 32. Imprivata Single Sign On In Place 33. Patch My PC in place for 3rd party application patching				

AMBITION: To provide sustainable					
Category	**AVERSE**	**CAUTIOUS**	**MODERATE**	**OPEN**	**HUNGRY**
	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	The Trust is eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

Strategic Objective 3: Efficiently and productively provide care within agreed financial limits

Assurance Committee: Finance, Performance and Investment Committee
Executive Lead: Director of Finance

RISK ID	3	Risk Description	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners

Inherent Risk			Risk as at September 2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	5	4	20	2	4	8

Risk Description: Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners **CAUSE:** • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to develop and deliver strategic financial plans • Failure to control costs or deliver CIP • Failure to stabilise Fragile Services • Failure to secure sufficient capital support to address significant backlog, and transformational requirements • Failure to ensure alignment of essential co-dependant clinical services • Failure to implement transformational change at sufficient pace • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV / NHS LTP)	• Operational Plan and HCP/ICS financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances Processes • Monthly financial reporting • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSEI annual provider Licence Declarations • Signed Contracts with all Commissioners • Signed SLAs with all partners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group • Increased collaboration across C&M to deliver transformational CIP contribution	• Currently no financial recovery plan that delivers break-even/ addresses drivers of the underlying financial position • National requirement for resubmission of 2022/23 Financial Plans • Lack of medium & long-term financial plan, taking in to account current position and savings from any reconfiguration • Lack of strategic capital plan • E-rostering system not fully utilised across the Trust. • Demand and Capacity process to inform Operational Planning	**LEVEL 1** (Operational Management) • Monthly CBU FP&I meetings now established • Use of Resources Programme Board • Corporate and CBU Efficiency Programme Group (EPG) meetings / CIP Council meetings to be established from June 2022 • Monthly budget holder meetings **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) • Finance & Performance Committee • Audit Committee • Annual Financial Plan • Monthly Finance Reporting • IPR • Annual Accounts • SLR/PLICs update reports • UoR Reports • Internal Audit Programme • National costing returns • Shaping care together programme **LEVEL 3** (Independent/Semi-Independent) • NHS England/Improvement monthly reporting • CQC Reports • CCG Contract Review Meetings • Head of Internal Audit Opinion • External Audit reports inc VfM Assessment	• Ability to monitor trajectory against financial recovery plan until developed • Demand and Capacity modelling to inform Operational Planning • Premium Rate Pay Control Panel across the CBUs in process of being established • CIP Council in process of being established • Trust PMO capacity to support delivery of CIP, UoR Action Plan, capital business cases, and service transformation	• Collaboration agreement in place with StHK • ~~Develop scenario-based approach to Operational plan/budget setting for 2022/23 – Final Plan Re-submission June 2022~~ **Completed** • Development of Medium & Long-Term Financial Model & strategic capital plan – note absence of national medium & long term financial framework including payment mechanisms and economic modelling assumptions required in order to provide robust Medium & Long-Term plan **– National Planning Guidance for 2023/24 – 2024/25 anticipated during December 2022** • Development and implementation of monthly financial reporting suite and forecasting model to drive ownership and accountability for performance – in place from April 2022 – automation opportunities with BI ongoing • Establish processes for Capacity and Demand planning from October 2022. • Establish processes for identifying, implementing, and monitoring delivery of efficiency/productivity (CIP) – fortnightly CIP Council commencing June 2022 • Management of rostering centralised from April 2022. E-rostering to be fully rolled out in all areas **– final area now under way with all users set up - anticipated completion during Q3** • Establish a Premium Rate Pay Control Panel across the CBUs – **completed – commenced June 2022** • Analysis of activity in relation to PbR to understand the drivers of changes, market share, and potential solutions – September 2022 • Seek all possible sources of capital and revenue funding through national bids to support capacity and transformation, including opportunities re co-location of services - ongoing

EFFECTS: • Failure to meet statutory duties • External Cash Support Requirements • NHS Single Oversight Framework Segmentation Status increase **IMPACT:** • Unable to deliver viable services • Loss of market share • Regulatory intervention					

The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

AMBITION: To provide care efficiently and productively, within agreed financial limits

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return**.**	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks**.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

Strategic Objective 4: Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	**Assurance Committee:** Workforce Committee **Executive Lead:** Director of HR and OD

RISK ID	**4**	**Risk Description**	**If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience**

Inherent Risk			**Risk as at September 2022**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	4	**12**	3	4	**12**	2	4	**8**

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience **CAUSE** Shortage of appropriately trained clinical staff in certain specialties and professions; Trust's geographic location; Trust's close proximity to other teaching hospitals with clearer USPs from a learning/ career development perspective; reputational damage over last 3 – 5 years has impacted on external perceptions of the Trust; Trust approach to recruitment and retention is underdeveloped across all areas. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; high vacancy and attrition rates; over-reliance on temporary workforce leading to increasing prevalence of fragile services; higher costs associated with temporary staffing; enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.	1. Our People Plan (Workforce and OD Strategy) aligned to NHS People Plan 2. Our Resourcing Plan (Strategy supported by clinical workforce plan). 3. Inclusive recruitment and selection processes in place 4. Overseas Recruitment Campaign for Nurses 5. Effective management of the junior doctor rotation programme and early indications of any shortages from the Lead Employer. 6. Job plans for medical staff. 7. Warm Welcome staff induction in place 8. Quality PDR process and career development discussion 9. Flexible working options in place including team rostering 10. Ward/departments non-medical staffing position is controlled through: 11. 3 x daily at staffing huddle; 12. 7 day staffing matron in place for oversight and management; 13. Weekly staffing review and sign off; 14. Roster sign off meeting. 15. People Activity Group (PAG) with oversight of business cases for additional staffing 16. Leadership development programmes & 360 feedback available to all staff 17. Apprenticeship programmes available to all staff from Level 2-7 qualifications 18. Effective approach to supporting attendance to reduce sickness absence levels.	1. Low number of applicants from BAME backgrounds successful at interview ~~2. In need of earlier identification of junior doctor rota gaps and proactive block booking to address.~~ ~~3. Alignment of job planning rounds to business planning cycle~~ 4. Poor PDR compliance rate ~~5. E-rostering system not fully utilised across the Trust~~ 6. Limited options for flexible working 7. Policy has too many stages/trigger points reducing effectiveness and limited manager informal interaction with staff in early stages of absence management 8. No easy ability for staff to move internally without full application process ~~9. Failure to meet essential skills training targets~~ 10. Education structure requires integration	**LEVEL 1** (Operational Management) 1. Workforce Committee 2. Workforce Improvement Group (WIG) oversees work against the four operational priorities: ○ Agile working ○ Workforce systems ○ Clinical workforce plan ○ Change management 3. Quality and Safety Committee 4. Clinical Effectiveness Committee 5. Finance, Performance and Investment Committee. 6. Risk and Compliance Group. 7. Clinical Effectiveness committee; 8. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 9. CBU Governance Meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): 2. PDR completion; 3. Sickness rates. 4. Absence Data 5. Turnover Data 6. Vacancy Rate 7. Time to Hire monitoring and reporting. 8. Apprenticeship Levy/Programmes 9. Staff Survey & Quarterly Staff FFT/Survey 10. GMC Medical Staff survey – annual 11. Nursing temporary staffing fill rate/ NHSP contract performance **LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement	1. Sickness absence not maintained below target 2. Low compliance rates for PDR completion ~~3. High nursing vacancy rates~~ 4. A number of medical vacancies have been vacant for a long time	1. Clinical workforce plan to be developed. A work stream has been established as part of Workforce Improvement group (led by the Deputy Medical Director) to develop a framework for workforce planning and link to Fragile Services and Shaping Care Together. Implementation of establishment control is required before a robust workforce plan can be developed, the implementation of establishment control is progressing at pace and the majority of the preparation work is now complete. **September 22 update:** Nursing and Midwifery workforce plan submitted to Workforce Committee for approval. Alignment to Medical and AHP workforce plan to follow (aiming for end of October) 2. Engagement planned with recent staff appointments (6-12mths) to review Recruitment and Selection process to identify improvements & develop further inclusive approaches Ongoing – expected completion date December 2021. **Sept 22 update:** The launch of Staff Networks in October 2022 will be better placed to ensure staff voices inform future changes & improvements. Improvements to date include applicant access to support from the Trust as a reasonable adjustment to complete an application, inclusion of key EDI charter marks e.g. Navajo, Disability Confident 3. ~~Alignment of business planning to Job Planning~~ **Completed** **September 22 update:** Next Job Planning Round to commence in October 2022 and is now aligned to business planning. 4. ~~E-rostering system now being rolled out to remaining departments~~ **Completed** **September 22 update:** All clinical departments are now complete, thus meeting Level of Attainment requirements. 5. Review of current rostering practice across each area and guidance and support is being offered to improve as phase 2 of the benefits realisation. 4 departments identified

		19. Updated Resourcing Plan required and no clinical workforce plan in place 20. Lead Employer progression 21. Internal transfer principles to be explored 22. Core mandatory & essential skills training programmes in place 23. Clinical Education Review undertaken 24. Bespoke and tailored support provided to newly recruited international colleagues. 25. Essential skills training action plan in place to drive compliance and reviewed monthly. 26. Early identification of junior doctor rota gaps and proactive block booking to address. 27. Alignment of job planning rounds to business planning cycle 28. E-rostering system fully utilised across all clinical departments at the Trust		2. CQC 3. CCG 4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		as pilots for team/self-rostering is now underway **September 22 update:** Evaluation to be undertaken by end of October 2022. 6. ~~Agile working group developing principles for hybrid working and review of flexible working policy to be piloted with CMO staff in **July 2021**.~~ **Completed** 7. Review of supporting attendance policy with support from NHS England/Improvement to address areas identified as outliers compared to Trust's with lower absences. **August 22 update**: Following discussion with staff side agreement to leave policy with extension and to review fully alongside Supporting staff with long term conditions and disabilities by August 2023. 8. Each CBU to have an improvement trajectory for planned reduction in sickness absence and progress to be monitored through monthly PIDA. **September 22 update**: HRAs and BPs working closely with all CBUs on long term cases and to ensure that appropriate management action has taken place in respect of short-term Absence. Monitored on quarterly basis and reported to Workforce Committee. Next report due October 2022. 9. Two joint Clinical Academic posts with Edge Hill University currently being advertised to increase attractiveness to medical posts at the Trust **September 22 update:** Awaiting Royal College approval of job description for 2nd post prior to readvertisement. 10. Internal transfer principles to be explored. There is no easy ability for staff to move without a full application process. T&F group established mid-October 2021 to assess need for transfer SOP with potential qualifying criteria to be determined. **September 22 update:** Internal Policy to be finalised during Quarter 3 (22/23), following work through Valuing Our People through Inclusion Group. Progress being made through working group. 11. ~~Essential Skills Risk under review and action plan to be implemented to achieve Trust target.~~ **Completed** 12. Clinical Education Risk & Governance structure & processes under review by Executive Team **September 22 update:** Extended to end of October 2022. 13. PDR action plan in place to drive improved compliance over the summer 2022 period (typical trend for reduced compliance) and progress monitored monthly **September 22 update**: All actions taken and the 55 non-compliant (excluding those staff on LTS) has reduced to 17. Each Exec

						Director scrutinising and challenging PDR rates for their areas of responsibility.
	The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To be the employer of choice in Merseyside and Lancashire					
	AVERSE	**CAUTIOUS**	**MODERATE**	**OPEN**	**HUNGRY**
	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return**.**	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks**.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

Risk Description: If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted

Strategic Objective 5: Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values

Assurance Committee: Workforce Committee
Executive Lead: Director of HR and OD

RISK ID	5	Risk Description	If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted

Inherent Risk			Risk as at September 2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
3	4	**12**	3	4	**12**	2	4	**8**

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted **CAUSES** Inappropriate behaviours: leaders not always supported or developed; no clear definition of what talent management looks like at the Trust; board approved leadership and staff engagement strategies not owned across the organisation; equality and diversity not fully recognised and responded to; ineffective team working; less than optimal management practice in some areas; lack of clarity for staff on direction of travel for the organisation. **CONSEQUENCE** Negative impact on quality of patient care, experience and service provision; poor retention of staff; inability to recruit the right people; staff are not developed to be patient-centred leaders; high levels of sickness; low staff morale; potential of poor outcomes of regulatory assessments; intervention by regulator(s)/ commissioner(s); reputational damage; loss of public confidence.	1. Our People Plan (Workforce and OD Strategy) aligned to NHS People Plan 2. Trust Values & Behaviours Framework 3. Trust values and behaviours embedded in the employee life cycle 4. Our Equality, Diversity, and Inclusion Plan in place to deliver Trust's mission and objectives 5. Equality, diversity, and inclusion networks in place 6. Just and learning principles embedded at the Trust, particularly in processes for raising/investigating concerns and lessons learned 7. Freedom to speak up guardian 8. Joint negotiating committee (JNC) 9. Staff Stories presented to Workforce Committee 10. Team development support available to promote positive relationships 11. Access to NHS Leadership Academy Programmes & 360 feedback, and internal leadership and management development programmes available 12. Mandatory and role specific training programme in place 13. Quality PDR discussions to promote positive behaviours 14. Talent management framework 15. Apprenticeship programmes leadership & management offer Levels 3-7 16. Board role modelling and visibility through: a. Executive Back to the Floor sessions. b. Non-Executive Board to Ward visits c. Staff Voice Partnership quarterly activities including Exec Pop Ups and Team Talks. 17. Staff communication and engagement plan 18. Embedding Values and Behaviours in Induction and PDR processes. 19. 'At Our Best' leadership programme	~~1. Awareness of Trust Values and Behaviour framework~~ 2. Limited alignment of values to key stages in employee life cycle ~~3. Up to date EDI mission and objectives required~~ 4. Low participation in staff networks ~~5. No awareness of Just and Learning Culture and alignment to processes for looking into incidents/lessons learned~~ 6. Team development interventions are currently expensive and resource intensive 7. No talent management/succession planning frameworks in place 8. Low visibility of leadership team reported in recent Staff Survey 9. Pause of Board Development sessions due to COVID-19. 10. ~~Schwartz round facilitators~~ 11. No Board Development programme in place for the year ~~12.~~	**LEVEL 1** (Operational Management) 1. Workforce Committee 2. Workforce Improvement Group oversees the Transformational Leadership programme outlined in Our People Plan 3. Valuing Our People Inclusion Group oversees the culture and staff engagement programmes outlined in Our People Plan. 4. EDI Special Interest Group 5. Quality and Safety Committee 6. Clinical Effectiveness Committee 7. Finance, Performance, and Investment Committee. 8. Risk and Compliance Group. 9. Clinical Effectiveness committee. 10. Remunerations and Nominations Committee. 11. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 12. CBU Governance Meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): ○ Mandatory training. ○ PDR completion. ○ Sickness rates. 2. Turnover. 3. Vacancies. 4. Performance Reports (monthly) 5. NHS staff Survey 6. Quarterly Staff Friends and family Test/Survey 7. GMC Medical Staff survey – annual **LEVEL 3**	1. Staff Survey Engagement score has improved in year but remains below national average in some areas. 2. Low compliance rates for PDR completion and need to ensure it meets the Trust's and individual's needs. 3. Need to understand and address poor engagement with equality, diversity, and inclusion networks. ~~4. High number of employee relations cases and concerns raised through Freedom to Speak Up linked to negative interactions and relationship issues~~	1. EDI Board development programme agreed to promote and embed inclusive leadership practices at a senior level. **Sept 2022 update:** Staff Voice Partnership (SVP) Autumn dates scheduled. Board Development under discussion led by Director of HR&OD with a focus on the role of the Board in EDI, regulatory requirements & accountability, how to develop an EDI journey and how to put theory into practice 2. Talent management/succession planning framework – participation in the Workforce Improvement Group Transformational Leadership workstream (Operations Career Development Framework). **Sept 2022 update:** Work ongoing to review internal leadership programme. Career pathway developed for nursing. 3. The Trust is adopting the Leadership Academy system leadership competency framework and will undertake a self-assessment with leaders through a programme of work overseeing by the Workforce Improvement Group. **Sept 2022 update:** Place system leadership programme launching 28th September 2022 with 4 S&O delegates 4. Work programmes identified by the Valuing Our People Inclusion group (VOPIG) from feedback from staff survey to improve staff engagement score. Quarterly Staff Survey to be launched on 1st July and regularly monitoring the impact of the VOPIG programme of work. **Sept 2022 update:** Next quarterly update due to Workforce Committee in October 2022. 5. ~~Revised proposals for strengthening engagement presented to the Executive Committee for review in March 2022.~~ **Completed**

		20. PDR Improvement Plan monitored though PIDA and the valuing our people inclusion. 21. A reciprocal arrangement in place through the Mediation Network accessed by the Trust on a case-by-case basis where appropriate. 22. The Trust has 7 trained Schwartz Round facilitators as well as access to a further 3 as part of Sefton Place partnership. 23. EDI strategic objectives for 2022-24 established 24. Just and Learning principles established and aligned to employee relations and incident management processes		(Independent/Semi-Independent) 1. NHS England / Improvement 2. CQC 3. CCG 4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education Northwest 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		
	The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To be the employer of choice in Cheshire & Merseyside

AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return**.**	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	**The Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks**.	Eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

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	**Assurance Committee:** Trust Board **Executive Lead:** Director of Transformation (CEO)

RISK ID	**6**	**Risk Description**	**If the Trust, as a small DGH, fails to exploit all potential opportunities to engage and collaborate with strategic partners; delivery of an acute services strategy will fail to provide sustainable services to our population.**

Inherent Risk			**Risk as at September 2022**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
4	5	**20**	3	5	**15**	2	5	**10**

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If the Trust, as a small DGH, fails to exploit all potential opportunities to engage and collaborate with strategic partners; delivery of an acute services strategy will fail to provide sustainable services to our population. **CAUSE** • Insufficient and inconsistent primary, community and intermediate care provision across Southport, Formby and West Lancashire • Lack of system-wide workforce planning to address reduction in supply of suitably skilled and experienced staff. • Emerging Cheshire & Mersey ~~Health & Care Partnership (CMHCP)~~ Integrated Care Board (ICB) wide acute provider partnership approach • Complex health economy • Lack of clarity about additional investment to address sustainability challenges • Lack of public and staff engagement to ensure effective co-production of potential solutions to clinical and financial sustainability challenges. **CONSEQUENCE** • Clinical unsustainability due to current and projected workforce gaps. • Failure to deliver safe, high quality patient care and experience in the most appropriate environment	1. Whole system engagement to address the required whole system change 2. SCT Programme Plan including key milestones to enable public consultation 3. Robust system governance structure in place to support the Shaping Care Together (SCT) programme • Programme Board • Operational delivery groups • Clinical Leaders Group 4. Strategic partnership (ALTC) established with StHK 5. Comprehensive trust service assessment completed to establish levels of fragility and core drivers 6. Member of Sefton ~~Integrated Care Partnership (ICP) Partnership~~ 7. Member of the Cheshire & Merseyside Acute Provider Collaborative. 8. Patient and Public Engagement strategy for SCT programme 9. Comprehensive due diligence completed, and documentation library created. 10. Quality and equality impact assessments completed and reviewed in advance of any changes to Trust service provision. 11. System Equality Impact Assessment process established. 12. Cheshire and Merseyside Integrated Care System governance structure	1. Clear alignment between Shaping Care Together programme, System Management Board & Sefton ~~ICP~~ Partnership 2. Sefton Brough is still developing plans for ~~ICP from June 2022~~the Place which are expected Autumn 2022. 3. Lack of established Patient & Public Reference Group 4. Expected outcomes and opportunities of partnership with StHK are still being explored for some service areas. 5. Identification of other key stakeholders for clinical services partnerships where StHK is not appropriate and needs to link into Place and Provider Collaborative discussions which are still at early stages. 6. Shaping Care Together programme is yet ~~to define preferred option~~ to secure capital and define preferred option 7. Clinical workforce strategy not fully developed. 8. Risks relating to current estates and infrastructure continues to be	**LEVEL 1** (Operational Management) 1. CBU FP&I (Monthly, Performance, Improvement, Delivery and Assurance (PIDA) Boards (Quarterly), with suite of measures. 2. Ongoing review and management of 'fragile services'. 3. Collaboration Senior Team Meetings (StHK & S&O Trust) reviewing immediate priorities and opportunities 4. Shaping Care Together (SCT) programme plan – monitored for delivery at Programme Board and Trust Board. 5. Patient and public engagement strategy monitored at Programme Board. 6. Equality Impact Assessment outcomes monitored at SCT programme board. ~~7. Haematology Assurance Group – partnership meeting to monitor improvement delivery~~ Project now complete 8. Ophthalmology Improvement Group – partnership meeting to develop and monitor system improvement plan 9. North Mersey Stroke Board – partnership board to develop and implement case for change, engagement & operational plans 10. Therapies Assurance Group – partnership meeting to monitor the improvement delivery. 11. Trust attending Cheshire and Merseyside Acute Provider clinical pathway collaboration meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Fragile Services reports to SOC and Board 2. Integrated Performance Report (IPR) to SOC and Q&S Committee (monthly) to monitor any impacts on patients as a result of the risk including: ○ Mortality ○ Incident data ○ CQUINS ○ Operational performance data ○ Complaints and compliments	Development of good working relationships with the new Primary Care Networks Understanding of the performance monitoring systems that will be established under the new NHS Bill that comes into effect on 1 July 2022	1. SCT Programme to develop Models of Care and define preferred option. **September 22 Update:** Models of Care developed, and initial options assesses against hurdle criteria. Revised programme timetable has been approved by programme board. On-going discussions with the ICBs and Places regarding the future role of SCT Programme and system ownership ~~2.~~ Establish Finance and Capital Assurance Group **September Update:** Group has been supported by MIAA to formalise the deliverable projects for 2022/23 which are expected by Autumn 2022. Trust DOF is now the nominated chair of the group. 3. Continue to develop collaboration opportunities with StHK a) Establish Therapies Assurance group by February 2022 **September 22 Update**: Work programme has now been developed with workstream leads in place, regular bi-monthly meeting booked in 2022 b) Ophthalmology clinical working group established to support clinical workforce recruitment challenges. **September 2022 Update:** Additional doctor recruitment has taken place which has significantly improved the position. Soft approach to opening to referrals commences in September starting with cataracts. Work continues between the STHK and S&O clinical teams. 4. Continue North Mersey Stroke Programme with implementation date of September 2022 **September 22 Update:** Full Business case formally approved by ICBs and implementation plans in place for 19/09/22 5. Continue to support Sefton Partnership Board with the development of priorities. High-level draft has now been produced by

	• Financial unsustainability due to increased costs • Poor estate utilisation due to inability to fully reconfigure services • Failure to provide acute core services to our population • Potential impact on neighbouring organisations if core acute services can no longer be delivered by the Trust • Reliance on other acute providers to support the delivery of clinical services • Reputational damage		defined within the SCT Programme (this includes the wider system) 9. ~~CCGs~~ Places are still defining their commissioning and transformation priorities for 22/23 10. ~~Cheshire and Merseyside Acute provider collaborative have not yet identified key clinical pathways for system collaboration~~.	3. Monthly reports to SCT Programme Board, SF&WL Joint Committee and NHSEI/CMHCP Oversight Group 4. Sustainability and collaboration update to Strategy and Operations Committee 5. Quarterly Joint Performance Meeting (NHSE, StHK and S&O) 6. LUHFT & S&O Partnership Board **LEVEL 3** (Independent/Semi-Independent) ~~1. Southport, Formby & West Lancashire Joint Committee~~ (under review as part of ICB/Place governance development) 2. Participation in the C&M ICS leadership and programme boards 3. Active member of Sefton ~~Integrated Care~~ Partnership ~~(ICP)~~ Attend the monthly Sefton Partnership Board 4. Active Member of the Cheshire & Merseyside Acute Provider Collaborative & supporting transformation/improvement work stream. 5. Active member of the Cheshire and Merseyside Independent Sector working group 6. Collaborative working with ~~CCGs~~ Place to develop commissioning and transformation priorities for 22/23 – draft priorities agreed and expected to be finalised Autumn 2022 7. Northern Clinical Senate and Yorkshire and Humber Clinical Senate Report recommendations 8. NHS England / NHS Improvement 9. CQC 10. Internal Audit 11. External Audit.		Seton Partnership Delivery Group and expected to be finalised by Autumn 2022 6. Develop a North Mersey Ophthalmology Steering group supported by local CCGs – March 2022. **September 22 Update:** Working Group established and being led by Sefton Place. Initial workstreams have been very proposed and scoping exercise now taking place. 7. Continue to develop Liverpool University Hospitals FT relationship with a particular focus on the SLAs already in place. **September 22 Update** Next Partnership Board is booked for 30th September 2022 and regular diary invites set for next 12 months. Meetings have taken place to support Ophthalmology, Vascular and ENT
	.					
	The Hospital Management Board can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

AMBITION: To provide sustainable services for the patients we serve

Category	AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
	Prepared to accept only the very lowest levels of risk, with the preference being for ultra-safe delivery options, while recognising that these will have little or no potential for reward/return	Willing to accept some low risks while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return.	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes.	Prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks.	The Trust is eager to seek original/creative/ pioneering delivery options and to accept the associated substantial risk levels in order to secure successful outcomes and meaningful reward/return.

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Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**05 October 2022**
Agenda Item	**SO176/22**	**FOI Exempt**	**NO**
Report Title	**CORPORATE RISK REGISTER**		
Executive Lead	Kate Clark, Medical Director		
Lead Officer	Matt Stephen, Assistant Director of Integrated Governance		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To provide an update on open risks in the Corporate Risk Register

Executive Summary

Continued training and support has been provided to the local governance teams and reviews of the current risk register have been underway. Advancements have been made to review these risks with their respective owners and the CBUs/BUs have provided updates against individual risks.

Corporate Risk Register

ID	ADO/Exec Lead	Title	Risk Lead	Rating (current)	Date of Last Review	Date of Next Review
2168	John McLuckie	Cyber Security - Unsupported systems **(NEW RISK ADDED to CRR AUGUST 2022)**	Paul Chadwick	**15**	07/09/2022	07/10/2022
2220	Lesley Neary	Covid 19 - Constitutional access standards	Chrisella Morgan	**16**	06/09/2022	06/10/2022
2230	Lesley Neary	Fragile Services	Nina Russell	**16**	18/08/2022	18/09/2022
1528	Kate Clark	Medication error and patient harm due to absence of an Electronic Prescribing and administration of Medicines (EPMA) system **(NEW RISK ADDED AUGUST 2022)**	John Williams	**16**	09/08/2022	09/09/2022
2411	John McLuckie	Major and sustained failure of essential IT systems	Paul Chadwick	**20**	07/09/2022	07/10/2022
2432	John McLuckie	Critical Infrastructure risk	Chris Davies	**20**	18/08/2022	18/09/2022

Closed Corporate Risks

2201 | Covid - 19 Workforce (Downgraded in July 22)
2031 | Risk to Patient Flow and Capacity on Southport site (Downgraded in August 22)

New risks for inclusion for CRR (Corporate Risk Register) in September

No risks have been escalated for September

Corporate Risk Register Heat Map

Corporate Risk Register	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)					
Unlikely (2)					
Possible (3)					2168,
Likely (4)				1528, 2220, 2230,	2411, 2432,
Almost Certain (5)					

Improvements since the last report

- **207** risks are open on the Trust risk register.
- **44** of these risks are not approved and are currently going through CBU governance and being reviewed.
- **6%** of risks are overdue. Overdue risks are being addressed with the CBU and are being closely monitored. **(Decrease of 1% since the last report)**
- A new report for overdue risks has been provided in this paper.
- **27** actions are overdue in the risk register. (Increase in 2 actions overdue since the last report but there have been actions closed and managed since, which means existing actions may have become overdue)
- There has been improved quality in the risk updates, controls and actions.
- Action plans are being reviewed and outstanding actions will be going through challenge at the Scrutiny & Assurance group.
- There are **6** risks which have been approved onto the Corporate Risk Register and are being monitored through Governance Groups as well as the Risk and Compliance Group. There is ongoing review of those risks scoring 15+ and these are being regularly reviewed and scrutinised in local Governance Committees.
- **0** risks have been escalated for removal from the Corporate Risk Register (CRR).
- **0** risks have been escalated for inclusion onto the Corporate Risk Register (CRR).
- New data tables have been attached to this report and will from part of the wider review and redesign of this report by Assistant Director of Integrated Governance in order to strengthen assurance.

The increase in risks since the last report show a positive risk reporting culture, with a good culture of closing risks after they have managed. **15** risks across all registers have been closed since the last report.

Recommendations

The Strategy and Operations Committee is asked to receive the Corporate Risk Register

Previously Considered By:	
☐ **Strategy and Operations Committee** ☐ **Finance, Performance & Investment Committee** ☐ **Remuneration & Nominations Committee** ☐ **Charitable Funds Committee**	☐ **Executive Committee** ✓ **Quality & Safety Committee** ☐ **Workforce Committee** ☐ **Audit Committee**
Strategic Objectives	
✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	
✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards	
✓ **SO3** Efficiently and productively provide care within agreed financial limits	
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Matt Stephen, Assistant Director of Integrated Governance	Kate Clark, Medical Director

Overdue risks:

11 Risk Incidents which are overdue a review before 08/09/2022

Business Unit	Risk ID	Risk Lead	Description	Current Risk Level	Date of last review	Next Review due
Executive Management	2203	Tony Ellis	If the Trust does not effectively communicate key messages during Covid to internal and external stakeholders there is a risk that mixed messages creating confusion/reputational damage with the local population and reduced staff morale.	Moderate risk	09/06/2022	09/08/2022
	2300	Mrs Chris Pilkington	If the trust fails to undertake the communication cascade exercise then we are in breach of completing our statutory requirements for CCA.	Moderate risk	05/07/2022	05/08/2022
Finance	2161	John Mcluckie	If the Trust fails to tackle its underlying deficit then the Trust could be put into financial special measures.	High Risk	08/07/2022	08/08/2022
Urgent Care	2019	Samantha Bennett	Risk: There is a risk to patients who are admitted to hospital with spinal fractures or poor experience and outcomes. Cause: This is caused by the lack of a clear and ratified pathway, care plan, stock of equipment, process and training.	High Risk	07/07/2022	07/09/2022
	2316	Ben Thompson-Jones	Risk: There is a risk that we fail to meet access standards within the Gastroenterology service. Cause: This is caused by insufficient capacity within the current funded 4 WTE workforce.	High Risk	07/07/2022	07/09/2022

	2403	Alexandra Gardner	Since temporary relocation of MDU to Ormskirk Risk has been identified that the service was reliant on location of Adult A&E and medical on call team to support care and treatment of vulnerable patients should an adverse reaction occur during treatment	High Risk	20/07/2022		07/09/2022
	2445	Alexandra Gardner	Due to increased ED attendances, increased acuity and challenges in discharges, there has been a sustained increase in the number of medical outliers across 14A, 10B, in CDU and Ward 1. These numbers often exceed 24 patients (including ward 1) which exceeds the number of which 1 consultant and junior can be responsible for, meaning the remaining outliers have to be split amongst other team members. Risk of continued pressure on the existing medical workforce establishment and medicine rota coordinator/OSM to staff these escalation areas without the appropriate funding or resource available	High Risk	09/08/2022		07/09/2022
Women & Children's	2459	Shyam Mariguddi	Instead of the RCPCH standard of 1 in 10 acute consultant rota, the department is functioning at 1 in 9. This impacts - timely review of patients - non compliance with CQC must do and RCPCH standard - reputation and employability of department as an outlier in the region - team morale - ability to move forwards in innovative work such as 'shaping care together'	Moderate risk	02/08/2022		06/09/2022
	2466	Nicky Taggart	Risk of harm to patients requiring paediatric dietetic care due to absence of funded service for West Lancs community and staff resource caused by long standing funding issue resulting in significant delays for patients	Moderate risk	02/08/2022		02/09/2022

	2491	Nicky Taggart	Impact of prolonged (over 12 months) directorate manager gap in Paediatrics includes - - inability to move forward with short, medium and long term agendas - inability to adequately prepare for reassurance processes including governance - inability to produce business plans, statements of case leading to impact on quality indicators and compliance with CQC actions - negative impact on wider team	High Risk	02/08/2022		31/08/2022
	2492	Nicky Taggart	The secretarial review has caused significant concern, and insecurity among the paediatric secretarial workforce and caused 2 permanent staff to resign. This combined with 1 retirement has caused significant gap. There is no clarity or timeline for review and new appointments cannot be made. Impact - very poor morale, with staff accessing stress counselling - staff actively thinking of leaving TRust - inability to maintain service and risk to patients - wider impact on department due to poor functioning of this key role	High Risk	01/08/2022		01/09/2022

Data Tables:

Business Unit	Very Low Risk			Low Risk			Moderate Risk				High/Extreme Risk			
	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Clinical Support Services	0	0	0	0	0	3	6	1	1	1	0	0	0	0
	0 = 0.00%			3 = 25.00%			9 = 75.00%				0 = 0.00%			
Corporate Governance	0	0	0	1	0	1	0	0	0	1	0	0	0	0
	0 = 0.00%			2 = 66.67%			1 = 33.33%				0 = 0.00%			
Estates & Facilities	0	0	0	0	0	4	3	1	2	0	0	0	1	0
	0 = 0.00%			4 = 36.36%			6 = 54.55%				1 = 9.09%			
Executive Management	0	0	0	1	0	2	2	0	0	2	0	2	0	0
	0 = 0.00%			3 = 33.33%			4 = 44.44%				2 = 22.22%			
Finance	0	0	1	0	0	3	0	1	2	1	1	0	1	0
	1 = 10.00%			3 = 30.00%			4 = 40.00%				2 = 20.00%			
Human Resources	0	0	0	0	0	1	1	1	0	1	0	0	0	0
	0 = 0.00%			1 = 25.00%			3 = 75.00%				0 = 0.00%			
	0	0	0	0	0	2	0	2	1	3	0	0	0	0

Integrated Governance & Quality	**0 = 0.00%**	**2 = 25.00%**	**6 = 75.00%**	**0 = 0.00%**

Medical Director	**0**	**0**	**0**	**3**	**0**	**6**	**3**	**2**	**1**	**0**	**0**	**1**	**0**	**0**
	0 = 0.00%			**9 = 56.25%**			**6 = 37.50%**				**1 = 6.25%**			

Performance Division	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	0 = 0.00%			**1 = 100.00%**			**0 = 0.00%**				**0 = 0.00%**			

Planned Care	**0**	**0**	**3**	**4**	**0**	**5**	**2**	**4**	**3**	**10**	**0**	**0**	**0**	**0**
	3 = 9.68%			**9 = 29.03%**			**19 = 61.29%**				**0 = 0.00%**			

Trust	**0**	**0**	**4**	**12**	**0**	**39**	**29**	**29**	**12**	**32**	**1**	**3**	**2**	**0**
	4 = 2.45%			**51 = 31.29%**			**102 = 62.58%**				**6 = 3.68%**			

Urgent Care	**0**	**0**	**0**	**0**	**0**	**4**	**4**	**12**	**0**	**5**	**0**	**0**	**0**	**0**
	0 = 0.00%			**4 = 16.00%**			**21 = 84.00%**				**0 = 0.00%**			

Women & Children's	**0**	**0**	**0**	**2**	**0**	**7**	**8**	**4**	**2**	**8**	**0**	**0**	**0**	**0**
	0 = 0.00%			**9 = 29.03%**			**22 = 70.97%**				**0 = 0.00%**			

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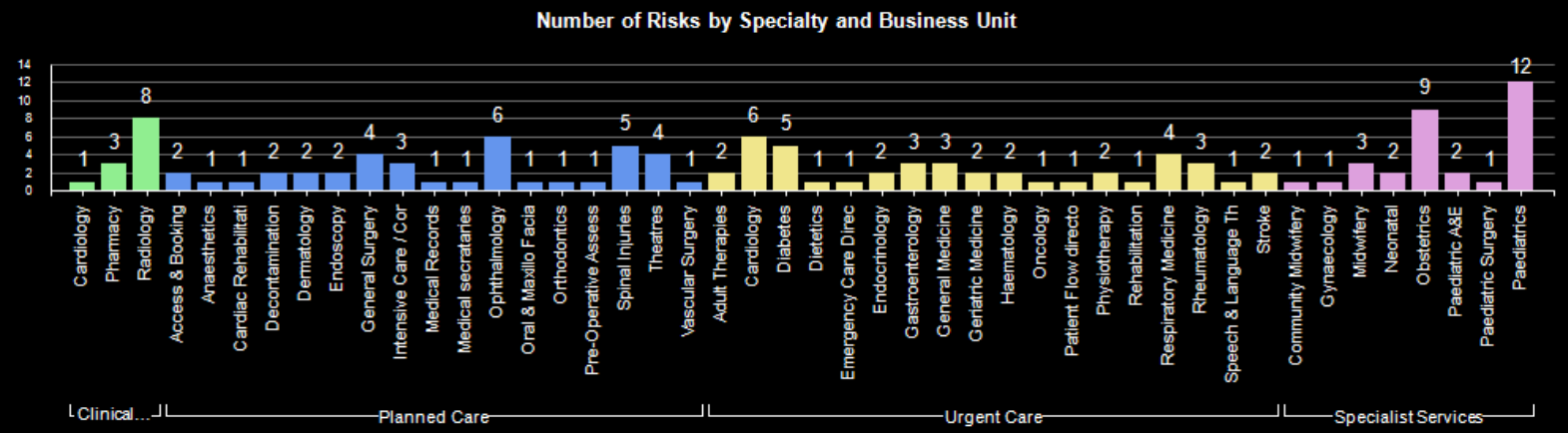
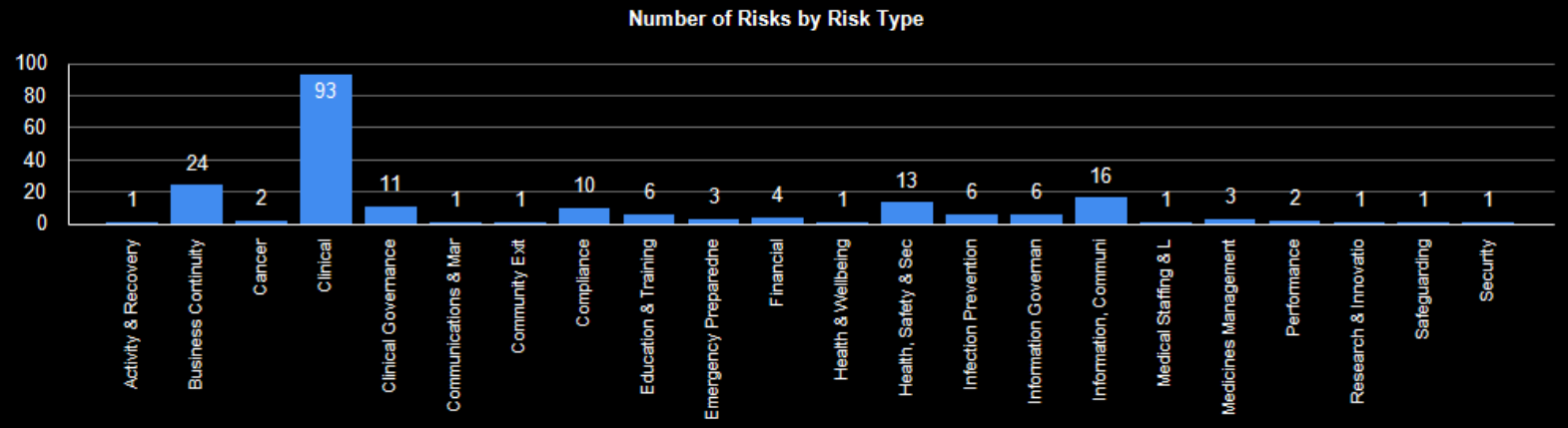
Number of Open Risks	Number of Risks Waiting to be Approved	Number of Overdue Risks	Number of Extreme Risks
207	44	11	6





Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**05 October 2022**
Agenda Item	**SO177/22**	**FOI Exempt**	**NO**
Report Title	**CHESHIRE AND MERSEYSIDE ACUTE AND SPECIALIST TRUSTS PROVIDER COLLABORATIVE (CMAST) JOINT WORKING AGREEMENT AND COMMITTEE IN COMMON**		
Executive Lead	Nicola Bunce, Director of Corporate Services		
Lead Officer	Nicola Bunce, Director of Corporate Services		
Action Required	✓ **To Approve** ☐ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

To secure Strategy and Operations Committee agreement and sign up to the CMAST Joint Working Agreement and Committee in Common.

The Trust has a duty to collaborate and to be part of one or more provider collaboratives. Trust approval of the Joint Working Agreement and Committee in Common Terms of Reference (TOR) is an important step in formalising the governance arrangements to enable CMAST to operate effectively.

Executive Summary

Cheshire and Merseyside (C&M) acute and specialist providers have come together to collaborate on matters that can be best progressed and responded to, at scale, and through shared focus or action. Working together achieved real and tangible benefits during the pandemic, with much of CMAST's foundations emerging from these activities but also building upon, wider and existing, local collaborative strengths such as the Cancer Alliance.

In identifying, promoting, and championing the benefits of collaboration NHS England have encouraged all providers to build on local successes through provider collaborative structures and now, also require all providers to be part of a collaborative. Furthermore, such a policy imperative is seen to ensure all providers support the delivery of the *triple aim* through:

- Aligning priorities, and
- Supporting establishment of the ICS with the capacity to support population-based decision-making, and
- Directing resources to improve service provision.

C&M Trust leaders have been working together to explore collaborative potential, develop ways of working and defining priorities over the last year. This work has included working with Hill Dickinson and external facilitators and both, Chief Executives and Chairs.

In addition to the triple aim priorities CMAST has identified complimentary key functions, that the collaborative can and should perform:

- Prioritising key programmes for delivery on behalf of the system
- Creating an environment of innovation, challenge, and support to deliver improved performance and quality of service provision

Following the success of previous CMAST initiatives and the establishment of the NHS Cheshire and Merseyside ICB it has been proposed, by CMAST members, and is now advocated that CMAST's ways of working should be embedded through a Joint Working Agreement. Such an approach provides a means to document the progress made, together within C&M, and provides an opportunity for Boards to demonstrate a shared commitment to the vision, priorities, and programmes of work that they have identified and initiated. Both internally and externally.

It is also proposed that CMAST more formally establish its governance to provide a route for shared and formalised decision making as and when required. This decision-making framework aims to underpin existing ways of working and provide a foundation to build from, as necessary, to fulfil either the need, potential or ambition of CMAST Boards.

The full documents are provided at Appendix A and Appendix B with summary details of both below:

- Joint Working Agreement (JWA) - to be read in conjunction with Committee in Common (CiC) Terms of Reference (ToR):

    - Covers: vision; function; priorities and 2022/4 work programme
    - Establishes: rules of working; process of working together; stages of decision making and scale of involvement and decision making
    - Sets: exit plan approach; termination approach; dispute resolution approach; information sharing and competition law principles; conflicts of interest approach

- Committee in Common - Terms of Reference - to be read in conjunction with JWA:

    - Sets out the C&M response, as proposed by Chairs and Chief Executives, to the Provider Leadership Board collaborative approach
    - Committees in Common: Staged levels of Committees in Common decision making; rules-based approach; will underpin clear and consistent communication supporting Board awareness and assurance
    - Sets aims and objectives of CiC
    - Establishes membership and signals wider engagement including minimum frequency of Chairs' engagement
    - Quorum
    - Annex A establishes potential activities delegated to the CiC when in scope of the CiC work as set in the JWA

    To note: NWAS is proposed as a participant of the meeting rather than as a member.

The documentation provides outputs that represent the culmination of a period of engagement and development with C&M Trust Board leadership and supporting officers. The approach represents the will and direction of this leadership steer and contribution and is put forward as representative of C&M's preferred way of operating.

The document delivers both a foundation and framework for CMAST development, decision making and supports its evolution. It focuses on approach and governance. Business and content scope will iterate and be defined by Boards as the scope and remit of CMAST develops and the ask of the system, for it, expand, vary, or diminish.

Recommendations

The Board is asked to

1. Approve the CMAST Joint Working Agreement to be signed by the Chief Executive on behalf of the Strategy and Operations Committee
2. Approve the establishment of a Committee in Common with Terms of Reference as proposed
3. To adopt and sponsor the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals

Previously Considered By:

☐ **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:**
Nicola Bunce, Director of Corporate Services	Nicola Bunce, Director of Corporate Services

Appendix A

Dated 2022

CHESHIRE & MERSEYSIDE ACUTE AND SPECIALIST TRUSTS PROVIDER COLLABORATIVE (CMAST) JOINT WORKING AGREEMENT

Between

(1) **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST**

(2) **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

(3) **SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST**

(4) **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST**

(5) **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST**

(6) **THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST**

(7) **LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST**

(8) **THE WALTON CENTRE NHS FOUNDATION TRUST**

(9) **LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**

(10) **ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST**

(11) **EAST CHESHIRE NHS TRUST**

(12) **ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST**

(13) **MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST**

and

(14) **NORTH WEST AMBULANCE SERVICE NHS TRUST**

CONTENTS

CLAUSE **PAGE**

1 Introduction

1.1 In this Agreement, the following words bear the following meanings:

Agreement	this agreement signed by each of the Trusts in relation to their joint working and the operation of the CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly.
CMAST Leadership Board	the CMAST CiC's meeting in common.
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
Meeting Lead	the CMAST CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of a CMAST CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices 1-14 to this Agreement;
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, Southport And Ormskirk Hospital NHS Trust, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT,

	Liverpool Women's NHS FT, Alder Hey Children's Hospital NHS FT, East Cheshire NHS Trust, St Helens And Knowsley Teaching Hospitals NHS Trust, Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change and develop CMAST as a provider collaborative.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a party to this Agreement as a participant in CMAST but is not forming a CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 The CMAST Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this agreement, this agreement shall not be legally binding. The CMAST Trusts enter into this agreement with the approval of their boards and intending to honour all their obligations to each other.

2 Background

Vision

2.1 CMAST has the immediate and short-term vision to ensure the coordination of an effective provider response to current system and NHS priorities including: ongoing pandemic response; NHS service restoration and elective recovery; support and mutual aid; sharing best practice, increasing standardisation and reducing variation. CMAST Trusts will work together to speak with one voice, enhancing our ability to lead on system wide programmes and workforce development, including harnessing clinical and professional leadership resources.

2.2 In the medium and longer term CMAST will develop an overview of existing services, locations and pathways to ensure they are patient-centred, productive, streamlined and of high quality. CMAST will work with the wider system and the ICB to ensure finances and organisational structures facilitate change and do not obstruct progress. The Trusts will work together, in places and with partners to ensure that those in greatest need have access to high quality services.

Key functions

2.3 The key functions of CMAST are to:

2.3.1 Deliver the CMAST vision;

2.3.2 Support the delivery of the ICS triple aim in Cheshire and Merseyside;

2.3.3 Align priorities across the member Trusts,

2.3.4 Support establishment of ICBs with the capacity to support population-based decision-making, and working with other collaboratives and partners to develop and support ICS maturity and encourage wider system working and collaboration

2.3.5 Direct operational resources across Trust members to improve service provision;

2.3.6 Prioritise key programmes for delivery on behalf of the Cheshire and Merseyside system; and

2.3.7 Create an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.

2.4 CMAST's stated priorities are to strengthen each of the Trusts by sharing collective expertise and knowledge to:

2.4.1 Reduce health inequalities;

2.4.2 Improve access to services and health outcomes;

2.4.3 Stabilise fragile services;

2.4.4 Improve pathways;

2.4.5 Support the wellbeing of staff and develop more robust workforce plans; and

2.4.6 Achieve financial sustainability.

2.5 The Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision making structures; the CMAST CiCs acting through the CMAST Leadership Board.

2.6 More specifically the CMAST CiCs and the CMAST Leadership Board will facilitate the Trusts' work in the following key work programmes at this initial stage of CMAST development*:*

2.6.1 Delivery and coordination of the C&M Elective Recovery Programme;

2.6.2 Cancer Alliance delivery and enablement – subject to the request of the Alliance;

2.6.3 Delivery and coordination of the C&M Diagnostics Programme including system decision making on pathology optimisation following existing C&M case for change and OBC;

2.6.4 Initiation of proposals and case for change for clinical pathway redesign - subject to discrete decision making as may be appropriate;

2.6.5 Coordinating and enabling CMAST members contribution and response to collective system wide workforce needs, pressures and the People agenda;

2.6.6 Coordinating and enabling CMAST members contribution and response to system wide financial decision making, pressures and financial governance;

2.6.7 Responding to and coordinating CMAST action in response to any national, regional or ICB initiated priorities for example TIF, system or elective capital prioritisation, 104 week wait delivery; and

2.6.8 The CMAST Trusts are part of the C&M ICS. Regional and inter regional relationships should first and foremost be guided by the ICB. To support this CMAST will provide both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate CMAST may seek to develop relationships with peers or for trusts, across other ICS's and ICB's (for example, related to specialised commissioning). This will be notified and communicated between the CMAST Trusts in accordance with the principle outlined in clause 4.6.

The areas within scope of this Agreement may be amended though variation, by Trust Board resolutions or agreement of the annual CMAST workplan.

2.7 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for CMAST will be complementary to (and do not revise or replace) the existing statutory duties of the Trusts (such as the delivery of NHS Constitutional Standards or equivalent). For avoidance of doubt there is no intention that the governance structure outlined in this Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3 Rules of working

3.1 The Trusts have agreed to adopt this Agreement and agree to operate the CMAST CiCs as the **CMAST Leadership Board** in line with the terms of this Agreement, including the following rules (the "**Rules of Working**"):

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

3.1.3 Having regard to staff and considering workforce in all that we do;

3.1.4 Consider the wider system impact and perspective and discuss proposals before any unilateral Trust action which may impact other Trusts;

3.1.5 Airing challenges to collective approach / direction within CMAST openly and proactively seeking solutions;

3.1.6 Support each other to deliver shared and system objectives;

3.1.7 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

3.1.8 Recognising and respecting the collective view and keeping to any agreements made between the CMAST CiC's;

3.1.9 Maintain CMAST collective agreed position on shared decisions in all relevant communications;

3.1.10 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

3.1.11 Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The CMAST CiCs shall meet together as the CMAST Leadership Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-14).

4.1.1 Meetings of the CMAST Leadership Board will be categorised under three types of business, dependent on the agenda to be discussed and whether any formal decisions are required to be taken:

A. CMAST Leadership Board – Operational business - Informal CEO discussions and representing the standard regular meeting structure; [1]

B. CMAST Leadership Board – Decisions to be made under the CMAST CiC delegations - CiC CEOs;

[1] Chairs will be invited to CMAST Leadership Board meetings, at least quarterly.

C. CMAST Leadership Board –CiC CEOs and Chairs discussion (or NED designate)

4.2 The CMAST CiCs shall work collaboratively with each other as the CMAST Leadership Board in relation to the committees in common model.

4.3 Each CMAST CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any CMAST CiC or its duty to act in the best interests of its Trust, each CMAST CiC shall seek to reach agreement with the other CMAST CiCs in the CMAST Leadership Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 When the CMAST CiCs meet in common, as the CMAST Leadership Board, the Meeting Lead shall preside over and run the meeting. The intention is that the current lead arrangements for the Meeting Lead will continue until 1 April 2024 [and thereafter rotate between the Trusts on a biannual basis with each Meeting Lead remaining in place for a period of 24 months].

4.5 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the CMAST Leadership Board which will reflect the principle of subsidiarity (that issues should be dealt with at the most immediate level that is consistent with their resolution) in the following approach:

Scale of involvement/impact	**Approach to decision**
Matter under discussion has no involvement or impact on other CMAST Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the CMAST Leadership Board if appropriate.
Matter only involves or impacts a smaller group of CMAST Trusts and not all (e.g. specialised commissioning issue for specialist trusts)	The CMAST CiC's for the Trusts involved shall consider the required decision if it is within their delegation as set out in the Terms of Reference. Notify the CMAST Leadership Board.
Matter involves or impacts all CMAST Trusts and comes within the delegation under the CMAST CiCs (e.g. collaborative approach to non-clinical services or workforce)	Matter to be dealt with through the CMAST CiCs at the CMAST Leadership Board in accordance with this Agreement and the Terms of Reference.

4.6 Each CMAST Trust will report back to its own Board and the CMAST Leadership Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the CMAST Trust Board meetings. The CMAST Trust chairs will (as well as their quarterly CMAST meetings - clause 4.1.1 above) meet regularly as a group to share information and for general discussions on CMAST on an informal basis. In addition, the CMAST Leadership Board will ensure that each CMAST programme should have a Chair sponsor appointed whose role will include updating the chairs meetings on the progress of the relevant programme.

4.7 When CMAST CiC meetings are intended to take decisions under the delegations made to those committees (in accordance with clause 4.1.1 B) then the meeting of CMAST (or if relevant, section of the meeting), will be held in public except where a resolution is agreed by the CMAST Leadership Board to exclude the public on the grounds that it is believed to not be in the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated and arising from the nature of that business or of the proceedings or for any other reason permitted by the

Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. Papers and minutes of CMAST meetings held in public will be published.

5 Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Agreement.

6 Exit Plan

6.1 Within three (3) months of the date of this Agreement the Trusts shall develop and agree an exit plan which shall deal with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this Agreement;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the CMAST CiC Chairs varying the Agreement under clause 10.6.2.

6.2 Once agreed by all of the Trusts, the exit plan shall be inserted into this Agreement at Appendix 15 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

7 Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant CMAST CiC committee and exit this Agreement ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the CMAST Leadership Board of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exit the Agreement,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 15) exit this Agreement.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its CMAST CiC and exits this Agreement then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this Agreement; or

7.3.2 Amend and replace this Agreement with a revised Agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8 Information Sharing and Competition Law

8.1 For the purposes of any applicable data protection legislation the Trusts shall be the data controller of any Personal Data (as defined in the UK General Data Protection Regulation (UK GDPR)) created in connection with the conduct or performance of the principles of this Agreement.

8.2 Where appropriate the CMAST Trusts agree to use all reasonable efforts to assist each other to comply with their respective responsibilities under any applicable data protection legislation. For the avoidance of doubt, this may include providing other Trusts with reasonable assistance in complying with subject access requests and consulting with other Trusts, as appropriate, prior to the disclosure of any Personal Data (as defined in the UK GDPR) created in connection with the conduct or performance of this Agreement in relation to such requests.

8.3 All Trusts will adhere to all applicable statutory requirements regarding data protection and confidentiality. The CMAST Trusts agree to co-operate with one another with respective statutory obligations under the Freedom of Information Act 2000 and Environmental Information Regulations 2004.

8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this Clause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired form other Trusts in connection with this Agreement which concerns:

8.4.1 any matter of commercial interest contained or referred to in this Agreement;

8.4.2 Trusts' manner of operations, staff or procedures;

8.4.3 the identity or address or medical condition or treatment of services received by any client or patient of any of the Trusts;

unless previously authorised by the Trusts concerned in writing, provided that these obligations will not extend to any information which is or shall become public information otherwise than by reason of a breach by a Trust of the provisions of this Agreement.

CMAST is committed to clear, consistent and transparent communication across the CMAST Trusts and with system partners' where appropriate. It is specifically recognised that CMAST Trusts are part of the ICS and members of Place Based Partnerships and will be working with their local partners and other collaboratives. Communication to and from Place Based Partnerships will be key for CMAST and the CMAST Trusts may be asked to represent both their own organisations and CMAST in such local place-based discussions.

8.5 For the avoidance of doubt, nothing in this Agreement shall be construed as preventing any rights or obligations that the Trusts may have under the Public Interest Disclosure Act (1998) and / or any obligations to raise concerns about any malpractice with regulatory or other appropriate statutory bodies pursuant to professional and ethical obligations including those obligations set out in the guidance issued by regulatory or other appropriate statutory bodies from time to time.

8.6 The Trusts acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this Agreement "Confidential Information" means all information provided in connection with this Agreement which is secret or otherwise not publicly available (in both cases in its entirely or in part) including commercial, financial, marketing or technical information, know-know or trade secrets, in all cases whether disclosed orally or in writing before or after the date of this Agreement.

8.7 The Trusts undertake for themselves and their respective Boards and employees that:

8.7.1 the disclosing Trust shall confirm whether information is to be regarded as confidential prior to its disclosure by clearly marking all such documents with 'Confidential';

8.7.2 they will use no lesser security measures and degree of care in relation to any Confidential Information received from the other Trusts than they apply to their own Confidential Information;

8.7.3 they will not disclose any Confidential Information of the other Trusts to any third party without the prior written consent of the disclosing Trust; and

8.7.4 on the termination of this Agreement, they will return any documents or other material in their possession that contains Confidential Information of the other Trusts.

8.8 The Trusts agree to provide in a timely manner and without restriction all information requested and required by the relevant designated CMAST Programme Support team (either internal team or external contractor where agreed) to carry out work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to CMAST activities.

8.9 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law to the extent applicable.

8.10 The Trusts will seek to agree a protocol to manage the sharing of information to facilitate the operation of CMAST across the Trusts as envisaged under this Agreement in accordance with competition law requirements, within three (3) months of the date of this Agreement. Once agreed by the Trusts (and their relevant information officers) , this protocol shall be inserted into this Agreement at Appendix 16 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

9 Conflicts of Interest

9.1 Members of each of the CMAST CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the CMAST Leadership Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of CMAST's decision-making processes.

9.2 The CMAST Leadership Board will agree policies and procedures for the identification and management of conflicts of interest which will be published on the CMAST website. It is proposed that such policies will either be CMAST developed or CMAST will support the adoption and application of the policy of the CMAST Chair and/or Meeting Lead.

9.3 All CMAST Leadership Board, committee and sub-committee members, and employees acting on behalf of CMAST, will comply with the CMAST policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by CMAST. Reuse / resubmission of host employer or home trust data, where applicable, will be supported

9.4 All delegation arrangements made by the Trusts will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures agreed by the CMAST Leadership Board.

9.5 Where an individual, including any individual directly involved with the business or decision-making of the CMAST Leadership Board and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CMAST Leadership Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Agreement and any agreed CMAST Conflicts of interest Policy and Standards of Business Conduct Policy.

10 Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Rules of Working set out in clause 3 above.

10.2 If a problem, issue, concern, or complaint comes to the attention of a Trust in relation to any matter in this Agreement, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the CMAST CiCs at the CMAST Leadership Board the appropriate course of action to take.

10.4 If the Meeting Lead and the CMAST Leadership Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by written notice. Any decision of the Meeting Lead and the CMAST Leadership Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the CMAST Leadership Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the CMAST Leadership Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

10.5.1 appointment of a panel of CMAST Leadership Board members who are not involved in the dispute to consider the issues and propose a resolution to the Dispute;

10.5.2 mediation arranged by C&M ICB for consideration and to propose a resolution to the Dispute; or

10.5.3 if considered appropriate selecting an independent facilitator and utilising the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the CMAST Trusts, the facilitator will be nominated by CEDR to assist with resolving the Dispute;

and who shall:

- be provided with any information they request about the Dispute;
- assist the Meeting Lead and CMAST Leadership Board to work towards a consensus decision in respect of the Dispute;
- regulate their procedure and, subject to the terms of this Agreement, the procedure of the Meeting Lead and CMAST Leadership Board at such discussions;
- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Working Days of their appointment; and
- where appropriate have their costs and disbursements met by the Trusts in dispute equally.

10.6 If the independent facilitator proposed under clause 1.5 cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only if after such further consideration the Trusts again fail to resolve the Dispute, the Meeting Lead and CMAST Leadership Board may decide to recommend their Trust's Board of Directors to:

10.6.1 terminate the Agreement;

10.6.2 vary the Agreement (which may include re-drawing the member Trusts); or

10.6.3 agree that the Dispute need not be resolved.

11 Variation

No variation of this Agreement shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12 Counterparts

12.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement.

12.2 The expression “counterpart” shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with English law.

This Agreement is executed on the date stated above by

……
For and on behalf of **COUNTESS OF CHESTER HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE CLATTERBRIDGE CANCER CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL HEART AND CHEST HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE WALTON CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL WOMEN'S NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **EAST CHESHIRE NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MID CHESHIRE HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **NORTH WEST AMBULANCE SERVICE NHS TRUST**

APPENDIX 1 – TERMS OF REFERENCE FOR THE COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Countess of Chester Hospital NHS Foundation Trust CiC]

APPENDIX 2 – TERMS OF REFERENCE FOR THE LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool University Hospitals NHS Foundation Trust CiC]

APPENDIX 3 – TERMS OF REFERENCE FOR THE SOUTHPORT AND ORMSKIRK HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Southport and Ormskirk Hospital NHS Foundation Trust CiC]

APPENDIX 4 – TERMS OF REFERENCE FOR WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 5 – TERMS OF REFERENCE FOR THE WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Wirral University Teaching Hospital NHS Foundation Trust CiC]

APPENDIX 6 – TERMS OF REFERENCE FOR THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Clatterbridge Cancer Centre NHS Foundation Trust CiC]

APPENDIX 7 – TERMS OF REFERENCE FOR THE LIVERPOOL HEART AND CHEST HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Heart and Chest Hospitals NHS Foundation Trust CiC]

APPENDIX 8 – TERMS OF REFERENCE FOR THE WALTON CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Walton Centre NHS Foundation Trust CiC]

APPENDIX 9 – TERMS OF REFERENCE FOR THE LIVERPOOL WOMEN'S NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Women's NHS Foundation Trust CiC]

APPENDIX 10 – TERMS OF REFERENCE FOR THE ALDER HEY CHILDREN'T HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Alder Hey Children's Hospital NHS Foundation Trust CiC]

APPENDIX 11 – TERMS OF REFERENCE FOR THE EAST CHESHIRE NHS TRUST CIC

[Insert Terms of Reference for the East Cheshire NHS Trust CiC]

APPENDIX 12 – TERMS OF REFERENCE FOR THE ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the St Helens and Knowsley Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 13 – TERMS OF REFERENCE FOR THE MID CHESHIRE HOSPITALS NHS TRUST CIC

[Insert Terms of Reference for the Mid Cheshire Hospitals NHS Trust CiC]

APPENDIX 14 – TERMS OF REFERENCE FOR THE NORTH WEST AMBULANCE SERVICE NHS TRUST CIC

[Not applicable]

APPENDIX 15 - EXIT PLAN

1 In the event of termination of this Agreement by all parties, the Trusts agree that:

1.1 each Trust will be responsible for its own costs and expenses incurred because of the termination of the Agreement up to the date of termination UNLESS it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;

1.2 upon reasonable written notice, each Trust will be liable for one thirteenth of any professional advisers' fees incurred by and on behalf of CMAST in relation to the termination of this Agreement (if any) up to and including the date of termination of this Agreement;

1.3 each Trust will revoke its delegation to its CMAST Committee in Common (CiC) on termination of this Agreement;

1.4 termination of this Agreement shall not affect any rights, obligations or liabilities that the Trusts have accrued under this Agreement prior to the termination of this Agreement; and

1.5 there are no join assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this Agreement how any joint assets or resources will need to be dealt with on termination of the Agreement.

2 In the event of an Exiting Trust leaving this Agreement in accordance with clause 7, the Trusts agree that:

2.1 a minimum of six months' notice will be given by the Exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the Exiting Trust's exit from CMAST and this Agreement up to and including the Exiting Trust's date of exit from this Agreement. Notwithstanding this, the Exiting Trust's total aggregate liability, in respect of such reasonable costs and the expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the CMAST CiC;

2.2 upon reasonable written notice from the other Trusts, the Exiting Trust shall be liable to pay [one thirteenth of] any professional advisers' fees incurrent by and on behalf of CMAST as a consequence of the Exiting Trust's exit from the Working Together Partnership and this Agreement up to and including the date of exit of the Exiting Trust from this Agreement;

2.3 the Exiting Trusts will revoke its delegation to its CMAST CiC on its exit from this Agreement;

2.4 the remaining Trusts shall use reasonable endeavours to procure that the Agreement is amended or replaced as appropriate in accordance with clause 7.3.2;

2.5 subject to any variation to or replacement of this Agreement in accordance with paragraph 2.4 above, and clause 7.3.2, this Agreement shall remain in full force and effect following the exit of the Exiting Trust from this Agreement

APPENDIX 16 - INFORMATION SHARING PROTOCOL

[to be inserted once agreed]

Appendix B

V5-2 September 2022

SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST

CMAST LEADERSHIP BOARD
TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER CMAST TRUSTS

TERMS OF REFERENCE

1 INTRODUCTION

1.1 In these terms of reference, the following words bear the following meanings:

CHESHIRE & MERSEYSIDE ACUTE AND SPECIALIST TRUSTS PROVIDER COLLABORATIVE OR CMAST	THE PARTNERSHIP FORMED BY THE TRUSTS TO WORK TOGETHER TO IMPROVE QUALITY, SAFETY AND THE PATIENT EXPERIENCE; DELIVER SAFE AND SUSTAINABLE NEW MODELS OF CARE; AND MAKE COLLECTIVE EFFICIENCIES. THIS OPERATES WITHIN THE NHS CHESHIRE & MERSEYSIDE INTEGRATED CARE SYSTEM.
CMAST AGREEMENT	THE JOINT WORKING AGREEMENT SIGNED BY EACH OF THE TRUSTS IN RELATION TO THEIR PROVIDER COLLABORATIVE WORKING AND THE OPERATION OF THE SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST CIC TOGETHER WITH THE OTHER CMAST CICS;
CMAST CICS	THE COMMITTEES ESTABLISHED BY EACH OF THE TRUSTS TO WORK ALONGSIDE THE COMMITTEES ESTABLISHED BY THE OTHER TRUSTS AND "**CMAST CIC**" SHALL BE INTERPRETED ACCORDINGLY;
CMAST PROGRAMME STEERING GROUP	THE GROUP, TO PROVIDE PROGRAMME SUPPORT AND OVERSIGHT OF THE DELIVERY OF AGREED COLLABORATIVE ACTIVITIES;
CMAST PROGRAMME LEAD	NAMED LEAD OFFICER OR ANY OF SUBSEQUENT PERSON HOLDING SUCH TITLE IN RELATION TO CMAST;
CMAST PROGRAMME SUPPORT	ADMINISTRATIVE INFRASTRUCTURE SUPPORTING CMAST;
MEETING LEAD	THE CIC MEMBER NOMINATED (FROM TIME TO TIME) IN ACCORDANCE WITH PARAGRAPH 7.6 OF THESE TERMS OF REFERENCE, TO PRESIDE OVER AND RUN THE CMAST CIC MEETINGS WHEN THEY MEET IN COMMON;
MEMBER	A PERSON NOMINATED AS A MEMBER OF AN CMAST CIC IN ACCORDANCE WITH THEIR TRUST'S TERMS OF REFERENCE, AND MEMBERS SHALL BE INTERPRETED ACCORDINGLY;
NHS CHESHIRE & MERSEYSIDE INTEGRATED CARE SYSTEM OR "C&M ICS"	THE INTEGRATED CARE SYSTEM (ICS) FOR CHESHIRE AND MERSEYSIDE BRINGING TOGETHER NHS ORGANISATIONS, COUNCILS, AND WIDER PARTNERS IN A DEFINED GEOGRAPHICAL AREA TO DELIVER MORE JOINED UP CARE FOR THE POPULATION.

SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST OF HOSPITAL TOWN LANE, KEW, SOUTHPORT, PR8 6PN ;
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST CIC	THE COMMITTEE ESTABLISHED BY SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST, PURSUANT TO THESE TERMS OF REFERENCE, TO WORK ALONGSIDE THE OTHER CMAST CICS IN ACCORDANCE WITH THESE TERMS OF REFERENCE;
TRUSTS	THE COUNTESS OF CHESTER HOSPITAL NHS FT, LIVERPOOL UNIVERSITY HOSPITALS NHS FT, SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST, WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT, WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT, THE CLATTERBRIDGE CANCER CENTRE NHS FT, LIVERPOOL HEART AND CHEST HOSPITAL NHS FT, THE WALTON CENTRE NHS FT, LIVERPOOL WOMEN'S NHS FT, ALDER HEY CHILDREN'S NHS FT, EAST CHESHIRE NHS TRUST, ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST AND MID CHESHIRE HOSPITALS NHS FT AND "**TRUST**" SHALL BE INTERPRETED ACCORDINGLY;
WORKING DAY	A DAY OTHER THAN A SATURDAY, SUNDAY OR PUBLIC HOLIDAY IN ENGLAND;

1.2 The Southport and Ormskirk Hospital NHS Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in CMAST to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a participant in CMAST but is not forming its own CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 Each Trust has entered into the CMAST Agreement on **[DATE]** and agrees to operate its CMAST CiC in accordance with the CMAST Agreement.

2 AIMS AND OBJECTIVES OF THE SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST CIC

2.1 The aims and objectives of the Southport and Ormskirk Hospital NHS Trust CiC are to work with the other CMAST CiCs on system work or matters of significance as delegated to the Southport and Ormskirk Hospital NHS Trust CiC under Appendix A to these Terms of Reference to:

2.1.1 provide strategic leadership, oversight and delivery of new models of care through the development of CMAST and its workstreams;

2.1.2 set the strategic goals for CMAST, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.3 consider different employment models for service line specialities including contractual outcomes and governance arrangements;

2.1.4 review the key deliverables and hold the Trusts to account for progress against agreed decisions;

2.1.5 ensure all Clinical Networks or other collaborative forums, by working in partnership with the ICB, have clarity of responsibility and accountability and drive progress;

2.1.6 establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

2.1.7 receive and seek advice from the relevant Professional (reference) Groups, including Clinical, Finance, Human Resources;

2.1.8 receive and seek advice from the NHS Cheshire and Merseyside Integrated Care Board;

2.1.9 review and approve any proposals for additional Trusts to join the founding Trusts of CMAST;

2.1.10 ensure compliance and due process with regulating authorities regarding service changes;

2.1.11 oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.1.12 review the CMAST Agreement and Terms of Reference for CMAST CiCs on an annual basis;

2.1.13 improve the quality of care, safety and the patient experience delivered by the Trusts;

2.1.14 deliver equality of access to the Trusts service users; and

2.1.15 ensure the Trusts deliver services which are clinically and financially sustainable.

3 ESTABLISHMENT

3.1 The Southport and Ormskirk Hospital NHS Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the Southport and Ormskirk Hospital NHS Trust CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Southport and Ormskirk Hospital NHS Trust CiC.

3.2 The Southport and Ormskirk Hospital NHS Trust CiC shall work cooperatively with the other CMAST CiCs and in accordance with the terms of the CMAST Agreement.

3.3 The Southport and Ormskirk Hospital NHS Trust CiC is a committee of Southport and Ormskirk Hospital NHS Trust's board of directors and therefore can only make decisions binding Southport and Ormskirk Hospital NHS Trust. None of the Trusts other than Southport and Ormskirk Hospital NHS Trust can be bound by a decision taken by Southport and Ormskirk Hospital NHS Trust CiC.

3.4 The Southport and Ormskirk Hospital NHS Trust CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Southport and Ormskirk Hospital NHS Trust CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

4 FUNCTIONS OF THE COMMITTEE

4.1 Paragraphs 15(1) and (2) of Part 3 of the National Health Service Trusts (Membership and Procedure) Regulations 1990 (SI 1990/2024) allow for any of the functions of a Trust to be delegated to a committee of the Trust consisting wholly or partly of directors of the Trust.

4.2 Southport and Ormskirk Hospital NHS Trust CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 FUNCTIONS RESERVED TO THE BOARD OF THE TRUST

Any functions not delegated to the Southport and Ormskirk Hospital NHS Trust CiC in paragraph 4 of these Terms of Reference shall be retained by Southport and Ormskirk Hospital NHS Trust's Board. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of Southport and Ormskirk Hospital NHS Trust to delegate functions to another committee or person.

6 REPORTING REQUIREMENTS

6.1 On receipt of the papers detailed in paragraph 13.1.2, the Southport and Ormskirk Hospital NHS Trust CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to Southport and Ormskirk Hospital NHS Trust's Board for inclusion on the private agenda of Southport and Ormskirk Hospital NHS Trust's next Board meeting in order that Southport and Ormskirk Hospital NHS Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The Southport and Ormskirk Hospital NHS Trust CiC shall send the minutes of Southport and Ormskirk Hospital NHS Trust CiC meetings to Southport and Ormskirk Hospital NHS Trust's Board, on a monthly basis, for inclusion on the agenda of Southport and Ormskirk Hospital NHS Trust's Board meeting.

6.3 Southport and Ormskirk Hospital NHS Trust CiC shall provide such reports and communications briefings as requested by Southport and Ormskirk Hospital NHS Trust's Board for inclusion on the agenda of Southport and Ormskirk Hospital NHS Trust's Board meeting.

7 MEMBERSHIP

7.1 The Southport and Ormskirk Hospital NHS Trust CiC shall be constituted of directors of Southport and Ormskirk Hospital NHS Trust. Namely the Southport and Ormskirk Hospital NHS Trust's Chief Executive who shall be referred to as a "Member".

7.2 Each Southport and Ormskirk Hospital NHS Trust CiC Member shall nominate a deputy to attend Southport and Ormskirk Hospital NHS Trust CiC meetings on their behalf when necessary ("**Nominated Deputy"**).

7.3 The Nominated Deputy for Southport and Ormskirk Hospital NHS Trust's Chief Executive shall be an Executive Director of Southport and Ormskirk Hospital NHS Trust.

7.4 In the absence of the Southport and Ormskirk Hospital NHS Trust CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 attend Southport and Ormskirk Hospital NHS Trust CiC's meetings;

7.4.2 be counted towards the quorum of a meeting of Southport and Ormskirk Hospital NHS Trust CiC's; and

7.4.3 exercise Member voting rights,

AND WHEN A NOMINATED DEPUTY IS ATTENDING A SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST CIC MEETING, FOR THE PURPOSES OF THESE TERMS OF REFERENCE, THE NOMINATED DEPUTY SHALL BE INCLUDED IN THE REFERENCES TO "MEMBERS".

7.5 When the CMAST CiCs meet in common, one person nominated from the Members of the CMAST CiCs shall be designated the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 NON-VOTING ATTENDEES

8.1 The Members of the other CMAST CiCs and the chief executive (or designated deputy) of the North West Ambulance Service NHS Trust shall have the right to attend the meetings of Southport and Ormskirk Hospital NHS Trust CiC. The Southport and Ormskirk Hospital NHS Trust's Chair shall be invited to meetings of the CMAST CiCs on at least a quarterly basis (or where the CiC feels it is appropriate – as set out in the CMAST Agreement under clause 4) as a non-voting attendee.

8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of Southport and Ormskirk Hospital NHS Trust CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CMAST CiCs.

8.3 The CMAST Programme Lead shall have the right to attend the meetings of Southport and Ormskirk Hospital NHS Trust CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3 inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CMAST CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the CMAST CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of Southport and Ormskirk Hospital NHS Trust CiC.

9 MEETINGS

9.1 Subject to paragraph 9.2 below, Southport and Ormskirk Hospital NHS Trust CiC meetings shall take place monthly.

9.2 The Southport and Ormskirk Hospital NHS Trust CiC shall meet with the other CMAST CiCs as the CMAST Leadership Board in accordance with the CMAST Agreement (as set out in clause 4 of the CMAST Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.

9.3 Any Trust CiC Member may request an extraordinary meeting of the CMAST CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the CMAST Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.4 Meetings of the Southport and Ormskirk Hospital NHS Trust CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.6 of the CMAST Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the Southport and Ormskirk Hospital NHS Trust CiC shall be confidential to the Southport and Ormskirk Hospital NHS Trust CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of Southport and Ormskirk Hospital NHS Trust's Board.

10 QUORUM AND VOTING

10.1 Members of the Southport and Ormskirk Hospital NHS Trust CiC have a responsibility for the operation of the Southport and Ormskirk Hospital NHS Trust CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the Southport and Ormskirk Hospital NHS Trust CiC shall have one vote. The Southport and Ormskirk Hospital NHS Trust CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be one (1) Member.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 CONFLICTS OF INTEREST

11.1 Members of the Southport and Ormskirk Hospital NHS Trust CiC shall comply with the provisions on conflicts of interest contained in Southport and Ormskirk Hospital NHS Trust Standing Orders, the CMAST Agreement and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Southport and Ormskirk Hospital NHS Trust Standing Orders also apply to conflicts which may arise in their position as a Member of the Southport and Ormskirk Hospital NHS Trust CiC.

11.2 All Members of the Southport and Ormskirk Hospital NHS Trust CiC shall declare any new interest at the beginning of any Southport and Ormskirk Hospital NHS Trust CiC meeting and at any point during a Southport and Ormskirk Hospital NHS Trust CiC meeting if relevant.

12 ATTENDANCE AT MEETINGS

12.1 Southport and Ormskirk Hospital NHS Trust shall ensure that, except for urgent or unavoidable reasons, Southport and Ormskirk Hospital NHS Trust CiC Members (or their Nominated Deputy) shall attend Southport and Ormskirk Hospital NHS Trust CiC meetings (in person) and fully participate in all Southport and Ormskirk Hospital NHS Trust CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the Southport and Ormskirk Hospital NHS Trust CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) to speak to the other or others, and be heard by the other or others simultaneously.

13 ADMINISTRATIVE

13.1 Administrative support for the Southport and Ormskirk Hospital NHS Trust CiC will be provided by CMAST Programme Support (or such other route as the Trusts may agree in writing). The CMAST Programme Support will:

13.1.1 draw up an annual schedule of CMAST CiC meeting dates and circulate it to the CMAST CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to CMAST CiC meetings; and

13.1.3 take minutes of each Southport and Ormskirk Hospital NHS Trust CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant Southport and Ormskirk Hospital NHS Trust CiC meeting.

13.2 The agenda for the Southport and Ormskirk Hospital NHS Trust CiC meetings shall be determined by the CMAST Programme Lead and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the CMAST Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST CIC

The Board of each Trust within CMAST remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to Southport and Ormskirk Hospital NHS Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the Southport and Ormskirk Hospital NHS Trust CiC to decide are set out in the table below.

If it is intended that the CMAST CiCs are to discuss a proposal or matter which is outside the decisions delegated to the Southport and Ormskirk Hospital NHS Trust CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the Southport and Ormskirk Hospital NHS Trust CiC meeting with a view to Southport and Ormskirk Hospital NHS Trust CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by Southport and Ormskirk Hospital NHS Trust's Board). Any proposals discussed at the Southport and Ormskirk Hospital NHS Trust CiC meeting outside of these parameters would come back before Southport and Ormskirk Hospital NHS Trust's Board.

References in the table below to the "Services" refer to the services that form part of the CMAST Agreement for joint working between the Trusts (as set out in Clause 2.6 of the CMAST Agreement and which may be supplemented or further defined by an annual CMAST Work Programme) and may include both back office and clinical services.

	Decisions delegated to Southport and Ormskirk Hospital NHS Trust CiC
1.	Providing overall strategic oversight and direction to the development of the CMAST programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	Seeking to determine or resolve any matter within the remit of the Southport and Ormskirk Hospital NHS Trust CiC referred to it by the CMAST Programme Steering Group or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the benefits and risks associated in terms of the impact to CMAST Programmes and recommending remedial and mitigating actions across the system;
5.	Formulating, agreeing and implementing strategies for delivery of CMAST Programmes;
6.	In relation to services preparing business cases to support or describe delivery of agreed CMAST priorities or programmes (including as required by any agreed CMAST annual work programme);

	Decisions delegated to Southport and Ormskirk Hospital NHS Trust CiC
7.	Provision of staffing and support and sharing of staffing information in relation to Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information; b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements; d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises; f. aligning the terms of and/or terminating relevant third-party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;

	Decisions delegated to Southport and Ormskirk Hospital NHS Trust CiC
12.	Reviewing the Terms of Reference and CMAST Joint Working Agreement on an annual basis.

APPROVED BY THE BOARD OF DIRECTORS: [DATE] 2022

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**05 October 2022**
Agenda Item	**SO178/22**	**FOI Exempt**	**NO**
Report Title	**INTEGRATED PERFORMANCE REPORT (IPR)**		
Executive Lead	EXECUTIVE MANAGEMENT TEAM (EMT)		
Lead Officer	Michael Lightfoot, Head of Information Katharine Martin, Performance & Delivery Manager		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

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

Executive Summary

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

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

Recommendations

The Strategy and Operations Committee is asked to receive the Integrated Performance Report detailing Trust performance in August 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	The 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

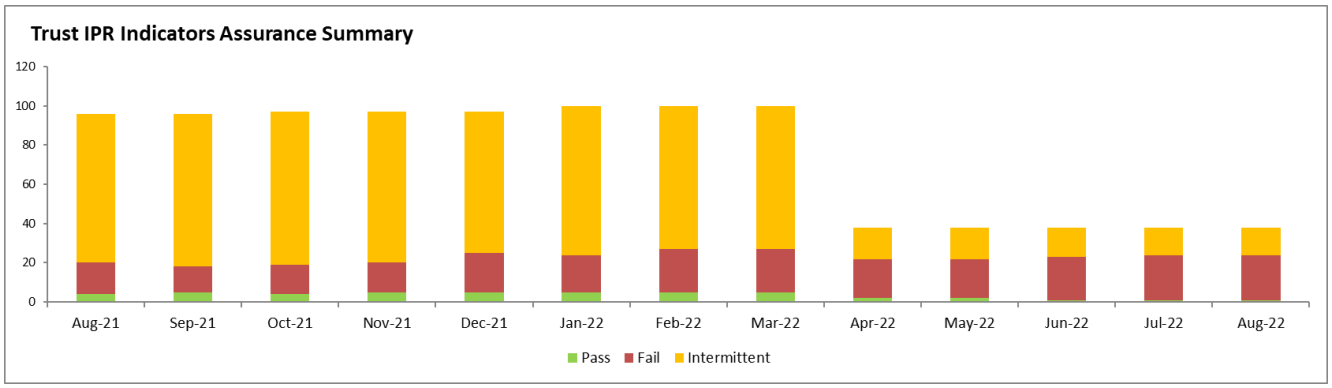
Operations - Trust Objective – Service

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 August 2022 (2022/23 YTD = 1).
There were no cases of MRSA in August. (2022/23 YTD = 0).
There were five C. Difficile (CDI) positive cases reported in August 2022 (2022/23 YTD = 22).
The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for August 2022 was 95.5%. This is based on 97.38% for Registered Nurses and 93.25% for Un-Registered Nurses.
There were four category 3 hospital acquired pressure ulcer reported in August (2022/23 YTD = 14).
There were 67 patient falls in August of which three resulted in moderate harm (2022/23 9 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 86.7% in August, from 87.8% in July.
The % of complaints responded to within timescales has achieved 55% in August against the 80% target, this is an improvement on the previous month (32.5%).
The Percentage of Patient Safety Incidents resulting in Moderate or above harm continues to perform lower than the target (target based on NHSE average NRLS published data).

Operational Performance

Overall Accident and Emergency performance for August 2022 was 73.7% (Adults ED 47.6%, Paeds ED 98.1% in August). This compares favourably with peers, with an England average of 71.4%, Northwest 69.7% and Cheshire & Mersey 72.5%. Combined attendances for SDGH and ODGH were 7095 in August compared to 7943 in July and 7426 in August 2021. 38.3% of Ambulance Handovers occurred within 15mins, a small increase on July (36.9%) but behind the 65% target. 66.1% of Ambulance Handovers were within 30mins, compared to 62.6% in July and short of the 95% target. 93 Ambulance Handovers breached 60mins in August, a reduction on the 127 reported in July.

Performance against the 14-day GP referral to Outpatients declined to 71.2% in July 2022 (latest data month), from 74.6% in June, this is against an average of 77.8% for England, 75.8% North West and 76.3% for Cheshire & Mersey. This has had an adverse effect on the 28 Day Faster Diagnosis Standard which achieved 65.4% in July (June 63%) against the 75% target. The 62-day cancer standard was below the target of 85.0% in month (July 2022) at 64.9% (62.1% in June). Whilst the Trust is below the average for Cheshire & Mersey (68.3%), it is above the England average of 61.6% and Northwest (61.3%). The Trust failed to achieve the 96% target for the 31-day target in July 2022 with 92.5% performance in month (June 93.1%). By way of comparison, in July, the England average of 92.9%, Northwest 94.3% and Cheshire & Mersey 95.7%.

Operational Performance continued

The average daily number of stranded patients in August 2022 remained high at 209 (July 210). The number of super-stranded patients continued the increasing trajectory, reporting the highest number for more than 2 years, from an average of 80 in July to 84 in August.

The Criteria to Reside metric is in excess of the 35 target, averaging 55 in August, a deterioration on the 45 reported in July. 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 August 2022 with 72% compliance, (72.9% in July), against the 92% target. The Trust continues to perform well in comparison to peers, for example the average for NHS Trusts in England was 61%, Northwest 56.6% and Cheshire & Mersey 58.4% (latest data July 2022).
There were 200 52+ week waiters at the end of August, a decrease on the 222 reported in July, with 22 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 August 2022 with 42.5% patients waiting longer than six weeks, an improvement on the previous month (44.9%) against a target of 1%. The Trust is an outlier for this standard, based on the latest published data (July 2022), the England average was 27.9%, Northwest 25% and Cheshire & Mersey 22.3%.

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 £8.0m deficit at Month 5 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 M5 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 is reporting delivery of CIP to M5 – with £8.1m schemes delivering, and 50% of the £3.0m Q4 system stretch target identified to-date.

Workforce

Personal Development Review compliance has increase in August to 76.3% against the 85% target. Performance in July was 74.4%. The 90% stretch target for Mandatory Training was implemented from June 2022 and the indicator is marginally behind the target at 88.9% for August (July 88.6%).

In month overall sickness decreased to 6.1% from 8% reported in July. 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 was below target at 4.9% in August (5.4% in July).

The overall Trust vacancy rate has decreased to 9.7% in August, from 10.5% in July, against the 7.4% target. In-month Staff turnover has decreased marginally to 1.2% in August from 1.4% in July (target 0.83%).

NHS
Southport and Ormskirk Hospital
NHS Trust

Integrated Performance Report
Strategy & Operations Committee Report

August 2022

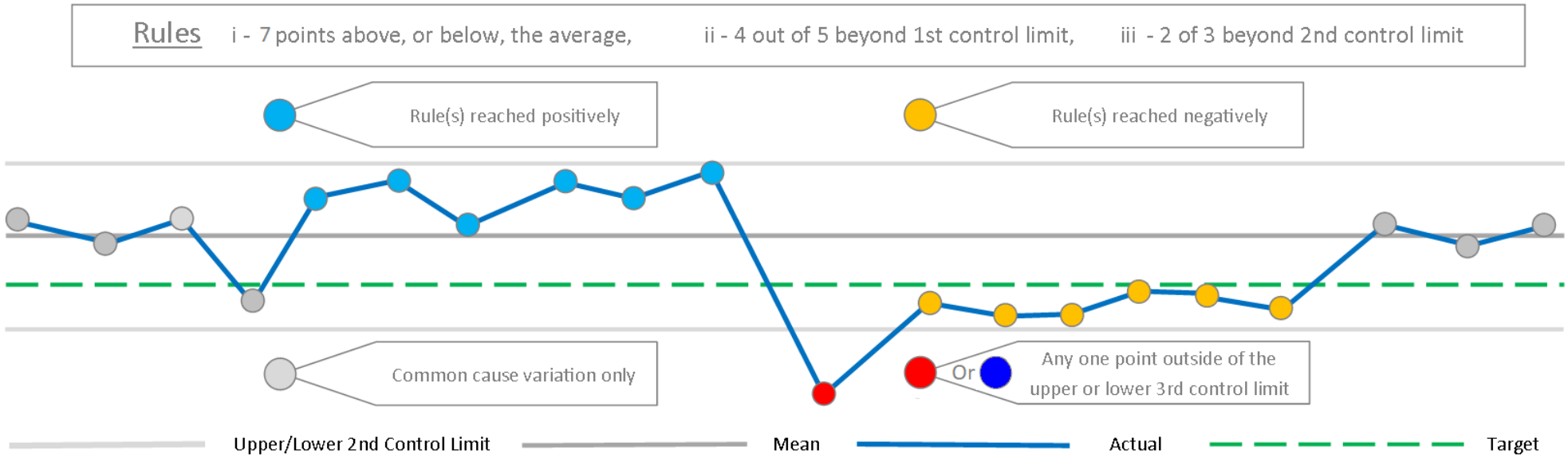
Guide to Statistical Process Control

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)

Personal Development Reviews

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 seven consecutive months. Performance of 95.5% in August relates to 97.38% for Registered Nurses and 93.25% for Un-Registered Nurses.
• Care Hours Per Patient Day (CHPPD) continues to be assured.

Management Action
• Registered nurse staffing vacancies continue to decease due to the success of our International Nurse Recruitment, with 166 now in the organisation, including 11 nurses working towards their OSCE, in conjunction with our successful local student recruitment programme.
• Areas over fill rate are those with an extremely high acuity of patients and those that have had an increase in staff to support patients in one ward.
• Non-registered nursing fall rates are indicative of the rising number of vacancies within the staff group, designated recruitment drives are underway, with the first one on the 23rd of September.
• The Care Hours Per Patient Day has shown to remain steady above plan for the last 6 months, this is not only a result of an increase in staffing but also as an increase in the acuity of patient seen on the wards.

Hospital Acquired Pressure Ulcers

Issues
• The Hospital acquired category 3 and 4 indicator is performing statistically as expected.
• The number of category 3 pressure ulcers remains above the target.

Management Action
• All Hospital Acquired Pressure Ulcers are subject to a Rapid Assessment Tool (RAT) which is presented at Harm Free Care panel.
• The Tissue Viability Team has a new lead commencing end of September.
• Several training initiatives brought to ward level for easy access of staff.
• SKKIN Bundle training to be recommenced x2 monthly.
• Team identifying ward training needs with ward managers and Link Nurses.
• Team identified training needed with risk assessment tool i.e. The Waterlow Score and have devised a training aid to increase staff understanding and application.
• The Trust is investing in new pressure relieving equipment.
• The Tissue Viability Team have been involved with estates and trailing and evaluating equipment.

Patient Falls

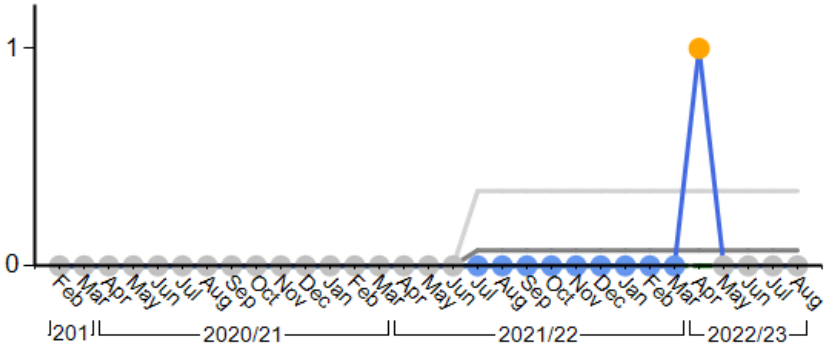
Issues
• The number of patient falls is statistically as expected in August and in-line with the average.
• Three falls resulting in moderate or above harm were reported in August, the same as the previous month. Whilst not statistically significant, this is above target.

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

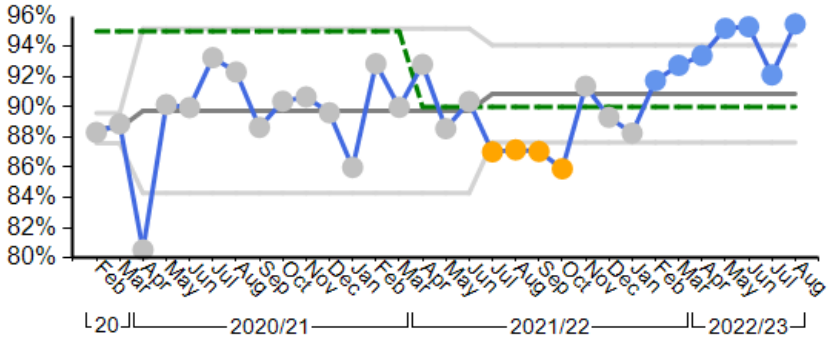
staff training).
• Continuing work to increase knowledge and understanding of the requirements for enhanced levels of care being given at a ward level.
• Enhanced level of care assessment being reviewed to make it more user friendly and fit for purpose.
• Falls Champion Education Day completed with excellent feedback and attendance.
• 'Stock check' completed of Ramblegard falls alarms, and actions implemented to manage this system more appropriately to monitor and store equipment.
• 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.
• Ramblegard yearly service to be completed at the end of September, bringing our stock levels up to original level. Storage options being reviewed to assist in managing this system more efficiently.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Never Events	0	0	0	Aug 22		0	0	Jul 22	0	1	
	Safe Staffing	90%	95.5%	N/A	Aug 22	H	90%	92.1%	Jul 22	90%	94.3%	
	Hospital Pressure Ulcers - Grades 3 & 4	1	4	4	Aug 22		1	4	Jul 22	12	14	
	Patient Falls - Trust	63	67	67	Aug 22		63	81	Jul 22	756	352	
	Falls - Moderate/Severe/Death	1	3	3	Aug 22		1	3	Jul 22	17	9	
	Percentage of Patient Safety Incidents - Moderate/Major/Death (related)	2.1%	1.4%	12	Aug 22		2.1%	0.9%	Jul 22	2.1%	0.8%	P

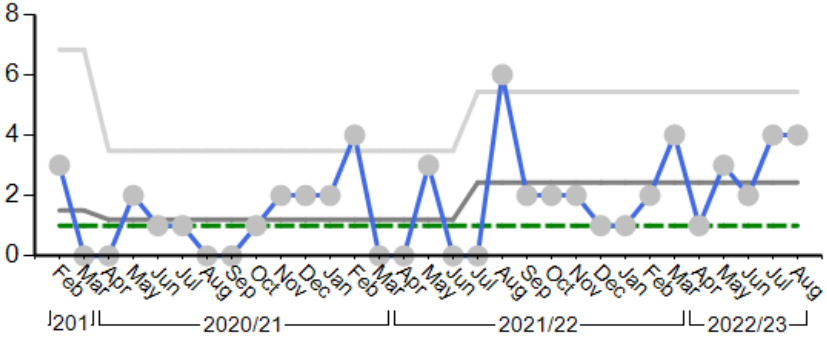
Never Events



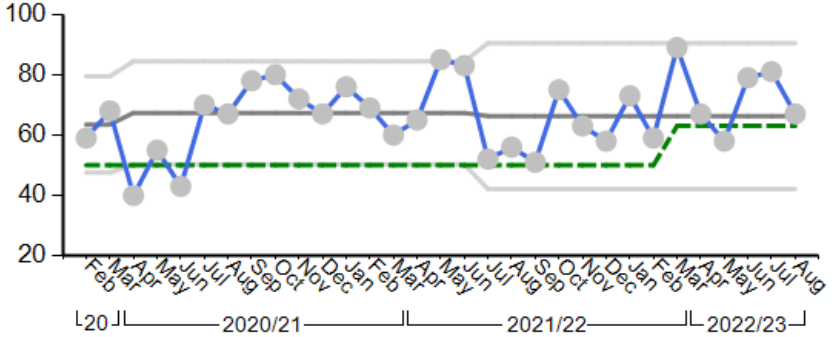
Safe Staffing



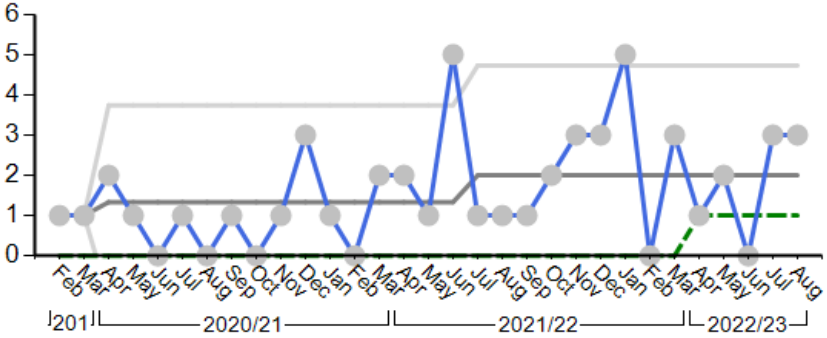
Hospital Pressure Ulcers - Grades 3 & 4



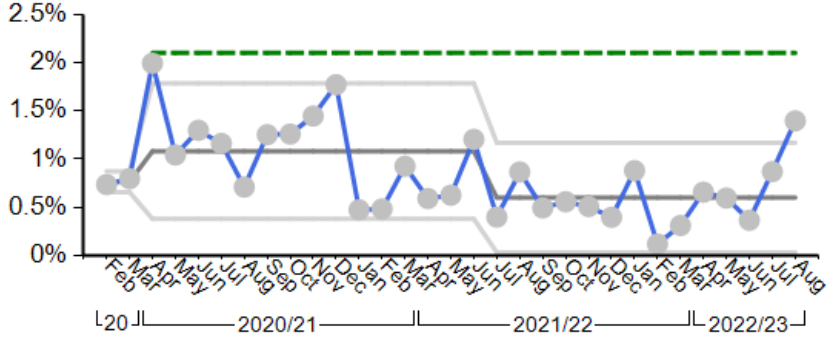
Patient Falls - Trust



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 August (2 Hospital Onset Hospital Acquired - HOHA and 1 Community Onset Hospital Acquired - COHA), which is an increase on the previous month and above target.
• The year-to-date figure is 2 over target.
• Data includes reoccurrences and all relate to elderly patients with multiple co-morbidities including infections that required treatment with antibiotics.

Management Action
• Each of the patients reviewed by the Microbiologist and the clinical team, or with the GP if a community patient.
• Formal RCAs completed on the hospital cases.
• Typing requested if link with other patients considered.
• Patients isolated and treated for C diff infection and vacated bed spaces cleaned with chlorine dioxide disinfectant.
• One of the patients identified with lapses in care relating to consultation with the Microbiologist and the IPC Team. These issues have been dealt with through the ward manager and safety huddles and the wider medical forum.

E-Coli

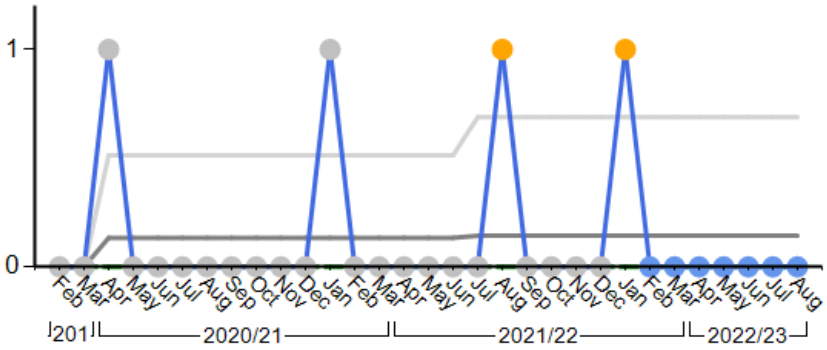
Issues
• Whilst the indicator is performing statistically as expected, with 8 (4 HOHA and 4 COHA) reported cases in August this is the highest for more than 2 years and an increase of 6 on the previous month.
• The Trust remains below the year to date trajectory.
• The majority of patients were elderly and had multiple co-morbidities.

Management Action
• Each of the patients were reviewed and treated throughout their stay with consultation with appropriate MDT members.
• Each of the patients were also reviewed and advice provided by the Microbiologist with respect to antimicrobial therapy.
• Diagnostic tests were completed appropriately, and treatment arranged.
• No apparent lapses in care.

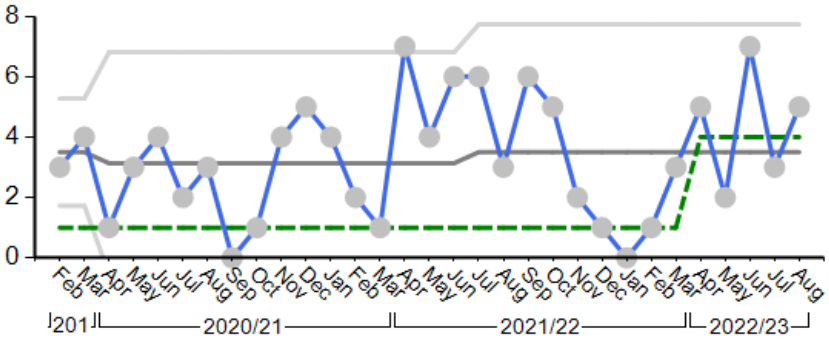
No MRSA infections were reported in August.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	MRSA	0	0	0	Aug 22		0	0	Jul 22	0	0	
	C-Diff	4	5	5	Aug 22		4	3	Jul 22	49	22	
	E. Coli	4	8	8	Aug 22		4	2	Jul 22	51	23	

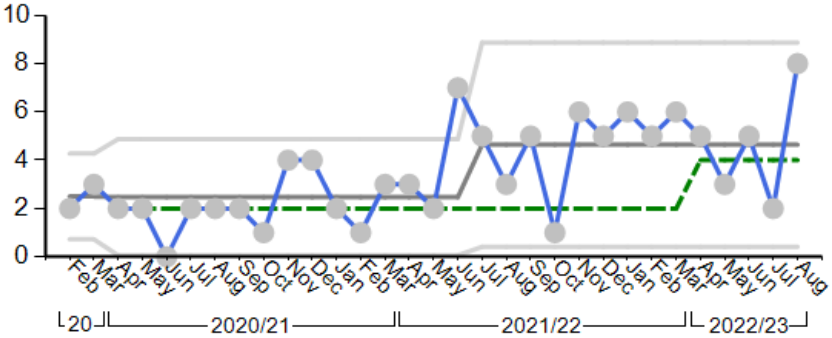
MRSA



C-Diff



E. Coli



Quality

Patient Experience

Complaints - % closed within 40 working days

Issues
• The indicator is failing assurance and whilst there has been a 22.5% increase in August, this remains behind the 80% target.
• 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.

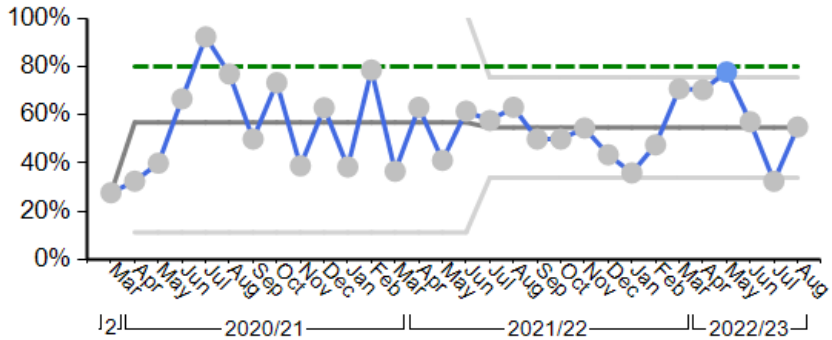
Management Action
• All CBU's have been asked to provide improvement plans.
• The CBU's continue to address their backlog of overdue complaints, with the number overdue continuing to reduce (17 on 14th September). This is expected to reduce further by the end of the month as the Women & Children's CBU have several complaint meetings scheduled.
• The Complaints training for the CBU's was stood down due to Full to Capacity; this will be re-arranged.

Friends and Family Test
Issues
• The indicator continues to fail the assurance measure and although is performing statistically as expected, there has been a 1.1% reduction in August.
• Performance in July has been impacted by a deterioration for Acute Inpatients, A&E, Outpatients and Postnatal Ward.
• The score for Acute Inpatients has decreased to 91.56% from 93.37 %. This remains below the internal indicator of 94% and July NHSE average of 94%. Themes alongside negative ratings are environment, staff attitude and implementation of care.
• A decreased score of 77.93% from 81.27% in Adult A+E and an increased in score to 94.03% from 87.23% in Paediatric A+E resulting in an overall figure of 82.2%. This remains above the Trust target of 77.8% and the July NHSE average of 75%.
• The experience of long waiting times in the adult A&E department continues to cause a higher number of negative responses and comments.
• A decreased score of 93.27% when compared to previous month of 94.99% this is marginally above the July NHSE average of 93%.
• Themes attached to negative scores within Outpatients are staff attitude, communication and environment.
• Increase in overall score for Labour Ward to 90.7% from 88.57%, this is below July NHSE average of 92%. Themes against negative ratings are staff attitude, communication and environment.
• A decrease in results from Postnatal Ward, from 84.21% in July to 81.25% in August, this is below July NHSE average of 91%. Themes against negative ratings are environment and implementation of care.

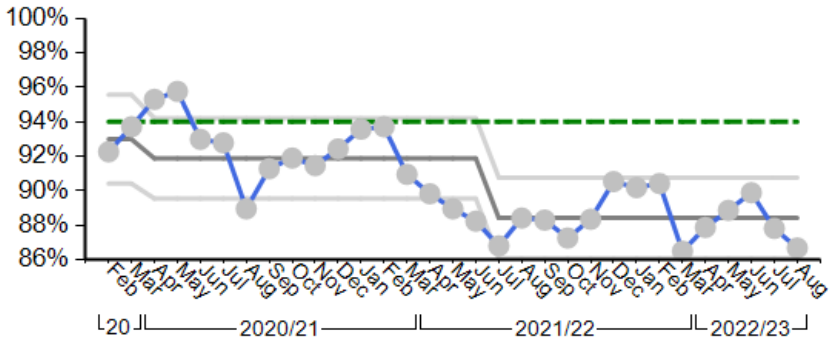
Management Action
• The profile of FFT continues to be raised as a valuable mechanism for receiving up-to-date patient feedback which is demonstrated via a 'You said, we did' approach on ward/dept quality boards.
• Monthly FFT summaries are shared with CBU's and are monitored through the Patient Experience 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.

		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%	N/A	Aug 22		80%	32.5%	Jul 22	80%	53.1%	F
	Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall	94%	86.7%	N/A	Aug 22		94%	87.8%	Jul 22	94%	88.3%	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 August 0.1% worse than July.
• The Trust remains in the top quartile nationally for ED performance, achieving 73.7% in August for the 4-hour standard. Significant pressures remain across all ED's in August 22, impacted by staff sickness, skill mix and patient acuity. The Trust performed ahead of the National average (71.4%), Northwest (69.7%) and Cheshire & Mersey (72.5%).
• 14.3% of patients spent longer than 12 hours in the department (996 patients), this is a deterioration on the 11.9% (932 patients) reported in July.
• A&E performance impacted by high bed occupancy levels, contributed to by IPC measures, surges in attendances and a requirement for all specialty reviews to be undertaken in A&E.
• Bed pressures lead to an increased LOS in ED with increased treatments and reviews undertaken in the department for patients who would previously have been admitted

Management Action
• Formalising SDEC pathways for appropriate conditions and ongoing plan to address workforce.
• Commence audit against May performance to understand response and actions and why performance showed improvements.
• 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 August is statistically as expected.
• Performance on 15 and 30min metrics worse than same period 2019/20 but better for >60mins.
• Ambulance arrivals were 19% lower in August than August 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.
• 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.
• 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 0.9% deterioration in August.
• 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 61%, Northwest 56.6% and Cheshire & Mersey 58.4% (latest data July 2022).
• There were 22 78-week waits at the end of August.
• Overall elective admitted activity achieved 78% of plan in August, a 3% improvement on the previous month.
• August activity impacted by workforce, theatre trauma cases and availability of beds.

Management Action
• Continued risk stratification of the waiting list.
• Trust is part of the Cheshire & Mersey wider elective restoration group.
• Workforce review within Ophthalmology to improve skill mix.
• Insourcing commenced throughout September 2022 to support increase in elective day case activity for Trauma and Orthopaedics. Business case to be presented at ETM re use of Salus centre as hub for trauma day case.
• Additional theatre sessions being identified to support increase in day case activity within Urology.
• Extraordinary PTL meeting commenced September 2022 to support 0 78-week patients by end of October 2022.
• Use of WLI's for weekend sessions for General Surgery.

Diagnostics

Issues
• The Diagnostic Waits indicator is failing assurance and showing special cause concern.
• Performance against the 1% target has improved in August to 42.5%, from 44.9% in July.
• The Trust is the worst performer in Cheshire & Mersey (July 2022 data) with performance for Cheshire & Mersey averaging 22.3%.
• Diagnostic scopes over-performed in August, delivering 110.2% against the plan.
• Scans underperformed in August, delivering 90.1% of the plan.
• National shortage of bowel preparation impacting scopes.
• Workforce pressures in ECG impacting activity.

Management Action
• Further Endoscopy insourcing planned with Your Medical to increase performance and maintain activity levels.
• Mutual aid provisionally agreed with STHK for ECG with arrangements to be formalised September 2022.

Stroke
Issues
• Due to validation delays impacted by the launch of the new HASU, the latest validated data remains June 22.
• Performance against the 90% stay on a Stroke ward continues to be challenged and has decreased from 54.8% in May to 47.1% in June.
• Compliance in June 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 4 of the 9 breaches. 4 avoidable.

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. An implementation date of 19th September has now been formally agreed for the S&O patient cohort and the FBC has been agreed by the ICB for 22/23.
• 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.

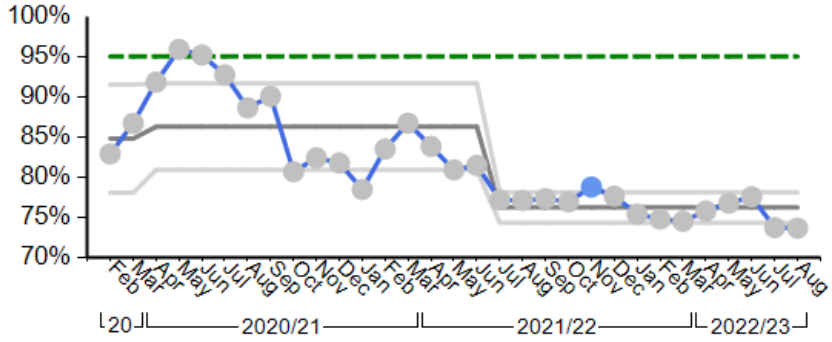
Discharge Communications

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

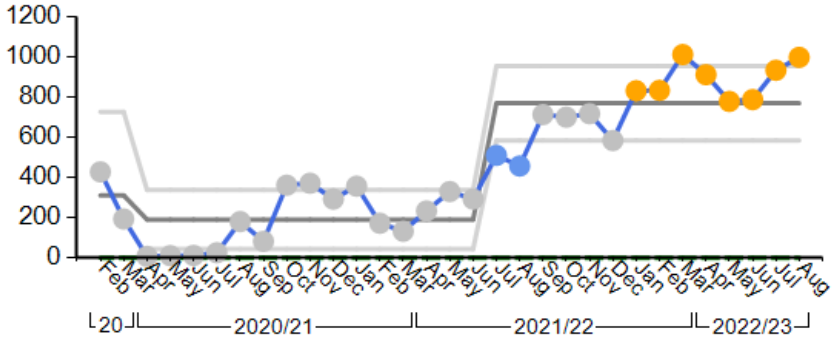
Management Action
• Meeting held with Pharmacy to understand the issues affecting E-Discharge compliance.
• Focus on wards using pink TTO’s, identification of wards with lower compliance and targeted training.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
!	Accident & Emergency - 4 Hour compliance	95%	73.7%	2618	Aug 22		95%	73.8%	Jul 22	95%	75.5%	F
	Number of Patients spending 12+ Hours in ED - Trust	0	996	N/A	Aug 22	H	0	932	Jul 22	0	4401	F
	% of Patients spending 12+ Hours in ED - Trust	2%	14.3%	N/A	Aug 22	H	2%	11.9%	Jul 22	2%	11.6%	F
	Ambulance Handovers - % within 15 Mins	65%	38.3%	693	Aug 22		65%	36.9%	Jul 22	65%	42%	F
	Ambulance Handovers - % within 30 Mins	95%	66.1%	381	Aug 22		95%	62.6%	Jul 22		69%	F
	Ambulance Handover Over 60 Mins	0	93	93	Aug 22		0	127	Jul 22	0	388	F
!	Diagnostic waits	1%	42.5%	2639	Aug 22	H	1%	44.9%	Jul 22	1%	44.4%	F
	Referral to treatment: on-going	92%	72%	4146	Aug 22	L	92%	72.9%	Jul 22	92%	73.8%	F
	52 Week Waits	68	200	200	Aug 22	H	80	222	Jul 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%	47.1%	9	Jun 22	L	80%	54.8%	May 22	80%	45.7%	F
	TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	60%	80%	2	Jul 22	H	60%	84.2%	Jun 22	60%	83.6%	?
	Outpatient Letters to GP's within 7 Days	85%	66.2%	3335	Jul 22		85%	71.8%	Jun 22	85%	68.7%	F
	E-Discharges within 24hrs	85%	72.8%	379	Jul 22		85%	71%	Jun 22		74.6%	F

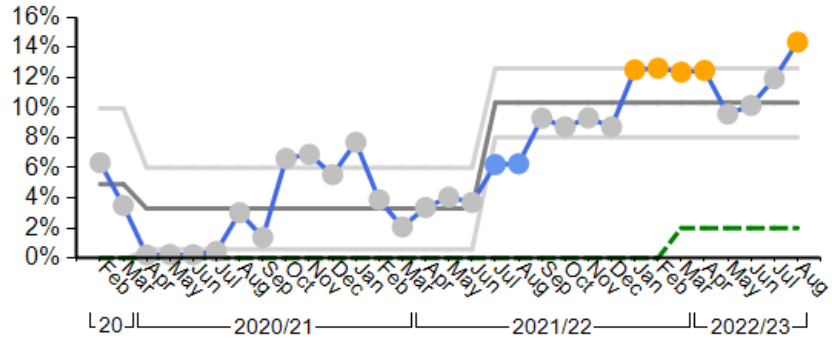
Accident & Emergency - 4 Hour compliance



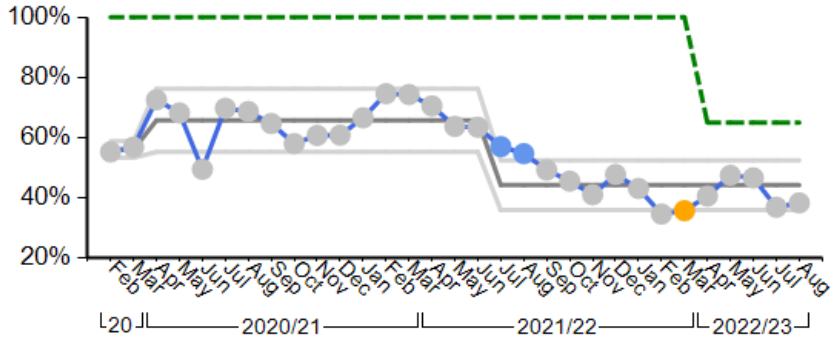
Number of Patients spending 12+ Hours in ED - Trust



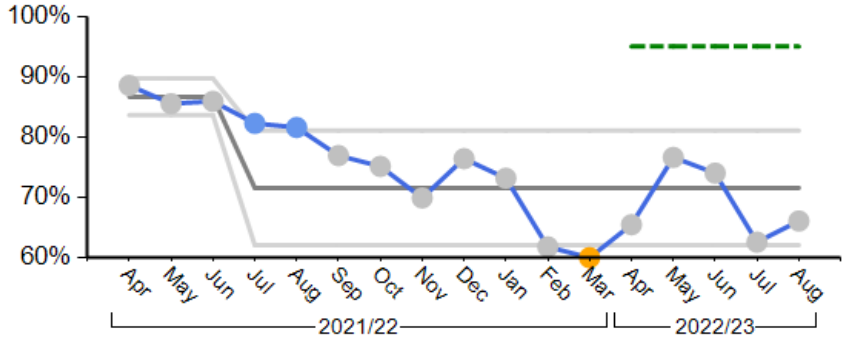
% of Patients spending 12+ Hours in ED - Trust



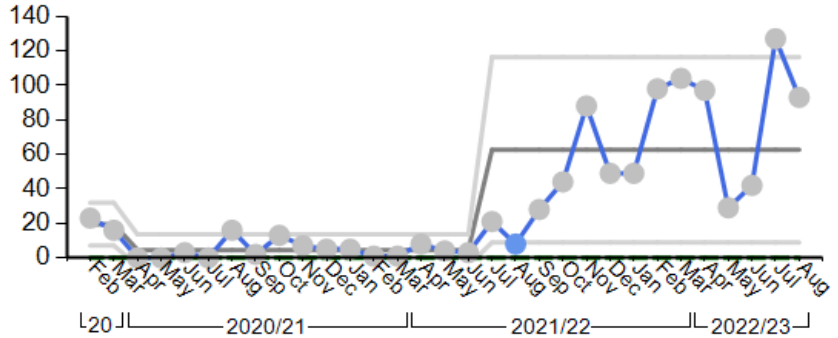
Ambulance Handovers - % within 15 Mins



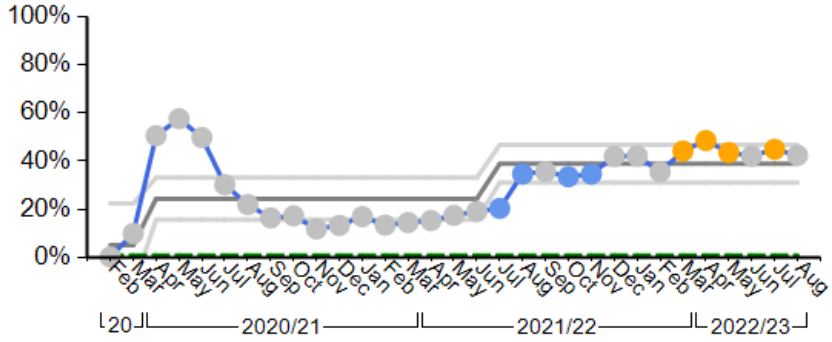
Ambulance Handovers - % within 30 Mins



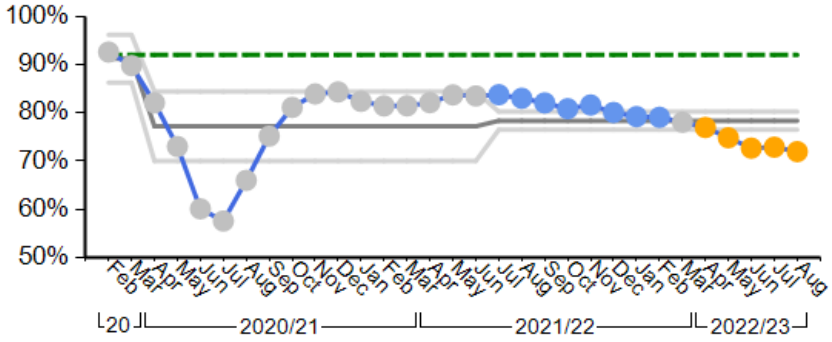
Ambulance Handover Over 60 Mins



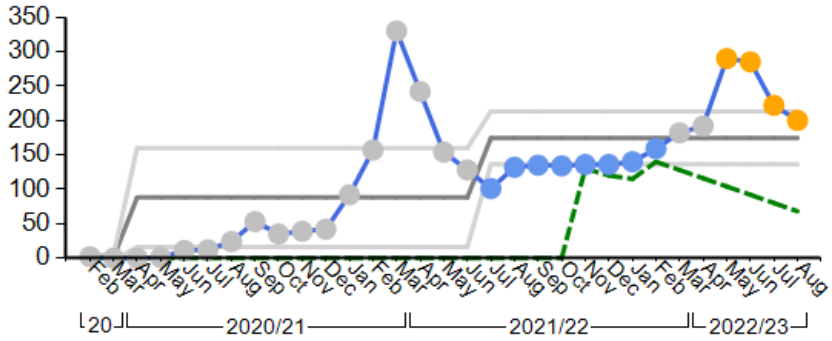
Diagnostic waits



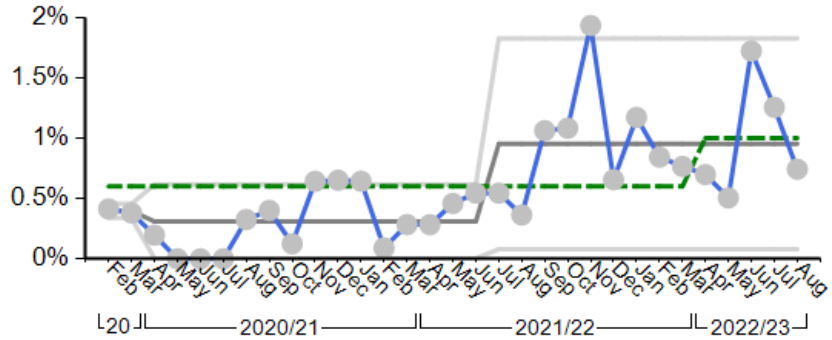
Referral to treatment: on-going



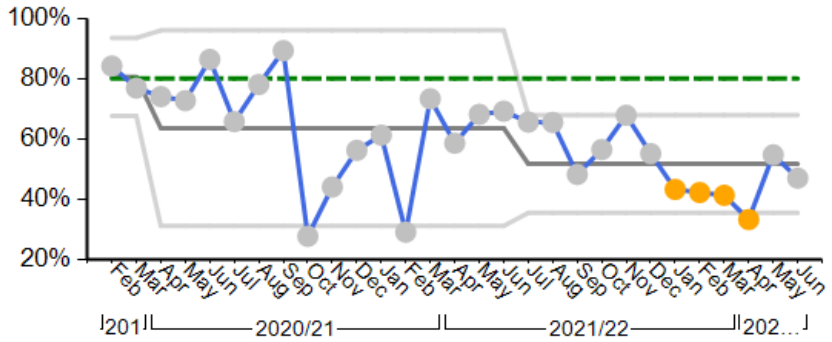
52 Week Waits



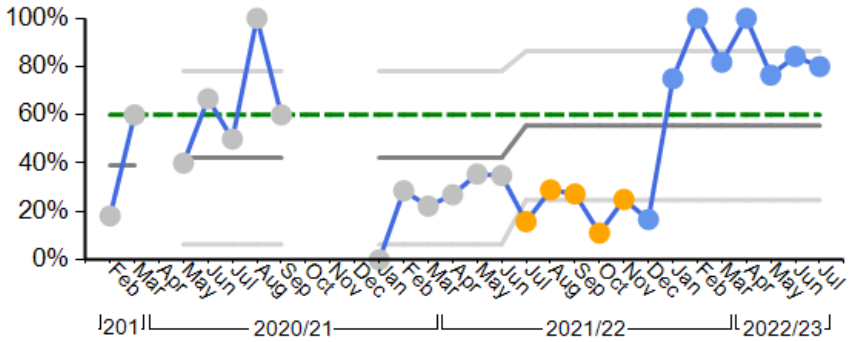
Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month



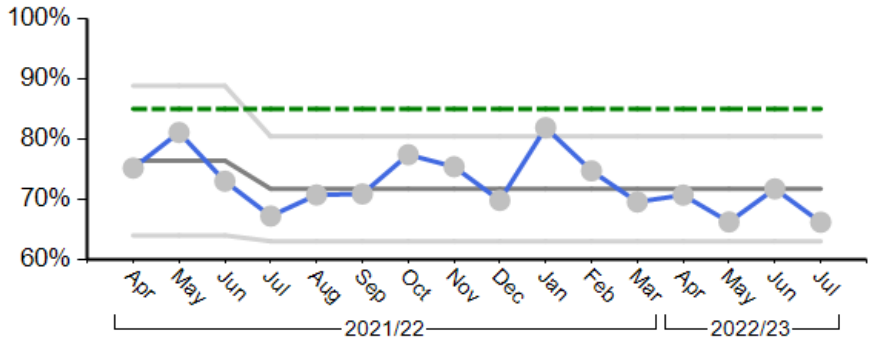
Stroke - 90% Stay on Stroke Ward



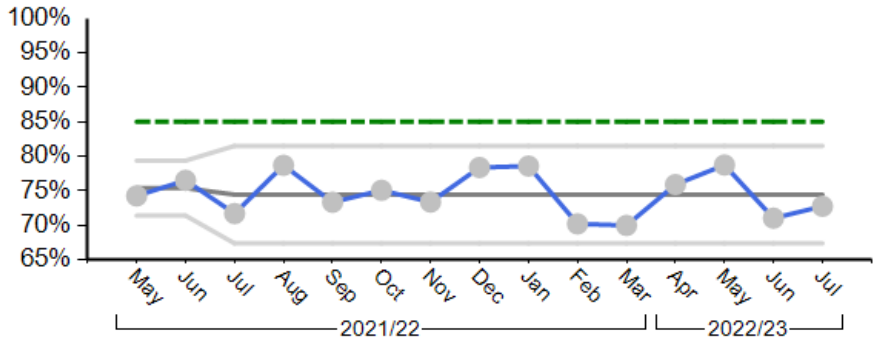
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care



Outpatient Letters to GP's within 7 Days



E-Discharges within 24hrs



Operations

Cancer

Issues

• The 28 Day Faster Diagnosis Standard is failing the assurance measure with performance remaining consistent with previous months. This standard is affected by the failure to achieve the 14-day referral to Outpatients standard which continues to be challenged, primarily due to a lack of capacity to accommodate the increase in referrals to the colorectal team following the introduction of high risk FIT. All tumour sites failed the two week wait target in July, reporting lack of capacity in rapid access clinics, with the exception of haematology.

• The 31-day target, although performing statistically as expected, has declined over the last two months and is at 92.5% in July against the 96% target. The England average was 92.9%, Northwest 94.3% and Cheshire & Mersey 95.7%. Dermatology is of most concern and is attributed to both capacity shortages in minor ops and a vacancy in the tracking team which led to a failure to escalate patients who were booked outside of time.

• The 62-day GP referral to treatment is failing the assurance measure but there has been some improvement in June and July, achieving 64.9% against the 85% target. Whilst the Trust is below the average for Cheshire & Mersey (68.3%), it is above the England average of 61.6% and Northwest (61.3%).

• All tumour sites had 62-day breaches reported in July, including 2 sites at 0% compliance (haematology and gynaecology) and 7.5 past day 104.

Management Action

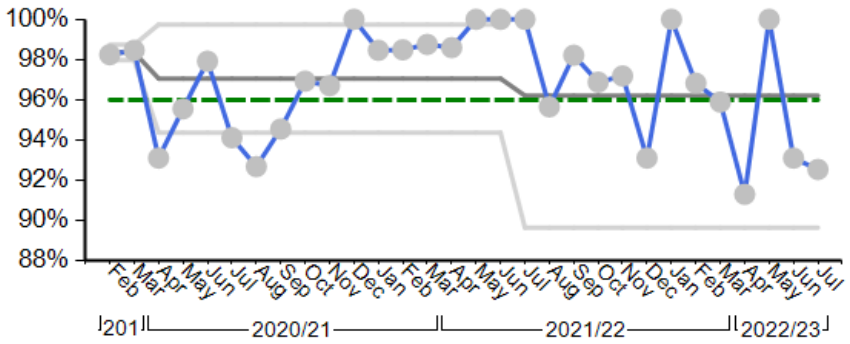
• Each tumour site has a cancer improvement plan with trajectories outlining when compliance will be achieved against the 28-day and the 62-day, and 104-day backlog reduced.

• Key workstreams relate to workforce, operations, communication and system working.

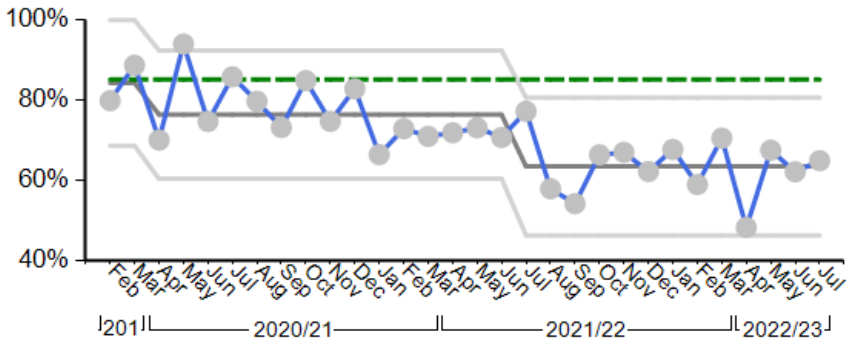
• Each improvement plan is presented on a rotational basis at a weekly cancer improvement meeting.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	31 day treatment	96%	92.5%	5	Jul 22		96%	93.1%	Jun 22	96%	94.8%	?
!	62 day GP referral to treatment	85%	64.9%	19.5	Jul 22		85%	62.1%	Jun 22	85%	61.5%	F
!	28 Day Faster Diagnosis Standard	75%	65.4%	371	Jul 22		75%	63%	Jun 22		65.1%	F

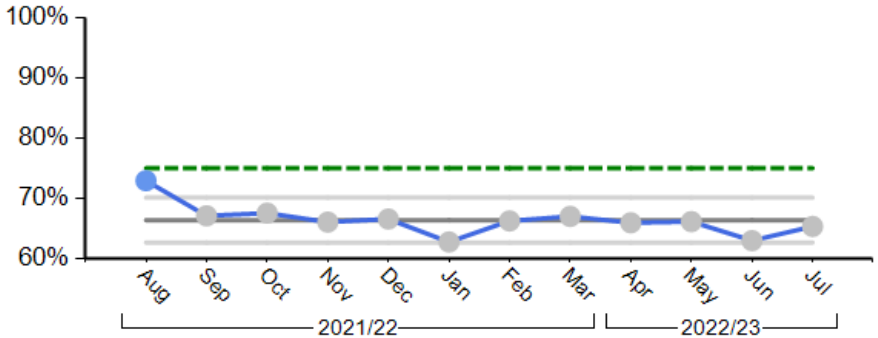
31 day treatment



62 day GP referral to treatment



28 Day Faster Diagnosis Standard



Operations

Productivity

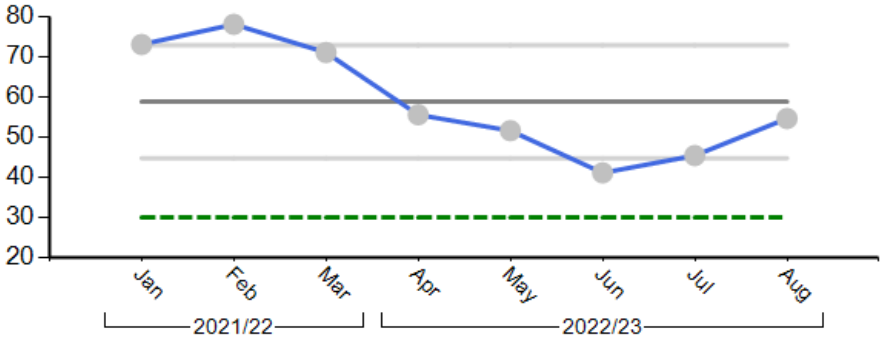
Stranded/Super Stranded Patients/Criteria to Reside

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.
• The number of Super-Stranded patients has increased in August to the highest level for more than 2 years and has breached the 3rd upper control limit.
• The number of 'No Criteria to Reside' patients has deteriorated in the last two 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 August.
• Increase in acuity of patients.
• Capacity of community services, care homes and local authority to support patients.
• Staffing challenges.

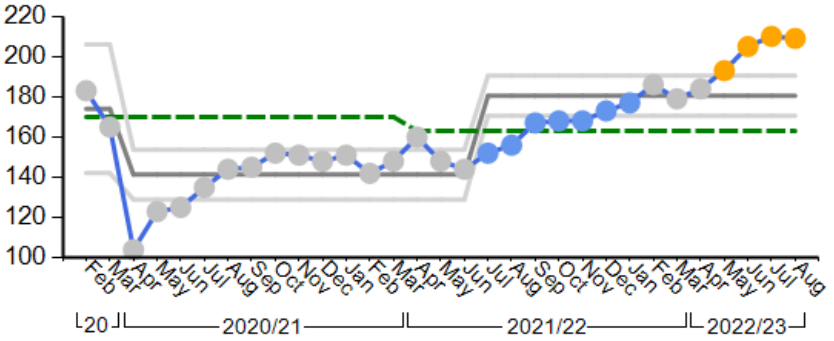
Management Action
• Focus on improvement of patients discharged by 5pm to ensure the trajectory is met, this resulted in a 6.9% improvement from May in patients being discharged after 5pm.
• Ensuring patients are discharged home before lunchtime to enable early transfer of patients waiting to be admitted in ED.
• Discharge Improvement Group in place.
• Implementation of ECIST recommendations, for example the inclusion of Criteria to Reside on all Board Rounds.

		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	55	54.6	Aug 22		30	45	Jul 22			
!	Stranded Patients (>6 Days LOS)	163	209	209	Aug 22	H	163	210	Jul 22	163	1001	F
!	Super Stranded Patients (>20 Days LOS)	53	84	84	Aug 22	H	53	80	Jul 22	53	374	F

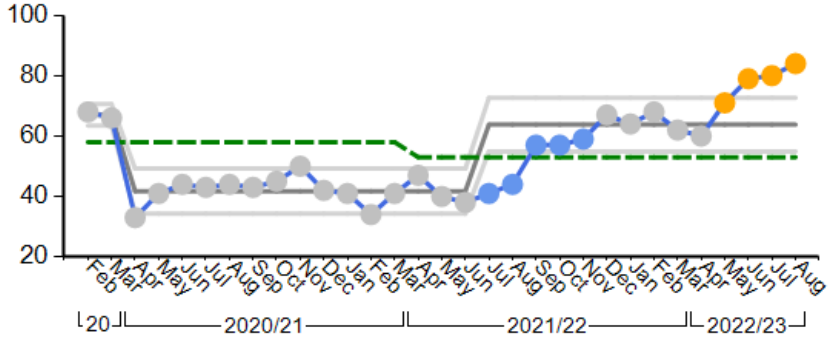
No Criteria to Reside - Avg No of Patients



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 although there has been a 2.9% increase in August.

Management Action
• See action plan included.

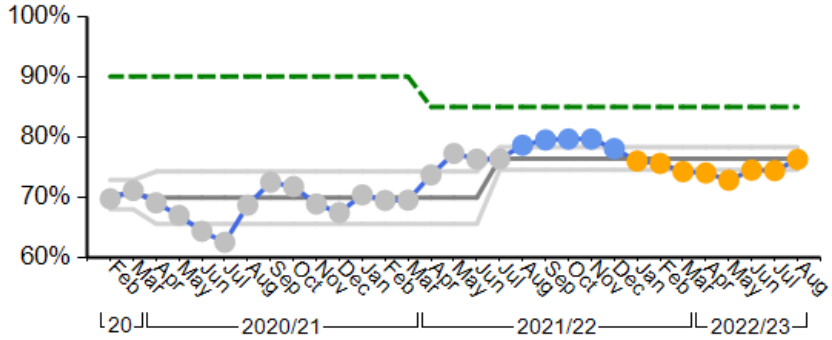
Mandatory Training

Issues
• The indicator is failing its assurance measure since the stretch target of 90% was implemented in June 2022.
• The Trust continues to see improvements in compliance and is 1.1% behind the stretch target in August.
• Conflict resolution remains an area of concern.

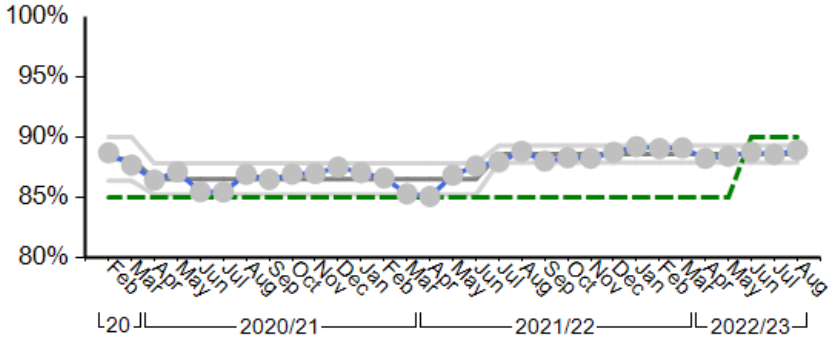
Management Action
• The Training Department is supporting the Health & Safety and Safeguarding Teams to implement a new training model underpinned by a full training needs analysis. The aim is to ensure that clinical staff only receive the relevant training to keep them and our patients safe.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
!	Personal Development Review	85%	76.3%	N/A	Aug 22	L	85%	74.4%	Jul 22	85%	74.4%	F
	Mandatory Training	90%	88.9%	N/A	Aug 22		90%	88.6%	Jul 22	90%	88.6%	F

Personal Development Review



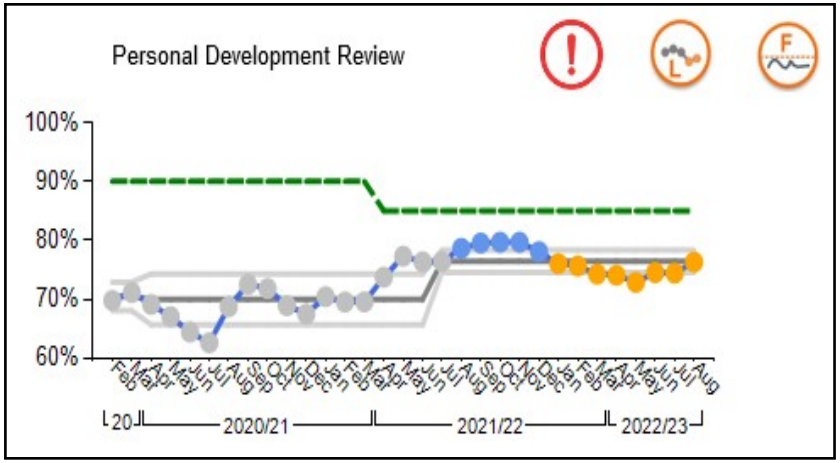
Mandatory Training



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%	76.3%	N/A	Aug 22	L	85%	74.4%	Jul 22	85%	74.4%	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: August has seen an increase in PDR completion compliance of 1.9%. Capital and Estates continue to improve, now sitting at 84.81%, an increase of 26.81% in last three months. Corporate compliance has dropped significantly by 9.89% and will require some additional activity this month to show a required improvement by next month. CBU compliance rates vary between 66.83% and 80.77%, showing improvements in MEC and PC but SS has further reduced by 4.69% and have reduced overall by 7.42% in the last two months.

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

Corporate PDR rate was increased after direct intervention by HRD

Escalation to SOLT for more senior direct intervention

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

Lists of outstanding PDRs are being provided to the Director of nursing who will require action by relevant managers to be compliant by 30th September. In areas where compliance remains low at that time, the relevant managers will be invited to a meeting at Director level to establish why the PDRs remain incomplete.

Mitigations: Following the December to May decreases and the increase in compliance in June, it is heartening to see an upward trajectory in August compliance rates.

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

Corporate teams remain best performing, in part due to the direct intervention by the HRD. 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 within expected levels and has decreased by 1.9% from July to August.
• This decrease is evident across all staff groups.
• Non-Covid sickness rates continues to fail its assurance measure but is showing special cause improvement with performance below target in August. Covid absences reduced by almost 20 over the month with covid absences ending the month at 16.84% of daily absences compared to 20.46% at the beginning of the month.

Management Action
• CBU and Departmental heads are provided with the data.
• During the whole of August more absences were closed than were commenced each week with 89 long term absences closed in month.
• Main reasons for absence continue to be gastro, cold / cough / flu and stress / anxiety / depression.
• Areas of specific concern are A&E and Spinal Injuries Unit, mostly these absences are short term in nature.
• HR has been working closely with managers to actively close absences and to supportively return colleagues to work, focussing on HCA absences as a hot spot group. Most typical absence type are MSK, cough / cold / flu and gastro issues.
• MSK hot spot areas have been flagged to H&S who have proactively visited them to ensure that good manual handling techniques are being used and providing training as required.

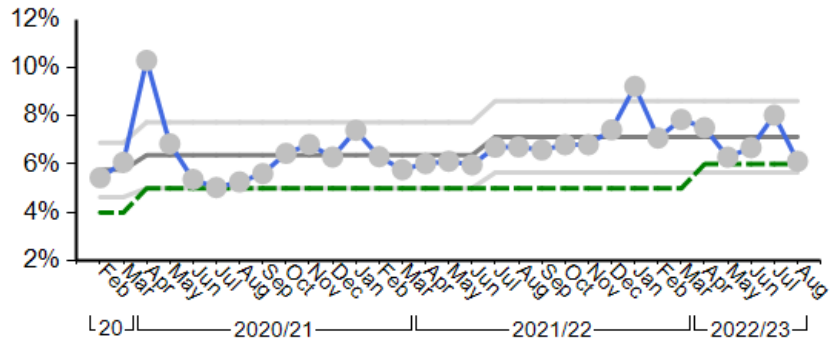
Vacancies

Issues
• The Trust overall vacancy rate continues to fail its assurance measure but has reduced by 0.8% in August.

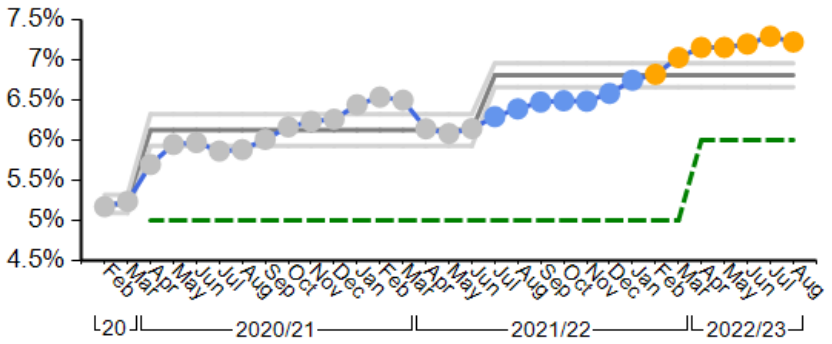
Management Action
• The Trust continues with a strong number of posts under offer so further improvements in the overall vacancy rate will continue.
• The Trust has 35 medical posts under offer which will help to improve the medical vacancy rate further and have an impact on our spend on contingent labour.
• HR are also working with the operational teams to ensure that the medical establishment is correct and we are recruiting to all our vacancies.
• Nursing continues to provide challenges; however the majority of vacancies are for HCAs and there are currently 41 posts under offer with further recruitment events planned for September and October, therefore we will move into winter in a far stronger position.
• The Trust has 26 AHP posts under offer, and a further 15 active pieces of recruitment activity which provides some assurance that recruitment is ongoing to support and fill our AHP vacancies.
• The Trust has also received our first radiographer through the regional recruitment, have received National funding to support some overseas recruitment of further Radiographers and OT's. It is anticipated that National funding may become available for further staff groups during the year, but there are issues around HCPC registration and equivalence of courses which must be resolved first.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Sickness Rate	6%	6.1%	N/A	Aug 22		6%	8%	Jul 22	6%	6.9%	
	Sickness Rate (Rolling 12 Month)	6%	7.2%	N/A	Aug 22	H	6%	7.3%	Jul 22	6%	7.2%	F
	Sickness Rate (not related to Covid 19) - Trust	5%	4.9%	N/A	Aug 22	L	5%	5.4%	Jul 22	5%	5.3%	F
	Trust Vacancy Rate – All Staff	7.4%	9.7%	N/A	Aug 22		7.4%	10.5%	Jul 22	7.4%	10%	F
	Staff Turnover	0.83%	1.2%	N/A	Aug 22		0.8%	1.4%	Jul 22	9%	6.8%	

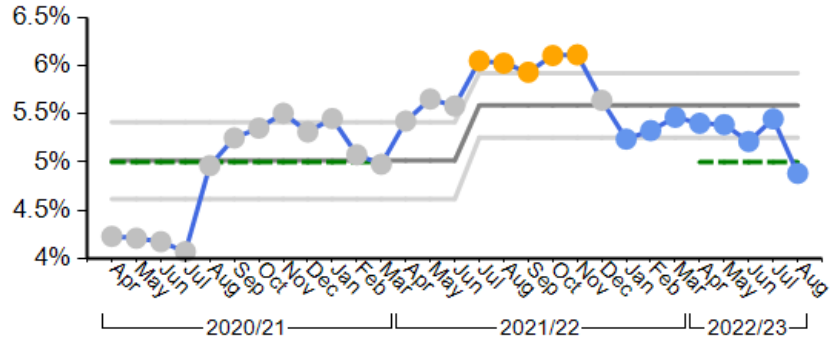
Sickness Rate



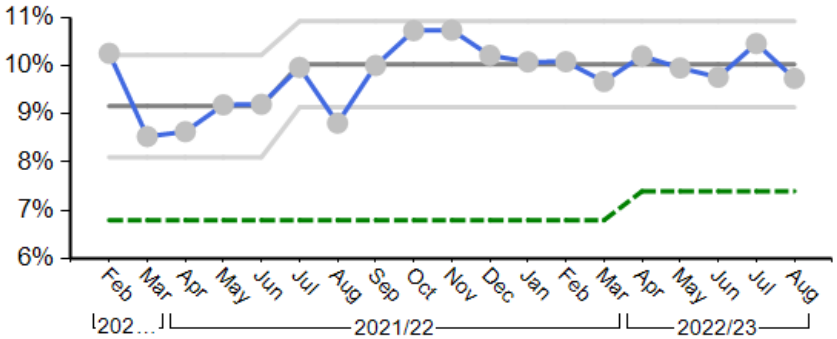
Sickness Rate (Rolling 12 Month)



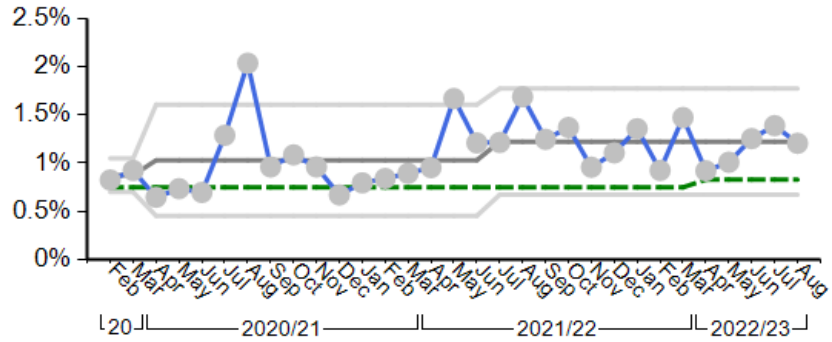
Sickness Rate (not related to Covid 19) - Trust



Trust Vacancy Rate – All Staff



Staff Turnover



Finance

Finance

The Trust is reporting a £8.0m deficit at Month 5 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 M5 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, or inflationary pressures.

CIP - The Trust is reporting delivery of CIP to M5 – 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 August was £6.1m. A reduction of £2.7m from July's position as anticipated by plan. Regional cash support will be required from October (£2m in October and a total requirement of £7m) as the Trust is operating with a planned £14.2m deficit in 2022/23. Discussions are ongoing with the ICS to secure cash support – including contract payments to be made on 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.

BPPC – Overall 95% target has now been achieved.

Debt over 90 days – This has increased by £107k since July with the main aspect relating to high value NHS invoices for Healthcare at Home drug recharges. An action plan on the top 10 debt over 90 days will be going to next month's Audit Committee.

Capital - There are no changes to the plan which stands at £15.8m and actual performance is slightly above the year-to-date budget.

	Latest				Forecast			Year to Date	
Indicator	**Plan**	**Actual**	**Period**		**Plan**	**Actual**		**Plan**	**Actual**
I&E surplus or deficit/total revenue	7.5%	7.5%	Aug 22		6.0%	6.0%		8.3%	8.3%
Capital Spend	£700K	£800K	Aug 22		£15,800K	£15,800K		£4,400K	£4,700K
Cash Balance	£7,000K	£6100K	Aug 22						

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	QUALITY & SAFETY COMMITTEE (QSC)
MEETING DATE:	26 September 2022
LEAD:	Gill Brown

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Alert Updates:

- Risk to the ward refurbishment programme and environment of ward 9A – Executive Committee reviewing options appraisal.
- Disruption to phone lines – funding secured for network upgrade. Current timescale for implementation under review.
- Delays in training to utilise automated blood fridge at ODGH have been resolved. Staff trained with date to go live.
- Increase in CDI – all cases reviewed – recurrent courses of antibiotic therapies for presumed infections in older population with multiple comorbidities noted.
- COVID inpatient activity – continues to fluctuate with gradual increase across C&M.

September Alerts:

- Increasing incidents of Violence and Aggression towards staff from patients and relatives – multifactorial action plan needed.
- Delays in AfC panel approval impacting on clinical effectiveness and quality – Escalation through Executive Committee.
- Essential Skills Training – Executive Committee to review compliancy and how this can be improved with specific reference to maintaining resuscitation training updates.
- SOCAAS | Ward Dashboard – safety culture / red flags - improvement regarding areas of non-compliance.

ADVISE

- **Learning from Deaths Q1 report**
  - One potentially avoidable death
  - Themes:
  - Nutrition & Hydration
  - Recognition of End of Life
  - Transcutaneous pacing

- **Patient Safety Report**
  - Progress noted in management of incidents and completion of actions

- **Core Mandatory and Essential Skills training Report**
  - Overall good compliance with mandatory training, subsets of poor compliance within essential skills training – see Alert

- **Quality Priorities Progress Report**
  - Progress noted. Complexity of AKI and hydration and nutrition programme noted. AKI team to bring update on actions pertaining to hospital acquired AKI to QSC in October

- **SOCAAS and ward dashboard**
  - Improvements noted overall with further review of assessment methodology.
  - Poor performance in 'safety culture' noted in some areas- included in Alerts for further review

ASSURE

- IPR reviewed
- Board Assurance Framework – Strategic Objective 1 reviewed

• AAA reports received from:
  o Clinical Effectiveness Committee.
  o Infection Prevention & Control Assurance Group.
  o Patient Experience & Community Engagement Group.
  o Safeguarding Assurance Group.
  o Patient Safety Group.
 	
• The following Annual Reports were received:
  o Resuscitation Annual Report 2021/22.
  o Research, Development & Innovation Annual Report 2021/22.	

New Risk identified at the meeting	• No new risks were identified at the meeting.
Review of the Risk Register (Detail the risks on the committee's risk register that were reviewed in the meeting, including scores C&L and current actions)	

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY & OPERATIONS COMMITTEE (SOC)**	**Date**	**05 October 2022**
Agenda Item	**SO180/22**	**FOI Exempt**	**NO**
Report Title	**LEARNING FROM DEATHS REPORT – Q1 (2022/23)**		
Executive Lead	Kate Clark, Medical Director		
Lead Officer	Chris Goddard, Associate Medical Director for Patient Safety		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To provide assurance.

Executive Summary

The report includes:

- Key and national mortality indicators.
- Overall statistical mortality position remains favourable.
- Avoidable Deaths and Lessons Learnt.
- Structured Judgement Reviews and Thematic Analysis.

Recommendations

The Strategy & Operations Committee is asked to receive the Learning from Deaths Quarter 1 Report.

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Chris Goddard, Associate Medical Director for Patient Safety	Kate Clark, Medical Director

Southport and Ormskirk Hospital
NHS Trust

Learning From Deaths

Quarter 1 2022-23

Southport and Ormskirk Hospital
NHS Trust

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Key national and local mortality indicators

	2021/22										2022/23		Target
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
Rolling 12 Month HSMR	72.7	73.5	75.2	77.1	74.4	73.3	73.2	72.2					100.0
Monthly HSMR	63.9	78.1	90.9	77.9	54.3	66.5	77.4	76.3					100.0
SHMI	99.4	100.3	99.9	100.9	100.9	100.1	99.6	99.7					100.0
Local HSMR Bronchitis	9.8	10.4	18.9	29.3	30.2	20.3	18.6	28.0					100.0
Local HSMR LRTI	23.8	24.0	32.0	90.6	77.0	76.1	52.9	46.3					100.0
Local HSMR Pneumonia	75.2	78.2	80.7	82.0	78.1	74.6	71.4	71.1					100.0
Local HSMR Septicemia	76.8	75.9	76.0	78.9	79.8	78.2	79.7	78.2					100.0
Local HSMR Stroke	90.5	88.0	90.8	86.3	79.1	81.4	78.4	76.1					100.0
Local HSMR UTI	80.7	89.8	88.8	89.4	77.3	66.0	64.9	71.5					100.0
Local HSMR Acute Renal Failure	79.2	75.2	80.3	81.1	84.6	87.0	79.9	81.6					100.0
Local HSMR FNOF	41.5	46.1	47.9	50.4	54.0	55.9	51.0	60.7					100.0
Mortality Screens - %	12.00%	13.33%	14.29%	95.95%	92.31%	92.65%	97.62%	97.33%	95.56%	97.33%	97.47%	98.44%	90.00%
SJRs	1.0			3.0	1.0	3.0		7.0	3.0		5.0		0.0
2nd Review	3.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
In Hospital Deaths	50.0	75.0	77.0	74.0	52.0	68.0	84.0	75.0	90.0	75.0	79.0	64.0	77.0
In Hospital Deaths Crude Rate	18.0	26.4	21.0	24.8	18.5	22.2	31.7	30.2	35.1	28.4	30.4	19.0	31.0
LD Deaths	0.0	0.0	1.0	2.0	0.0	1.0	0.0	0.0	2.0	0.0	0.0	0.0	1.0
Sickness Absence Medics	1.22%	1.36%	1.65%	1.91%	3.15%	1.93%	2.89%	4.84%	4.42%	4.25%	3.03%	2.07%	1.00%

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

- Overall statistical mortality position remains favourable.
- Crude death rate continues to exhibit variation.
- Process measures of mortality governance are improved over historical positions.

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Avoidable deaths Quarter 1 2022-23*

There were no deaths identified in quarter one that were definitely avoidable.

One death was identified where avoidability cannot be fully determined, although there are areas for learning:

- A patient was admitted to hospital with a fall and a new spinal fracture. This fracture did not require surgery. There is evidence that the patient vomited and potentially aspirated in the emergency department.
- The patient developed aspiration pneumonitis a few days subsequently and died from this. Escalation was inappropriate due to her underlying health.
- The investigation identified discrepancies regarding whether the patient was fed or not and in what position.

*Given the timescale for an investigation to be completed this period relates to the time the reviews were completed, not the period when the death occurred.

Avoidable deaths Quarter 1 2022-23

Learning:

Three main strands are identified:

- Documentation of events, such as the provision of meals, needs to occur so its clear what has happened.
- Communication of significant information about care such as being NBM or needing log rolling, needs to be easily seen and understood by all staff, particularly in busy environments.
- We look after many frail and elderly patients; falls can be a due to many reasons, its important to actively look for acute medical conditions that may have contributed or indeed be caused by the fall.

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SJR Quarter 1 2022-23

7 SJRs were completed in Q4

Avoidability of death rating as follows:

Definitely not avoidable: 6
Slight Evidence of avoidability: 1

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

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Quarter 1 Thematic Analysis.
Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

Nutrition and Hydration

- Swallowing is frequently impaired in the frail elderly population, this can manifest as poor nutritional intake or aspiration events. Both are potentially devastating. Nasogastric feeding can be useful, but is not appropriate in every case.

- Consideration should be taken of the views of the patient and family and documented. The sooner these issues are noted and talked about, the sooner appropriate interventions or appropriate decisions not to intervene can be taken.

- Much (but not all) acute kidney injury can be caused or exacerbated by dehydration. Patients with AKI should be assessed for fluid administration, most will need some supplementation.

- Remember continuation of critical medicines may require the insertion of a NG tube or consideration of a change or route – discuss with pharmacy.

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NHS Trust

Quarter 1 Thematic Analysis.
Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

End of life Care

- Good communication is paramount. The most important point is to recognise – and communicate – that a patient is 'sick enough to die'.

- This allows a conversation with the patient, and possibly the family, about what is important to them. This doesn't mean that active treatment has to stop – this can continue, provided it is wanted and has an appropriate chance of success. What this does allow is to plan for what happens if it doesn't work.

- As doctors, we don't like to consider that our treatments may fail – but they frequently do, and its right that patients understand this.

- Not explaining this 'uncertain recovery' leads to confusion in families, mixed messages and complaints.

- Remember to consider the appropriateness of investigations that are unlikely to change the outcome or the management at the end of life – these can cause unnecessary distress.

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NHS Trust

Quarter 1 Thematic Analysis.
Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

Cardiac Arrest

- We have seen a number of cases of CPR being started when patients have a valid DNACPR. Communication of resuscitation and escalation status is very important. The forthcoming Treatment Escalation Proforma is designed to assist in communicating this.

- Treatment of brady-arthymias with transcutaneous pacing has been delayed or poorly implemented in a couple of cases. The defibrillators in the trust have recently changed – check you are trained on these – contact the resus department to arrange an update. All members of the cardiac arrest team should have an up-to-date ALS certificate. Courses are available through the resus department.

- Echocardiography (if trained) is useful in cardiac arrest for potential tamponade or PE.

- In cardiac arrest with a known or highly suspected ACS as the cause thrombolysis can be considered as transfer for PPCI is impossible unless ROSC occurs.

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Quarter 1 Thematic Analysis.
Sources: Medical Examiner Database, Bereavement Database, Structured Judgement Review, Serious Incident Investigation

Communication

- There were multiple examples of good documentation of family discussions and clinical rationales. There were good examples of managing family conflict with time and consistency of message.

- The Dementia and Delerium team were frequently useful for aiding communication with families around cognitive decline.

- Families frequently reported that the quality of updates on the progress of their relatives was high, they often felt fully informed.

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Workforce Committee
MEETING DATE:	27 September 2022
LEAD:	Lisa Knight

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Essential skills training – whilst overall average is on target, concern with compliance for specific courses such as resus.
- WRES / WDES – increase in percentage of staff experiencing bullying and harassment, prompted increase focus on civility and respect training, and creating safe conversations with Board members to get underneath this.
- PDR – Slow improvement towards greater assurance that >85% of staff had a performance and development conversation in last 12 months.
- Guardian of Safe Working post remains unfilled.

ADVISE

- High turnover of Healthcare Assistants in first 12 months of employment – bespoke induction and cohort recruitment and support being introduced.
- Level of bank nursing spend attributed to complex needs of patients – alternative resourcing solutions being explored.
- Policy Development Framework – work plan developed to address number of out-of-date policies and improve management of this in partnership with staff side going forward.
- Amount of money being lost from apprenticeship levy – shift in emphasis from using levy to support development and more towards growing our own. Recruitment of new Apprenticeship and Work Experience Lead underway.

ASSURE

- Library and Knowledge Services Strategy – service demonstrating positive impact on clinical and non-clinical outcomes against other comparators and strategy aligned to other Trust strategies such as health and wellbeing, quality improvement and cost improvement
- Reduction in nurse agency spend.
- Significant recruitment activity impacting positively on staffing levels.

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**	**05 October 2022**
Agenda Item	**SO182/22**	**FOI Exempt**	**NO**
Report Title	**WORKFORCE RACE EQUALITY STANDARD REPORT (WRES)**		
Executive Lead	Jane Royds, Director of Human Resources and OD		
Lead Officer	Sonya Clarkson, Deputy Director of Human Resources and OD		
Action Required	✓ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

This report provides an overview and analysis of the Workforce Race Equality Standard (WRES)

Executive Summary

The following is an overview of the WRES Highlights for 2021/22:

Workforce data metrics:

- An **increase** in BME staff in non–clinical bands 2,3,4 & 5.
- An **increase** in BME staff in clinical bands 3,5 & 6.
- An **increase** of **5.09%** in BME staff being appointed from shortlisting across all posts to **22.00%**.
- **0** BME member of staff entered the formal disciplinary process (lower than last year) compared to **3** white staff entered the formal disciplinary.

Staff survey data:

- A **6.1% increase** in BME staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months.
- A **0.2% increase** in BME staff experiencing harassment, bullying or abuse from staff in last 12 months.
- An **1.8% increase** in BME staff experiencing discrimination at work from any of the following manager/team leader or other colleagues.
- A **3.9% increase** in BME staff believing that Trust provides equal opportunities for career progression or promotion.

The activities to address the gaps between the experience of BME staff have been aligned to an overarching 'EDI / Sense of Belonging' Plan which forms one of the pillars of the Trust's 'Our People Plan'.

Our actions will be informed by our Staff Networks and monitored by the Trust's Valuing our People & Inclusion Group, JNC and Workforce Committee and reported to the NHS Cheshire and Merseyside ICB.

Recommendations

The Strategy and Operations Committee is asked to receive the report and to approve the action 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:**
Barrie Morgan-Scrutton, Interim Diversity and Inclusion Lead	Sonya Clarkson, Deputy Director of Human Resources and OD

Workforce Race Equality Standard Report April 2021 – March 2022

1. Executive Summary

This purpose of this report is to inform and provide the Workforce Committee with an update relating to the Workforce Race Equality Standard (WRES) results and actions. Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS provider organisations.

2. Introduction

NHS England and the NHS Equality and Diversity Council introduced the Workforce Race Equality Standard (WRES) in 2015. Since then, NHS organisations have been compelled to review their workforce race equality performance and develop action plans to make continuous improvement on the challenges within this agenda.

The WRES is made up of nine indicators: the first four measure staff experience over a 12-month period for harassment, bullying, or abuse from patients, relatives, or the public. Another four measure workforce data, in relation to fellow colleagues, managers or team leaders and progression opportunities. Indicator nine considers BME representation on executive boards, in relation to the workforce.

The main purpose of the WRES is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff,
- to improve BME representation at the Board level of the organisation.

The data presented refers to the period April 2021 to March 2022 with the staff survey results from November 2021.

2.1 Key data

Staff Profile

As of March 2022, Southport and Ormskirk Hospitals NHS Trust employed 3304 staff which consisted of:

- 9.11% - Black Minority and Ethnic groups
- 72.09% - White staff
- 18.80% - Not stated / unspecified / prefer not to answer

NHS Staff Survey 2021

The NHS Staff Survey was completed by **1,335** staff, this is a response rate of **42%**, the average combined percentage for combined acute and community trusts in England is 46%

3. WRES Highlights 2021-2022

The information below provides a comparison for the WRES reports for 2021-22 and 2020-21. The information provides the Trust figures compared to the average for combined acute and community hospitals. All figures are self-populated taken from the WRES template provided by NHS England.

BME staff increase in clinical and non–clinical bands:

The 2021-22 WRES report highlights:

- Non-clinical roles have seen an increase in bands 2,3,4 and 5
- Clinical roles have seen an increase in bands 3,5 and 6

Relative likelihood of BME and white staff being appointed from shortlisting across all posts:

- 1557 BME staff were shortlisted and 70 were appointed
- 2433 white applicants were shortlisted and 542 appointed

WRES data highlights that there has been a 5.09% increase in BME staff being successful at interview and being hired by the Trust.

- 22.00% in 2021-22
- 16.91% in 2020-21

Relative likelihood of BME and white staff entering the formal disciplinary process

- The number of BME staff entering the disciplinary process in 2021-22 is **0** this is equal to 20/2021.
- 1.3 white staff entered the formal disciplinary process in 2021-22
- 1 record for ethnicity unknown for 2021-22.

4. NHS staff survey responses that are specific to WRES questions

The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

- +6.1% increase for BME staff
- +3.7% increase for white staff

The Trust figures compared to the average combined acute and community Trusts is **-0.4%** lower for white staff and **equal** for BME staff.

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

- +0.2% increase for BME staff
- -0.9% decrease for white staff

The Trust figures compared to the average combined acute and community Trusts is **-0.6%** lower for white staff and **-2.6%** lower for BME staff.

Percentage of Trust staff believing that the Trust provides equal opportunities for career progression or promotion

- +1.1% increase for BME staff
- +0.9% increase white staff

The Trust figures compared to the average combined acute and community Trusts is **-7.7%** lower for white staff and **+3.9%** higher for BME staff.

In the last 12 months have you personally experienced discrimination at work from any of the following manager/team leader or other colleagues?

- +10.96% increase for BME staff
- +1.3% increase for white staff

The Trust figures compared to the average combined acute and community Trusts is **-0.5%** lower for white staff and **+8.1%** higher for BME staff.

5. Workforce Staff Data: Clinical & Non-Clinical Workforce

1/ Non-Clinical
Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:

• Non-Clinical staff
• Clinical staff – of which
- Non-Medical staff
- Medical and Dental staff

Note: Definitions are based on Electronic Staff Record occupation codes with the exception of Medical and Dental staff, which are based upon grade codes.

PLEASE NOTE WERE THE % RATE DOES NOT EQUATE TO 100% THIS IS DUE TO INFORMATION- NOT STATED

Non – Clinical

	2021-2022		2020-21	
Band	**BME**	**White**	**BME**	**White**
Band 2	5.64%	79.90%	5.06%	85.57%
Band 3	2.79%	82.12%	2.73%	91.26%
Band 4	1.19%	88.69%	1.18%	91.13%
Band 5	1.54%	84.62%	0%	94.20%
Band 6	0.00%	82.26%	1.78%	89.29%
Band 7	0.00%	86.00%	4.17%	89.58%
Band 8a	0.00%	54.55%	0%	85.71%
Band 8b	0.00%	92.59%	0%	100%
Band 8c	0.00%	50.00%	0%	75%
Band 8d	0.00%	62.50%	12.50%	75%
Band 9	50.00%	50.00%	0%	0%
VSM	0.00%	60.00%	0%	100%

Clinical

	2021-2022		2020-21	
Band	**BME**	**White**	**BME**	**White**
Band 2	6.32%	72.63%	7.24%	78.90%
Band 3	2.87%	85.17%	1.91%	77.01%
Band 4	6.10%	74.39%	8.40%	76.33%
Band 5	13.45%	56.80%	6.78%	82.85%
Band 6	6.29%	82.47%	5.53%	88.37%
Band 7	2.33%	85.21%	3.40%	89.36%
Band 8a	10.53%	69.74%	10.77%	84.62%
Band 8b	0.00%	81.82%	0.00%	95.83%
Band 8c	0.00%	85.71%	0.00%	75%
Band 8d	0.00%	100.00%	0.00%	50%
VSM	0%	100%	0%	0%
WHO3	0%	100%	0%	100%
WHO7	0.00%	66.67%	16.67%	83.33%

Medical & Dental Consultants			
2021-22		**2020-21**	
BME 42.24%	**White** 34.48%	**BME** 45.37%	**White** 40.74%
Medical & Dental Non –Consultant Career Grades			
2021-22		**2020-21**	
BME 49.45%	**White** 20.88%	**BME** 50.53%	**White** 29.47%
Medical & Dental Trainee Grades			
2021-22		**2020-21**	
BME 27.94%	**White** 50.00%	**BME** 26.87%	**White** 59.70%
Board			
2021-22		**2020-21**	
BME 0.056%	**White** 94.44%	**BME** 14.29%	**White** 85.71%

Relative likelihood of white staff being **appointed from shortlisting** compared to BME staff is.

2021-2022	**2020-21**	**Difference**
times more likely 2.2 Auto calculated	times more likely 1.38 Auto calculated	**+0.82**

2021-22	**Headcount**		**Relative likelihood of white staff appointment from shortlisting**
	Shortlisted	Hired	Hired%
BME	1557	158	10.00%
White	2433	542	22.00%
Unknown	86	39	45.00%
2020-21	**Headcount**		**Relative likelihood of appointment from shortlisting**
	Shortlisted	Hired	Hired- %
BME	343	58	16.91%
White	1731	405	23.40%
Unknown	65	30	46.15%

Relative likelihood of BME staff entering **formal disciplinary process** compared to white staff

2021-2022	2020-21	Difference
times more likely 0.01 Auto calculated	times more likely 2.04 Auto calculated	+2.03

2021-22	Head Count	Relative likelihood of BME staff entering into formal disciplinary process compared to white staff
BME	0	0.00%
White	3	0.00%
Not Stated	1	0.00%
Total	**4**	
2020-21	**Head Count**	**Relative likelihood of BME staff entering formal disciplinary process compared to white staff**
BME	1	0.19%
White	5	0.38%
Not Stated	0	0.00%
Total	**6**	

Relative likelihood of white staff accessing **non-mandatory training & CPD** compared to BME staff is

2021-22	2020-21	Difference
White staff 0.98 times more likely Auto calculated	White staff 0.95 times more likely Auto calculated	+0.03

2021-22	Head Count	Enrolment Head Count	Ratio
BME	301	290	96.00%
White	2376	2229	94.00%
Not Stated / Not Given	607	580	96.00%
2020-21	**Head Count**	**Enrolment Head Count**	**Ratio**
BME	260	219	84.23%
White	2649	2110	79.65%
Not Stated / Not Given	322	252	78.26%

6. NHS Staff Survey 2021

The 2021 NHS Staff Survey was completed by **1,335** staff, this is a response rate of **42%**, the average combined percentage for combined acute and community trusts in England is **46%.**

For each of these four staff survey indicators, the standard compares the metrics for each survey question response for white and BME staff.

Figures in bold highlight BME figures

NHS staff survey responses that are specific to WRES questions:

Indicator 5:

The percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months

- BME staff have seen a **6.1% increase**
- White staff have seen a 3.7% increase

The Trust figures compared to the average combined acute and community Trusts is **0.4%** lower for white staff and **Equal** for BME staff.

Data for reporting year 2021	**Data for previous year 2020**	**2021 Average (median)** for
BME staff **28.8**% White staff 26.1%	BME staff **22.7**% White staff 22.4%	Combined Acute and Community Trusts BME staff - **28.8%** White staff - 26.5% **SOHT– Equal below average for BME staff**

Indicator 6:

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

- White staff have seen a 0.9% reduction
- BME staff have seen a **0.2% increase**

The Trust figures compared to the average combined acute and community Trusts is +0.7% higher for white staff and **1.8% higher** for BME staff.

Data for reporting year 2021	**Data for previous year 2020**	**2021 Average (median)** for

BME staff **31.9%** White staff 24.2%	BME staff **30.9%** White staff 25.1%	Combined Acute and Community Trusts BME staff- **28.5%** White staff– 23.6% **SOHT– 0.9% above average for BME staff**

Indicator 7:

Percentage of Trust staff believing that Trust provides equal opportunities for career progression or promotion

- BME staff have seen a **1.1% increase**
- White staff have seen 0.9% increase

The Trust figures compared to the average combined acute and community Trusts is -7.7% lower for white staff and **+3.9% higher** for BME staff.

Data for reporting year 2021	**Data for previous year 2020**	**2020 Average (median)** for
BME staff **48.5%** White staff 50.9 %	BME staff **71.9%** *1 BME staff **47.4%** *2 White staff 84.0 %*1 White staff 50.0 %*2	Combined Acute and Community BME staff **72.5% *1** BME staff **44.6%*2** White staff 87.7% *1 White staff 58.6% *2 **SOHT +1.1 Higher average for BME staff**

*1 = Data from 2021 Staff Survey result March 2022

*2 = The data has been calculated differently this year from previous years. In previous years, the percentage was reported was those saying 'yes' as a proportion of all staff excluding those who said 'don't know'. This approach has been applied to the historical data in the 2021 reports, which explains the difference you can see.

Indicator 8:

In the last 12 months have you personally experienced discrimination at work from any of the following manager/team leader or other colleagues?

- BME staff have seen a **11.00% increase**
- White staff have seen 1.3% increase

The Trust figures compared to the average combined acute and community Trusts is 0.5% lower for white staff and +**8.1 higher** for BME staff.

Data for reporting year 2021	**Data for previous year 2020**	**2020 Average (median)** for

BME staff **25.4%** White staff 6.2 %	BME staff **14.4%** White staff 4.9 %	Combined Acute and Community Trusts BME staff - **17.3%** White staff– 6.7% **SOHT +8.1 higher average for BME staff**

Indicator 9:

Percentage difference between the organisations' Board membership and its overall workforce disaggregated:

- By voting membership of the Board
- By executive membership of the Board

The information below provides information on the headcount and percentage difference between the organisations board membership and its overall workforce for BME and white Staff

By executive and non-executive board membership =
BME: 0.056% White: 85.70%

2021-21

Headcount		**Headcount %**	**Board Headcount**	**Board Headcount %**
BME	**301**	**9.11%**	**1**	**0.056%**
White	2382	72.09%	17	94.44%
Not Stated	621	18.80%	0	0 %

2020-21

Headcount		**Headcount %**	**Board Headcount**	**Board Headcount %**
BME	**260**	**8.0%**	**2**	**14.30%**
White	2649	82.0%	12	85.70%
Not Stated	322	10.00%	0	0%

% Difference Total Board - Overall Workforce

BME	**6.00%**

7. Our People Plan

The fundamental purpose of Our People Plan is to identify the Trust's people priorities and to ensure that everyone connected to the Trust understands the contribution they make.

There are several people priorities, with specific emphasis on the culture and behaviours we are working towards.
The diversity of our workforce is a key indicator of an inclusive culture by setting the right cultural and behavioural tone by celebrating difference, empowering others to make their own unique contribution, and actively listening and then taking supported action.
The following key actions taken from our overarching action plan have been identified for the next 12 months to increase the diversity in our workforce, promote an inclusive and supportive culture and improve the experience of colleagues with protected characteristics. The impact of these actions will be measured by improvements to the WRES indicators.

- **We will promote inclusion**

The Trust will increase understanding to tackle inequalities by promoting cultural awareness through a Trust diversity calendar of events, observing religious, holy days and festivals together, engaging with national and international days of importance, and supporting key campaigns such as Black History Month and Hate Crime Awareness Week.

- **We will embed a Just and Learning culture**

The Trust will continue to embed a just and learning culture to create an environment where staff feel supported and empowered to learn when things do not go as expected and treating each other with civility and respect.

- **We will proactively support career development and training for staff from underrepresented groups**

Specific training on cultural and unconscious bias will be rolled out, and career development opportunities and support will be aimed at staff from BME staff. For example, a bespoke offer for our recently recruited International Nurses to ensure they are not just integrated into the Trust but are given every opportunity to build their career here.

- **We will engage in key initiatives to support inclusion**

The Trust will encourage staff from BME backgrounds to become more actively involved in shaping more inclusive practices across the Trust. For example, through the establishment of a new Multi-cultural Staff Network where staff voices from BME backgrounds can shape and influence Trust policies and procedures, identify opportunities and help prioritise improvement in areas such as recruitment and selection.

8. Trust actions taken to be compliant with the WRES

- WRES reporting template completed and sent to NHS England (Aug 2022)
- WRES report completed, to be hosted onto the Trust website (Sept 2022)
- WRES action plan in place and reviewed monthly with monitoring via the Valuing Our People & Inclusion Group, JNC and Workforce Committee
- WRES report and action plan to be sent to the NHS Cheshire and Merseyside ICB

6. Recommendations

The Committee is asked to note the WRES indicators, and the actions identified to address the gaps highlighted.

Southport and Ormskirk Hospital NHS Trust

Appendix 2 Equality Diversity & Inclusion: Five-year action plan (Year 3)

EDI SIG strategic objectives	Actions agreed	Named Person /Team & Date	Progress in 2021/22 (Year 2) and plans for 2022/23
To embed accountability and make workforce diversity an organisational priority	**Establish EDI Special Interest Group** *reporting to sub-Board Committee (chaired by an Executive Sponsor)*	**Director of Finance / Director of HR & OD / Deputy Director of HR & OD**	• SIG established with representation from the senior executive leadership team, subject matter specialists and staff with lived experience, aiming to increase membership with Chairs of Staff Networks • EDI SIG reviewed the Trust's data against key equality indicators and triangulated with other key indicators and staff feedback to determine the Trust's strategic EDI objectives. • Engagement with NHS Cheshire and Merseyside ICB on how to support BME staff
	Consistent and regular communication to and from the Board		• Consistent communication of the importance of EDI from Executives through Team Brief and Trust Newsletter • CORE 20 plus 5 priorities being determined at Exec Level and progress to be regularly reported to Quality & Safety Committee
	Improve access to training & awareness		• Membership of the 'Diversity in Healthcare Partners Programme in 2022' to access the latest thinking and networking opportunities • External Provider commissioned to deliver 10 x training sessions for staff & managers including cultural awareness and unconscious bias

EDI SIG strategic objectives	Actions agreed	Named Person /Team & Date	Progress in 2021/22 (Year 2) and plans for 2022/23
To improve the chances of getting on a shortlist when applying for a job or moving up the career ladder, especially if staff have a protected characteristic	**Improve staff equality monitoring**	**Head of Resourcing (By end Sept 2022)**	• Data cleanse on ESR planned in Q2 2022-23 engaging staff in updating their records.
	Increase cultural awareness	**Senior HR Partner / L&OD Manager (Management Essentials by Dec'22)**	• Unconscious bias training incorporated into R&S training. • Leadership and management training programmes under development to also include focus on unconscious bias and compassionate leadership.
	Promote the Trust as an equality opportunities employer	**Recruitment Manager (By Dec'23)** **EDI Team (Review Mar'23)**	• Roots and branch review of R&S process currently being scoped with intention to engage with staff networks to identify actions to remove barriers in shortlisting and onboarding stages initially. • Positive action statements to be developed and included in recruitment advertisements • Developing plan to review charter marks to potential applicants with protected characteristics are encouraged to apply to the Trust • Starting to re-engage with external stakeholders to increase interest in Trust and improve staff experience and services through feedback
	Improve career development	**Professional and practice development team (Ongoing)** **L&OD Manager (Dec'23)**	• Bespoke programme developed for International Nurses (Apr-Jun '22) to strengthen sense of belonging and develop confidence to progress at the Trust. Programme to be rolled out to other staff groups • Career pathways - improve career development, job satisfaction and support individuals to learn new skills and

EDI SIG strategic objectives	Actions agreed	Named Person /Team & Date	Progress in 2021/22 (Year 2) and plans for 2022/23
		HR Business Partner - Planned Care (Mar'23)	take on extra responsibilities that enable them to progress within the organisation. • Continue to promote the Trust's commitment towards more agile, flexible working and raising awareness of the opportunity for staff to request flexible working from day 1 of employment
To strengthen a sense of belonging to the S&O community, whether a new or existing member of staff	**Increase participation and number of staff networks**	**EDI Team (Review Mar'23)**	• Promotion of staff networks and their benefits planned for September 2022 – establishment of a Multicultural Network.
To improve how supported staff feel as a member of the S&O community	**Staff voice partnership to increase confidence amongst staff to speak up**	**L&OD Manager (Review Mar'23)**	• Phase 1 completed through Staff Voice Partnership to help improve lived experiences, including feeling able to disclose their protected characteristics • Phase 2 under development and due to be launched in October 2022. • Launch of Civility & Respect agenda through our improved induction offer linked to a Just & Learning Culture approach – this will be expanded in year 3 across the employee lifecycle processes e.g. appraisal

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**05 October 2022**
Agenda Item	**SO182/22**	**FOI Exempt**	**NO**
Report Title	**WORKFORCE DISABILITY EQUALITY STANDARD REPORT (WDES)**		
Executive Lead	Jane Royds, Director of Human Resources and OD		
Lead Officer	Sonya Clarkson, Deputy Director of Human Resources and OD		
Action Required	✓ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

This report provides an overview and analysis of the Workforce Disability Equality Standard (WDES)

Executive Summary

The following is an overview of the WDES Highlights for 2021/22

- The 2021-22 Trust ESR figures for staff highlighting they have a disability is **3.28%**.
- Disabled staff being appointed from shortlisting across all posts is **1.66%** less than non-disabled staff.
- The Trust's ESR figures highlight that **no disabled staff** entered the formal capability process on the grounds of performance in 2021-22, this is the same as 2020-21 (only staff who enter the formal capability procedure on the grounds of performance are included in the figures).
- Disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public has seen an **increase of 11.0%**.
- Disabled staff experiencing harassment, bullying or abuse from managers has seen an **increase of 7.1%**.
- Disabled staff experiencing harassment, bullying or abuse from other colleagues has seen an **increase of 8.5%**.
- Percentage of Trust staff believing that Trust provides equal opportunities for career progression or promotion is 43.0**%** for disabled staff this is a **reduction of 9.6%.**

The activities to address the gaps between the experience of disabled staff have been aligned to an overarching 'EDI / Sense of Belonging' Plan which forms one of the pillars of the Trust's 'Our People Plan'.

Our actions will be informed by our Staff Networks and monitored by the Trust's Valuing our People Inclusion Group, JNC and Workforce Committee and reported to the NHS Cheshire and Merseyside ICB.

Recommendations

The Strategy and Operations Committee is asked to receive the report and to approve the action 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:**
Barrie Morgan-Scrutton, Interim Diversity and Inclusion Lead	Sonya Clarkson, Deputy Director of Human Resources and OD

Workforce Disability Equality Standard Report April 2021 – March 2022

1. Executive Summary

This paper provides an overview of the Workforce Disability Equality Standard (WDES) and the Trust's data and responses to the various metrics against the 10 indicators within the Workforce Disability Equality Standard (WDES).

2. Introduction

The Workforce Disability Equality Standard (WDES) is mandated by the NHS Standard Contract and will apply to all NHS Trusts and Foundation Trusts from April 2019. The WDES is a data-based standard that uses a series of measures (metrics) to improve the experience of disabled staff in the NHS.

The WDES comprises of a set of metrics. All the metrics draw from existing data sources (recruitment dataset, ESR, NHS Staff Survey, HR data) except for one; Metric 9b asks for narrative evidence of actions taken, to be written into the WDES annual report.

The annual collection of the WDES metrics will allow the Trust to better understand and improve the employment experiences of disabled staff in the NHS.

3. WDES Highlights 2021-22

The information below provides highlights of the WDES report for 2021-22.

a. Recording a disability:

Trust figures on ESR highlight **3.28%** staff out of **3,319** staff have a disability

NHS Staff Survey highlights **23.7%** of staff out of the **1,335** who completed the NHS Staff Survey highlighted they have a disability.

b. Percentage of disabled staff being appointed from shortlisting is **15.33%** for disabled compared to **13.67%** for non-disabled staff.

Relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff is **1.12** (A figure below 1:00 indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting.)

c. ESR data highlights the relative likelihood of staff entering the formal capability process for disabled is **0%** which is the same as last year.

d. Disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public is **11.00% higher** than for non-disabled staff.

e. Disabled staff experiencing harassment, bullying or abuse from managers is **7.1% higher** than non-disabled staff.

f. Disabled staff experiencing harassment, bullying or abuse from other colleagues is **8.5% higher** than non-disabled staff.

g. Percentage of Trust staff believing that the Trust provides equal opportunities for career progression or promotion is **43.0%** for disabled staff, 52.6**%** for non-disabled staff, a difference of **9.6%**

Staff Profile

As of March 2022, Southport and Ormskirk Hospitals NHS Trust employed **3,319** staff of whom **3.28%** of the workforce has disclosed that they consider themselves to have a disability, **74.30%** of staff have told us they don't consider themselves to have a disability with the remainder **22.42%** either not declaring, preferring not to say and the others are unspecified.

Disability	Headcount	Percentage %
No	2466	74.30% of staff do not consider themselves to have a disability
Not Declared & Other	744	22.42% of staff have not declared preferred not to say or unspecified
Yes	109	3.28% of staff have highlighted they have a disability
Grand total	**3319**	

Workforce Metrics Data

Three workforce metrics compare the data for both disabled and non-disabled staff.

Note: Definitions for these categories are based on Electronic Staff Record occupation codes except for medical and dental staff, which are based upon grade codes.

Workforce Disability Equality Standard Indicators:

For each of workforce indicators, the standard compares the metrics for disabled and non-disabled staff where the figures do not equate to 100% this is due to the information not stated / not given

4. Workforce Indicators

1/ Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

Clusters:

Cluster 1 (Bands 1 - 4)
Cluster 2 (Band 5 - 7)
Cluster 3 (Bands 8a - 8b)
Cluster 4 (Bands 8c - 9 & VSM
Cluster 5 (Medical & Dental Staff, Consultants)
Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)
Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)

Current Year 2021 – 22

Non – Clinical		
Cluster	**Disabled**	**Non-Disabled**
Cluster: 1	3.6%	67.2%
Cluster: 2	6.6%	73.6%
Cluster: 3	0%	73.0%
Cluster: 4	0%	100.0%
Clinical		
Cluster	**Disabled**	**Non-Disabled**
Cluster: 1	3.1%	76.8%
Cluster: 2	3.4%	77.7%
Cluster: 3	2.1%	72.9%
Cluster: 4	0.0%	88.9%
Cluster 5: Medical & Dental Consultant		
Disabled		**Non-Disabled**
1.7%		73.5%
Cluster 6: Med & Dental Consultant Non –Consultant Career Grade		
Disabled		**Non-Disabled**
2.2%		73.9%
Cluster 7: Medical & Dental Trainee Grades		
Disabled		**Non-Disabled**
0.0%		77.9%

Indicator 2/ Relative likelihood of non-disabled staff to disabled being appointed from shortlisting across all posts

	Head Count		
WDES Category	Shortlisted	Appointed	Relative likelihood of staff shortlisted /appointed %
Disabled	198	27	0.14 13.64%
Non-Disabled	3797	582	0.15 15.33%
Not declared	81	42	0.52 51.85%
Relative likelihood of relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff.			**1.12** times more likely

Indicator 3/ Relative likelihood of disabled staff compared to non-disabled staff entering

the formal capability process, as measured by entry into the formal capability procedure.

Note: This metric will be based on data from a two-year rolling average of the current year and the previous year.

2020-2021 & 2021-2022

Average over 2 years	Entering formal capability Process	Trust Headcount & %	Relative likelihood of staff entering the formal capability process
Disabled	0	109 - 3.28%	0
Non-Disabled	0.5	2466 – 74.30%	0
Not declared Prefer not to answer Unspecified	0 0 0	744 – 22.42%	0
Total	0.5	**3319**	
Relative likelihood of Disabled staff compared to non-disabled staff			0

5. NHS Staff Survey Responses 2021

The 2021 NHS Staff Survey was completed by **1,335** staff this is a response rate of **42%** with an average of **46%** for combined acute and community trusts in England and compares with a response rate in the Trust in 2020 of **45.4%**

Indicator 4a/ Percentage (%) of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from Patients/Service users, relatives or other members of the public their managers and colleagues.

Category	**2021**	**2020**	**Average from Trusts**
Non-disabled	24.2% **2% increase**	22.2%	25.2% **1% below average**
Disabled	35.2% **10.1% increase**	25.1%	32.4% **2.8% below average**

The results from the latest staff survey in 2021 indicate that disabled staff are more likely to have experienced harassment, bullying or abuse from Patients/Service users, relatives, or other members of the public their managers and colleagues than non-disabled staff.

Indicator 4b/ Percentage of disabled staff compared to non – disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

Category	**2021**	**2020**	**Average from Trusts**
Non-disabled	42.6%	50%	46.2%

	7.4% reduction		**3.6% below average**
Disabled	51.1% **10.7% increase**	40.4%	47% **4.1% below average**

The result from the latest staff survey could indicate that staff with or without a disability could have an issue with reporting an experience of harassment, bullying or abuse at work.

Indicator 5/ Percentage believing that trust provides equal opportunities for career progression or promotion

Category	2021	2020	Average from Trusts
Non-disabled	52.6% **1.4% increase**	51.2%	56.8% **4.2% below average**
Disabled	43.0% **1.0% increase**	42%	51.4% **8.4% below average**

The results show a reduction in disabled staff believing the Trust provides equal opportunities or career progression or promotion compared to last year, there has been an increase for non–disabled staff.

Indicator 6/ Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Category	2021	2020	Average from Trusts
Non-disabled	21.0% **2.6% increase**	18.4%	23.7% 2.7**% below average**
Disabled	34.1% **6.9% increase**	27.2%	32.2% **1.9% below average**

The results highlight that disabled staff are **MORE** likely to feel pressure from their manager to come to work than none disabled staff.

Indicator 7/ Percentage of disabled staff compared to non–disabled staff saying that they are satisfied with the extent to which their organisation values their work

Category	2021	2020	Average from Trusts
Non-disabled	40.5% **4.5% reduction**	45.0%	43.3% **2.8% below average**
Disabled	30.0% **3.6% reduction**	33.6%	32.6% **2.6% below average**

The results of the latest survey highlight that disabled staff are LESS likely to feel satisfied with the extent to which the Trust values their work.

Indicator 8/ Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

Category	2021	2020	Average from Trusts
Disabled	74.5% **7.1% increase**	77.6%	75.5% **1% below average**

Indicator 9a/ The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

Category	2021	2020	Average from Trusts
Non-disabled	6.9% **0.1% reduction**	7.0%	7.0% **0.1% below average**
Disabled	6.2% **0.2% reduction**	6.4%	6.4% **0.2% below average**
Trust average	6.7% **0.2% reduction**	6.9%	

Indicator 9b/ Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard? **(Yes)**

NHS Staff Survey	Disability Staff Network
Disability Confident Employer Scheme	Shielders Support Group
Reasonable Adjustment Disability Passport	Health & Wellbeing Programme

Indicator 10/ Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated

	2021-22	2020-21
Non-disabled	25.08%	28%
Disabled	-3.28%	-3%
Not Stated	-21.8%	-25%

Disability	Headcount	Headcount %	Board Headcount	Board Headcount %
No	2466	74.30%	17	100.0%
Not Declared & Other	744	22.42%	0	0.0%
Yes	109	3.28%	0	0.0%

6. Our People Plan

The fundamental purpose of Our People Plan is to identify the Trust's people priorities and to ensure that everyone connected to the Trust understands the contribution they make. There are a number of people priorities, with specific emphasis on the culture and behaviours we are working towards.

The diversity of our workforce is a key indicator of an inclusive culture by setting the right cultural and behavioural tone by celebrating difference, empowering others to make their

own unique contribution, and actively listening and then taking supported action cannot be understated.

The following key actions have been identified for the next 12 months to increase the diversity in our workforce, promote an inclusive and supportive culture and improve the experience of colleagues with protected characteristics. The impact of these actions will be measured by improvements to the WDES indicators.

- **We will promote inclusion**

The Trust will raise awareness and understanding to staff through a Trust diversity calendar of events, recognising national and international days of importance, and supporting key campaigns such as Disability Awareness Week and Deaf Awareness Week.

- **We will embed a Just and learning culture**

The Trust will continue to embed a just and learning culture to create an environment where staff feel supported and empowered to learn when things do not go as expected and treating each other with civility and respect.

- **We will proactively support career development and training for staff from underrepresented groups**

Specific training on neurodiversity and unconscious bias to be rolled out, and career development opportunities and support will be aimed at disabled staff to ensure they can build their career in the Trust. Managers will also receive training related to reasonable adjustments to help remove any barriers to progression.

- **We will engage in key initiatives to support inclusion**

The Trust has signed up to the Disability Confident Scheme and will encourage disabled staff to become more actively involved in shaping more inclusive practices across the Trust. For example, opportunities to be active members of various Trust committees and groups to share lived experiences of working here, development of the Ability Staff Network to identify initiatives and help prioritise areas for improvement and involvement in process review groups such as Recruitment and Selection and policy development.

7. Trust actions taken to be compliant with the WDES

- WDES reporting template completed and sent to NHS England (Aug 2022)
- WDES report completed and will be uploaded onto the Trust website (Sept 2022)
- WDES Action plan completed and to be reviewed and updates to be provided at each Valuing Our People & Inclusion Group and Workforce Committee
- WDES report and action plan to go to Trust board
- WDES report and action plan to be sent to the NHS Cheshire and Merseyside ICB.

8. Recommendations

The Committee is asked to note the improvements in the WDES indicators and the actions identified to address the gaps highlighted

Southport and Ormskirk Hospital NHS Trust

Appendix 1 Equality Diversity & Inclusion: Five-year action plan (Year 3)

EDI SIG strategic objectives	Actions agreed	Named Person /Team & Date	Progress in 2021/22 (Year 2)
To embed accountability and make workforce diversity an organisational priority	**Establish EDI Special Interest Group** *reporting to sub-Board Committee (chaired by an Executive Sponsor)*	**Director of Finance / Director of HR & OD / Deputy Director of HR & OD**	• SIG established with representation from the senior executive leadership team, subject matter specialists and staff with lived experience, aiming to increase membership with Chairs of Staff Networks • EDI SIG reviewed the Trust's data against key equality indicators and triangulated with other key indicators and staff feedback to determine the Trust's strategic EDI objectives • Engagement with NHS Cheshire and Merseyside ICB on how to support disabled staff
	Consistent and regular communication to and from the Board		• Consistent communication of the importance of EDI from Executives through Team Brief and Trust Newsletter • CORE 20 plus 5 priorities being determined at Exec Level and progress to be regularly reported to Quality & Safety Committee
	Improve access to training & awareness		• Membership of the 'Diversity in Healthcare Partners Programme in 2022' to access the latest thinking and networking opportunities • External Provider commissioned to deliver 10 x training sessions for staff & managers, including cultural awareness, unconscious bias and dyslexia & reasonable adjustments
To improve the chances of getting on a shortlist when applying for a job or	**Improve staff equality monitoring**	**Head of Resourcing (By end Sept 2022)**	• Data cleanse on ESR planned in Q2 2022-23 engaging staff in updating their records. Looking at 'not declared' to reduce this.

EDI SIG strategic objectives	Actions agreed	Named Person /Team & Date	Progress in 2021/22 (Year 2)
moving up the career ladder, especially if staff have a protected characteristic	**Increase disability awareness**	**Senior HR Partner (Management Essentials by Dec'22)**	• Unconscious bias training incorporated into R&S training. Leadership and management training programmes under development to also include focus on unconscious bias and compassionate leadership.
	Promote Trust as an equality opportunities employer	**Recruitment Manager (By Dec'23)** **EDI Team (Review Mar'23)**	• Roots and branch review of R&S process currently being scoped with intention to engage with staff networks to identify actions to remove barriers in shortlisting and onboarding stages initially. • Positive action statements to be developed and included in recruitment advertisements i.e. Disability Confident Employer Charter Mark • Developing plan to review charter marks to potential applicants with protected characteristics are encouraged to apply to the Trust • Starting to re-engage with external stakeholders to increase interest in Trust and improve staff experience and services through feedback
	Improve career development	**L&OD Manager (Dec'23)** **HR Business Partner - Planned Care (Mar'23)**	• Career pathways - improve career development, job satisfaction and support individuals to learn new skills and take on extra responsibilities that enable them to progress within the organisation. • Continue to promote the Trust's commitment towards more agile, flexible working and raising awareness of the opportunity for staff to request flexible working from day 1 of employment

EDI SIG strategic objectives	Actions agreed	Named Person /Team & Date	Progress in 2021/22 (Year 2)
To strengthen a sense of belonging to the S&O community, whether a new or existing member of staff	**Increase participation and number of staff networks**	**EDI Team (Review Mar'23)**	• Promotion of staff networks and their benefits planned for September 2022 – establishment of an Ability Network.
To improve how supported staff feel as a member of the S&O community	**Staff voice partnership to increase confidence amongst staff to speak up**	**L&OD Manager (Review Mar'23)**	• Phase 1 completed through Staff Voice Partnership to help improve lived experiences, including feeling able to disclose their protected characteristics • Phase 2 under development and due to be launched in October 2022. • Launch of Civility & Respect agenda through our improved induction offer linked to a Just & Learning Culture approach – this will be expanded in year 3 across the employee lifecycle processes e.g. appraisal

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS COMMITTEE (SOC))**	**Date**	**05 October 2022**
Agenda Item	**SO183/22**	**FOI Exempt**	**NO**
Report Title	**NURSING AND MIDWIFERY STRATEGY 2022/25**		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Stephen Mellars, Deputy Director of Nursing, Midwifery and Therapies		
Action Required	✓ **To Approve** ☐ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

To provide the Strategy and Operations with oversight and assurance relating to the overall strategic aims and objectives for the Nursing and Midwifery Teams to continue to deliver and maintain outstanding care delivery for our patients and a positive working environment for our patients.

Executive Summary

Our Nursing and Midwifery Strategy and delivery plan sets out how we will deliver the Trust's strategic priorities and is aligned to 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 reflects the Nursing and Midwifery Strategy for Cheshire & Merseyside.

In 2019 Ruth May, CNO for England, announced a three-point nursing strategy designed to help nurses deliver the NHS Long Term Plan.

Our ambitious delivery plan details our objectives across 2022-25 and highlights the key priorities for 2022-23. We have developed the plan recognising the current challenges placed on us at this time of restoration of services following the Covid-19 pandemic, against our commitment to delivering excellent care, for every patient, every time.

Recommendations

The Strategy and Operations Committee is asked to approve the Nursing and Midwifery Strategy 2022/25

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:**
Stephen Mellars, Deputy Director of Nursing and Therapies Sonya Clarkson, Deputy Director of Human Resources	Brendan Prescott, Deputy Director of Quality, Risk and Assurance

NHS
Southport and Ormskirk Hospital
NHS Trust

Nursing and Midwifery Strategy 2022-25

Delivering excellent care.
For every patient. Every time.

Contents

Foreword by Lynne Barnes, Director of Nursing, Midwifery and Therapies

I am delighted to introduce our Nursing and Midwifery Strategy for 2022-2025 which sets out our priorities for the coming years. The overall aim is for the strategy to support our nurses and midwives to continue in delivering excellent care, for every patient, every time, in what is an exciting time to be a member of Team.

Every year brings fresh challenges, but also more opportunities and as nurses and midwives we can lead the changes necessary to ensure the continued delivery of high quality, person-centered care, fit for current and future generations.

As I reflect over the last two years, I am in awe of the courage and compassion shown by each member of our workforce. Nurses and midwives have been at the forefront of our response to the COVID-19 pandemic and your commitment has shone through. Thank you for everything you have done and continue to do for our patients and each other, during these challenging times as we continue to face the ongoing changes across the world and within healthcare.

This document describes the Nursing and Midwifery Strategy for the next three years with particular focus on the first twelve months which is a time of recovery and restoration during our emergence from the pandemic.

As we move forward, we will continue to adapt to new and emerging models of care to meet the needs of our diverse communities. This strategy sets out aims and ambitions to modernise our profession, develop our staff and encompass new and exciting roles across the Trust.

This strategy has been developed in consultation with members of our workforce through several forums and demonstrates the Trust's commitment to involving you in decisions about our future strategic direction. The feedback we have received, alongside the objectives set by the Chief Nursing Office and Chief Midwifery Officer for England, has helped shape our plans for the next three years.

Lynne Barnes
Director of Nursing, Midwifery and Therapies

Introduction

Our Nursing and Midwifery Strategy is designed to reflect the ambitions set out within the Trust's Our People Plan and ensure we have full integration with the Medical and Allied Health Professional workforce plans to form a Trust clinical workforce plan over the coming years.

As the Trust starts to engage with staff and the public on the 'Shaping Care Together' programme, there is a refreshed opportunity to work in partnership with others and redefine how we provide hospital services, make them fit for the future and ensure they are safe, sustainable and high quality. We want to keep services as local as possible, where it is appropriate, and keep our focus on the delivery of the highest quality clinical care provided by the range of excellent professionals we have working in our local hospitals.

Our Nursing and Midwifery Workforce Strategy sets out the approach for attracting staff in the short- to medium-term, enabling the Trust to provide the best care and outcomes for all. It will also provide a sustainable framework to support and develop the nursing and midwifery workforce and secure a strong pipeline for the future.

It sets out how we will deliver the Trust's strategic priorities and is aligned to the national picture set out by both the Chief Nursing Officer (CNO) and Chief Midwifery Officer (CMO) and reflects the Nursing & Midwifery Strategy for Cheshire & Merseyside.

In 2019 Ruth May, CNO for England, announced a 3-point nursing strategy designed to help nurses deliver the NHS Long Term Plan, with the following priorities:

- A workforce that is fit for the future
- A collective voice that is powerful and heard
- A renewed pride in the profession

In March 2022, Donna Ockenden published an independent review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust and identified 15 immediate and essential actions for all maternity services to implement, with the following key priory areas:

- Workforce planning and sustainability
- Safe staffing
- Escalation and accountability
- Clinical Governance and leadership
- Incident investigation and complaints
- Learning from maternal deaths
- Multidisciplinary training
- Complex antenatal care
- Labour and birth
- Preterm birth

Background

As a Trust, we have historically faced significant challenges, specifically around our ability to attract nursing staff. Up until recently, the Trust had one of the highest nurse vacancy levels in the United Kingdom and limited success in generating a pipeline of nurses following placements. We continue to face the challenge of supporting our existing staff and emerging talent while building a workforce that is capable and flexible enough to meet the changing healthcare needs of the local population. Recent policy developments are driving a range of changes including:

- Funding of the training for healthcare staff
- How staff continue to learn and develop their careers
- How staff are recruited and the sources of recruitment
- Modelling teams to meet emerging needs and demand
- Redesigning roles to help fill skills gaps.

To deliver these challenges we need to continue to work effectively and collaboratively with local and national partners. We need to redesign and shape the workforce, develop new and existing roles to meet workforce constraints and current and future service needs while supporting our staff with the knowledge, skills, and confidence to operate in a dynamic environment. A focus will be to enable long term workforce planning through incorporating new models of care and roles. We will look for innovative solutions to pilot and where successful, the ability to scale and replicate.

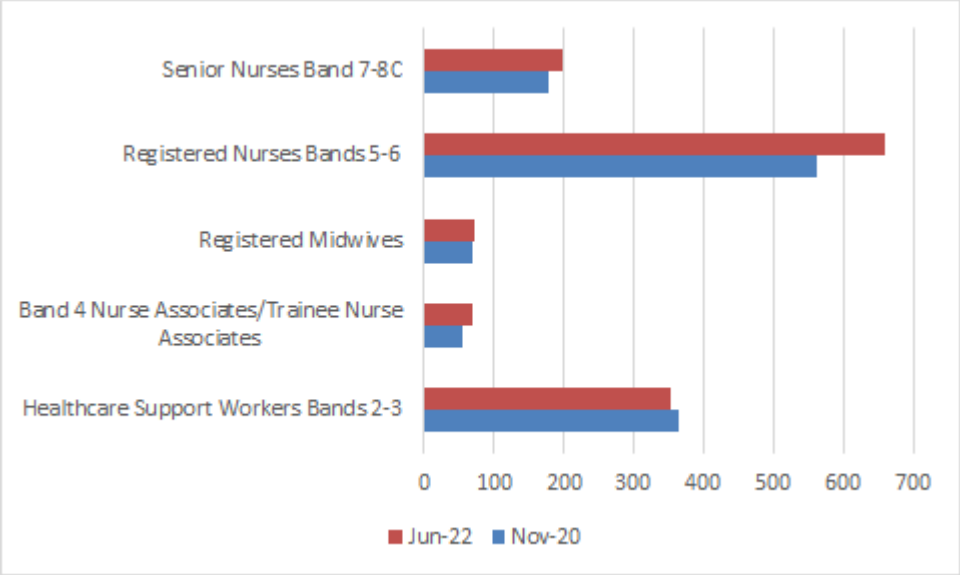
Consequently, this has had a direct impact on our agency spend, and the lack of experienced staff has a knock-on effect on the quality of placements, resulting in a perpetuating cycle of poor attraction of staff to the Trust.

In November 2020, when we were beginning our International Recruitment campaign, the Trust had 144.22 registered nursing and midwifery vacancies and high agency spend as a direct consequence. A variety of strategies were adopted to address the vacancy gaps, reduce agency spend and stimulate the pipeline in order to mitigate a return to this position in the future.

As at 30th June 2022, the nursing and midwifery workforce has significantly less vacancies and is comprised as follows:

- 197 Senior Nurses Band 7-8b
- 659 Registered Nurses Band 5-6
- 110 Registered Midwives
- 68 Band 4 Nurse Associates/Trainee Nurse Associates
- 353 Healthcare Support Workers Bands 2 -3

With a much-improved establishment position and tighter grip on agency usage, it is time to further refine our strategy in favour of a move towards a more proactive approach to workforce planning, which is robust and flexible enough to meet the challenges in the current climate.



It is anticipated that going forward this strategy will help the Trust to achieve improved retention of the nursing and midwifery workforce and enhanced ability to recruit to agreed establishment levels.

Our nursing and midwifery workforce challenge

The national context

Analysis by the King's Fund, the Health Foundation and the Nuffield Trust suggests the health service could be short of more than 350,000 nursing and allied health professional staff if it continues with current practices. The challenges of attracting, recruiting and retaining staff is a key feature as we emerge from the pandemic and will remain so for future years. This is a national problem and has been acknowledged by the Chief Nursing Officer in the NHS Long Term Plan.

The regional context

The findings from the 2022 workforce planning round show Trusts require an additional 7,500 staff by 2023 across the Northwest. The Cheshire and Merseyside region plans make up 2,092 of that figure, equating to a 3.1% growth in the workforce. Trusts also aim to significantly reduce temporary staffing usage by 516 bank WTE and 126 agency WTE as a direct result. The confidence to attract to this level is low, particularly in respect of the additional 928 registered nursing and midwifery roles (+5% growth) and 500 health care support workers.

The local context

The increasing difficulty of attracting, recruiting, and retaining staff has been a key challenge for the Trust and reflects the national position. Workforce expenditure remains high through extensive dependency on bank and agency staff, resulting in the need to resort to incentive schemes and off framework agencies in times of significant surge.

Our current bank usage (based on 31st March 2022) is 140 WTE registered nurses per month, and 132 WTE Healthcare Support Workers. We have also used a further 15 WTE of agency nursing. This is somewhat higher that the vacancy gap we currently have, but it is noted that there was a significant surge in sickness during March due to a spike in COVID 19 and this had a detrimental impact on clinical staffing levels. Southport and Ormskirk NHS Trust continue to face the challenge of supporting our existing staff and emerging talent while building a workforce that is capable and flexible enough to meet the changing healthcare needs of the local population. Recent policy developments are driving a range of changes including:

- Funding of the training for healthcare staff
- How staff continue to learn and develop their careers
- How staff are recruited and the sources of recruitment
- Modelling teams to meet emerging needs and demand
- Redesigning roles to help fill skills gaps

There will be a small but steady number of retirements expected by experienced nurse practitioners as we go forward. This will need careful management in some areas where more than one nurse will likely to be retiring at the same time. However, turnover of more junior nurses has generally been low and therefore the skills and knowledge of senior nurses will continue to be shared with their colleagues. This will mobilise and increase the development opportunities for junior nurses and allow for succession planning.

Our underpinning approach

Patient care across the NHS is changing with an emphasis on ensuring that care is shifted closer to home. It is envisaged that care will become more integrated, progressed more quickly by technology, with patients becoming more informed and empowered. This will inevitably result in our workforce needing to develop new skills and competencies to work in a very different way, as well as the development of a flexible workforce model with clear career pathways to support progression.

The Trust will take a leading role to work as part of the wider system to ensure that the workforce is aligned to these new models of care and system working across organisational boundaries. This aspect of our work hinges critically on clear workforce plans, taking account of the future context of healthcare delivery to address these challenges. Our challenge is to continue to work effectively and collaboratively with local and national partners and embed workforce modelling and planning which is clinically led and addresses both short- and long-term workforce issues.

This will require the development of new and existing roles to meet workforce constraints, current and future service needs, as well as supporting our staff with the knowledge, skills and confidence to operate in a dynamic environment.

The Trust will utilise the Health Education England (HEE) Star workforce planning methodology as a simple, coherent framework to facilitate and guide workforce conversations. It equips provider systems, Integrated Care Boards (ICB) and People Boards with a single framework to define key workforce requirements, determine responsive solutions and deliver the best care to patients

The nursing and midwifery strategic aims are:

Workforce that is **valued**
Embedding **safety**
Clear **communication**
Achieving person-centred care through improved **systems**
Raising standards of **care**
Evidence-based **pathways** to improve outcomes

Our focus for the first twelve months will be:

- We need to recruit and retain enough people with the skills required
- Build places of work that are rewarding, positive and filled with opportunity
- Develop the quality of our management and leadership at every level
- Tackle inequality and break down the barriers that are preventing too many from reaching their potential
- Create an infrastructure that enables more volunteers to support our front-line staff

Strategic aims

1 - Workforce that is valued

Promoting the Trust as an Employer of Choice

Many of the operational challenges we face across the NHS stem from a mismatch in the supply of, and demand for, high quality individuals required to deliver the best care to our patients. Through this strategy, we will seek to address the drivers for turnover so that we minimise vacancies and reliance on temporary staff. Whilst developing an excellent employer brand we would expect to attract and retain the best people in the NHS to deliver the best possible care. We will ensure our dedicated and hardworking staff feel valued and respected, so they will recommend us as a place to work and provide treatment to their friends and families. We will achieve this through listening to our staff and acting on their feedback to ensure we implement sustainable recruitment and retention solutions and creating a psychologically safe environment for our staff to flourish.

Compassionate leadership

Great leadership is the bedrock of any organisation and in challenging times compassionate leadership is even more important to ensure staff are supported and guided in the right way that empowers them to be at their best. We will focus attention at all levels of the organisation and ensure we develop and grow both our current and future leaders.

Flexible working

Many people, even the most career orientated, have ambitions for their lifestyle beyond the workplace. Given the pressures associated with many roles, many people choose to leave their chosen profession due to work-life/'quality of life' balance not being met. We need to re-think our cultural approach to flexible working and recognise this means different things to different people.

Maximising the opportunities of new roles

New roles such as Advanced Clinical Practitioners and Physician Associates must play a significant role in supporting the medical workforce, for example addressing the gaps in junior doctor rotas. Advanced Practitioners hold a Masters level qualification and exercise a broad range of clinical examination and interventional skills, working autonomously for patients with complex multi-dimensional disease pathways. They can undertake many of the clinical duties traditionally carried out by junior doctors and are the stable underpinning practitioners who see, treat, prescribe, and discharge patients. These roles also support career development pathways for senior health care professionals and can significantly improve quality of care and patient experience. In the past we have struggled as an organisation to recruit to qualified Advanced Nurse Practitioners. This has invariably led to clinical teams being supported by Trainee Advanced Practitioners which takes up to 2 years, depending on the specific clinical programme, putting further pressure medical gaps in clinical services. Trainee posts have been attractive to recruit to but then candidates realise that other sectors offer additional pay benefits on qualification and then leave the Trust to further their career pathway.

The trust has now engaged and is in partnership with Edge Hill University to give trainee Advanced Practitioners the opportunity to lecture on BSc courses to enhance their experience of training. The Trust is also extending this opportunity to qualified Advanced Practitioners to lecture on the MSc courses to offer a wider attraction for them to stay within the Trust post qualification.

Graduate Physician Associates, who work under the supervision of the medical workforce, are an integral part of enhancing the patient care experience. Taking medical histories, performing clinical examinations, diagnosing illnesses, analysing test results, developing management plans, and providing health promotion and disease prevention advice for patients. Recruitment to these roles, especially on inpatient wards, theatres, emergency department and in clinics, is essential to complement the medical workforce and will contribute to the emerging medical model.

Overseas recruitment

As a Trust, we have invested in overseas recruitment for nursing staff and secured from NHS England to ensure both pastoral and clinical support is available for the nurses. To date, feedback has been very positive and retention rates are high. Whilst we reduce the size of each cohort, we recognise the need to be flexible and continue to recruit internationally over the short to medium term should the need arise. However, we will place increased emphasis on creating a supportive and inclusive culture, where diversity is embraced, and cultural differences are respected. We will continue to support all overseas recruits with their pastoral and professional and skills development needs, so they feel a sense of belonging and can have successful careers in the Trust and the wider NHS.

Partnerships

In a competitive labour market, we recognise that by partnering with other organisations we can offer more varied roles and strengthen our position as an Employer of Choice. We will continue to work closely with our higher education partners, which include the Edge Hill University and the University of Central Lancashire, in developing strategic links to support our ambition to achieve University Hospital status. We will create an education offer that meets the needs of our current and future workforce and provides opportunities for career progression from apprentice to qualified healthcare practitioner. A strong focus will be given to developing mutually beneficial roles with other Trusts and Education Providers, broadening the attraction of working at the Trust. We have already made a great start working in partnership with the local University, Edge Hill, to develop joint clinical academic consultant posts and we want to build on this to increase attractiveness to nursing posts and play a part in shaping the curriculum for trainees.

Career development

To achieve a Better Workplace means engaging and supporting our workforce to deliver the services our patients need now and in the future. This means a continued focus on personal development and learning, new and innovative approaches to team working which will facilitate health and social care integration, and a fresh approach to leadership development and succession planning. A clear focus will be given on strengthening the capability of the workforce and identifying clear roles and responsibilities which challenge traditional ways of

working across all professions and health and social care boundaries through the introduction of integrated working over 7 days. Training and development to enable competencies to be met together with clear career pathways to support talent management, succession planning, and more flexible working conditions will be key to recruitment and retention.

In order to retain our staff, we will provide appropriate opportunities for development and can facilitate conversations to aid people looking for career support. We aim to assist staff in visualising the route for development, with clear career pathways, quality development conversations and personal development objectives. We will use opportunities available through the apprenticeship scheme or preceptorship programmes to help people reach their potential within the Trust, celebrating and sharing their success stories.

On boarding

Significant progress has been made to reduce time to hire, with an increased emphasis on engaging with new recruits between offer of employment and joining the Trust. We will maximise this opportunity to develop a strong relationship between the applicant and their new team, ensuring that they feel both comfortable and supported when joining the Trust. We will formalise and enhance this interaction and the induction checklist to include an expectation of pre-employment contact and engagement. Specific targeted recruitment events, with interviews and offers given on the day, will be set up for any designated hard to recruit staff or if numbers of vacancies reach an unmanageable threshold, such as Health Care Support Workers.

Induction

Certain staff groups will require an enhanced induction period and whilst for many this is covered by the preceptorship model; we will ensure this enhanced support is offered more widely. This support has been offered successfully to our Band 5 overseas recruitment posts and it has paid dividend in the fact that the leaver rate for that group is low. In terms of our non-qualified nursing workforce, we have recognised that they also need individual support and to this end we have introduced designated induction days and targeted training for cohorted groups of new non-qualified starters to build upon the sense of team spirit and comradery.

Preceptorship and retention

We will extend the current preceptorship model to encompass final placement students, utilising the learning from the paid placements for final year students during Covid-19. By starting the preceptorship early, students gain some of the softer skills required to successfully transition into nursing whilst in a slightly more protected environment.

The current preceptorship programme will also extend and provide career advice towards the end of the preceptorship period, reducing the risk of losing staff who often will look elsewhere for other opportunities at this point. We will offer career support to the preceptees in their chosen direction and by having the conversation, we can look to put appropriate support in place.

As part of the non-qualified pathway, we currently run the Care Certificate Award for that cohort at Band 3 level, candidates who have achieved the Care Certificate Award and particularly the high achievers will then become the Preceptors for those newly recruited to Band 2 posts. A non-qualified preceptorship program is currently being developed by the Head of Professional Practice in conjunction with the National Health Service England (NHSE) Regional Lead.

Professional Nurse Advocates (PNA) and Professional Midwife Advocates (PMA)

Professional nursing and midwifery leadership, and clinical supervision, are essential in enabling nurses and midwives to continually improve the care they provide to patients and their families, as well as to protect their own and their colleague's health and wellbeing. The role of the Professional Nurse Advocate (PNA) within the Trust provides nurses with that restorative clinical supervision, and support. The PNA supports a continuous improvement process that aims to build on the personal and professional leadership of nurses, enhancing the quality of care for patients, and supporting the preparedness for appraisal and professional revalidation. The restorative function of the PNA role has been shown to have a positive impact on the physical and emotional wellbeing of staff as it reduces burnout, stress absence, and improves job satisfaction and above all patient experience. For these reasons the Trust will fully support staff entering into the training of staff so that each clinical area will have a professional Nurse Advocate, or access to one.

Clinical placements

We aim to improve the conversion of students and trainees engaging with the Trust as part of their clinical degrees or on placement at the Trust to permanent roles post-qualification. We will do this by ensuring all placements in the Trust are of high quality, deliver the right learning outcomes, and offer a positive student experience. We will also facilitate, working with Edge Hill University, post graduate students to come into the Trust as part of their clinical placements, to work alongside qualified Advanced Practitioners. This will not only enhance their training experience, but it will showcase what services and development opportunities the Trust can offer post qualification.
By strengthening this pipeline, we will improve the long-term staffing position and build a more sustainable future for the Trust. Moving forward those nursing students who have had their placements through the Trust, in conjunction with Edge Hill University, will not need to have a formal interview in order to join the Trust, enhancing our overall commitment to supporting trainees into practice.

Apprenticeships

The Trust has had a great deal of success in utilising the apprenticeship levy prior to the onset of COVID-19. Our current utilisation of the levy is at 45%. We aim to increase this through introducing new roles and attracting new and existing talent to develop their career at the Trust. Going forward, all Bands 2-4 administrative and clerical roles will be considered for apprenticeships when being advertised. We will continue to increase opportunities to enter into nursing through the nursing degree apprenticeship and the nurse associate role and seek to enhance the offer further with the implementation of the healthcare assistant apprenticeship.

2 - Embedding safety

We want our workforce to adapt to the ever-changing needs of modern healthcare. It is vital that we embrace technological advances and innovate to continue to deliver care that is safe, effective and achieves a positive patient experience. We will embed a culture of safety improvement and effective care that reduces harm, improves outcomes and enhances patient experience. We will learn from mistakes and near misses and enhance the delivery of care.

To achieve this, we will:

- Reduce the number of hospital harms (or lapses in care) for our patients through robust review and promoting a learning culture.
- Ensure our staffing resources are used to their full potential and rosters are efficiently and safely produced. Rostering practice needs to continue to improve and all CBU's should continue to monitor it through their team meetings and their governance arrangements. Weekly updates from the central team are distributed to all CBU users to highlight the teams that are not achieving the KPI in accordance with the Roster Management Policy, CORP 88.
- Maintain a high standard of safeguarding practice when caring for patients at risk with vulnerabilities
- Ensure all staff have a voice that counts and are encouraged and supported to speak up/raise any concerns to develop a safer, learning organisation.
- Ensure that the Ward Dashboard is fully displayed and scrutinised at relevant Committees to afford assurance against the metrics
- Ensure we feedback and share and embed lessons learnt from patient safety incidents across all
  CBU's and external stakeholders

3 – Clear communications

We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors and use this feedback to help us improve our services. We want our workforce to recognise and respect the varying needs of patients (including children) for information and explanation and give them the information they want or need, using appropriate language in a way that they can understand.

It is vital that we listen to everyone and respond appropriately and in a timely manner.

To achieve this, we will:

- Continue to improve communication by ensuring patients receive the right level of information that they need, in a way that is meaningful to them
- Further enhance the patient's voice based on "what matters to them" and ensure each area has a Patient Experience/Dignity Champion
- Further develop and embed ward/departmental patient experience dashboards to enable local monitoring and to drive improvements in patient engagement and feedback
- Ensure our senior nurses and ward and department managers are visible, to strengthen engagement and communication with patients, their families, carers and staff, responding

to any comments or concerns they may have. Widely communicate and share the changes made as a result of patient feedback to further embed improvements Trust-wide.
- Work collaboratively with external such as the Maternity Voices Partnership and Healthwatch to ensure experience for patients, parents and their families is the best it can be

4 – Achieving person-centred care through improved systems and processes

We want our workforce to have the capabilities to access and understand the latest digital systems and use them to inform decisions and improve patient care. It is vital that we use technology to reduce duplication of work and increase patient facing time. We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centered, reliable, and fit for purpose.

To achieve this, we will:

- Continue to embrace a positive attitude towards technology and innovation and its potential to improve care and outcomes which will support the improvement of the digital capabilities of everyone working in healthcare
- Integrate more digital technology during face-to-face assessments and reviews, ensuring real-time input into systems in conjunction with the patient
- Increase patient involvement when utilising digital technology in patient care i.e., patient portals
- Contribute to the development and implementation of the digitalisation of the nursing record
- Embed a process for continual engagement with the digital quality audit tool 'Tendable' to drive and monitor patient care improvements at a local level

5 - Raising standards of care

We want our nurses and midwives to have 'pride in the profession' recognising and articulating the contribution they make to patient outcomes through their delivery of evidence-based interventions. We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families.

It is vital that we maintain our culture of caring and continuous improvement and that nurses and midwives actively seek to learn from incidents and complaints, sharing best practice and lessons learned across the Trust and wider profession.

To achieve this, we will:

- Ensure protected leadership time for nursing and midwifery managers in line with service demands
- Promote the wider uptake of the PNA and PMA role and give protected time for both roles support our staff both professionally and personally through Reflection

and Action Learning Sets.

- Support nurses and midwives to actively participate in local multi-disciplinary groups focused on identifying and addressing areas for improvement (shared decision- making)
- Raise the profile of audit, research, development and improvements in nursing and midwifery
- Support the Ward Manager roles with a bespoke Ward Manager Development Programme to enhance care delivery and their career profiles.
- Ward Embed local accreditation via the Trust's Southport and Ormskirk Clinical Assessment and Accreditation Scheme (SOCAAS) for areas such as Outpatients and Theatres, and Emergency Departments.
- Put a reviewed process in place to support the increase in standards for SOCAAS to reflect the achievement towards a Diamond Standard.

6 - Evidence-based pathways to improve outcomes

We want our nurses and midwives to increase collaborative working with patients, primary care providers and community partners to develop end to end care pathways. It is vital that we support shared decision-making so that patients receive the most appropriate care tailored to their needs in the most appropriate setting. As far as is practical and appropriate, we will reduce variations in care pathways to improve outcomes, whilst recognising the specific individual needs of every patient.

To achieve this, we will:

- Actively promote and support patients to adopt more 'self-care' to encourage the individual to take responsibility for their own health and wellbeing
- Continue to make all our services accessible to everyone to improve patient experience and reduce health inequalities
- Undertake equality analyses for all service changes involving nursing and midwifery services
- Explore opportunities to develop rotational posts across specialties.
- Work with external partners such as Higher Education Institutes to support innovative practice.
- As part of a sustainable solution to improving the flow and supply of staff for the future, the Trust is committed working with local education providers to promote working within the NHS as a career of choice. There are over 350 careers within the NHS and by working to engage with those in education. We will raise awareness of these and develop a strong pipeline for the future through attendance at local careers events and developing a programme of community engagement from primary school upwards. To maximise impact, clinical staff will attend to inspire by sharing their story and showcase their profession. We will offer career progression opportunities for those staff.

Measuring our impact

As with any Plan it is imperative that we constantly monitor and refine our approaches to ensure that we are successful, and we continue to improve. Measures for this Plan will be reported regularly to Workforce Committee, providing assurance on the delivery of the outcomes.

This Plan aims to impact on a number of performance measures across the Trust and these include:

- Improved Friends and Family Test scores
- Improvements in the average theatre case per list and less cancellations and improved efficiency
- Registered Nursing and Health Care Support Worker trajectories plotting progress made against an aspirational target of 'zero' vacancies by 2023.
- Decrease in Waiting List Initiatives, the use of NHS Professional and agency to enable better triangulation with Financial Plans
- Reduce temporary staffing spend from current 5.7% against pay bill position
- Robust plans in place to mitigate £485k spend on incentive schemes through Winter
- Improved staff engagement scores due to better working conditions, more opportunities for career progression and flexible working
- Manage sickness absence rates in line with Trust target (6%) (reduction from 14.88% for N&M and 14.82% for HCSW)
- Increases in applications per advert and improved length of time to hire (aspirational target is 30 days)
- Reduce overall turnover to reduce staff turnover to 10% (from average 6-7 HCSW leavers per month to 3)
- Increased opportunities for entry into nursing and midwifery careers
- An increase in both the PNA and PMA numbers
- Increased Health Care Support preceptorship numbers with improved retention

Our Delivery Plan

Key areas of focus	Key deliverables 2022/23	Key deliverables 2023/24
Looking after our people Staff health and wellbeing Staff engagement and communication People management practices	Implement Team Time / Schwartz Rounds Supporting Ward Manager development sessions Listening plan – Quarterly 'Listening Weeks' and Staff Voice Partnership. Career development conversations 'Scope for Growth' embedded in PDR (aiming for 100% PDR compliance) Onboarding, induction and preceptorship programme in place for new Health Care Support Workers Midwifery Support Workers framework designed inc. career pathway and preceptorship	Regular engagement in Schwartz Rounds by multidisciplinary teams Midwifery Support Workers framework implemented
Belonging to the NHS Promoting inclusion Improving our leadership culture	100% Nursing and Midwifery Managers B7+ attended Civility and Respect training Bespoke career development support for International Nurses Review core leadership development offer to incorporate compassion and just and learning principles.	95% all nursing and midwifery workforce attended Civility and Respect Awareness sessions Values based recruitment practices adopted for all nursing and midwifery recruitment Target for attendance at core leadership development programme by band
New ways of working Agile and digital working Workforce planning Change management	Increased promotion of flexible working and number of requests for flexible working amongst nursing and midwifery staff group Improve rostering practices	Improved staff retention Increased fill of hard to recruit to posts through introduction of new roles or joint appointments, such as Advanced Nurse Clinical Academic Collaborative in house nurse bank with StHK
Growing for the future Workforce recruitment and development	Deliver on nurse recruitment (+40 IR nurses) Deliver on Midwife Recruitment (3 IR Midwives by November 2022) Increased placements offered to nursing and AHP students with Edge	Strengthened pipeline into careers at the Trust Implement the nursing workforce recommendations from the Kendall Bluck review.

	Hill and UCLAN Conversion of some nursing posts to AHP (Frailty, Surgical, Anaesthetics) Conversion of some health care support worker posts into ward-based support roles Implement the nursing workforce recommendations from the Kendall Bluck review. Recruit fixed term cohort of ward-based support roles as part of Winter Plan Rotational nurse teaching sessions (12 weeks) at Edge Hill University Develop in-house development programme for care support workers	Increased number of Apprenticeships amongst band 1 – 4 roles

Summary

This strategy outlines our goals of what outstanding care is as well as what our staff can expect and aspire to in terms of their own career development.

We also recognise there may be a need to update the strategy in line with changes to the operating environment or world events such as the COVID-19 pandemic.

This strategy will be implemented in conjunction with the following:

- Our People Plan
- Health Work and Wellbeing Strategy 2022-25
- Our Resourcing Plan 2022-2025
- Patient Experience and Inclusion Strategy 2022-2025
- Patient Safety Strategy 2022

Further reading

Always Events ® www.england.nhs.uk/always-events/

Ockenden Review of Maternity services March 2022 www.england.nhs.uk/publication/ockenden-review-of-maternity-services/

Pathway to Excellence ® www.england.nhs.uk/nursingmidwifery/shared-governance-and-collective-leadership/nursing-midwifery-excellence/
Shared Governance and Collective Leadership www.england.nhs.uk/nursingmidwifery/shared-governance-and-collective-leadership/
Matron's Handbook July 2021 www.england.nhs.uk/mat-transformation/matrons-handbook/

Birthrate Plus ® www.birthrateplus.co.uk/

NHS Workforce Race Equality Standard (WRES) www.england.nhs.uk/about/equality/equality-hub/equality-standard/
NHS Workforce Disability Equality Standard (WDES) www.england.nhs.uk/about/equality/equality-hub/wdes/
SafeCare Allocate www.allocatesoftware.co.uk/solutions/workforce-need/care/safecare/

Trust Objectives 2022 – 2023 Trust Objectives 2022/23

Deprivation of Liberty Safeguards www.cqc.org.uk/sites/default/files/Deprivation%20of%20liberty%20safeguards%20code%20of%20practice.pdf
Maternity Voices http://nationalmaternityvoices.org.uk/

PLACE https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place
NHS People Plan 2021 - https://www.england.nhs.uk/ournhspeople/

Workforce Standards RCN 2021 - https://www.rcn.org.uk/professional-development/publications/rcn-workforce-standards-uk-pub-009681

Shared Decision-Making Summary guide https://www.england.nhs.uk/wp-content/uploads/2019/01/shared-decision-making-summary-guide-v1.pdf
NHS Long Term Plan 2019 - https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

Tendable https://www.tendable.com/

Schwartz Rounds https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/reflective-practice/schwartz-rounds

Professional nurse advocate A-EQUIP model: A model of clinical supervision for nurses https://www.england.nhs.uk/publication/professional-nurse-advocate-a-equip-model-a-model-of-clinical-supervision-for-nurses/

Health Education England: A Health and Care Digital Capabilities Framework
www.hee.nhs.uk/sites/default/files/documents/Digital%20Literacy%20Capability%20Framework%202018.pdf

Health Education England Accelerated Workforce Redesign, Star Model.

HEE Star: Accelerating workforce redesign | Health Education England

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**05 October 2022**
Agenda Item	**SO184/22**	**FOI Exempt**	**NO**
Report Title	**GUARDIAN OF SAFE WORKING QUARTERLY TRUST REPORT (01 April - 30 June 2022)**		
Executive Lead	Dr Kate Clark, Medical Director		
Lead Officer	Dr Kate Clark, Medical Director		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To update on issues related to Guardian of Safe Working

Executive Summary

Key Messages and Recommendations:

1) Trainees are much more engaged with the exception report process. If Supervisor meetings are not happening trainees are requesting payment; this should default to TOIL.
2) Trainees continuing often to stay late in surgery rather than elsewhere.
3) Issues around phlebotomy services not providing adequate ward service.
4) Only partial spend of the HEE Facilities funding.

Recommendations

The Strategy and Operations Committee is asked to receive the Guardian of Safe Working Quarterly Report.

Previously Considered By:

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

Strategic Objectives

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

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

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

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

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

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

Prepared By:	**Presented By:**
Dr Kate Clark, Medical Director	Dr Kate Clark, Medical Director

Southport and Ormskirk Hospital NHS Trust

THE GUARDIAN OF SAFE WORKING
QUARTERLY TRUST REPORT

01 April – 30 June 2022

INTRODUCTION

As we currently are in the processes of appointing a Guardian of Safe Working, this report has been prepared on behalf of the Medical Director collating information with regard to safe working for trainee doctors. This information is produced from Hours, Pattern and Service Support Exception Reports generated by trainees Education Exception Reports are monitored by Director of Medical Education who will report on these to Board.

1. EXCEPTION REPORT OVERVIEW (30 June 2022)

Covid-19 and its ramifications continue to affect day to day hospital work and so affect trainees.

Trainees are much more engaged with the Exception Report system overall. They tend to see it as individually transactional though, in that if they stay late, they are compensated rather than a tool to collectively improve things. There have recently been exceptions reports regarding levels of senior support during a shift and this was addressed promptly by the clinical director. It is encouraging to see that the system is being used to report more than just additional hours. There has also been an improvement in the reporting from non-foundation doctors, which again is encouraging as the system is in place for all junior doctors.

A recurrent theme is that meetings with Education Supervisors are not being recorded on the system. The importance of carrying out these meetings and ensuring that the doctors' concerns are addressed is being reiterated to the Supervisors and the Resourcing team are issuing reminders to the Supervisors with outstanding exceptions each week. These are escalated through clinical leadership teams as required and discussed at the Medical Leadership team meeting.

It has also again been stated that consultants are discouraging exception reporting in some areas and again clear messaging has been sent to Consultants to advise against this.

Some Consultants continue to expect new trainees to be up to speed immediately in new role (balance between being new and performing at expected level for a new trainee).

There were no immediate patient safety issues raised via exception reports during this period.

Reference period of report	01/04/2022 – 30/06/22
Total number of exception reports received	12
Number relating to immediate patient safety issues	0
Number relating to hours of working	11
Number relating to pattern of work	0
Number relating to educational opportunities	0

Number relating to service support available to the doctor	1

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	5
Total number of overtime payments	6
Total number of work schedule reviews	0
Total number of reports resulting in no action	1
Total number of organisation changes	0
Compensation	0
Unresolved	0
Total number of resolutions	**12**
Total resolved exceptions	**12**

1.1. MEDICINE

Workload across the organisation remains high, however only 1 exception was recorded during this period.

1.2. SURGERY

10 Exception Reports this quarter generally for additional hours due to excessive workload. These are predominantly on the Foundation year 1 rota, and work is ongoing to try to improve this.

2. PAYMENT AND FINES

There have been no GoSW fines levied in the last 12 months.

3. ROTA COMPLIANCE AND IN-HOUSE LOCUM ARRANGEMENTS

There were no Work schedule reviews during this period.

All rotas are now compliant with the 2016 Junior Doctor Contract rule.

DOCTORS NOT ON THE NEW CONTRACT

All trainees are on the 2016 contract.

No concerns about safe working from non-trainee doctors have been escalated to the GoSW.

4. VACANCIES (as of 30th June 2022)

SOHT continue to actively recruit and therefore vacancy rates are changing frequently – there are currently 11 vacancies spread across the specialties.

A number of offers have very recently been made and this has been partly due to HR pushing hard to advertise. The overall number of vacancies is reducing and this is helping to reduce episodes of excessive workload.

However there has been a rise in sickness (mainly due to Covid) and this has led to short notice rota gaps and has had an impact on staffing levels particularly overnight.

5. TRAINEE CONCERNS

Trainee doctor forums have now been agreed for the second Wednesday of every month.

a) Attendance at the TDF remains variable although overall more trainees are participating.

b) Previously issues raised by trainees had not been followed up when an action was required by the trainee. The forum now has an action log and this is reviewed to ensure actions are completed with email follow up when trainees either don't attend or haven't completed an action.

c) Trainees report staying late to complete ward tasks.

d) The relevant Rota's now have Self Development Time included. This is mostly in blocks of 4 or more hours which is popular and said to work well. Medicine trainees have an hour before and after teaching and are experiencing difficulties achieving the required protected self-development time. They have been encouraged to exception report when teaching is cancelled or they are not able to attend due to operational pressures.

e) The new leave policy which prescribes a maximum seven days to decision on approval / rejection of leave has been implemented. Trainees are still experiencing difficulties in obtaining leave. Specific examples have been requested to enable further review.

f) Concerns were raised pertaining to the oversight of covering gaps in rosters, with trainees feeling that it was very last minute. Roster teams have been reconfigured and are monitoring rota gaps in advance with requests to bank and agency. It was agreed that further attempts would be made to share information to provide this assurance and differentiate between short notice sickness causing gaps and gaps due to longer term vacancies.

g) Further clarity was requested regarding rates of pay for different grades and levels of approval within the organisation. This information is contained within operational plans and was shared with the TDF members.

6. FACILITIES

Facilities funding of over £60,000 has been made available for the Trust's Trainee doctors to improve rest and related facilities. It has been used to upgrade the mess in ODGH (indirectly funded) and to improve the Senior Trainee room at SDGH.

There remains an outstanding proposal to change the kitchen/bar/toilets area in the CEC to a bigger sleep area with non-gendered bathrooms.

Estate's capacity to do this remains an issue.

Funding has been provided to replace sofas and chairs in the doctors' mess at Southport.

7. ADDITIONAL GOSW CONCERNS

In terms of management priorities

1) At present we have no Guardian of Safe Working in post, the function has been jointly supported by the Executive Medical Director, Director of Medical education and Head of Resourcing.
2) Support has been sought from partners, STHK and consideration of a job share has been discussed.

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Finance, Performance, and Investment Committee
MEETING DATE:	26 September 2022
LEAD:	Jeff Kozer

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The Trust continues to experience performance issues with the telephony network. As part of the levelling up of digital capability the Trust is planning to remedy the current issues once the new network is installed. The IT team are looking into whether there are remedial steps that can be take in the meantime to improve the current performance.
- The Trust is reporting a £8m deficit at month 5, 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 5 the Trust is delivering to plan. With regards to Elective Recovery Fund (ERF) the Trust has assumed payment in full up to month 5 and will assume this is extended up to month 6. 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 September report included a profiled financial plan to demonstrate the timing of the various elements of the plan to support providing greater assurance re delivery.
- The cash balance at the end of August is £6.1m. The ICB finance team have made payments on the first of the month from August instead of 15th, and discussions are ongoing about additional support required from October.
- A&E performance in August 2022 compares positively to peers and top quartile nationally and best acute performer in C&M but below the national standard.

ADVISE

- A paper was approved at the Executive Committee to increase the engineer input to the network remediation programme, in order to be able to reduce timelines for the work.
- As part of the frontline digitisation initiative a three-year investment bid has been submitted to the ICB and the Trust is awaiting confirmation of circa £21m of funding.
- Rheumatology collaboration with STHK due to commence in October which will result in additional direct clinical sessions and support to complete a service review.
- Whilst still below the national standards, the Trust has seen improvements across all cancer metrics.

ASSURE

- The theatre fire storage work at Ormskirk has been completed.
- The second temporary backup generator has been decommissioned and removed from site.
- A Reinforced Autoclaved Aerated Concrete (RACC) survey was undertaken and there was no evidence of it being present on either site.
- The new laundry service is on track to go live 01 October
- The Medicine and Emergency 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 95.1%, which is slightly above the 95% target.
- The capital programme spend at month 5 is slightly above the plan of £4.4m at £4.7m.
- North Mersey Stroke Pathway went live on 19 September 2022 and initial feedback has been positive with Southport creating capacity for repatriations within the required

timescales. Will continue to monitor for next eight weeks with the aim of deescalating stroke from the fragile service list. • Secured additional capital funding to support elective restoration and increase capacity. In addition, also secured funding to support 14 steps down beds in community. • Performance for 104+ weeks, 78+ weeks and 52+ weeks best acute trust across C&M.
New Risks identified at the meeting: None
Review of the Risk Register: No action taken

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Executive Committee
MEETINGS HELD:	September 2022
LEAD:	Anne-Marie Stretch

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Preparation for Industrial Action (12/09/2022)
The Committee had received an update on the potential for industrial action to be taken by NHS staff as well as the preparatory actions required. It was noted that the Royal College of Nursing (RCN) had progressed to a statutory ballot and that discontinuous industrial action by nurses had been proposed from 28 October 2022. Other unions including UNISON, RCM, GMB, SoR, SoP were currently consulting members about industrial action.

IT Network (20/09/2022)
The Committee received an update following the network outage on 08 September and 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.

ADVISE

Maternity Action Plan Update (standing item)
The Executive Committee received a weekly update on progress in implementing and embedding the action plan.
An additional bid for the national maternity support funds had been submitted and included funding for clinical director capacity, Midwifery Support Workers (recruitment, retention, and training) and bereavement support (moving towards seven-day cover.)

HR Policy Update (05/09/2022)
It was agreed that an extension to the review date of 12 months would be granted to the HR policies that remained legally compliant.

Performance Tier 2 Meeting (05/09/2022)
There was feedback from the meeting where the Trust's continued improvement in cancer services performance had been recognised.

Uplift to On Call Availablity Supplement (12/05/2022)
The Committee approved the % increase of the on call availability supplement in line with the nationally agreed pay award.

2022 Pay Award and Pensions Implications (12/05/2022)
The committee received a briefing on the action taken for Trust staff who had been identified as being negatively impacted by increased pension contributions as a result of the 2022/23 pay awards.

Repurposing of Ward 11a Escalation Ward into a Ready for Discharge Ward – Update (20/09/2022)

The Committee discussed the closure of Ward 11a as an escalation ward and agreed that at this current time due to current bed deficit, high levels of bed occupancy and long waits in ED should remain open. The committee agreed to review the staffing model and the use of Ward 11a as the ward is currently staffed predominantly through temporary staffing.

Update on Chase Heys Beds (20/09/2022)
The bid had been approved to create 14 step down beds which would enable the movement of patients from the hospital without the need for a Trusted Assessor Document (TAD) to a facility where they would be assessed and receive therapy support (from Trust staff).

Monthly Staffing Report (20/09/2022)
The Committee received an update on the monthly staffing, vacancy rates, recruitment, and establishment reviews.

System Responses (27/09/2022)
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.

CT Scanner Order (27/09/2022)
Committee agreed that due to the lead time the order for the new CT scanner should be placed as the CDC funding allocation had been confirmed.

ASSURE

Hips and Knees Contract (30/08/2022)
The Executive Committee approved the awarding of a four-year contract, to Johnson and Johnson Medical Ltd to provide Hip and Knees implants.

Nursing and Midwifery Strategy (05/09/2022)
The Executive Committee reviewed the Nursing and Midwifery Strategy and agreed to recommend it to the SOC for approval. The need for a fully integrated clinical workforce strategy was acknowledged as the next phase of development.

Cost Improvement Programme (CIP) Update (20/09/2022)
CIP had been delivered to plan and new schemes identified which were being developed. The need to complete Quality Impact Assessments on all schemes was noted as a priority.

The planned approach to budget setting/business planning for 2023/24 had been discussed and this would include early identification of the CIP schemes, so they were identified before the start of the financial year.

Capital Programme prioritisation (27/09/2022)
Committee reviewed and agreed the priority schemes for the remaining internal capital in 2022/23.

Board to Ward Visits (27/09/2022)
Committee reviewed the impact of the Board to ward visit programme and agreed a number of proposals to evolve the format to improve staff engagement and Director visibility.

Staff Voice Partnership (27/09/2022)
The committee received a briefing on the outcome of the first phase of the Staff Voice Partnership activities.

Electronic Document Management Maintenance Contract (27/09/2022) The Committee agreed to extend the contract with the current provider for a further three years.	
New Risk identified at the meeting	Impact of potential national industrial action on patient services.
Review of the Risk Register	