Southport and Ormskirk Hospital NHS Trust

AGENDA
STRATEGY AND OPERATIONS (S&O) COMMITTEE
To be held at 0930 on Wednesday 01 June 2022

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0930***
SO095/22 (P)	**Patient Story** *Purpose: To **receive** the patient story*	*No*	*L Barnes*	15 mins
SO096/22 (V)	**Chair's welcome and note of apologies** *Purpose: To **record** apologies for absence and confirm the meeting is quorate.*	*No*	*Chair*	
SO097/22 (D)	**Declaration of interests** *Purpose: To **record** any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
SO098/22 (D)	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 04 May 2022.*	No	*Chair*	10 mins
SO099/22 (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**
SO100/22 (D)	NHS Data Security and Protection Toolkit Update *Purpose: To **note** the* NHS Data Security and Protection Toolkit Update	*No*	*J McLuckie*	10 mins
SO101/22 (D)	**Effectiveness Review - Annual Workplans** a) Strategy and Operations Committee b) Assurance Committees *Purpose: To **approve** the Annual Workplans*	*No*	*N Bunce*	10 Mins
INTEGRATED PERFORMANCE REPORT				**1015**

SO102/22 (D)	**Integrated Performance Report (IPR)** a) Quality and Safety b) Operations c) Finance d) Workforce *Purpose: To **receive and note** the IPR for assurance.*	*No*	*L Barnes* *K Clark* *L Neary* *J McLuckie* *J Royds*	20 mins
QUALITY & SAFETY				**1035**
SO103/22 (D)	**Quality and Safety Committee AAA Highlight Report** *Purpose: To **receive** the Quality and Safety AAA Highlight report*	*No*	*G Brown*	5 Mins
SO104/22 (D)	**Draft Quality Account 2021/22** *Purpose: To **approve** the Quality Account 2021/22*	*No*	*L Barnes* *K Clark*	10 mins
SO105/22 (D)	**Maternity Report including Ockenden II Self-Assessment** *Purpose: To **receive** the Maternity Report*	*No*	*L Barnes*	10 mins
WORKFORCE				**1100**
SO106/22 (D)	**Workforce Reports** a) Committee AAA Highlight Report *Purpose: To **receive** the Workforce reports*	*No*	*L Knight*	20 mins
FINANCE, OPERATIONS AND INVESTMENT				**1120**
SO107/22 (D)	**Finance, Performance and Investment Reports** a) Committee AAA Highlight Report *Purpose: To **receive** the Finance, Performance and Investment Reports*	*No*	*J Kozer*	15 mins
CORPORATE				**1135**
SO108/22 (D)	**Executive Committee AAA Highlight Report** *Purpose: To **receive** the Executive Committee AAA Highlight Report*	*No*	*AM Stretch*	5 Mins
CONCLUDING BUSINESS				**1140**
SO109/22 (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*

			5 mins
SO110/22 (V)	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*	*Chair*	
	Date and time of next meeting: 0930 Wednesday 06 July 2022		***1200 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 04 May 2022
(Approved by the Strategy and Operations Committee on 01 June 2022)

Present

Name	Initials	Title
Richard Fraser	RF	Chair, STHK
Ann Marr	AM	Chief Executive
Lynne Barnes	LB	Director of Nursing, Midwifery and Therapies
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
Rowan-Pritchard-Jones	RPJ	Medical Director, STHK
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

In Attendance

Name	Initials	Title
Geoffrey Appleton	GA	Board Advisor, STHK
Sandra Croston	SC	Spinal Unit Manager *(Item SO071/22 only)*
Caroline Dawn	CD	Assistant Director of Operations Clinical Support Services, STHK
Linda Douglas	LD	Freedom to Speak Up Guardian *(Item SO083/22 only)*
Tony Ellis	TE	Communications and Marketing Manager *(Part 1 only)*
Stephen Mellars	SM	Deputy Director of Nursing *(Item SO071/22 only)*
Alan Sharples	AS	Board Advisor, STHK
Juanita Wallace	JW	Assistant to ADCG (minute taker)
Joan Woods	JWo	Matron, Spinal *(Item SO071/22)*

Apologies

Name	Initials	Title
Gill Brown	GB	Non-Executive Director, STHK & S&O
Paul Growney	PG	Non-Executive Director, STHK
Anne-Marie Stretch	AMS	Managing Director

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
SO071/22	**Patient Story**	
	SM introduced the patient story video which was provided by a patient who had been admitted to the Regional Spinal Injuries Centre in April 2021	

following an accident and continued to receive care as an inpatient. He shared his thoughts about the impact of restricted visiting on the unit due to Covid-19 and how this had impacted on both his physical and emotional wellbeing throughout his lengthy admission.

When the Spinal Unit was reopened to visitors in July/August 2021 patients were allowed one nominated visitor per week, however, if there were any Covid-19 outbreaks visiting would again be suspended. The patient reflected that he and his wife had felt isolated despite being in daily contact via Facetime on his iPad.

The patient commented on the effect that Covid-19 sickness absence had on staff and patients and that this meant there were limited socialising activities for patients as the had to remain in their rooms to prevent the spread of the infection.

LB asked about the current visiting arrangements and JWo advised that there were now designated daily visiting hours for each patient and that the Team worked with visitors to accommodate their needs e.g. if they were travelling a long distance. Patients and visitors were also now being encouraged to make use of the spinal garden during visits.

SR asked how the changes to visiting arrangements were communicated to relatives. JWo advised that the spinal unit had monthly patient forums to discuss issues and advise of any developments and patients were encouraged to provide feedback to their relatives. The Clerical support team was also communicating relevant information to the relatives, so they knew when the situation changed.

RF asked if it had been difficult to coordinate suitable visiting times as the patient's wife had been travelling from Cumbria and SC advised that they tried to manage this according to each patient's needs and would try to arrange additional visiting time if needed when relatives travelled long distances.

NB reflected on the difference that having access to an iPad had made for the patient and asked if the Trust had provided access to iPads for those who didn't have one of their own. JWo advised that the Trust was able to provide access to iPads, but the majority of this patient group did have their own devices.

RF thanked the patient for sharing his experiences and for the work that he and his colleagues in the Mountain Rescue Team do and also thanked the staff for their hard work

	RESOLVED The Strategy and Operations Committee **received** the Patient Story	
SO072/22	**Chair's Welcome and Note of Apologies**	
	RF welcomed all to the meeting and in particular welcomed John Howard, a member of the public who was in attendance. He also welcomed Caroline Dawn, Assistant Director of Operations, Clinical Support Services, STHK, who was attending the meeting as an observer as part of the NHS Leadership Academy, Nye Bevan course. Additionally he welcomed GL who was attending this first meeting in his role as Director of Finance at St Helens and Knowsley Teaching Hospitals (STHK). Apologies for absence were **noted** as detailed above.	
SO073/22	**Declaration of interests**	
	There were no declarations of interests in relation to the agenda items.	
SO074/22	**Minutes of the previous meetings**	
	The Committee reviewed the minutes of the previous meeting held on 06 April 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 April 2022	
SO075/22	**Matters Arising and Action Logs**	
	The meeting considered updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. **RESOLVED:** The Strategy and Operations Committee **approved** the action log	
STRATEGIC AND GOVERNANCE		
SO076/22	**Audit Committee AAA Highlight Report**	
	IC presented the AAA Highlight Report and advised that: • a theme had emerged around the number of policies and procedures that had not been reviewed in a timely manner and the Committee was advised of the plan that was in place to strengthen the review process	

	and create a trajectory of improvement to address the backlog of policies that were out of date by the end of December 2022. • The Committee had recognised that the new cleaning standards were wider than previously experienced, and this was potentially a new or increased risk. The Committee had asked where these will be reported and monitored, and which assurance committee(s) would need to be involved. It was noted that the Audit Committee could, if necessary, add this to the internal audit programme at an appropriate time. • BAF Risk 4, Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated, had been discussed and the Committee had agreed that the section of the risk relating to staff feeling valued and motivated required additional evidence of the actions being taken to provide assurance that it was being effectively addressed. • Following a discussion around Anti-Fraud training, it had been agreed that whilst this did not need to form part of the mandatory training, there was a need to review the current training offered and provide assurance that staff continued to receive initial and periodic refresher training. KC confirmed that the introduction of the new cleaning standards was being monitored by the Infection Prevention and Control (IPC) Group which reported into the Quality and Safety Committee. LK confirmed that BAF Risk 4 had already been picked up by the Workforce Committee and that the actions and evidence sections would be updated to ensure clarity. The Audit Committee had been assured by the Head of Internal Audit Opinion Report that indicated that the Trust had made significant progress in the last 12 months and received substantial assurance in relation to the Trust's systems of internal control. The Audit Committee had approved the Anti-Fraud and Internal Audit Plans for 2022/23 as well as the External Audit Plan and fees for 2022/23. **RESOLVED:** The Strategy and Operations Committee **noted** the Audit Committee AAA Highlight Report	
INTEGRATED PERFORMANCE REPORT		
SO077/22	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 March 2022.	

	a) Quality and Safety Performance Report	
	KC and LB jointly presented the report which provided an overview of performance against the quality and safety performance metrics. It was noted that: • Staffing had shown an improvement in month. LB advised that the Trust had achieved 100% fill rate for registered nurses despite being in escalation and had received a letter from the Chief Nursing Officer for England in recognition of this achievement. • Work around the recruitment to vacant Health Care Assistants (HCA) posts was ongoing and was on track for all vacancies to be filled by end of August 2022. • There had been an increase in patient falls and pressure sores, mainly in the frailty and high risk areas and there were lessons to be learnt from this. LB advised that the creation of the frailty unit was a priority for the year and that progress was being made. SR commended LB and the team on achieving the 100% fill rate for registered nurses, especially with the challenges around sickness absence and Covid-19 and asked how this had been achieved. LB advised that this was due to the successful recruitment of international nurses as well as the use of NHS Professionals. The Trust had used an allocate and arrive system which had worked well and more staff than needed had been booked. It was noted that this was an ongoing piece of work. RF reflected on his recent interactions with a parent whose child had been hospitalised. The parent had complimented the Trust on the care that her child, who had special needs, had received during his stay in hospital. Unfortunately, the child had tested positive for Covid-19 and had to be moved to a different ward which did not initially provide the same special needs care and the parent had contacted RF to advise of this. This had been feedback to the ward and the situation had been dealt with immediately and the parent was happy with the outcome. RF thanked KC, LB and the team for resolving the complaint. KC advised that there had been an increase in the number of Escherichia coli (E.coli) cases recorded over the previous few months. It was noted that, following a review of all cases, there had been no apparent lapses in care. There had been 30 reported hospital acquired Covid-19 cases in March, which compared favourably with other trusts in the North West region. **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 against the constitutional standards and highlighted that: • The Trust had peaked at 71 Covid-19 cases in February 2022 and 70 cases in March 2022 and patients were being cared for across three wards. This followed a similar pattern to other trusts in the region. • There had been a slight reduction in Urgent and Emergency Care 4hour wait performance to 74.3% when compared to February 2022. However, the Trust compared positively against peers and was the best performing Trust in the Cheshire and Merseyside (C&M) excluding Alder Hey Children's NHS Foundation Trust. • High bed occupancy at the Southport site had resulted in patients being bedded in the Emergency Department (ED) and the Clinical Decisions (CDU) overnight. • Consistently high levels of ED attendances had resulted in bed capacity issues and ambulance handover times had increased. • 52-week waits were slightly below trajectory and accounted for 1.5% of the total waiting list at S&O compared to all of Cheshire and Merseyside (C&M) which was 5.5%. The Cancer performance 2weeks wait metrics had declined to 77.1% against the 93% target and LN advised that a review of the underlying data for Cancer Pathways would be undertaken as a part of the data quality assurance programme. Additionally, the Trust had sought mutual aid support as well as assistance from the C&M Cancer Alliance to develop an improvement plan. LN advised that the Emergency Care Improvement Support Team (ECIST) had been on site and the report of their findings would be presented to the Executive and Finance Performance and Investment Committees. RC commented that urgent care performance was challenged nationally and asked if LN would share the outcome of the ECIST visit and recommendations and learning with STHK. IC suggested that it would be useful to include national performance figures for the cancer standards in the IPR to give some context to the Trust performance. LN agreed to look into how this could be presented. NB commented that there might be a delay in the national figures being reported. AS commented that most of the performance against constitutional targets appeared to have declined and asked if this was winter related. LN confirmed that the metrics for the previous three months had been	

	impacted by winter pressures as well as the lifting of the Covid-19 restrictions and that this was the case most years. It was anticipated that the position would stabilise going forward. RF reflected that the lifting of the Covid-19 restrictions for the general population posed an increased risk to staff and patients. KC advised that the visiting remained closely controlled to reduce the risk of cross infection and visitors and patients were reminded of the importance of maintaining social distance and wearing of face masks **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 spend on bank and agency staff during 2021/22 was £30m and that in 2022/23 there would need to be a focus on pay overall including the bank and agency spend. The Trust had achieved the 2021/22 financial plan and achieved a small surplus of £81k at the end of the year. £6.6m of CIP had been achieved, although £3.8m was non-recurrent. Cash balances at the end of March were £18.5m and the capital programme had been delivered. AS queried whether the 100% fill rate for registered nursing had been achieved at the expense of financial performance as the overbooking of NHSP staff would come at a cost. JMcL advised that the premium rate payments reported covered all groups of staff, and that nursing was one element. The increased recruitment of consultants would help to drive costs down as locum appointments could be ended. LB commented that she was confident that the balance was right and that the calculations of the number of staff needed from NHSP was based on sickness absence (mainly Covid-19) and the number of beds in use. **RESOLVED** The Strategy and Operations Committee **received** the Financial Performance Report	
	d) Workforce Performance Report	
	JR presented the Workforce Performance report and advised that: • Core Mandatory Training remained at 89.1% • PDR compliance had fallen to 74.3% • Overall sickness absence in March was 7.9%	

	• There was a slight reduction in the overall vacancy rate in March. The Nursing vacancy rate had seen a significant improvement due to the recruitment of Band 5 and HCA roles. The Medical vacancy rate would continue to show improvement during the year as staff already appointed took up post. • There had been a significant improvement in the Time to Hire rate. **RESOLVED** The Strategy and Operations Committee **received** the Workforce Performance Report	
QUALITY AND SAFETY		
SO077/22	**Quality and Safety Report**	
	a) Quality and Safety Committee AAA Highlight Report	
	RT presented the AAA Highlight report and alerted the Committee to the following: • The IPC AAA Highlight Report had noted concerns in compliance with hand hygiene and PPE compliance following an outbreak of norovirus and the situation was being closely monitored. • The Patient Safety Update had noted the appointment of the Falls Lead Nurse who would provide support to patients with cognitive impairment and raise staff awareness. • The Committee had been advised that a business case was being prepared to substantively fill the cleaning rotas that would meet the new cleaning standards for domestic and environmental cleaning. RT advised that the Committee had received a summary of the findings with immediate actions and next steps from the final Ockenden Report . The Committee had been assured by the presentation that highlighted the great progress in musculoskeletal services in implementing PIFU and the plans to introduce this in other specialities to generate additional outpatient capacity to help elective recovery. **RESOLVED:** The Strategy and Operations Committee **received** the AAA Highlight Report from the Quality and Safety Committee.	
SO079/22	**Ockenden II Report Briefing**	
	LB presented the Ockenden II Briefing Report following the publication of the Ockenden Review in March 2022 and highlighted the importance of reading the report for all Trust Board members to understand what had	

	gone wrong at Shrewsbury and Telford. LB on behalf of S&O Trust, had extended condolences to all the families involved in the report. It was noted that there were 15 immediate and essential actions to support service improvements for women and their families which every Trust, Integrated Care System (ICS) and Local Maternity Service (LMS) must consider and act upon. LB advised that these actions would improve not just maternity services, but all services and that the lessons learnt would be shared Trust wide. LB reported on action that had already been taken and advised that the Continuity of Carer programme had been suspended until the Trust was assured that staffing levels were safe and met the recommendations outlined in the report. The role of Patient Safety Specialist for the service was also being explored. LB outlined the next steps which included: • LB and RT would be on site on a regular basis and there would be a site visits by the regional team including the Chief Midwifery Officer. • It was expected that further direction would be received from the regional team around key priorities once the East Kent report into maternity services had also been published. RF reflected that this report had been the most painful read in his 14 years with the NHS and highlighted the multiple tragedies caused by the lack of honesty and transparency. **RESOLVED:** The Strategy and Operations Committee **received** Ockenden II Report Briefing	
SO080/22	**CQC Registration Annual Declaration**	
	LB presented the report which provided a summary of the policies, processes and practices across the Trust to demonstrate how ongoing compliance was maintained with the fundamental standards required by the CQC. IC commented that the green score for Fundamental Standard 7 (Premises and equipment) seemed contradictory based on the current issues with backlog maintenance and RF agreed with this comment. NB advised that this related mainly to the provision of the correct equipment for patients and the standard of environmental cleanliness. LB advised that the compliance was not about national building guidance but compliance against relevant IPC standards.	

	JMcL agreed that this was more around having regular checks in place than backlog maintenance and that, two to three years ago he would have agreed with IC as there had been no fire safety officer in post and no risk assessments or regular electrical tests had taken place, however, this had now been rectified. NB commented that the management of hazardous and clinical waste was in line with current legislation, and this would have contributed to the standard being scored as green. KC commented that one of the key elements of fundamental standards was to ensure that processes were in place to identify any issues and, as this is linked to the Board Assurance Framework (BAF) this was clearly identifiable. **RESOLVED:** The Strategy and Operations Committee **received** assurance that the Trust continues to be registered with the CQC	
WORKFORCE		
SO081/22	**Workforce Reports**	
	a) Workforce Committee AAA Highlight Report	
	LK presented the AAA Highlight report and advised there were no issues to be escalated to the Strategy and Operations Committee as alerts. LK advised that there had been a further reduction in the Performance Development Review (PDR) rate and an interventional approach was being adopted by the Workforce Directorate to ensure compliance increased. The Committee had been assured by the Just and Learning Culture Thematic Presentation which had generated discussions around the links to the Driving Work Culture Change and the Annual Staff Survey Results 2021. It was noted that this presentation had set the tone for the meeting. **RESOLVED:** The Strategy and Operations Committee **received** the AAA Report from the Workforce Committee	
SO082/22	**2021 Staff Survey Results and Action Plan**	

	JR presented 2021 Staff Survey Results and Action Plan which provided a summary of the key results from the recent Staff Survey and recommendations for next steps in response to the feedback from staff. She advised that: • the survey had taken place between October and November 2021 • 280 trusts had taken part with over 595,270 responses being received. • there had been some significant changes to the content of the survey and that the themes had been aligned to the People Promise. • following a change to the benchmarking groups, the number of organisations in the Trust's benchmarking group had increased from 85 to 126 in 2021 • 1,335 completed questionnaires had been returned from S&O from a workforce of 3,218 • The response rate of 42% was consistent with other comparators but was a reduction from 45% in the previous year. The national average was 46% • Corporate Services, and Capital and Facilities had the highest response rates whilst Medicine and Emergency Care had the lowest response. • There had been a reduction in staff recommending the Trust as a place to work or receive treatment score and this was an area of concern. • Whilst there had been a decrease in the staff morale rate it was still above average when compared to the national position. The launch of a Listening Plan would form a key part of the actions to address the survey feedback and would be monitored through the Valuing People Inclusion Group and updates would be provided to the Workforce Committee. JK asked if there were any areas of concern in different departments that JR was aware of. JR advised that the data provided could not be analysed at departmental level, but other indicators such as high sickness absence and a low PDR completion rate were used to identify areas of concern and support would be put in place to assist these departments. Additionally, the HR team were working with the OD team at STHK to use the same dashboard which would allow greater drill down into the data and free text comments to identify hotspots. The Trust would also continue to share the action plans with NHSI to continue to learn and improve. GA reflected on the small changes that were being seen around culture change and suggested that there might be a correlation with the key themes identified in the Freedom to Speak Up Guardian's Report. Additionally, he commented that the action plans presented were sufficient	

	but asked how these would be achieved. He suggested the running of a shadow Board as, from his experience, this provided a better understanding for staff of the actions of the Board. JR commented that shadow boards had been run successfully in the past and that attendees had progressed in their careers. AM reflected on the positive takeaways from survey as well as the action plan presented and commented that additional work would be required to ensure that staff felt valued as this would lead to staff feeling more positive about working for the Trust. JR commented that there had been a general decline across all organisations, and this was mainly due to the challenges faced by NHS staff during the pandemic over the previous two years. Additionally she hoped that the positive impact of the partnership working between STHK and S&O Trusts would be reflected in the next round of staff survey results. AS asked if the Trust would be hosting a 'start of the year' conference as this was an important medium to deliver information to staff. AM advised that this had been scheduled to take place in the next couple of weeks. **RESOLVED:** The Strategy and Operations Committee **received** 2021 Staff Survey Results and **approved** Action Plan	
SO083/22	**Freedom to Speak Up Quarter 4 Report**	
	LD presented the Freedom to Speak Up Quarter 4 Report which provided assurance that staff members felt able to raise their concerns from a wide constituent across the organisation 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 11 concerns had been raised during the period and covered the following themes: • System/Process • Behaviour/Relationship (Attitude) • Patient Safety • Leadership LD advised that during 2021/22 a total of 51 concerns had been raised with the Freedom to Speak Up (FSUP) Guardian which was a slight reduction when compared to the previous year. It was noted that, as per guidance received from the National Guardians Office around reporting, if multiple members of staff raised the same concern these were recorded and reported as individual cases.	

	LD advised that she and LB conducted regular walkarounds at the Southport site to interact with colleagues and would be doing with same at the Ormskirk site. This was an opportunity to gather soft intelligence and she would discuss ways to take this forward with AMS. LD advised that the National Guardians Office was developing a revised policy template as well as amendments to the Freedom to Speak Up Guardian training and she would provide further information once the changes had been confirmed. It was noted that the recent Staff Survey results had indicated that the Trust was below average in relation to the questions around speaking up and raising concerns. LD recognised the work required to encourage staff members to raise their concerns and to achieve this an action plan had been drawn up which included attending listening events and a targeted focus on Freedom to Speak up during October. LD advised that the final module of the Freedom to Speak Up E-learning package had been launched and was designed for leaders at all levels to help foster a speaking up culture in their organisations. AS reflected on the number of concerns that had been raised anonymously which was an indicator that staff possibly did not feel confident. The large proportion of concerns raised by administrative staff was also noted. LB agreed with AS that the high number of concerns raised by administration staff was an area of concern. LD advised that she thought it could be related to changes in working relationships and would complete a deep dive to potentially identify any areas of concern. It was noted that any concerns raised via the FSUP Guardian had been addressed quickly by senior management, but it was more difficult to give this positive feedback to individuals if they raised concerns anonymously. RF asked if the tables included in the report could be updated to include information for previous quarters to enable comparison and LD agreed to look into this for the next quarterly report. **RESOLVED:** The Strategy and Operations Committee **approved** Freedom to Speak Up Quarter 4 Report	
SO084/22	**Guardian of Safe Working Report – Quarter 3**	
	KC presented the Guardian of Safe Working Report which provided an update on issues related to Guardian of Safe Working for Quarter 3.	

	It was noted that the Trust did not currently have a Guardian of Safe Working (GoSW) in post despite it being widely advertised. In the absence of the GoSW reporting was being managed by KC and the Head of Resourcing who had reviewed the exception reports. It was noted that there had been a reduction in the number of exception reports and that all exceptions reported had been resolved. KC was working with the Medical Education Team to ensure a better understanding of exception reporting as well as to identify ways of addressing both short and long term concerns. **RESOLVED:** The Strategy and Operations Committee **received** the Guardian of Safe Working Report	
FINANCE, OPERATIONS AND INVESTMENT		
SO085/22	**Finance, Performance and Investment Committee Reports**	
	a) Finance, Performance and Investment Committee AAA Highlight Report	
	JK presented the AAA Highlight report and alerted the SOC to the following: • The final draft financial plan for 2022/23, showed an improved position from the first draft submission with a deficit of £20.5m. Due to the current financial ICS position, there might need for further iterations as there was an expectation that all ICSs would breakeven. • Work was ongoing to finalise the plan for the IT network replacement programme. • A&E performance in March 2022 was significantly below the national standard but compared positively to peers and was first out of all acute trusts across the C&M region. • There had been a slight reduction in 12hour breaches The report also advised that: • The Committee had approved the Private Patient and Overseas Visitors policies • Discussions were ongoing with Liverpool University Hospitals NHS Foundation Trust (LUHFT) regarding the feasibility of expediting the implementation of the North Mersey Stroke pathway for S&O patients from September 2022 as well as the Service Level Agreement (SLAs) relating to some fragile services. JK advised that the Sefton had been selected as one of the three pilot sites nationally for the Optometry First model and workshops were in place to facilitate the process, which would allow for the utilisation of all available	

	ophthalmology resources across the system to improve current waiting times and clinical outcomes and this would have a positive impact for the Trust. **RESOLVED:** The Strategy and Operations Committee **received** the AAA Report from the Finance, Performance and Investment Committee.	
	b) Final Financial and Operational Plan 2022/23	
	JMcL presented the final draft 2022/23 Financial and Operational Plan and advised that the following updates had taken place since the draft Financial Plan had been presented in April 2022: • £6.2 net improvement to system allocations • £1.1m assumed release of annual leave accrual • £0.2m interest associated with revenue funding removed • Change to backlog capital from £26m to £3.2m for fire and safety and a further £7m pending a formal ICS allocation process JMcL advised that the current system deficit in Cheshire and Merseyside of between £190m and £200m was not deemed to be acceptable and could impact on the ICS's ability to access other sources of funding. It was noted that the Capital Resource Limit of £5.5 remained unaltered. The Trust had been requested remove the £26m included for backlog maintenance and to include £3.2m confirmed funding for Fire Safety, as well as further £7m for backlog pending a formal ICS allocation process. AM advised that she would be discussing this with the Designate Chief Executive of the Integrated Care Board (ICB). **RESOLVED:** The Strategy and Operations Committee **received** final 2022/23 Financial and Operational Plan.	
CORPORATE GOVERNANCE		
SO0086/22	**Executive Committee Report**	
	KC presented the AAA highlight report that detailed the activity and reports considered by the ETM during April and alerted the Committee to • The Deprivation of Liberty Safeguards (DoLS) would be replaced with a scheme called Liberty Protection Safeguarding (LPS). The amount of work anticipated under the new scheme was extensive and would impact on the Trust Safeguarding Team and the Assistant Director of Safeguarding would provide further updates to the Executive Committee (EC).	

	• The Committee had reviewed the Ockenden II report and had agreed to add the Ockenden II compliance to the Quality Priorities for 2022/23 and the remove Continuity of Carer priority. • The Director of Nursing and the Medical Director had provided an update on the maternity incident and advised that the internal and external incident response and governance processes were being followed and staff were being supported. **RESOLVED:** The Strategy and Operations Committee **received** the AAA Highlight Report from the Executive Committee	
CONCLUDING BUSINESS		
SO087/22	**Questions from Members of the Public**	
	It was noted that no questions had been received from members of the public.	
SO088/22	**Any Other Business**	
	In response to JK's comment around the instability of the network and its impact on effective participation in the meeting, JMcL advised that the IT team were investigating steps to resolve this in the short term, which included the replacement of the Virtual Private Network and well as the replacement of cross site switches. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 1157. The next meeting would be held on **Wednesday 01 June 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	✓											
Geoffrey Appleton	✓											
Gill Brown	✓											
Nicola Bunce	✓											
Ian Clayton	✓											
Rob Cooper	✓											
Paul Growney	A											
Lisa Knight	✓											
Jeff Kozer	✓											
Gareth Lawrence	A											
Rowan Pritchard Jones	A											
Sue Redfern	✓											
Alan Sharples	✓											
Anne-Marie Stretch	✓											
Rani Thind	✓											
Christine Walters	✓											
S&O Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Lynne Barnes	✓											
Kate Clark	✓											
John McLuckie	✓											
Lesley Neary	✓											
Jane Royds	✓											
Nina Russell	✓											
✓ = In attendance A = Apologies												

Strategy and Operations Committee (Part 1)

Matters Arising Action Log

Action Log updated 27 May 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
SCO031/21	03/11/2021	**Summary Report of changes to IPC Assurance Framework**	Mr McLuckie to present the outcome of the Six Facet once the updated national building standards guidance had been received.	J McLuckie	03/11/2021	~~March 2022~~ ~~May 2022~~ June 2022	**November Update:** Action progressing and not due **February Update:** Review is due to be completed by end March and update to be provided at the meeting scheduled for 04 May 2022 **April Update:** A desktop exercise has been completed and is currently under review. **May Update:** The desktop exercise review has been completed. **Action completed**	**Completed**
SO049/22	06/04/2022	**Board Assurance Framework**	BAF to be updated to reflect the abovementioned amendments as well as the inclusion of an additional risk around the condition of the estates and the backlog maintenance issues	N Bunce	01/06/2022	Jun-22	**April Update:** BAF to be updated	**Green**
SO050/22	06/04/2022	**Corporate Risk Register**	CW requested that firm dates as well as additional information around the mitigations be included in the plan. Additionally she recommended that the Business Continuity Plan (BCP) be updated to provide assurance that, if the risk materialised, evidence would be robust that the Trust would continue to operate	J McLuckie	06/07/2022	Jul-22	**April Update:** Action plan to be updated to reflect firm dates as well as additional information around mitigations and the BCP to be updated to provide assurance.	**Green**

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**01 June 2022**
Agenda Item	**SO100/22**	**FOI Exempt**	**NO**
Report Title	**NHS DATA SECURITY AND PROTECTION TOOLKIT UPDATE**		
Executive Lead	John McLuckie, Director of Finance and SIRO		
Lead Officer	Stephen Brooks, Head of Information Governance		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ☐ **To Receive**	

Purpose

To update the group regarding the Trust progression on the 2021/22 NHS Digital Data Security and Protection Toolkit (DSPT).

Executive Summary

- The Data Security Protection Toolkit (DSPT) measures assurance against the 10 National Data Guardian's 10 data security standards by mandating that NHS Trust's submit 110 mandatory evidence items across 38 assertions.
- The Trust has currently submitted evidence items for 106 out of 110 mandatory items.
- The Trust is currently not compliant with assertion 3.2.5, Training Compliance, with 92.02% of staff completing their training when 95% compliance is required.
- The Trust is currently not compliant with the three assertions in section 9.2. These assertions are around PEN Testing. IT have booked PEN testing to take place on the 06 to 13 June 2022.
- Head of Information and Cyber Security Manager attended the Merseyside and Cheshire Cyber Incident Exercise on the 29 April 2022. This attendance and involvement in this exercise provided the evidence necessary for the completion of assertion 7.2. Further details regarding this event will be provided at the Resilience Group Meeting on 26 May 2022 and the Information Governance Steering Group 24 May 2022.
- Head of Information Governance attended the national DSPT webinar 09 May 2022.
- The MIAA conducted the preliminary audit of the Trust's DSPT submission on 29 March 2022 with the secondary audit taking place on 23 May 2022.
- The Trust is on track to submit all the remaining evidence items by the 30 June deadline in order to receive 'Standard Met'. If the Training Compliance does not reach 95% then the Trust will be rated as 'Standard Met – Improvement Plan in Place'.

Recommendations

The Strategy and Operations Committee is asked to note the NHS Data Security and Protection Toolkit Update and to ensure that the Trust achieves the 95% compliance with Training by the end of June 2022.

Previously Considered By:

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

Strategic Objectives

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

Southport and Ormskirk Hospital NHS Trust

✓ **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 Brooks, Head of Information Governance	John McLuckie, Director of Finance and SIRO

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Data Security and Protection Toolkit Update

	Managerial Lead: Stephen Brooks – Head of Information Governance & Ginu Mammen – Cyber Security Manager
	Executive Lead: John McLuckie – Executive Director of Finance and SIRO
	Executive State: • The Data Security Protection Toolkit (DSPT) measures assurance against the 10 National Data Guardian's 10 data security standards by mandating that NHS Trust's submit 110 mandatory evidence items across 38 assertions. • The Trust has currently submitted evidence for 106 out of 110 mandatory DSPT items. • The Trust is currently not compliant with assertion 3.2.5, Training Compliance, with 92.02% of staff completing their training when 95% compliance is required. • The Trust is currently not compliant with the three assertions in section 9.2. These assertions are around PEN Testing. IT have booked PEN testing to take place on the 06 to 13 June 2022. • Head of Information and Cyber Security Manager attended the Merseyside and Cheshire Cyber Incident Exercise on the 29 April 2022. This attendance and involvement in this exercise provided the evidence necessary for the completion of assertion 7.2. Further details regarding this event will be provided at the Resilience Group Meeting on 26 May 2022 and the Information Governance Steering Group 24 May 2022. • Head of Information Governance attended the national DSPT webinar 09 May 2022. • The MIAA conducted the preliminary audit of the Trust's DSPT submission on 29 March 2022 with the second audit taking place on 23 May 2022.

Background:

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

The 10 data standards are organised into 3 leadership obligations these being.

People	Process	Technology
Ensure staff are equipped to handle information respectfully and safely, according to the Caldicott Principles	*Ensure the organisation proactively prevents data security breaches and responds appropriately to incidents or near misses*	*Ensure technology is secure and up to date*
1. All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal	4. Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access	8. No unsupported operating systems, software or internet browsers are used within the IT estate.

confidential data is only shared for lawful and appropriate purposes.	data to personal confidential data on IT systems can be attributed to individuals	
2. All staff understand their responsibilities under the National Data Guardian's Data Security Standards including their obligation to to handle information responsibly and their personal accountability for deliberate or avoidable breaches.	5. Processes are reviewed at least annually to identify and improve processes which have caused breaches or near misses, or which force staff to use workarounds which compromise data security.	9. A strategy is in place for protecting IT systems from cyber threats which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually.
3. All staff complete appropriate annual data security training and pass a mandatory test, provided through the revised Information Governance Toolkit	6. Cyber attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken immediately following a data breach Also known as a data breach. A security incident where sensitive and personal information is copied, transmitted, viewed, or stolen. See also: Cyber Security Guidance. More or a near miss, with a report made to senior management within 12 hours of detection.	10. IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.
	7. A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management.	

The DSPT measures assurance against the 10 National Data Guardian's 10 data security standards by mandating that NHS Trust's submit 110 mandatory evidence items across 38 assertions.

The Head of Information Governance and Cyber Security Manager have been working towards completing and collating evidence to complete the mandatory submission items. 106 of 110 mandatory items are complete and the evidence has been collected and is ready for submission. Before the MIAA audit and the final DSPT submission the completed items will have their evidence reviewed to ensure that it is up-to-date and accurate. The Trust's baseline audit submission was submitted, as required by NHS Digital on 28/01/2022.

Progress:

The Head of Information Governance and Cyber Security Manager have been managing the submission of evidence for the DSPT. The Head of Information Governance has been collating and submitting the organisational submission evidence whilst the Cyber Security Manager has been collating and submitting the IT and technical evidence. Updates are provided on the DSPT progress to the Trust's Senior Information Risk Owner (Executive Director of Finance), Caldicott Guardian (Medical Director) and Data Protection Officer (previously the Associate Director of Corporate Governance and now the Head of Risk Assurance at St Helens and Knowsley Teaching Hospitals Trust) at the bi-monthly Information Governance Group (IGSG).

The Trust currently has four mandatory items outstanding if the evidence for these mandatory requirements is not submitted then the Trust would be unable to submit a successful Toolkit for 2021/22 which could affect the Trusts reputation in safeguarding personal data.

The four outstanding area are:

3.2.1 - Have at least 95% of all staff, completed their annual Data Security Awareness Training?

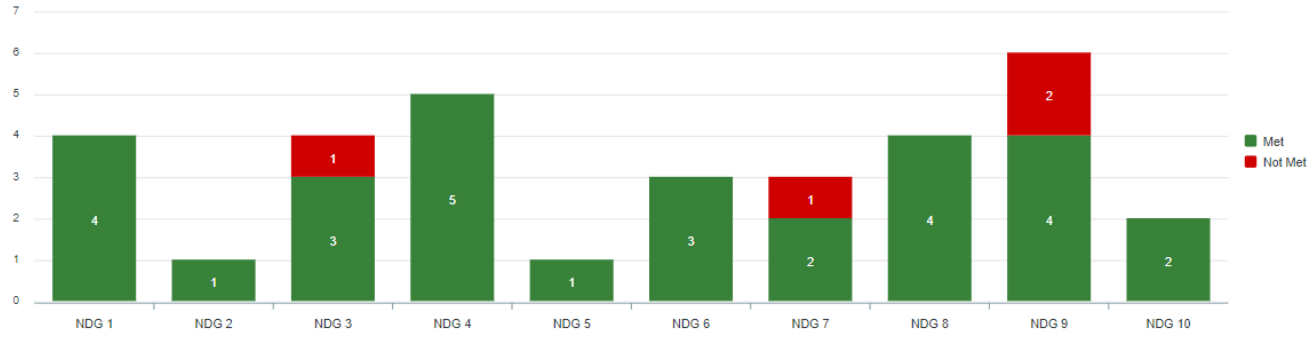
- As of 23/05/2022 the Trust's training compliance is at 92.02%.
- The Head of Information Governance sends a weekly reminder to all staff whose compliance has lapsed.
- The Information Governance Officer sends reminders to supervisors whose staff compliance has lapsed.
- The Head of Information Governance sends reminders to the ADOs regarding their staff compliance.
- IG Training can be completed electronically via ESR, through the completion of IG Handbook and through attendance at the face-to-face training.
- Head of Information Governance attended the national DSPT webinar 09 May 2022 which covered the difficulty NHS organisations are experiencing with attaining the 95% compliance rating.
- IG Training compliance is monitored at the IGSG.

9.2.1 - The annual IT penetration testing is scoped in negotiation between the SIRO, business and testing team including a vulnerability scan and checking that all networking components have had their default passwords changed to a high strength password.

9.2.2 - The date the penetration test and vulnerability scan was undertaken.

9.4.4 - Security deficiencies uncovered by assurance activities are assessed, prioritised and remedied when necessary in a timely and effective way.

- The Cyber Security Manager has booked Sapphire Cybersecurity to conduct a PEN test against the Trust's technical infrastructure on the 6th-13th June 2022. Once completed assertion 9.2.1, 9.2.2 and 9.4.4 will be completed.



NDG 1 - Personal Confidential Data
NDG 2 - Staff Responsibilities
NDG 3 - Training
NDG 4 - Managing Data Access
NDG 5 - Process Reviews
NDG 6 - Responding to Incidents
NDG 7 - Continuity Planning
NDG 8 - Unsupported Systems
NDG 9 - IT Protection
NDG 10 - Accountable Suppliers

The three outstanding mandatory evidence items around the Trust's annual PEN testing will be completed before the submission of the DSPT to NHS Digital on the 30 June 2022.

All endeavours are being made to ensure that 95% of staff have completed their annual Information Governance Training by the time of submission. This is a difficult target to achieve as the total is constantly changing day by day as staff complete their training and other staff lapse. The Head of Information is currently sending weekly reminders to staff whose compliance has lapsed or will lapse

within the next month to ensure that they complete their training. Training can be completed either as a face-to-face session, eLearning or through the completion of the IG Handbook.

IG Training Compliance

The Trust currently has an IG compliance rating of 92.02%, this total however changes daily as staff complete their training or their compliance expirers. The table below shows a breakdown of compliance and non-compliance by CBU.

CBU	Compliant	Due before June 2022	Expired
347 Capital and Facilities	94.22%	5.47%	5.78% (18)
347 Corporate	96.00%	7.67%	4.00% (12)
347 Medicine and Emergency Care	89.66%	8.13%	10.34% (89)
347 Planned Care Division	92.79%	6.21%	7.21% (67)
347 Specialist Services	91.05%	5.91%	8.95% (52)
(blank)	88.24%	17.65%	11.76% (2)
Grand Total	**92.02%**	**6.81%**	**7.98%**

The largest areas of non-compliance with 89 and 67 staff members with expired compliance is Medicine and Emergency Care and Planned Care. The ADOs from all areas have received regular updates as have the staff and their supervisors regarding the issue on non-compliance. The CBU listed as '(blank)' is where the CBU has not been entered against the staff members name on ESR which is the source system of the training data.

Staff can complete their IG training through ESR, at a face-to-face session or through the completion of the IG Assessment which is part of the IG Handbook.

A break down on individual team compliance can be found at the end of this report.

Conclusion

If the Trust cannot achieve the 95% then it will achieve the 'Standard Met – Improvement Plan in Place' rating. On the 09/05/2022 NHS Digital hosted a webinar specifically around the 95% training compliance evidence submission. Nationally 40% of NHS organisations are struggling to meet that requirement this year due to the pandemic pressures. The outcome of the webinar was that if a Trust does not meet the training requirement, then they will be classed 'Standard Met – Improvement Plan in Place' but this status will be removed as soon as the standard is met.

The Head of Information Governance is confident that with the support of the management team the Trust will have a training compliance rate of 95% to achieve the 'Standards Met' rating.

The remaining three evidence items will be produced as part of the PEN testing which has been booked to take place in June. The PEN test will happen after the MIAA phase 2 audit so the findings of the PEN test cannot be submitted as part of the phase 2 audit, but it will be submitted, along with any remedial actions and plans, as part of the Trust's DSPT submission. The findings of the PEN testing will be reported at the IM&T Committee with the result report being immediately made available to the Senior Information Risk Owner (DOF).

Recommendations:

Training – Compliance is currently at 92.02%. There needs to be a focused piece of work to ensure the 95% compliance can be achieved by the end of June.

PEN Testing – This has been booked to take place on 06 to 13 June 2022. Once completed assertion 9.2.1, 9.2.2 and 9.4.4 will be finalised. Any actions that come from the PEN testing will not impact on the successful completion of the DSPT as the DSPT evidence needed is around the annual completion and assigning of tasks that come from the PEN test.

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS COMMITTEE**	**Date**	**01 June 2022**
Agenda Item	**SO101/22**	**FOI Exempt**	**NO**
Report Title	**EFFECTIVENESS REVIEW – ANNUAL WORKPLANS 2022/23**		
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 present the annual workplans for the Strategy and Operations Committee and Assurance Committees that have been reviewed and updated as part of the annual effectiveness review.

Executive Summary

The Strategy and Operations Committee approved a revised workplan in February 2022 to ensure it started 2022/23 with a clear understanding of the programme of work to deliver the functions delegated from the Board as part of the Agreement for long Term Collaboration (ALTC) with St Helens and Knowsley Hospitals NHS Trust.

Following this each of the assurance committees has also undertaken a review of its individual work plan, and these have all now been reviewed to ensure they align and the roles and responsibilities of each are clear and taken together form an effective governance structure (Appendix 1).

This work has supported the review of the terms of reference for each committee that was undertaken when the ALTC came into effect.

The Strategy and Operations Committee is asked to formally approve the work plans for 2022/23.

Recommendations

The Strategy and Operations Committee is asked to approve the changes to the workplans of the SOC and the reporting assurance committees for 2022/23.

Previously Considered By:

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

Strategic Objectives

✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
✓ **SO3** Efficiently and productively provide care within agreed financial limits
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated

Southport and Ormskirk Hospital NHS Trust

✓ **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 1 – Work plans 2022/23

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STRATEGY AND OPERATIONS COMMITTEE ANNUAL WORKPLAN 2022/23 (Proposed)

Agenda Item/Report	Purpose	Lead	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
PRELIMINARY BUSINESS														
Chairs welcome & note of apologies	Note	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Declarations of Interests	Note	All	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Minutes of previous meeting	Approve	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Matters Arising	Receive	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Action Log	Approve	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
PATIENTS AND STAFF ENGAGEMENT														
Patient Story	Assurance	DoN / Patient Exp. Matron	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
STRATEGIC CONTEXT														
Opening Budget and Operational Plan	Approve	DoF	✓											✓
Approval, mid-year, year-end review of annual Trust Objectives	Approve	ManD		✓					✓					✓
Approval/Annual Review of Trust Strategies	Approve	Lead Director	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
(Standing item – as required)														
Performance														
Integrated Performance Report (Quality, Activity, Performance & Workforce)	Assurance	DoF, COO, MD, DoN, HRD	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Winter Plan and review of effectivness	Approve	COO							✓					✓
COMMITTEE ASSURANCE REPORTS														
Executive Management Committee	Assurance	ManD		✓	✓	✓		✓	✓	✓	✓		✓	✓
Quality and Safety Committee	Assurance	Committee Chair		✓	✓	✓		✓	✓	✓	✓		✓	✓
Finance, Performance and Investment Committee	Assurance	Committee Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Workforce Committee	Assurance	Committee Chair	✓		✓			✓		✓			✓	
Audit Committee	Information	Committee Chair	✓		✓				✓				✓	
Charitable Funds Committee	Information	Committee Chair	✓		✓				✓				✓	
QUALITY AND SAFETY														
Quality Account and Quality Improvement Priorities	Approve	DoN / MD	✓										✓	
Learning from Deaths Report	Assurance	MD	✓			✓			✓				✓	
Safe Nursing and Midwifery Staffing Establishment Report (bi-annual)	Approve	DoN						✓						✓
CQC Annual Registration Declaration (March) and Action Plan Progress Reports	Approve	DoN	✓			✓				✓				✓
Maternity Report (Including Ockenden, CNST Updates, establishment reviews)	Assurance	DoN			✓			✓			✓		✓	
Mixed Sex Annual Declaration	Approve	DoN												✓
WORKFORCE														
Freedom to Speak Up Report and Annual Self-Assessment	Assurance	DoN / FTSUG		✓				✓			✓			✓
Guardian of Safe Working Report	Assurance	MD / GOSW		✓				✓			✓			✓
Annual Staff Survey Results and Action Plan	Assurance	DoHR&OD		✓									✓	
OD Strategy / Our People Plan Progress Report	Approve	DoHR&OD		✓						✓			✓	
Gender Pay Gap Annual Declaration	Assurance	DoHR&OD		✓										
WRES and WDES Reports and Action Plans	Approve	DoHR&OD			✓									
Medical Revalidation Annual Report and Declaration	Approve	MD						✓						
REGULATORY, RISK AND CORPORATE GOVERNANCE														
Corporate Risk Register	Receive	DoN	✓			✓			✓				✓	
Board Assurance Framework	Approve	CoSec	✓			✓			✓				✓	
Committee Terms of Reference and Annual Work Plans (Meeting Effectiveness Review and SOC and Committee arrangements for the following year)	Approve	CoSec		✓						✓				
CONCLUDING BUSINESS														
Questions from the public	Receive	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Meeting Evaluation and Effectiveness Review	Note	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
AOB	Note	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Date and Time of next meeting	Note	Chair	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
ANNUAL REPORTS														
Annual Resuscitation Report	Assurance	MD				✓								
Infection Prevention and Control and IPC Assurance Framework	Approve	DoN / MD				✓								
Annual Patient Safety Report	Assurance	DoN				✓								
Safeguarding Annual Report	Assurance	DoN				✓								
Health and Safety Annual Report	Assurance	DoN				✓								
Annual Emergency Planning Report and EPRR Annual Compliance Statement	Approve	COO						✓						
Annual Complaints and Service Experience Reports	Assurance	DoN		✓										
Information Governance Annual Report	Approve	DoF			✓									
CLOSED SESSION														
CEO Report (or more frequently if required)	Receive	CEO		✓		✓			✓		✓			✓
Serious Untoward Incidents	Receive	DoN	✓		✓			✓		✓			✓	
Staff suspensions	Receive	DoHR/OD	✓		✓			✓		✓			✓	
Fragile Services - Update	Receive	DoT	✓		✓			✓		✓			✓	
ALTC Progress Report, including feedback from the Quarterly Joint Meetings	Receive	ManD	✓	*	✓	✓		✓	✓	✓	✓		✓	✓

Finance, Performance & Investment Committee – Annual Business Cycle 2022/23

Agenda Item/Report	Frequency	By	Apr M12	May M1	Jun M2	Jul M3	Aug No Mtg	Sept M4&M5	Oct 3 M6	Nov M7	Dec No Mtg	Jan M8&9	Feb M10	Mar M11
General & Closing Business														
Declarations of Interests	monthly	All	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Minutes	monthly	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Matters Arising and action log	monthly	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
COVID-19 Status Reports (time limited for 2022/23)	monthly	COO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Items for Escalation to the Strategy & Operations Committee	monthly	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
AOB														
FINANCE, PROCUREMENT & INVESTMENT:														
Finance														
Finance Director's Report (incl CIP, capital, cash and debtors)	monthly	DoF/DDoF	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
CIP Updates by CBU ADOs	quarterly	ADOs				✓ (Q1)			✓ (Q2)			✓ (Q3)		
Procurement Updates, including Register of Contracts & Tenders	quarterly	HoP	✓			✓			✓			✓		
Review of NHS Contract Position	annually	DoF						✓						
Benchmarking: Use of Resources/Model Hospital Updates/Reference Costs (Standing agenda item to be reported when new reports received)	As required	DoF	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Development of the Operational Plan, including the capital programme	annually	DoF/COO											✓	✓
Review of business cases/benefits realisation reports from previous investments (Standing agenda item to be reported as needed)	As required	Executive lead												
SLR/PLICS Updates	annually	SCA										✓		
Performance														
Integrated Performance Reports	Monthly	COO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Activity against plan	Monthly	COO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
UEC Performance Reports	Monthly	COO	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Fragile Services Update	Monthly	DoT	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Investment														
Annual review of progress in delivering the Estates and Facilities Management Strategy	annually	DoF							✓					
Annual review of progress in delivering the IM&T Strategy	annually	DoF				✓								
GOVERNANCE														
Risk & Governance														
Review of Extreme Operational Risks	monthly	DoF	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
BAF Strategic Risks- Finance & Constitutional Standards	quarterly	ADCG			✓			✓				✓		✓
Committee Effectiveness Review	monthly	Chair	✓	✓	✓	✓		✓	✓	✓		✓	✓	
Annual effectiveness review	annually	ADCG		✓										
FP&I Annual Business Cycle	annually	ADCG												✓
FP&I Terms of Reference-Review	annually	ADCG												✓
Assurance														
AAA Highlight Reports:														

Agenda Item/Report	Frequency	By	Apr M12	May M1	Jun M2	Jul M3	Aug No Mtg	Sept M4&M5	Oct 3 M6	Nov M7	Dec No Mtg	Jan M8&9	Feb M10	Mar M11
■ Capital Investment Group	monthly	DoF	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
■ IM&T Committee	monthly	DoF	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
■ E&F Governance Group	monthly	DoF	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
■ Business Development and Investment Group	monthly	DoF	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Review of Sub-Group Terms of Reference: ▪ IM&T Committee ▪ Capital Investment Group ▪ Estates & Facilities Governance Group ▪ Business Development & Investment Group	annually	ADCG											(✓(((((	

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WORKFORCE COMMITTEE (WFC)

ANNUAL BUSINESS CYCLE: 2022/23 Version 2 (Updated April 2022)	LEAD	FREQUENCY	APR 22 Q1	MAY 22 Q1	JUNE 22 Q1	JULY 22 Q2	AUG 22 Q2	SEPT 22 Q2	OCT 22 Q3	NOV 22 Q3	DEC 22 Q3	JAN 23 Q4	FEB 23 Q4	MAR 23 Q4
PRELIMINARY BUSINESS														
Chair's Welcome and Note of Apologies	CHAIR	MONTHLY	✓	✓	✓	✓	***** No WFC Meeting scheduled for August *****	✓	✓	✓	***** No WFC Meeting scheduled for December *****	✓	✓	✓
Declaration of Interests concerning Agenda Items	CHAIR	MONTHLY	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Minutes of the Previous Meeting	CHAIR	MONTHLY	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Matters Arising and Action Log	CHAIR	MONTHLY	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Monthly Thematic Presentation	LEAD	MONTHLY	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Staff Story	LEAD	QUARTERLY				✓			✓			✓		
RISK AND GOVERNANCE			APR 22 Q1	MAY 22 Q1	JUNE 22 Q1	JULY 22 Q2		SEPT 22 Q2	OCT 22 Q3	NOV 22 Q3		JAN 23 Q4	FEB 23 Q4	MAR 23 Q4
Workforce Committee Terms of Reference	CHAIR	ANNUALLY		(SOC)										✓
Workforce Committee Cycle of Business	CHAIR / DHR	ANNUALLY	✓	(SOC)										
Board Assurance Framework – Strategic Objective 4 & 5	DHR	QUARTERLY	(SOC)		✓	(SOC)		✓	(SOC)			✓	(SOC)	✓
HR Risk Register	DHR	MONTHLY	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
PERFORMANCE			APR 22 Q1	MAY 22 Q1	JUNE 22 Q1	JULY 22 Q2		SEPT 22 Q2	OCT 22 Q3	NOV 22 Q3		JAN 23 Q4	FEB 23 Q4	MAR 23 Q4
Integrated Performance Report (IPR) – HR Indicators	DHR	MONTHLY	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
WORKFORCE / ORGANISATIONAL DEVELOPMENT STRATEGY			APR 22 Q1	MAY 22 Q1	JUNE 22 Q1	JULY 22 Q2		SEPT 22 Q2	OCT 22 Q3	NOV 22 Q3		JAN 23 Q4	FEB 23 Q4	MAR 23 Q4
Bi-Annual Safe Staffing Report	DON	BI-ANNUALLY				✓		(SOC)					✓	(SOC)
Freedom to Speak Up Report and Annual Self-Assessment	DON / FTSUG	QUARTERLY / ANNUALLY	✓ (Q4)			✓ (Q1)				✓ (Q2)			✓ (Q3 inc. Annual SA)	(SOC)
Guardian of Safe Working – Quarterly and Annual Reports	MD / GOSW	QUARTERLY / ANNUALLY	✓ (Q4 inc. Annual Summary)			✓ (Q1)				✓ (Q2)			✓	(SOC)
Annual Staff Survey Results	DHR	ANNUALLY	✓	(SOC)										
Our People Plan / Staff Survey Action Plan – Quarterly Report	DHR	QUARTERLY				✓			✓			✓	(SOC) (inc. Annual Summary)	
Gender Pay Gap Annual Declaration	DDHR	ANNUALLY											✓	(SOC)
Equality, Diversity and Inclusion Annual Report	DDHR	ANNUALLY										✓	(SOC)	
WRES and WDES Reports and Action Plans	DDHR	ANNUALLY						✓	(SOC)					

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QUALITY & SAFETY COMMITTEE (QSC)

ANNUAL BUSINESS CYCLE: 2022/23 Version 6 (Updated April 2022)	LEAD	FREQUENCY	APR 22 Q1	MAY 22 Q1	JUNE 22 Q1	JULY 22 Q2	AUG 22 Q2	SEPT 22 Q2	OCT 22 Q3	NOV 22 Q3	DEC 22 Q3	JAN 23 Q4	FEB 23 Q4	MAR 23 Q4
PRELIMINARY BUSINESS														
Monthly Presentation	*LEAD*	*MONTHLY*	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Chair's Welcome and Note of Apologies	*CHAIR*	*MONTHLY*	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Declaration of Interests concerning Agenda Items	*CHAIR*	*MONTHLY*	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Minutes of the Previous Meeting	*CHAIR*	*MONTHLY*	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Matters Arising and Action Log	*CHAIR*	*MONTHLY*	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Quality and Safety Committee Terms of Reference	*CHAIR*	*ANNUALLY*	✓	(SOC)										✓
Quality and Safety Committee Cycle of Business	*CHAIR/ DON/MD*	*ANNUALLY*	✓	(SOC)										
Operational Update (Including Quarterly Cancer Improvement Plan)	*COO/DCOO*	*MONTHLY*	✓	✓ & CI Plan	✓	✓		✓ & CI Plan	✓	✓ & CI Plan		✓	✓ & CI Plan	✓
CQC Registration and Action Plan	*DON/MD*	*QUARTERLY*			✓	(SOC)			✓	(SOC)			✓	✓ & (SOC)
EXCEPTION REPORTS (Alert/Advise/Assure (AAA) Reports from sub-groups)			APR 22 Q1	MAY 22 Q1	JUNE 22 Q1	JULY 22 Q2		SEPT 22 Q2	OCT 22 Q3	NOV 22 Q3		JAN 23 Q4	FEB 23 Q4	MAR 23 Q4
Clinical Effectiveness Committee (CEC)	*MD*	*MONTHLY*	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Infection, Prevention & Control Assurance Group (IPCAG)	MD	*MONTHLY*	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Safeguarding Assurance Group (SAG)	*DON*	*BI-MONTHLY*		✓		✓			✓			✓		✓
Patient Experience and Community Engagement Group (PECEG)	*DON*	*MONTHLY*	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Patient Safety Group (PSG) (Includes Harm Free Care, Patient Safety Monthly Update, Claims & Mitigations)	*DDOQ*	*MONTHLY*		✓	✓	✓		✓	✓	✓		✓	✓	✓
Quality Programme Board (QPB) (*linked to Quality Priorities*)	*DON/MD*	*MONTHLY*		✓	✓	✓		✓	✓	✓		✓	✓	✓
SAFE			APR 22 Q1	MAY 22 Q1	JUNE 22 Q1	JULY 22 Q2		SEPT 22 Q2	OCT 22 Q3	NOV 22 Q3		JAN 23 Q4	FEB 23 Q4	MAR 23 Q4
Integrated Performance Report (IPR) – quality and safety metrics	*DON/MD*	*MONTHLY*	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Safeguarding Annual Report |	*DON*	*ANNUALLY*			✓	(SOC)								
Safety of Medicines & Controlled Drugs – Annual Report	*MD*	*ANNUALLY*				✓								
Infection, Prevention and Control Board Assurance Framework & Annual Report	*MD*	*ANNUALLY*			✓	(SOC)								
Mixed Sex Annual Declaration	*DDON*	*ANNUALLY*											✓	(SOC)
Patient Safety Annual Report	*DDOQ*	*ANNUALLY*			✓	(SOC)								

***** No QSC Meeting scheduled for August *****

***** No QSC Meeting scheduled for December *****

Maternity Report (Includes Ockenden Progress Report)	*SS-CBU*	*QUARTERLY*		✓	(SOC – Mat Report)	✓		(SOC – Ockenden)		✓ (SOC- Mat Report & Ockenden in Dec 22)			✓	(SOC – Ockenden)
EFFECTIVE			**APR 22 Q1**	**MAY 22 Q1**	**JUNE 22 Q1**	**JULY 22 Q2**		**SEPT 22 Q2**	**OCT 22 Q3**	**NOV 22 Q3**		**JAN 23 Q4**	**FEB 23 Q4**	**MAR 23 Q4**
Research & Development Annual Report	*MD*	*ANNUALLY*				✓								
Clinical Audit Annual Report	*MD*	*ANNUALLY*			✓									
Learning From Deaths Quarterly Report	*MD*	*QUARTERLY*	(SOC) Q4		✓	(SOC) Q1		✓	(SOC) Q2			✓	(SOC) Q3	✓
Core Essential Skills Training Compliance	*DDOQ*	*QUARTERLY*	✓					✓				✓		
CARING			**APR 22 Q1**	**MAY 22 Q1**	**JUNE 22 Q1**	**JULY 22 Q2**		**SEPT 22 Q2**	**OCT 22 Q3**	**NOV 22 Q3**		**JAN 23 Q4**	**FEB 23 Q4**	**MAR 23 Q4**
Patient Experience Annual Report (Includes Annual Complaints and Service Experience Reports, and National Patient Experience Surveys)	*DON*	*ANNUALLY*			✓									
End of Life Report Annual Report	*MD*	*BI-ANNUAL*		✓									✓	
RESPONSIVE			**APR 22 Q1**	**MAY 22 Q1**	**JUNE 22 Q1**	**JULY 22 Q2**		**SEPT 22 Q2**	**OCT 22 Q3**	**NOV 22 Q3**		**JAN 23 Q4**	**FEB 23 Q4**	**MAR 23 Q4**
Cancer Services Annual Report	*COO*	*ANNUALLY*						✓						
Annual Resuscitation Report	*DON/MD*	*ANNUALLY*			✓	(SOC)								
Serious Untoward Incidents	*MD*	*BI-MONTHLY*	(SOC)	✓	(SOC)	✓		(SOC)	✓	(SOC)		✓	(SOC)	✓
WELL-LED			**APR 22 Q1**	**MAY 22 Q1**	**JUNE 22 Q1**	**JULY 22 Q2**		**SEPT 22 Q2**	**OCT 22 Q3**	**NOV 22 Q3**		**JAN 23 Q4**	**FEB 23 Q4**	**MAR 23 Q4**
Board Assurance Framework – Strategic Objective 1	*DON/MD*	*BI-MONTHLY*	(SOC)		✓	(SOC)		✓	(SOC)			✓	(SOC)	✓
Southport & Ormskirk Clinical Assessment and Accreditation Scheme (SOCAAS) Including Ward Dashboard & Tendable	*DON*	*QUARTERLY*		✓				✓		✓			✓	
Quality Account	*DON/MD*	*ANNUALLY*	✓ (Update on Report progress)	✓ (Final Report)	(SOC)									✓ (Headlines & Contents)
Quality Priorities	*ADOQ*	*BI-ANNUALLY*						✓						✓
CLOSING BUSINESS			**APR 22 Q1**	**MAY 22 Q1**	**JUNE 22 Q1**	**JULY 22 Q2**		**SEPT 22 Q2**	**OCT 22 Q3**	**NOV 22 Q3**		**JAN 23 Q4**	**FEB 23 Q4**	**MAR 23 Q4**
Any Other Business	CHAIR	MONTHLY	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓
Quality and Safety Committee – Committee Effectiveness Review	*CHAIR/ALL*	*MONTHLY*	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**01 June 2022**
Agenda Item	**SO102/22**	**FOI Exempt**	**NO**
Report Title	**INTEGRATED PERFORMANCE REPORT (IPR)**		
Executive Lead	Executive Committee		
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 SOF 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.

The changes to some of the metrics or targets, based on National Priorities and local and national benchmarking data, has been implemented and the SPC charts have been re-based to look at the last 12 months.

Recommendations

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

Previously Considered By:

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

Strategic Objectives

✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
✓ **SO3** Efficiently and productively provide care within agreed financial limits
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated

✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Katharine Martin, Performance & Delivery Manager	Executive Committee

Southport and Ormskirk Hospital NHS Trust

Trust Board - Integrated Performance Report

Performance Summary

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

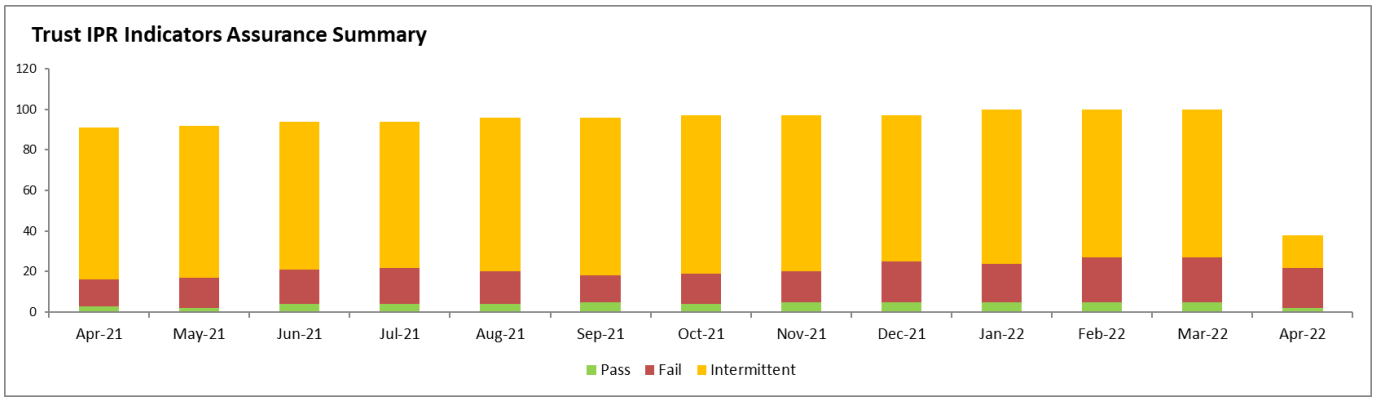
Quality - reflects those metrics aligned to Strategic Objective **S01** – *Improve clinical outcomes and patient safety to ensure we deliver high quality services*.

Operations - **S02** – *Deliver services that meet NHS Constitutional Standards and regulatory standards*

Finance - **S03** – *Efficiently and productively provide care within agreed financial limits.*

Workforce - **S04** – *Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated* and **S05** – *Enable all staff to be patient-centred leaders building an open and honest culture and the delivery of the Trust values.*

The changes to the IPR for the new financial year have now been implemented and the chart below reflects the reduced number of indicators being reported in 2022/23.
The rebasing of the SPC's on the last 12 months and using the second control limit has resulted in the majority of indicators this month failing assurance. Finance indicators are not being reported using SPC.
The indicators assured this month are Percentage of Patient Safety Incidents - Moderate/Major/Death(related) and Mandatory Training.



Southport and Ormskirk Hospital NHS Trust

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 was one Never Events in April 2022. (2022/23 YTD = 1).
There were no cases of MRSA April. (2022/23 YTD = 0).
There were five Hospital Onset Hospital Acquired C. Difficile (CDI) positive cases reported in April 2022.
The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for April 2022 was 93.4%. This is based on 96.98% for Registered Nurses and 89.14% for Un-Registered Nurses.
There were two category 3 hospital acquired pressure ulcers reported in April.
There were 65 patient falls in April of which two resulted in moderate harm in April. All pressure ulcers and falls with harm are managed through the Harm Free Care panel.
The Patient Friends & Family Test - % that would recommend declined to was 87.9% in April, from 86.5% in March, against a response rate of 27.1%.
The % of complaints responded to within timescales has maintained the improvement noted in March with performance at 70.4% in April but remains below the 80% target.

Operational Performance

Overall Accident and Emergency performance for April 2022 was 75.8% (Adults ED 53.6%, Paeds ED 96.3% in April). Combined attendances for SDGH and ODGH were 7451 in April compared to 8287 in March and 7451 in April 2021. 40.6% of Ambulance Handovers occurred within 15mins, an increase on March (35.8%) but behind the 65% target. Similarly, 65.5% of Ambulance Handovers were within 30mins, compared to 60% in March and short of the 95% target. 97 Ambulance Handovers breached 60mins in April, a reduction on the 104 reported in March.

Performance against the 62-day cancer standard was below the target of 85.0% in month (March 2022) at 70.5%, 2021/22 66.6%. This is an improvement on February which was 58.9%. The Trust was 0.1% below the target for the 96% 31-day target in March 2022 with 95.9% performance in month (February 96.8%), 2021/22 was ahead of target at 97.8%. The 28 Day Faster Diagnosis Standard failed to achieve the 75% target in March, achieving 67%.

The average daily number of stranded patients in April 2022 increased to 184 from 179 in March. The number of super-stranded patients decreased marginally, from an average of 62 in March to 60 in April. The new Criteria to Reside metric is in excess of the 35 target, averaging 56 in April, but an improvement on the 71 reported in March. All these metrics were impacted by delays in care packages, availability of community beds and multiple Covid outbreaks in care homes.

Operational Performance continued

The 18-week referral to treatment target (RTT) was not achieved in April 2022 with 77% compliance, 1.1% lower than the previous month, against the 92% target. The Trust continues to perform well in comparison to peers. There were 192 52+ week waiters, an increase on the 182 reported in March. 22 patients had waited longer than 78 weeks at the end of April, the target is to achieve 0 by the end of April 2023. There remained no 104-week waiters. The diagnostic target was not achieved in April 2022 with 48.6% patients waiting longer than 6 weeks, a deterioration on the previous month (44.2%) against a target of 1%.

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 £1.8m deficit at Month 1 in line with 2022/23 Plan.

The 2022/23 Plan sets out a £20.5m deficit after applying:
- £5.3m ERF Income
- £7.8m CIP (3.5%)

Pending confirmation of ERF calculations and System performance, the Trust has assumed 100% achievement of ERF funding in M1.
ERF performance is highlighted as a risk to delivery of 2022/23 Plan in view of continued operational pressures experienced into 2022/23.
System planning discussions are still ongoing in view of a financial gap across C&M.
There may be an issue with accessing national sources of capital funding until an accepted 2022/23 Plan is submitted by C&M.

CIP - The 2022/23 financial plan sets out a CIP requirement of 3.5% (£7.8m). Schemes totalling £0.28m have been delivered in Month 1, with under-performance mitigated by non-recurrent schemes.

Cash - The cash balance at the end of April was £12.5m.
A monthly forecast for 2022/23 is shown in section 8. Regional cash support will be required from October as the Trust is operating with a planned £20.5m deficit in 2022/23.

BPPC – The Trust is currently achieving 97% against a 95% target.

Capital - This totals £10.282m and includes agreed public dividend capital of £3.2m for fire safety.
Negotiations for further funding to tackle significant backlog maintenance are ongoing – with a System Backlog Maintenance Prioritisation Panel meeting on 27th June.
Bids for CDC (Community Diagnostic Centre) and TIF (Targeted Investment Fund – endoscopy investment) are due to be submitted to NHSEI by July 2022.

Southport and Ormskirk Hospital NHS Trust

Workforce

Personal Development Review compliance has reduced in April to 74.1% against the 85% target. Performance in March was 74.3%. Mandatory training compliance remains ahead of target and was 88.2% in April. The 90% stretch target for Mandatory Training will be implemented from June 2022.

In month overall sickness decreased to 7.5% from 7.9% reported in March. The rolling 12-month figure is 7.2%. This is against sickness targets for 2022/23 of 6% (5% non-Covid, 1% Covid). Non-Covid Sickness accounted for 5.5% of the sickness, illustrating the on-going effects of the Covid-19 pandemic on sickness rates.

The overall Trust vacancy rate has increased to 10.2% in April, from 9.7% in March against the 7.4% target. In-month Staff turnover has decreased to 10.9% in April from 0.9% in February (target 0.83%).

Southport and Ormskirk Hospital NHS Trust

Integrated Performance Report

Strategy & Operations Committee

April 2022

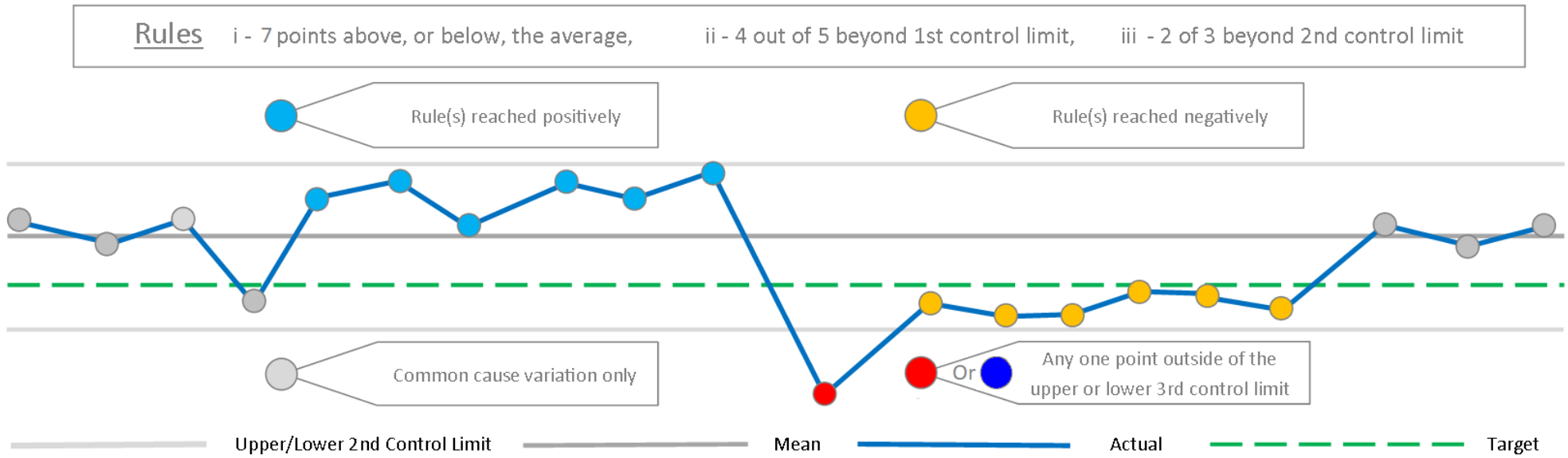
Guide to Statistical Process Control

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

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

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

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



Executive Summary

		Assurance			Variation				
									
Quality	Infection Prevention and Control	0	0	3	0	0	0	0	3
	Harm Free	0	1	5	0	0	1	1	4
	Patient Experience	2	0	0	0	0	1	0	1
Operations	Cancer	2	0	1	0	0	0	0	3
	Access	12	0	1	5	5	1	0	2
	Productivity	0	0	3	2	0	0	0	1
Finance	Finance	2	0	1	2	0	0	0	1
Workforce	Sickness, Vacancy and Turnover	3	0	2	1	0	0	1	3
	Organisational Development	1	1	0	0	1	0	0	1

Assurance

Measures the likelyhood of targets being met for this indicator.

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

Variation (Past 3 Months)

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

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

Quality

Harm Free

Never Event

Issues
• A Never Event was reported in April.
• A local assessment of risk determined that there is a low risk of this event occurring again in the near future as there are no apparent high impact system failures evident.

Management Action
• An internal patient safety alert.
• Notification of the incident was sent to the Cheshire and Mersey Critical Care Network to raise awareness and vigilance.
• A debrief of the incident was performed providing support to the staff involved and to capture details of the event to support learning and further review.
• Discussion of the incident took place at the Critical Care Department Safety Meeting.
• Discussion at the Trust Serious Incident Review Group of the known facts to date.
• A presentation has been prepared which will be presented at the Departmental Governance and Audit Meetings.

Safe Staffing

Issues
• The Safe Staffing indicator is showing special cause improvement, exceeding the target in April and a further increase on the previous month.
• The split for April is 96.98% for Registered Nurses and 89.14% for Un-Registered Nurses.
• Care Hours per Patient Day (CHPPD) continues to be assured, performing ahead of target.

Management Action
• Safer staffing continues to rise as we close the gap on nurse vacancies within the organisation.
• Reviewing of the data is taking a more focused approach to ensure a concise and accurate reflection of staffing within distinct wards and departments.
• As a direct result of the increase in staffing and the maintain escalation areas within the organisation care hours per day remain at a consistent level.

Patient Falls

Issues
• The number of patient falls reduced significantly in April, and although it remains statistically as expected, is below average and 2 over the target.
• Two falls with harm were reported in April, which is above target but below average.
• Thematic review has identified issues around use of visual cues for patients at risk of falls, issues with falls equipment, completion of lying and standing blood pressure and risk assessment documentation.

Management Action
• To promote the use of visual cues to identify patients at risk of falls, e.g. yellow anti-slip socks.
• Following a number of falls in the bathrooms, toilet sensors have now been installed and are in use.
• Enhance the role of the ‘Falls Champions’ on each ward including providing more in-depth training.
• Additional education sessions being completed both ward based and as part of preceptee workshops in addition to training on falls alarm equipment.
• Planned audits looking at Bed rails use/assessment.
• The Trust Falls Lead to undertake walkarounds to identify environmental and procedural elements we can improve on the spot.
• To implement a consistent approach to post-falls management, in line with NICE recommendations.
• A review of the documentation and risk assessments used within AED and a planned trial of more visual aids such as yellow blankets and yellow bags within AED to highlight patients at risk right from the beginning of their journey through the trust.

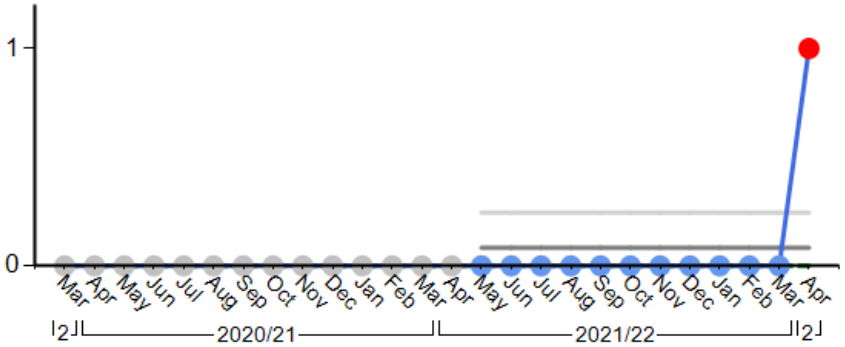
Hospital Acquired Pressure Ulcers

Issues
• Category 3/4's have reduced from 4 in March to 2 in April which is in-line with the average but above target.

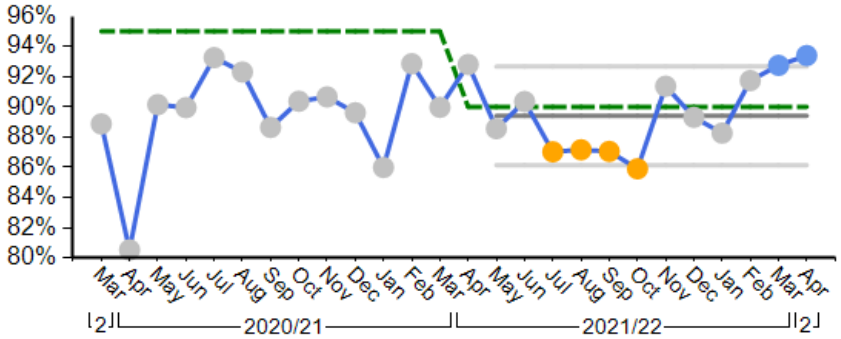
Management Action
• All hospital acquired pressure ulcers are subject to root cause analysis which is presented at the Harm Free Care Panel.
• Themes from investigations have resulted in a renewed focus on the importance of accurate and timely risk assessment, as this results in patients having the right preventative measures in place.
• Delivering 'ten minute message" training initially to AED and then to rest of urgent care, focusing on risk assessment, skin inspection and correct diagnosis.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Never Events	0	1	1	Apr 22		0	0	Mar 22	0	1	
Safe Staffing	90%	93.4%	N/A	Apr 22		90%	92.8%	Mar 22	90%	93.4%	
Hospital Pressure Ulcers - Grades 3 & 4	1	2	2	Apr 22		1	4	Mar 22	12	2	
Patient Falls - Trust	63	65	65	Apr 22		63	89	Mar 22	756	65	
Falls - Moderate/Severe/Death	1	2	2	Apr 22		0	3	Mar 22	17	2	
Percentage of Patient Safety Incidents - Moderate/Major/Death(related)	2.1%	0.8%	7	Apr 22		2.1%	0.8%	Mar 22	2.1%	0.8%	

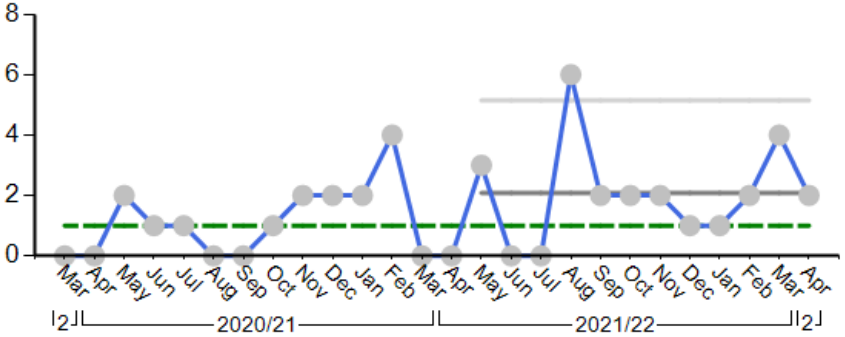
Never Events



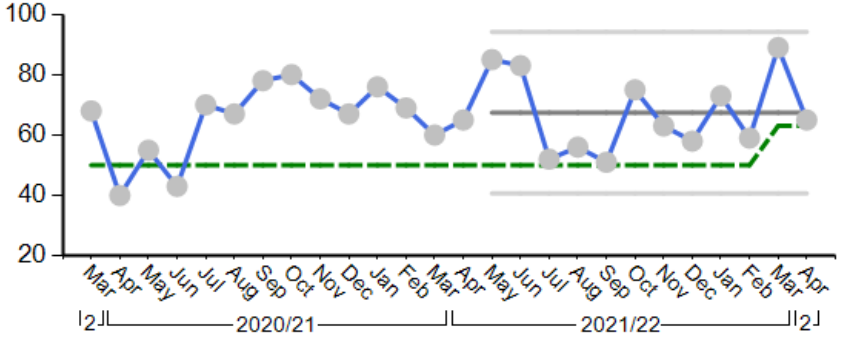
Safe Staffing



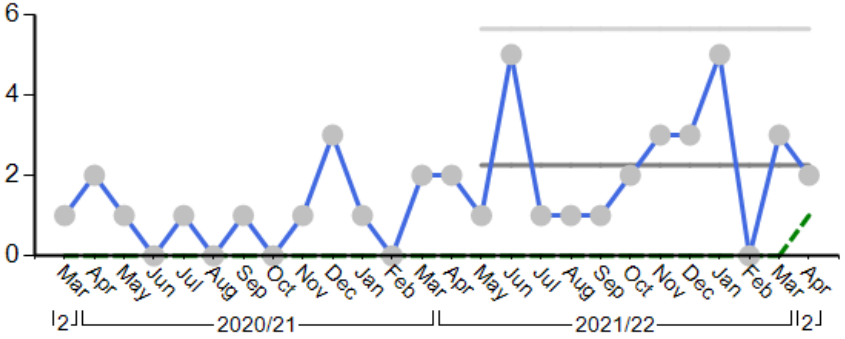
Hospital Pressure Ulcers - Grades 3 & 4



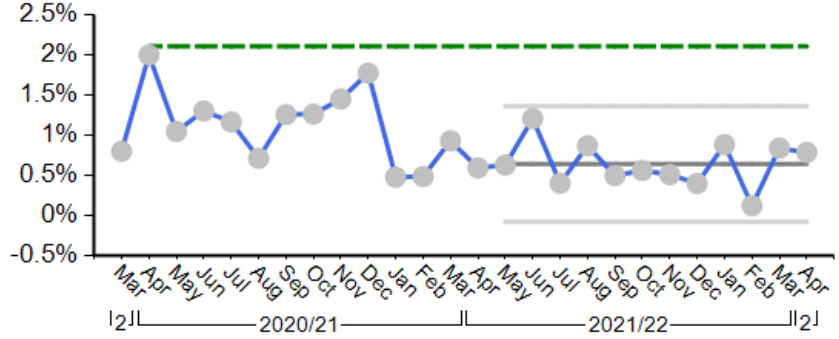
Patient Falls - Trust



Falls - Moderate/Severe/Death



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



Quality

Infection Prevention and Control

C.Diff

Issues
• Five c.diff infections were reported in April, all Hospital Onset Hospital Acquired, an increase of 2 on the previous month.
• Whilst this is statistically as expected, this is above the target.
• The Trust target for the year, as published in the NHS Standard Contract 2022/23 is a maximum of 49 cases (both Hospital Onset Hospital Acquired and Community Onset Hospital Acquired).

Management Action

• 4 out of the 5 cases have RCA's pending.
• Initial investigations show 2 cases with no lapses in care.
• One case has identified a further review of cleaning is required.
• Two cases had delays in isolation due to the Trust being at full to capacity.

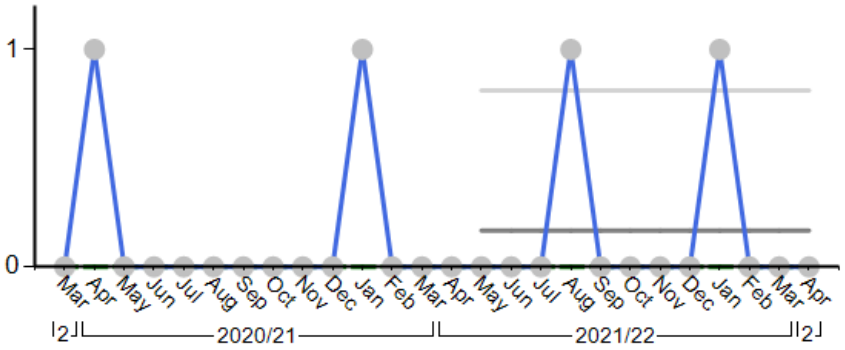
E-Coli

Issues
• Five cases reported in April, a decrease of 1 on the previous month.
• Whilst this is statistically as expected, this is above the target.
• The Trust target for the year, as published in the NHS Standard Contract 2022/23 is a maximum of 51 cases (both Hospital Onset Hospital Acquired and Community Onset Hospital Acquired).

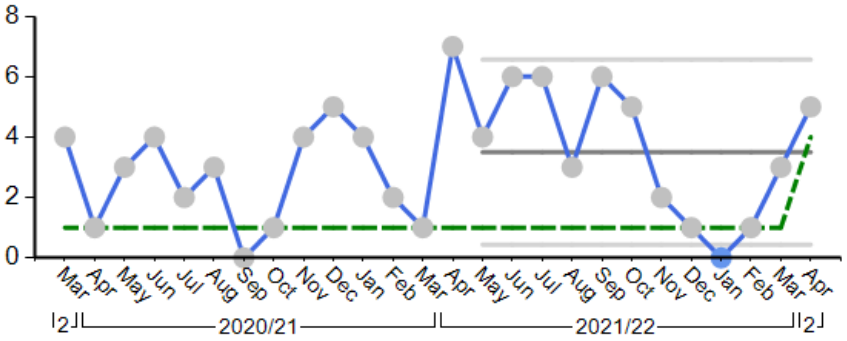
Management Action
• All cases have been reviewed with the clinical teams and no lapses in care have been identified.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
MRSA	0	0	0	Apr 22		0	0	Mar 22	0	0	
C-Diff	4	5	5	Apr 22		1	3	Mar 22	49	5	
E. Coli	4	5	5	Apr 22		2	6	Mar 22	51	5	

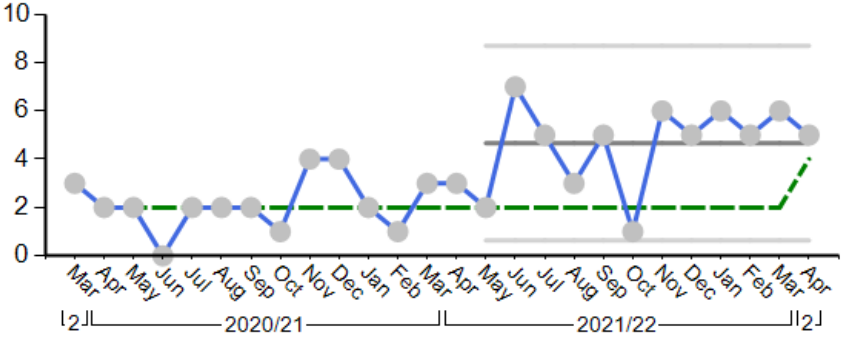
MRSA



C-Diff



E. Coli



Patient Experience

Complaints - % closed within 40 working days

Issues
• This metric is failing its assurance measure as the target has not been achieved since February 2021.
• The indicator is however showing special cause improvement, maintaining performance in-line with the second upper control limit for the second consecutive month.

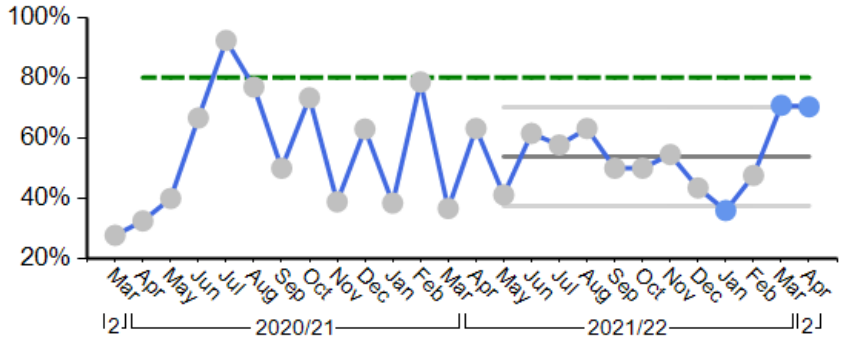
Management Action
• A new SOP has been drafted which breaks down the necessary stages involved in the response and allocates timescales to each stage. It also has clear escalation channels when timescales within each stage are exceeded.
• Analysis of the breaches of the 40-day timescales for 2021/22 showed the average time to close complaints that breached was 47 days.

Friends and Family Test

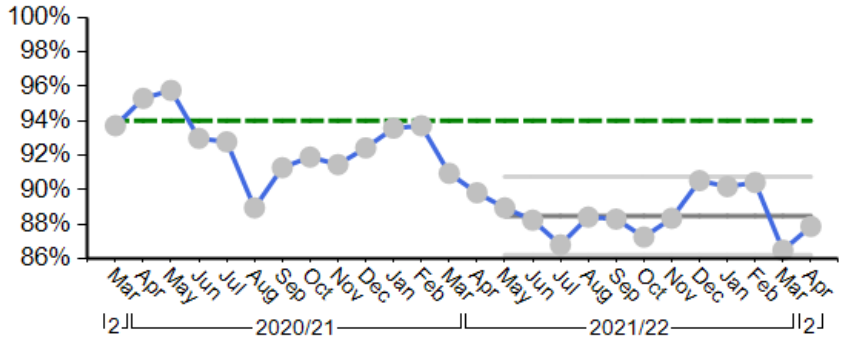
The overall Trust score for those that have rated their experience as ‘very good/good’ has increased slightly on previous month, however, remains below performance indicator.
The profile of FFT continues to be raised as a valuable mechanism for receiving up-to-date patient feedback. The display of FFT feedback via the 'You said, we did' on ward/dept quality boards is regularly supported.
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.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Complaints - % closed within 40 working days	80%	70.4%	N/A	Apr 22	H	80%	70.8%	Mar 22	80%	70.4%	F
Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall	94%	87.9%	N/A	Apr 22		94%	86.5%	Mar 22	94%	87.9%	F

Complaints - % closed within 40 working days



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



Operations

Access

A&E

Issues
• All metrics relating to A&E performance are failing their assurance measures and showing special cause concern.
• The Trust remains challenged against the 4hour standard against attendances 4.1% lower than the same period 2019/20.
• The Trust remains in the top quartile nationally for ED performance. Significant pressures remain across all ED's in April 22 with C&M overall reporting (71.2%), Northwest (68.46%) and Nationally (71.62%).
• High bed occupancy within the Trust, impacted by IPC measures and Covid-19 positive patients, has resulted in a high proportion of patients spending longer than 12 hrs in A&E.
• A reduction in NEL admissions, impacted by bed pressures, has resulted in longer stays in A&E as increased treatment and reviews are undertaken in the department for patients who would previously have been admitted.

Management Action
• All patients have multiple specialty reviews undertaken in ED to ensure that admission is clinically required, and all escalation areas have remained open.
• Several actions underway to improve performance, detailed in the Urgent & Emergency Care Update paper, including pathway reviews, 3x daily huddles and review of IPC measures.

Ambulance Turnaround Times

Issues
• The metrics have been updated in-line with the 2022/23 Guidance based on % within 15mins and % within 30mins.
• Both metrics failing their assurance measure and showing special cause concern.
• Ambulance performance impacted by staffing challenges and space in the department as demand exceeds capacity.

Management Action
• Several actions ongoing to address ambulance performance and minimise any risk of harm. These are detailed in the Urgent & Emergency Care Update paper and include introduction of handover checklist and NWAS clinical criteria for SDEC Medical.

Referral to Treatment

Issues
• The Referral to treatment: on-going indicator continues to fail assurance and shows special cause concern with a small deterioration in April.
• The number of 52-week waits has increased and is above the trajectory.
• April activity impacted by staffing due to sickness and vacancies.
• The long waiters has been impacted by 115 patients re-entering the RTT pathway following a conversion from surveillance scope to active pathway scope (as per funding agreement with Cancer Alliance).

Management Action
• Continued risk stratification of the waiting list.
• Trust is part of the Cheshire & Mersey wider elective restoration group.
• Review of insourcing (HBS) and Outsourcing (Renacres) opportunities.
• Review of elective flow at SDGH underway.
• Continue to review and maximise theatre utilisation and productivity.
• Ongoing discussions with LIVES progressing to address long waiters within Vascular.

Diagnostics

Issues
• The Diagnostic Waits indicator is failing assurance and showing special cause concern.
• Performance against the 1% target has deteriorated in April to 48.6% which is outside the second control limit.
• Performance impacted by 3 days lost activity on MRI due to issues with the MRI scan. Similarly, lost capacity at the Walton Centre following CT downtime.
• Workforce challenges within CT and Non-Obstetric Ultrasound.
• Diagnostic scopes over-performed in April, delivering 143% of 2019/20 activity.

Management Action
• CT scan at the Walton Centre reinstated and improvement anticipated by June 2022.
• New MRI template review undertaken, and open hours being extended. Potential opportunity to use Walton Centre for MRI's being explored.
• Workforce solutions under review for Scopes including review of job plans to manage High risk FIT process.

Stroke

Issues
• Performance against the 90% stay on a Stroke ward continues to be challenged and has further declined in March (latest data month) to 41.4%.
• Compliance in March 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.
• Compliance in March has also been 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.
• A norovirus outbreak on the Stroke Unit also resulted in breaches of this metric in March.

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'. Once established, the 90% stay on a Stroke ward metric will no longer be held by Southport and Ormskirk NHS Trust.
• 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.

TIA

Issues
• The indicator is showing special cause improvement as the changes to the reporting of this metric have been implemented.
• The data for January – March 2022 is based on validated TIA referrals only and results in an improved position.

Management Action
• Work is ongoing to validate the referrals from April – December 2021 to ensure there is a full year based on reporting true TIA referrals. This will exclude those who are receiving the requiring interventions, on appropriate medication, or referrals which are not appropriate for a TIA clinic appointment.
• An SOP will be written to support this process of validation.

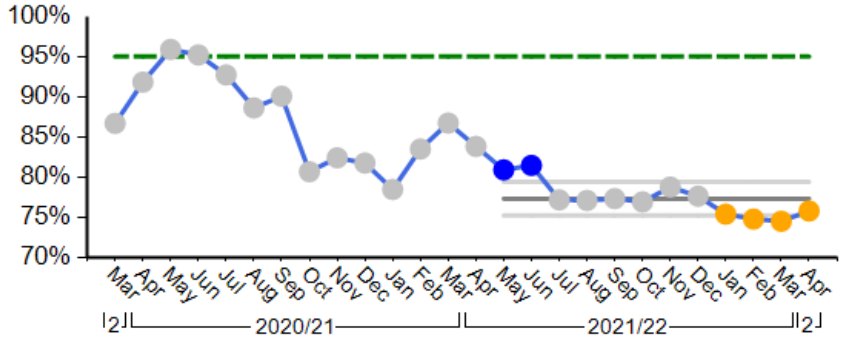
Discharge Communications

Issues
• Two new metrics have been added, Outpatient Letters to GP's within 7 Days and E-Discharges within 24hrs.
• Both indicators are failing their assurance measures, but current performance is statistically as expected.

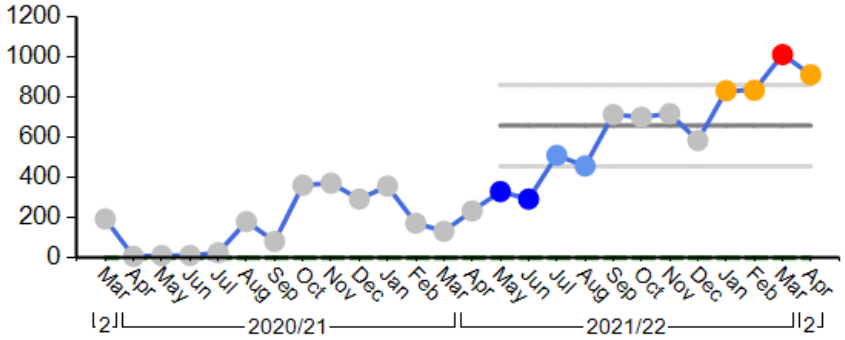
Management Action
• Work is underway to understand the data and understand the specialities and factors impacting the ability to achieve the target.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Accident & Emergency - 4 Hour compliance	95%	75.8%	2335	Apr 22		95%	74.5%	Mar 22	95%	75.8%	
Number of Patients spending 12+ Hours in ED - Trust	0	910	N/A	Apr 22		0	1010	Mar 22	0	910	
% of Patients spending 12+ Hours in ED - Trust	2%	12.5%	N/A	Apr 22		2%	12.3%	Mar 22	2%	12.5%	
Ambulance Handovers - % within 15 Mins	65%	40.6%	661	Apr 22		100%	35.8%	Mar 22	65%	40.6%	
Ambulance Handovers - % within 30 Mins	95%	65.5%	384	Apr 22			60%	Mar 22		65.5%	
Ambulance Handover Over 60 Mins	0	97	97	Apr 22		0	104	Mar 22	0	97	
Diagnostic waits	1%	48.6%	3532	Apr 22		1%	44.2%	Mar 22	1%	48.6%	
Referral to treatment: on-going	92%	77%	2892	Apr 22		92%	78.1%	Mar 22	92%	77%	
52 Week Waits	116	192	192	Apr 22		128	182	Mar 22	0	242	
Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month	1%	0.7%	15	Apr 22		0.6%	0.8%	Mar 22	1%	0.7%	
Stroke - 90% Stay on Stroke Ward	80%	41.4%	17	Mar 22		80%	42.3%	Feb 22	80%	56.6%	
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	60%	81.8%	2	Mar 22		60%	100%	Feb 22	60%	29.1%	
Outpatient Letters to GP's within 7 Days	85%	70.5%	3691	Mar 22		85%	74.7%	Feb 22		73.9%	
E-Discharges within 24hrs	85%	80.2%	259	Apr 22		85%	70%	Mar 22		80.2%	

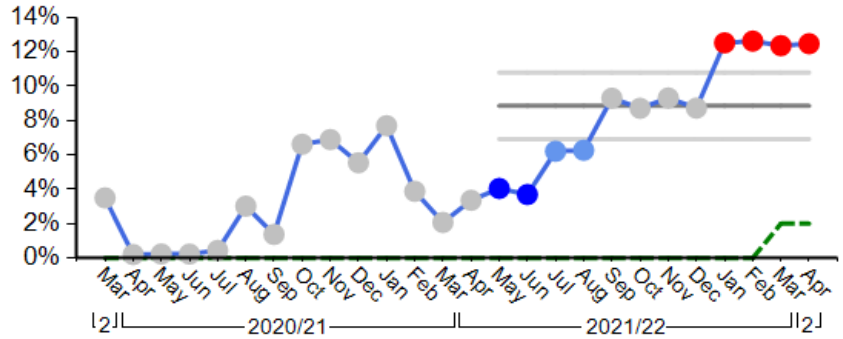
Accident & Emergency - 4 Hour compliance



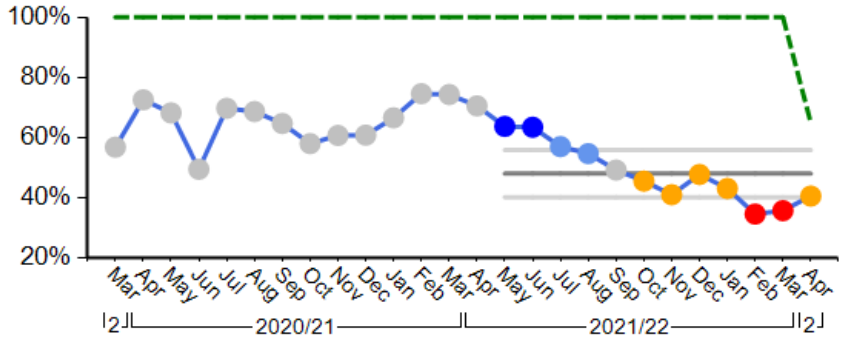
Number of Patients spending 12+ Hours in ED - Trust



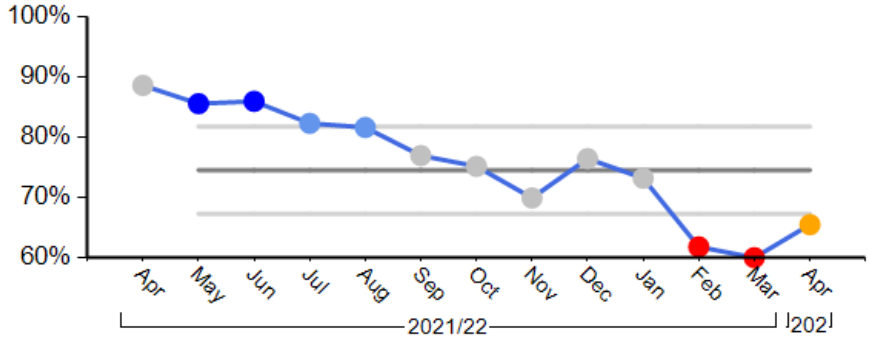
% of Patients spending 12+ Hours in ED - Trust



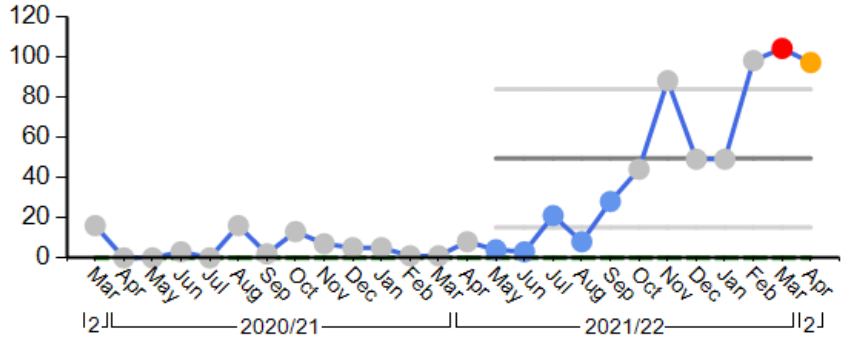
Ambulance Handovers - % within 15 Mins



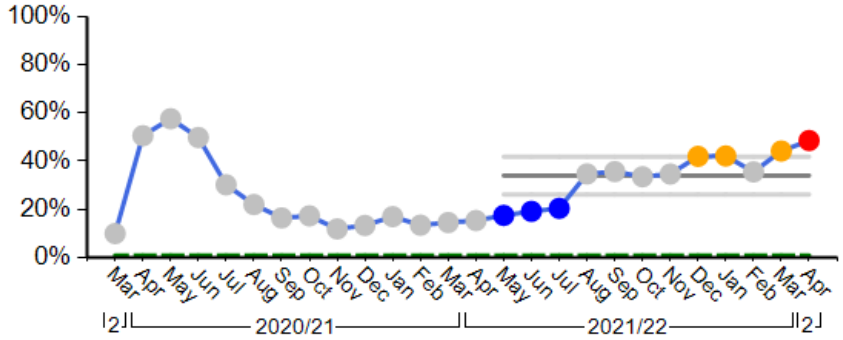
Ambulance Handovers - % within 30 Mins



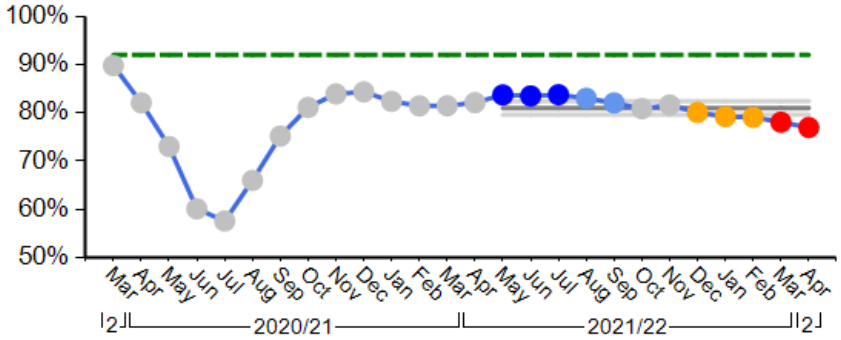
Ambulance Handover Over 60 Mins



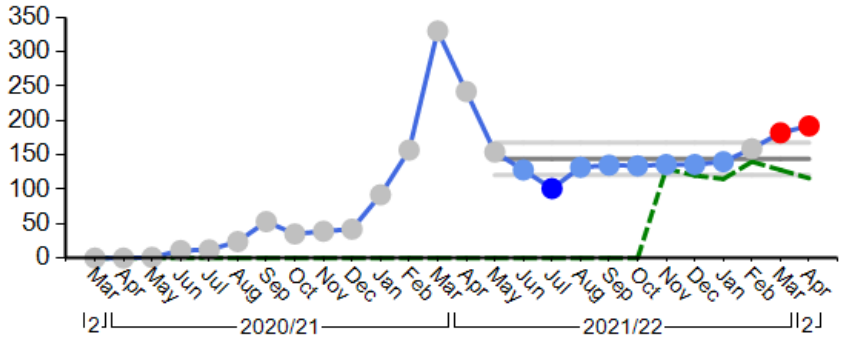
Diagnostic waits



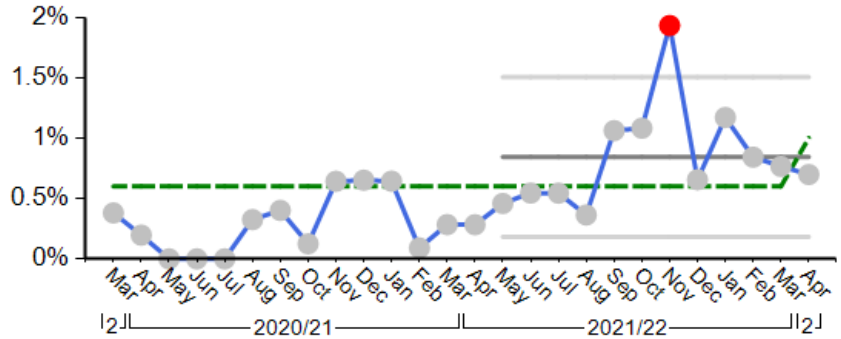
Referral to treatment: on-going



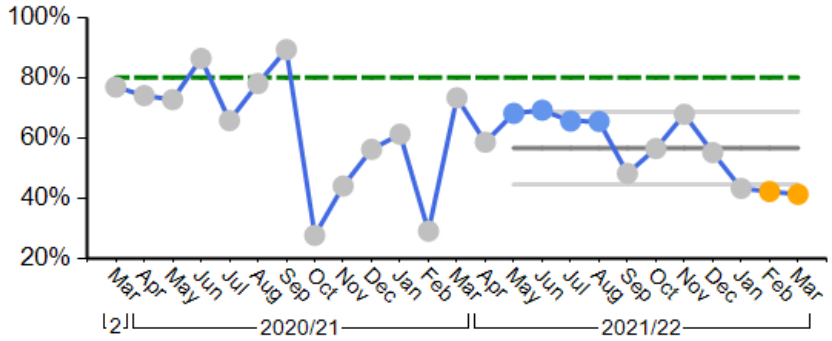
52 Week Waits



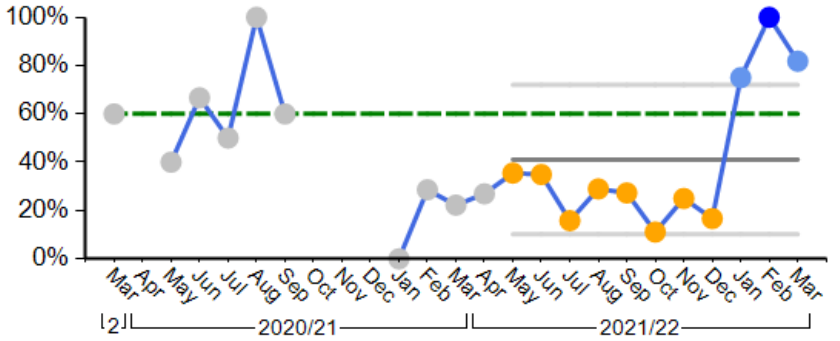
Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month



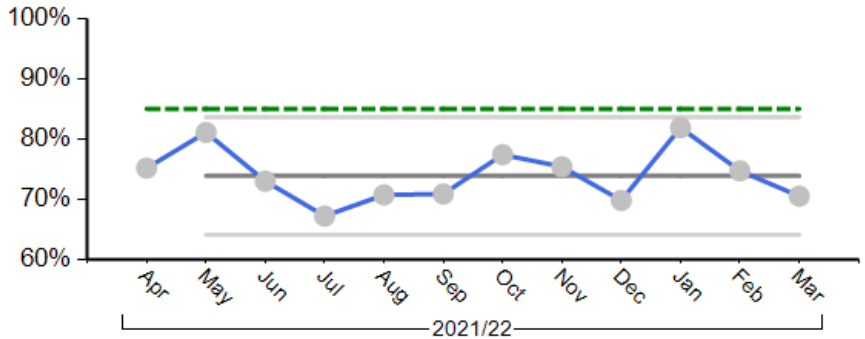
Stroke - 90% Stay on Stroke Ward



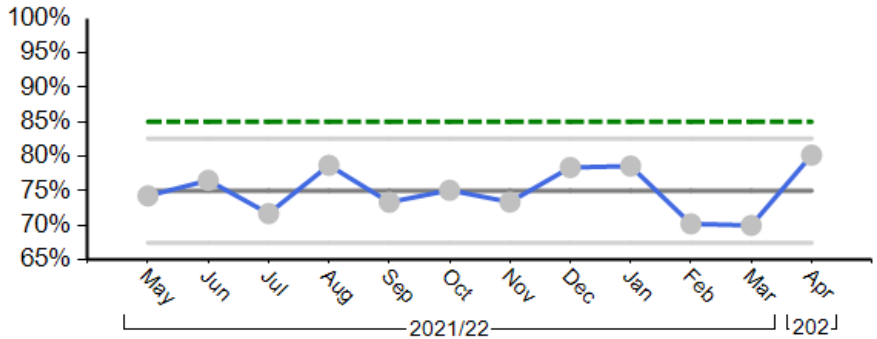
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care



Outpatient Letters to GP's within 7 Days



E-Discharges within 24hrs



Operations

Cancer

Issues

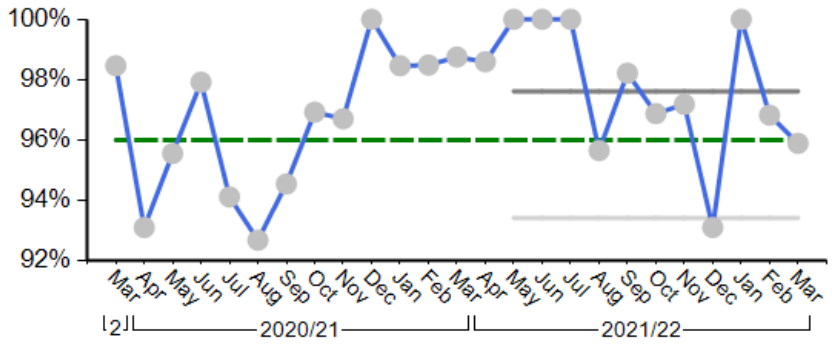
• The 62-day GP referral to treatment indicator is failing assurance although performance in the latest data month (March) demonstrates an improvement and is above the average for the last 12 months.
• The 28 Day Faster Diagnosis Standard is also failing assurance.
• Challenges remain with diagnostic capacity to accommodate the increased referrals across all modalities, in particular endoscopy.
• Staffing challenges within some specialties affecting the ability to deliver increased clinic capacity.
• Delays with Radiology and Histology.

Management Action

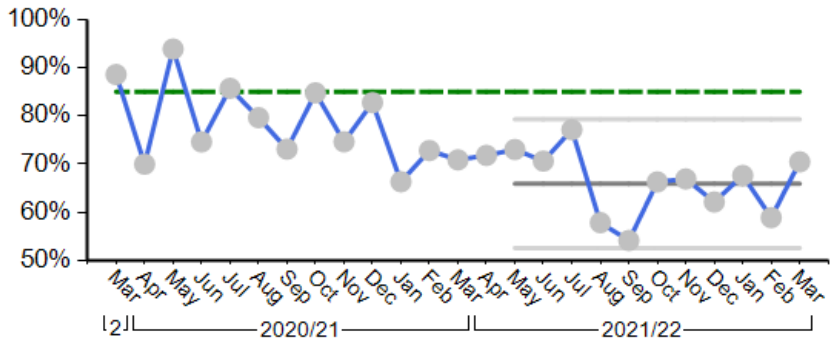
• The Trust has successfully recruited 3 full time Cancer Pathway Navigators. All navigators are now in post and are currently undergoing their training inductions.
• Planned trajectories are in place across all tumour groups.
• Capacity and demand modelling to help meet the 75% Faster Diagnosis Standard.
• The continued work of the Endoscopy Improvement Board to review Endoscopy capacity.
• Early alert and escalation for Radiology and Histology delays.
• Introduction of High-risk FIT to improve clinical pathways.
• Work with the GP's to alleviate issues with referrals not being done correctly.
• Recruitment to Locum Consultant posts.
• Development of new EBUS service for Lung patients.
• Work with the Cancer Alliance for the Head & Neck RDS pathway.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
31 day treatment	96%	95.9%	3	Mar 22		96%	96.8%	Feb 22	96%	97.8%	
62 day GP referral to treatment	85%	70.5%	18	Mar 22		85%	58.9%	Feb 22	85%	66.6%	
28 Day Faster Diagnosis Standard	75%	67%	373	Mar 22		75%	66.3%	Feb 22		67%	

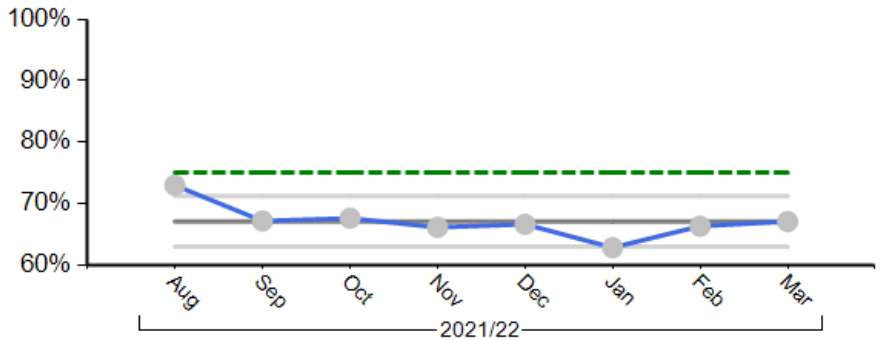
31 day treatment



62 day GP referral to treatment



28 Day Faster Diagnosis Standard



Operations

Productivity

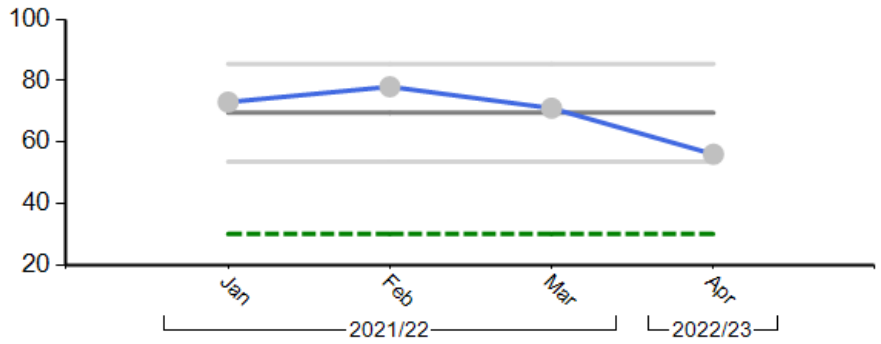
Stranded/Super Stranded Patients/No Criteria to Reside

Issues
• Both indicators are showing special cause concern and performance has been in excess of the target for the last 8 months. Assurance for both metrics is intermittent as the target was achieved May – August 2021.
• The number of Super-Stranded patients has been reducing for the last 2 months.
• 55% of beds are occupied by patients staying 7+ days.
• The 'No Criteria to Reside' is a new indicator added for this year which identifies patients who don't meet the national criteria to reside.
• Indicators impacted by significant delays in for care packages; community teams report high acuity and pressure to support the numbers of fast track patients at home; community beds running at near 100% alongside multiple Covid outbreaks in care homes.

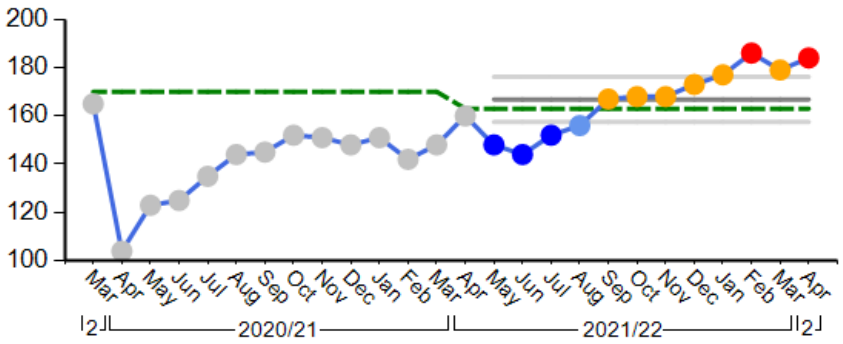
Management Action
• Focus on improvement of patients discharged by 5pm to ensure the trajectory is met including a planned campaign to ensure patients can return home before lunchtime.
• Discharge Improvement Group in place.
• Implementation of ECIST recommendations, for example the inclusion of Criteria to Reside on all Board Rounds.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
No Criteria to Reside - Avg No of Patients	30	56	56	Apr 22		30	71	Mar 22			?
Stranded Patients (>6 Days LOS)	163	184	184	Apr 22	H	163	179	Mar 22	163	184	?
Super Stranded Patients (>20 Days LOS)	53	60	60	Apr 22	H	53	62	Mar 22	53	60	?

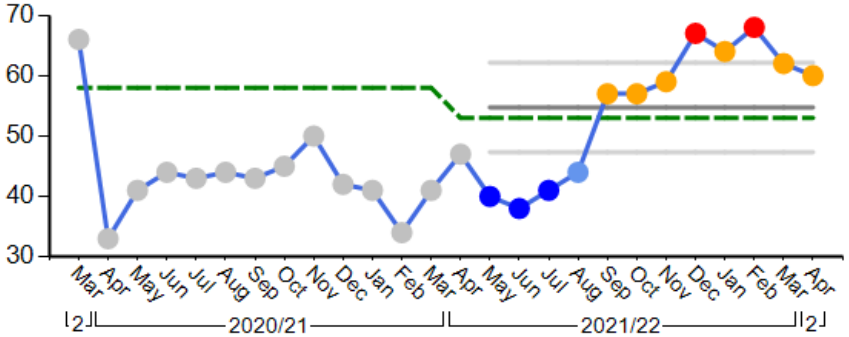
No Criteria to Reside - Avg No of Patients



Stranded Patients (>6 Days LOS)



Super Stranded Patients (>20 Days LOS)



Workforce

Organisational Development

Personal Development Reviews

Issues
• The indicator is failing its assurance measure and show special cause concern, continuing the deteriorating trajectory since November 2021.
• Performance continues to be impacted by the operational pressures experienced by the Trust

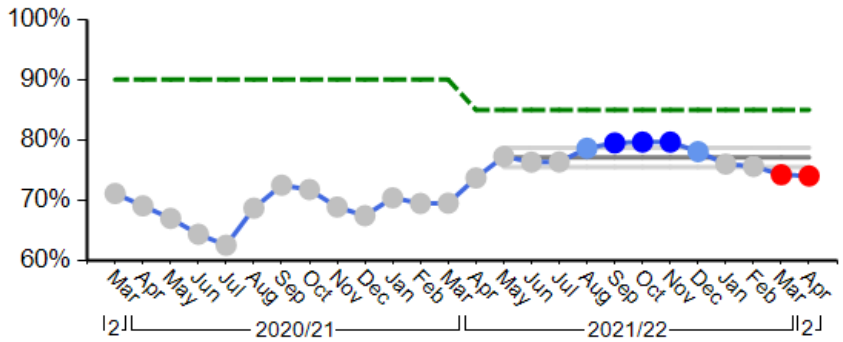
Management Action
• Improvement trajectories from CBUs have been requested to show a 10% improvement in compliance by the end of Spring.
• Compliance records are being monitored closely by CBUs and Departments
• Concentration in April has been on trying to ensure that any PDRs out of date in month are completed initially prior to any 'out of date' requirements. There has been some success in this area but not significant enough to maintain the completion date from last month.

Mandatory Training (Includes: NHS Core Skills Framework & statutory training)

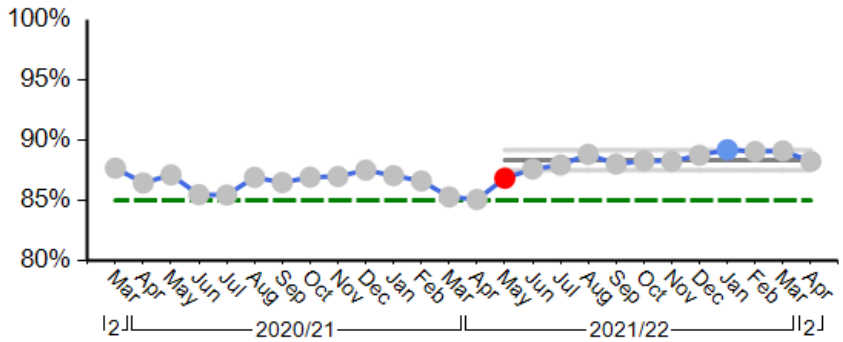
Issues
• The Mandatory Training indicator is currently assured against the 85% target. However, plans to increase to a stretch target of 90% in June 2022 will impact the assurance unless improvements are made.
•
Management Action
• The Trust has successfully maintained above the 85% target over the last 12-month period, a significant achievement during the Covid19 pandemic. In view of this, the Workforce Committee has determined that it's the right time to move to the 90% target in line with the People Plan. The revised target will apply from June 2022 onwards following the required system changes and relevant communications to the CBUs.
• Conflict resolution and moving & handling training remain a concern in the absence of in-house trainers, although plans are in place to recruit and appoint to the posts.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Personal Development Review	85%	74.1%	N/A	Apr 22		85%	74.3%	Mar 22	85%	74.1%	
Mandatory Training	85%	88.2%	N/A	Apr 22		85%	89.1%	Mar 22	90%	88.2%	

Personal Development Review



Mandatory Training



Workforce

Sickness, Vacancy and Turnover

Sickness

Issues

• In month sickness rates have decreased marginally and are statistically as expected.
• The rolling 12-month sickness rate continues to increase and at 7.2% is the highest reported.

Management Action

• Coaching and mentoring of managers continues in line with policy requirements for management intervention.
• Although LTS absence rate is falling, focus remains on returning colleagues to work.
• Audit work in respect of RTWI compliance and follow up actions commenced – initial results show that approx. 75% of RTWIs in the sample size were completed but not necessarily in line with expected timeframes and outcomes. This is being picked up in both training and 121 discussions with appropriate managers.
• Long- and short-term absences by week are monitored with the majority falling into the short term category.
• MSK is a concern, particularly with domestic staff in month and, whilst there is an ageing workforce, there is a need for targeted referrals and health advice for this group of staff.

Vacancies

Issues
• The overall vacancy rate is failing its assurance measure and is 2.8% above the target, this is a 0.5% increase on the previous month but remains statistically as expected.

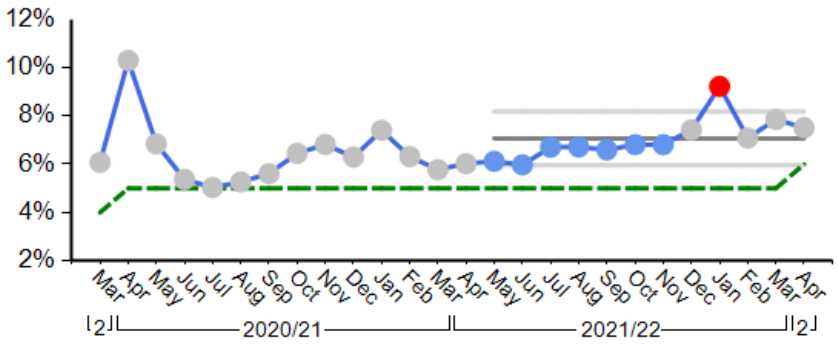
Management Action
• There are a further 24 Medical posts under offer.
• The Trust is currently working on the Medical position for August, trying to ensure that the rotation has minimal impact on staffing levels although we are aware we will lose some of our clinical fellows are they take up training positions.
• The Trust is now actively working on our Heathcare Assistant vacancies and have recruitment events being publicised, with a strong number of candidates showing interest.
• The Trust has a planned programme of support, both in terms of the care certificate and ensuring they have pastoral support in place. Our aim is that these groups from the recruitment events will start in cohorts and attend training and induction together to help to bolster an informal support network alongside the pastoral support.
• Band 5 vacancies remain low and the Trust is currently working to ensure we place all our students under offer into the remaining 20 vacancies.
• Due to the cyclical nature of AHP recruitment we are aware that we do get a spike in vacancies at this point in the year but are working with the team to ensure we capture as many of the newly qualified staff as possible in July/August.

Turnover

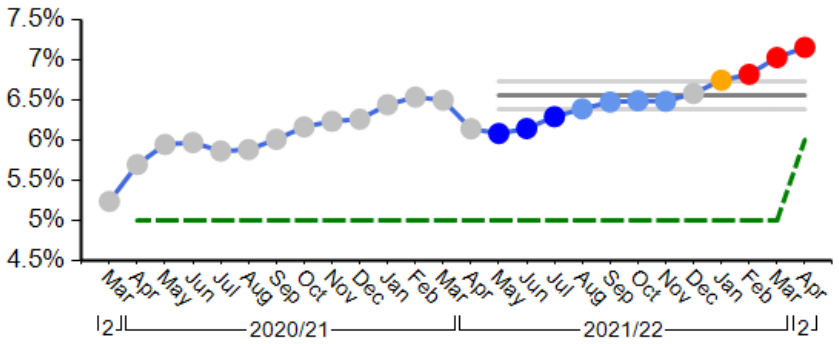
Issues
• In-month turnover is statistically as expected and is just 0.07% above target in April.
Management Action
• Whilst the figures continue to be impacted by the students who took paid positions to support during covid we are constantly reviewing turnover and looking for ways to reduce this.
• The Trust has noted that we have many of our Healthcare assistants leaving within the first twelve months, and this is the reason the Trust is improving the induction and pastoral support.
• Promotional materials are being developed, demonstrating career pathways to show that this can be a stepping-stone into nursing.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Sickness Rate	6%	7.5%	N/A	Apr 22		5%	7.9%	Mar 22	6%	7.5%	
Sickness Rate (Rolling 12 Month)	6%	7.2%	N/A	Apr 22		5%	7%	Mar 22	6%	7.2%	
Sickness Rate (not related to Covid 19) - Trust	5%	5.5%	N/A	Apr 22			5.5%	Mar 22	5%	5.5%	
Trust Vacancy Rate – All Staff	7.4%	10.2%	N/A	Apr 22		6.8%	9.7%	Mar 22	7.4%	10.2%	
Staff Turnover	0.83%	0.9%	N/A	Apr 22		0.8%	1.5%	Mar 22	9%	6.8%	

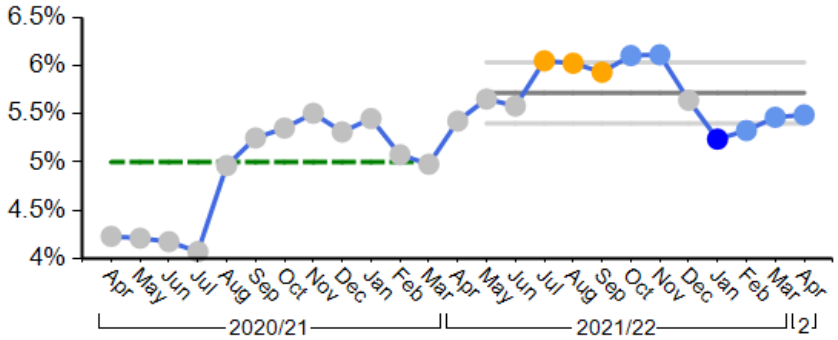
Sickness Rate



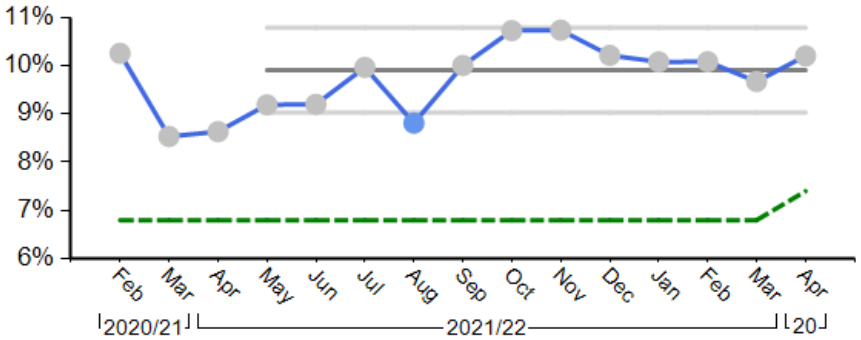
Sickness Rate (Rolling 12 Month)



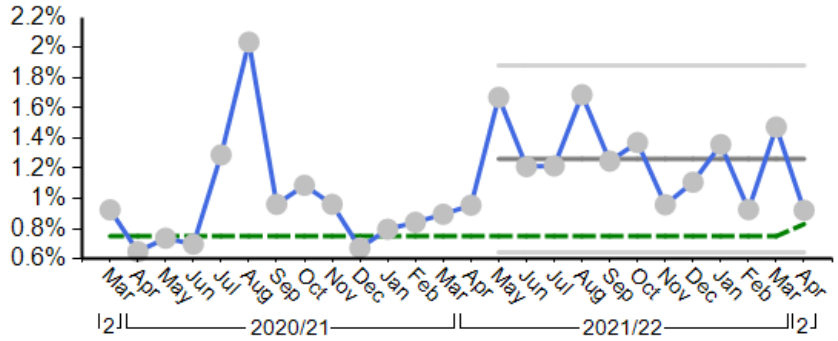
Sickness Rate (not related to Covid 19) - Trust



Trust Vacancy Rate – All Staff



Staff Turnover



Finance

Finance

The Trust is reporting a £1.8m deficit at Month 1 in line with 2022/23 Plan.

The 2022/23 Plan sets out a £20.5m deficit after applying:
- £5.3m ERF Income
- £7.8m CIP (3.5%)

Pending confirmation of ERF calculations and System performance, the Trust has assumed 100% achievement of ERF funding in M1.
ERF performance is highlighted as a risk to delivery of 2022/23 Plan in view of continued operational pressures experienced into 2022/23.
System planning discussions are still ongoing in view of a financial gap across C&M.
There may be an issue with accessing national sources of capital funding until an accepted 2022/23 Plan is submitted by C&M.

CIP - The 2022/23 financial plan sets out a CIP requirement of 3.5% (£7.8m). Schemes totalling £0.28m have been delivered in Month 1, with under-performance mitigated by non-recurrent schemes.

Cash The cash balance at the end of April was £12.5m.
A monthly forecast for 2022/23 is shown in section 8. Regional cash support will be required from October as the Trust is operating with a planned £20.5m deficit in 2022/23.

BPPC – The Trust is currently achieving 97% against a 95% target.

Capital - This totals £10.282m and includes agreed public dividend capital of £3.2m for fire safety.
Negotiations for further funding to tackle significant backlog maintenance are ongoing – with a System Backlog Maintenance Prioritisation Panel meeting on 27th June.
Bids for CDC (Community Diagnostic Centre) and TIF (Targeted Investment Fund – endoscopy investment) are due to be submitted to NHSEI by July 2022.

	Latest				Forecast			Year to Date	
Indicator	**Plan**	**Actual**	**Period**		**Plan**	**Actual**		**Plan**	**Actual**
I&E surplus or deficit/total revenue	9.3%	9.3%	Apr 22		9.0%	9.0%		9.3%	9.3%
Capital Spend	£00K	£00K	Apr 22		£10,400K	£10,400K		£00K	£00K
Cash Balance	£14,600K	£12500K	Apr 22						

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Quality and Safety Committee
MEETING DATE:	23 May 2022
LEAD:	Gill Brown

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- **Maternity Quarterly Update Report** including an update on Ockenden (1 and 2) – challenges with compliance relating to workforce.
  Update provided relating to recent maternal death – investigation progressing following completion of StEIS report.

- **Operational Update:**
  Cancer Performance and Improvement Plans – Histology capacity (delivered by STHK) resulting in delays – to be addressed through pathology contract meeting.
  Tumour group pathways shared to provide understanding of actions in place and oversight of potential 104 days cancer pathway breaches.

ADVISE

- **Never Event – retained guide wire -** Learning presented at Trust brief, Trust wide communications and reviewed through SIRG. Ongoing actions to identify any additional human factors training needed. (Datix ID 108997)

- **IPR -** High number of Nosocomial Covid-19 cases noted. Remains comparable with peers and reduction seen since report produced.

ASSURE

- **Monthly presentation** – Staff Voice Partnership (Our Listening Plan) was well received and demonstrated organisational intent to promote a just and learning culture

- **SOCASS report –** Well received, consensus that it provided assurance regarding the ongoing improvements and congratulations given to teams

- **MIAA Audit (Moderate Assurance)– Lessons Learnt Report (2021/22)** – Noted that assurance provided that actions are in place to address the three recommendations.

- **Patient Safety Report (Month 1) –** Noted as providing relevant information. Supplemented for this month with the National template for review of patients breaching 12 hour decision to admit wait in ED.

- **Quality Account 2021/22** (Draft) submitted for comments and approval from the Committee for submission to SOC on 08 June

New Risk identified at the meeting	• No new risks were identified at the meeting.

Review of the Risk Register
(

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Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**01 June 2022**
Agenda Item	**SO104/22**	**FOI Exempt**	**YES / NO**
Report Title	**DRAFT QUALITY ACCOUNT 2021/22**		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Brendan Prescott, Deputy Director Quality, Risk and Assurance Jo Simpson – Assistant Director of Quality		
Action Required	✓ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To submit the final draft version of the Quality Account for 2021- 22 for review and approval.

Executive Summary

The draft of the 2021/22 Quality Account has been completed in line with the National Health Service (Quality Accounts) Regulations 2010 as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012.

The Trust has worked closely with St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) Quality Colleagues to ensure a consistent format and contact for the document whilst retaining a Southport & Ormskirk Hospital NHS Trust focus. The Trust continues to develop the Account up to the scheduled publication date to incorporate 2021/22 year end data and publication of annual reports.

The Quality & Safety Committee reviewed and provided feedback on the document on 23 May 2022 which has been incorporated into the current draft version.

The Director of Nursing, Midwifery and Therapies and Executive Medical Director will present the draft Account to a number of partners including CCGs at a Quality Accounts event scheduled for 10 June 2022. The feedback from our partners including Healthwatch will be included in the final published account. There was no requirement for the Account to be reviewed by our External Auditors this year. The final draft is attached as Appendix 1.

Recommendations

The Strategy and Operations Committee is asked to review and approve the draft Quality Account 2021/22.

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 TICK RELEVANT BOX AND DELETE

✓ **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:**
Brendan Prescott, Deputy Director Quality, Risk and Assurance Jo Simpson – Assistant Director of Quality	Lynne Barnes, Director of Nursing, Midwifery and Therapies

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Southport and Ormskirk Hospital
NHS Trust

Quality Account
2021/22

Delivering excellent care.
For every patient. Every time.

Contents

Our Vision

Delivering excellent care.
For every patient. Every time.

Our vision is “Delivering excellent care for every patient, every time” so that patients and their families can be confident that this Trust remains absolutely focused on positive outcomes for them and that this is understood to be everyone’s responsibility. It is underpinned by our SCOPE values; Supportive, Caring, Open and Honest, Professional and Caring as shown in our Values Charter below.

Trust Values

1.1 Statement on quality from the Chief Executive of the Trust

Southport and Ormskirk Hospital NHS Trust is pleased to present the Trust's annual Quality Account for the period 1st April 2021 to 31st March 2022. I am very proud to present this account as Chief Executive which documents our progress, performance, and achievements over the past year, as well as outlining the priorities for improving quality in 2022-23.

Over the past 12 months this Trust has continued to meet the challenge of COVID-19 19 which has brought sustained demands on our workforce. Staff have continued to work incredibly hard to provide the best care and treatment for our patients and we have continued to develop flexibly to maintaining the essential services for the people we care for. Like the rest of the NHS, The Trust now faces a number of new challenges as we continue to manage our response to the pandemic whilst working towards a plan for recovery and restoration and realignment of services in the longer term.

This last year has also provided us with many exciting opportunities and in September 2021, our Trust entered a partnership with St Helens and Knowsley (STHK) Teaching Hospital NHS Trust. The agreement for long-term collaboration, which has the backing of NHS England was also unanimously approved by our Trust Board. A key focus on the collaboration has been to develop joint working where appropriate which has supported several fragile services. The enthusiasm shown by the teams has been a testament to their commitment to the patients and services alike. This has allowed us to stabilise two previously at-risk services and develop key work programs for the coming year. Alongside this we also managed to secure additional investment to develop and improve a number of clinical areas which has included the endoscopy unit and a new discharge lounge.

A review of the quality of Dysphagia care provided to patients with Parkinson's disease was the subject of a project within the Trust and now a Parkinson's Disease Nurse has been appointed to develop our services further.

We are also entering a new and evolving landscape with the emergence of Integrated Care Systems and the notable shift towards working as a system across Cheshire and Merseyside. This will change how we work with system partners and we how shape our own ambitions and longer-term plans through engaging on the Shaping Care Together project with system and place colleagues.

There were no Care Quality Commission (CQC) Inspections undertaken between 1st April 2021 to 31st March 2022 and a Trust rating of Requires Improvement remains in place. As part of the CQC's transitional regulatory approach to monitoring, the Trust completed and submitted a monitoring template for Maternity Services in September 2021 and for Medicine Core Services in November 2021. I am pleased to confirm that no concerns were raised as a result of these reviews and improvement was noted. We maintain a positive and open relationship with our CQC colleagues and face-to-face engagement meeting started once again in September 2021. We look forward to continuing our improvement journey with regulatory partners.

July 2021 saw the relaunch of the Trust's Patient Engagement Strategy which will support delivery of an excellent experience to patients, carers, and families.

From the 2021 Staff Survey the majority of staff told us they feel proud of the difference they make to our patients, and they feel trusted in their job to perform your role. These positive results reflect the Trust's vision of delivering the best care to every patient, every time.

Staff also told us there is a mutual respect and a strong sense of teamwork among colleagues. I am extremely grateful that despite all the challenges of recent years our Southport and Ormskirk values continue to underpin everything we do. There are, of course, areas for development and over the coming months and throughout 2022-23, our important staff engagement programme will continue with colleagues from the Executive Team.

I am pleased to note that in the last 12 months we have managed to recruit 100 international nurses, which has had a significant positive impact on patient care. I was also proud to receive feedback from Ruth May (Chief Nursing officer) to congratulate us on our improvement in nursing fill rate, this is a huge achievement for the Trust.

This Quality Account details the progress we have made with delivering our agreed priorities and our achievement of national and local performance indicators, highlighting the particular challenges faced during the year. It outlines our quality improvement priorities for 2022-23.

I am pleased to confirm that the Trust Board of Directors has reviewed the Quality Account for 2021-22 and confirm that it is a true and fair reflection of our performance and that, to the best of our knowledge, the information contained within it is accurate . We Trust that it provides you with the confidence that high quality patient care remains our overarching priority and that it demonstrates the care and services we have continued to deliver during the ongoing challenges in 2022-23.

I remain extremely proud of all our staff who continue to give the best of themselves to care for the people who need us, as well as supporting each other through these very difficult times. Their enduring courage and unwavering commitment during the pandemic are appreciated by all members of the Board. I would like to offer my sincere gratitude and ongoing thanks to all our staff for everything they continue to deliver during this most challenging of times.

Ann Marr OBE
Chief Executive
Southport & Ormskirk NHS Hospital Trust

1.2 Shaping Care Together

Shaping Care Together is a programme run by NHS leaders in Southport, Formby and West Lancashire that seeks to 'futureproof' NHS services by exploring new ways of working and delivering services as well as utilising money, staff, and buildings to maximum effect.

Many of our hospital services were designed decades ago to respond to the health needs of the population at that time and this means we need to review what services we provide to ensure they meet today's challenges and expectations. At the beginning of 2021, the Shaping Care Together Programme began asking local people what they thought about the health and care services provided in Southport, Formby and West Lancashire.

Extensive consultation with local communities has been documented in the paper, 'Our Challenges and Opportunities' an engagement document that represents the next step in our journey to involve residents in designing high-quality health and care services that are sustainable for years to come

Following engagement with local people:

- More than 50 public or private stakeholder meetings
- More than 2400 responses to the online "have your say" questionnaire, including 350 staff and 557 comment cards completed
- More than 18,000 website visits and 600,000 social media views
- **More than 94 per cent agree that healthcare should be "local where possible and specialist where necessary"**

1.3 Summary of quality achievements in 2020-21

Quality of Services Overall

There were no CQC Core Service inspections in 2021/22 therefore the December 2019 rating of Requires Improvement remains.

Well-led

- The Trust recorded a mean Freedom to Speak Up Index score of 77.0% in 2020 (published in 2021), an increase from 74.6% for the previous year.
- Finance - The Trust signed up to Future Focussed Finance. Future-Focused Finance is a national programme designed to engage everyone in improving NHS finance to support the delivery of quality services for patients. The programme consists of national and regional events, networks, resources, and talent development programmes – all designed to advance the understanding of finance in the NHS. Underpinning all the work are commitments to value

the diversity within NHS finance teams and to challenge behaviours that contribute to inequality in access to development and opportunities for some.

- The performance and business intelligence team along with Informatics colleagues in IT and the Project Management Office (PMO), have been accredited with Level 1 in Excellence in Informatics by the Informatics Skills Development Network and aspire to achieve the Level 2 accreditation in the coming year.
- The Trusts support services continued to improve development of Attend Anywhere to support remote consultations so that our staff and patients could make the most of their time whilst staying safe.
- The Health & Well Being Team has since 2013 continued to maintain SEQOHS (Safe, Effective, Quality, Occupational Health Service) accreditation. In addition, the team won a Supporting Occupational Health and Wellbeing Professionals National Award for their outstanding contribution to Diversity and Inclusion, in relation to the support offered to Ethnic Minority colleagues who were vaccine hesitant.

National Staff Survey

1,335 completed questionnaires were returned from 3,218 questionnaires sent to staff for the latest survey reported in March 2022. This provided a 41.8% response rate (1,335 responses from a usable sample of 3,197), which is a slight reduction compared to last year (45.4%).

The majority of our staff told us they felt trusted to do their jobs and felt proud of the difference they made.

Staff

Our fantastic staff have once again represented our Trust with care, professionalism, and innovation .

Consultant Obstetrics & Gynaecology Surgeon Sanjeev Sharma's lifetime work in women's healthcare was recognised with a Lifetime Achievement Award at the Time to Shine Awards in December 2021.

Mr Sharma joined what would become Southport and Ormskirk Hospital NHS Trust in 1992, and developed a first-class fertility service at Ormskirk hospital that made dreams come true for many hundreds of couples. He is pictured here with his wife, Deepali. Sadly, Mr. Sharma has since died drawing many emotional tributes from his friends and colleagues at the Trust.

The Paediatric Diabetes Team won two accolades: Finalists in the HSJ Diabetes Initiative of the Year in their Value Awards- eventually receiving the Highly Commended award.
Finalists in the 2021 NHS Parliamentary Awards for Excellence in healthcare.

We awarded Safeguarding Ambassador status to our first staff who achieved Safeguarding Adults Level 2, Safeguarding Children Level 2 and MCA Level 2 this year. This group of staff have received additional information to that provided within the online training to enable them to support staff, identify and report safeguarding concerns and in assessing capacity and applying the principals of MCA in everyday practice. The 4 study days were each focused on a specific theme and included MCA and DoLS, Domestic and Sexual Abuse, Child Protection, Neglect and Self-neglect.

Our Critical Care team were shortlisted in the Emergency and Critical Care category of the 2021 Nursing Times Award with their entry "**Tailoring critical care training to our local demographics and vision**". The team won this category in 2020 awards, with their virtual video tour of the Critical Care department, to help alleviate families fears during COVID-19 visiting restrictions

Patient Safety

Throughout 2021 -22 we have started the process of reviewing the way in which we report, review, and learn from safety incidents at the Trust. This is to make sure we are in the best place to align ourselves to the planned launch of the national Patient Safety Incident Response Framework (PSIRF) in 2023.

We have reviewed our safety meeting structures which take place on a weekly basis. We have developed new reporting tools to support staff in reviewing when things do not go according to plan. More importantly this helps support learning and action from carrying out reviews to reduce the risk of harm keep our patient population safe.

As an organisation we remain a high reporter of incidents with a low incidence of harm compared to national peers. We will also continue our improvement work to develop as a learning organisation to ensure we are able to feedback to colleagues when an incident is reported or when a complaint about care is received.

We continue to work with our Human Resource colleagues in developing just, learning principles to strengthen how we investigate and work with staff when an incident occurs.

Clinical Effectiveness

We are delighted that Southport and Formby District General Hospital has again achieved the required standard for accreditation as a Major Trauma Unit for 2021-2022.

Cheshire and Merseyside Major Trauma Network said clinical standards had been met in the most challenging of times and it was "a credit to those delivering and supporting the service". The network team said the review demonstrated excellent clinical engagement and a continued desire to improve services offered to our patients suffering from major trauma.

The following areas of good practice and/or significant achievement were noted:

- Network pathway for spinal fractures has been successfully adopted to good effect
- Head Injury Trauma (HIT) score also adopted and is making a difference
- Accident & Emergency nurses have been enrolled on Liverpool John Moore University emergency care course; some have already completed it and feedback had been excellent
- Continuation of simulations throughout COVID-19
- Continued success of the Thoracic Wall Injury Support Team (TWIST) inhouse pathway
- Ratification and introduction of management of vertebral fractures guidelines

Gastroenterology Service working with the Estates and Facilities team successfully completed their refurbishment of the admission area three weeks early, allowing them to increase bookings immediately which had a positive impact on Elective Restoration and made strides towards their work aiming for Joint Advisory Group (JAG) accreditation. This has had significant impact enhancing our patients' experience with the creation of individual rooms

1.5 Patient Experience

Patient experience is fundamental to quality healthcare and a positive experience leads to better outcomes for our patients, as well as improved morale for our staff. Patient experience is at the heart of the Trust's vision to provide quality patient care and we strive to continuously learn from patient and carer experience to drive improvements and share best practice.

Patient stories continue to be a critical part of the patient experience agenda throughout the Trust. Due to the pandemic and the subsequent move to virtual meetings, patients have been unable to present their stories in person this year. However, to overcome this we have been able to film or audio record patients/carers telling their stories in their own words. These have been shared at the Strategic and Operations Committee and the Patient Experience and Community Engagement Group

(PECE). Patient stories have directed a number of improvements across the Trust such as a review of catering in the Regional Spinal Injuries Unit and a review of the support following transition to a ward following a stay on Critical Care Unit (CCU) and after discharge.

We are delighted to be able to share patient comments and compliments with our staff through our twice weekly Trust News e-mail update and through Twitter and The Meeting Place. Several examples are celebrated throughout this document

The Trust promotes patient and family engagement through a number of forums, many of which have continued virtually during the year. Patient representation is a valued part of PECE and carer representation has been integral to the improvement work of Dementia and Delirium Care within the new Admiral Nurse Steering Group.

Our Trust-wide PECE consists of staff, patients, and external stakeholders such as Healthwatch Sefton, Sefton Advocacy and Maternity Voices Partnership. Over the last twelve months the group has continued to meet monthly via virtual meetings and has supported service developments to ensure progress with the Patient Experience Strategy 20 -24.

A number of changes have been made as a result of patient feedback including:

- An improved process for managing patient property within the Accident and Emergency Department.
- Yellow boxes to support safe storage of items such as hearing aids, dentures etc. for patients with enhanced care needs.
- Development of a new communication care plan for use in adult inpatient ward areas.
- Introduction of snacks on the maternity wards.
- Free car parking for resident parents.
- A change of name for the Genito Urinary clinic to Westview to support privacy and dignity for patients.

In response to the first COVID-19 outbreak The Trust introduced a ‘Letter to Loved Ones’ service which is still promoted in response to the ongoing restrictions of visiting. Relatives of inpatients can email messages, cards and pictures which will be printed and delivered daily.

In addition to this, to further support communication between our patients and their families, all adult inpatient areas have access to I-PADS to support ZOOM calls. Dedicated support is also in place on the Southport DGH site to support requests for ZOOM calls. This support was increased over the Christmas and New Year period to enable additional opportunities for patients to talk with their families.

During the Christmas period, the Trust was able to ensure that patients were able to participate in the festive events:

- A Christmas Carol Singalong was recorded and played via Hospital Radio throughout the festive period. During allocated times leading up to Christmas Trust staff were able to attend wards to lead the 'singalong'.
- Monies from the Trust Charitable fund was used to purchase Christmas presents for all patients. These consisted of toiletry sets, selection boxes, colouring books, my first Christmas baubles and personalised baby grows.
- A visit to both hospital sites by 'Little Legs' the miniature pony.

1.5.1 Bereavement

At the beginning of the COVID-19 pandemic, the need for an enhanced bereavement service was identified. Despite the ability to now host end of life visiting, some key elements of this service have been maintained and were recognised as quality priority for the Trust in 2021/22:

- Working in partnership with the Trust Chaplaincy and Spiritual Care Service.
- Calls to bereaved families have continued and are completed by experienced staff who offer a supportive listening ear, signpost to information, and assist with any other issues.
- Families are also offered a bereavement card and a memory box

1.5.2 Volunteer Service

The Trust volunteer service has been integral in supporting patient experience across our organisation, particularly over the last twelve months. Despite the pandemic having an impact on the number of volunteers, a successful bid for NHS England monies in December 2021 has supported additional administration support for recruitment. As a result of this, volunteers have experienced a speedier recruitment process from expression of interest to starting in post.

The service has also been able to extend its volunteering opportunities to 16–17year olds. This has enabled not only the replacement of volunteers to existing roles but the implementation of new roles within:

- Pharmacy services
- Paediatric ward
- Accident and Emergency
- Discharge Support
- Welcomers
- Bleep Holders/runners.
- Ward volunteers

What our patients said about us in 2021/22

'Very understanding and professional. I couldn't have asked for anything more from them. Very Caring and sympathetic. I have a lot of faith in the NHS.'

Adult Accident and Emergency

'My son was seen and triaged quickly, and then seen by Drs very shortly after. Caring and kind staff.'

Children's Accident and Emergency

'One of the best wards I have ever been on and I've been on a few!

The care has been absolutely fantastic- highly recommend. The food was great too'

Adult Inpatients

'The nurses went above and beyond to make sure my daughter was comfortable and pain free – they also looked after myself and are very hardworking – proud of the NHS.'

Children's Ward

'We felt immediately at ease with our midwives. My wife was very nervous after previous complications and she was respected and listened to throughout all stages of her delivery.'

Birth

'Absolutely amazing, ,myself and my baby were thoroughly looked after and every single member of the team ensued that were both as happy and comfortable and looked after ...everyone went above and beyond for us.'

Post Natal Ward

'Very comfortable and the matron/staff are very easy to talk too.'

Southport Centre for Health and Wellbeing – Sexual Health Clinic.

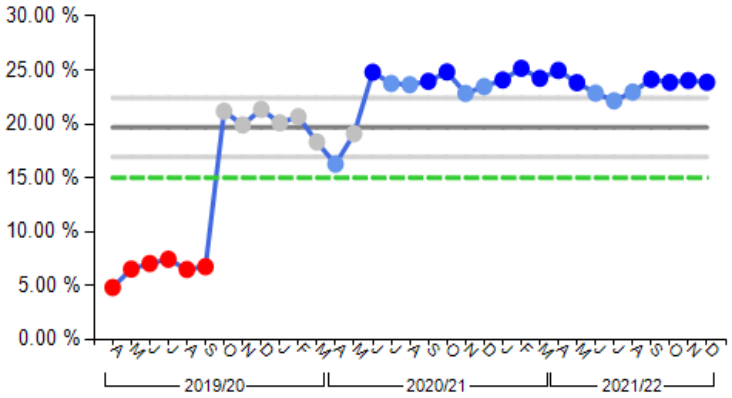
I went to see a doctor about shortness of breath. The doctor was very helpful, explained my condition very well and did some other tests on the same day. I wasn't expecting such a detailed explanation.

Outpatient Dept

1.5.3 Friends and Family Test

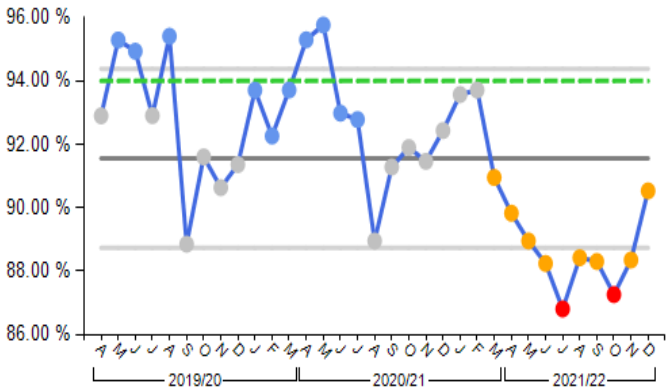
The Friends and Family Test is a Department of Health initiative that was introduced in April 2013. It is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Listening to the views of our patients helps to identify what is working well, what can be improved -and how. From April 2020, a new question replaced the original FFT question *'Would you recommend?'* Patients are now invited to rate the overall experience of using a service and are given the opportunity to also offer feedback of their experiences.

FFT responses as % of discharges – Trust



FFT can currently be accessed via automated messaging or via an online survey tool which is available on the Trust website. Postcards were withdrawn to maintain safety throughout the pandemic. However, despite this, the Trust has maintained a satisfactory response rate which is consistently above the internal performance indicator of 15%.

Percentage of patients who rate their overall experience as Very Good / Good.



The ongoing pressure of the Pandemic and high levels of patient activity is reflected within recent Trust FFT scores. From NHSE data, this is demonstrated both locally and nationally particularly within the Accident and Emergency service.

FFT data is reported monthly from ward to board level.

Triangulation with local and national survey data, concerns and complaints has resulted in improvements such as:

- The Silent Night Campaign to improve noise levels at night.
- Implementation of a new communication care plan.
- Provision of ZOOM calls to maintain patient and family communication.
- A+E refreshment rounds in response to extended waiting times.

"We visited Southport A&E and the staff were wonderful. They were obviously very busy but still had time to put my mum at ease, laugh and joke with her and make sure she was cared for. The matron in charge even managed to find a sandwich as my mum hadn't eaten all day. Can't fault any of the people we dealt with"

Southport Emergency Department

YOU SAID	WE DID
"The noise throughout the night is relentless. Ward doors are left open, so the noise echoes throughout the ward"; (Ward 14a)	A 'Silent Night' Campaign was launched in Dec-21. This included information posters directed to both patients and staff on ways to reduce noise, particularly during the night. The Trust charitable fund supported the purchase of 2000 Sleep Well packs that include ear plugs and eye masks. 'Silent Night' mugs were given to ward night staff to continually prompt regarding the campaign.
"No food offered and as partners weren't allowed in - no way of getting anything." (Adult Accident and Emergency)	Two hourly refreshment rounds implemented up till midnight within the Adult A+E department. This ongoing need has secured successful recruitment of two full time housekeepers.
'I felt uncomfortable asking for directions to the GUM clinic' (Genito Urinary Medicine)	To support privacy and dignity for patients , following consultation the name of the GUM clinic has been changed to 'Westview' .

1.5.4 Complaints

Feedback from our patients, their families, and carers, gives the Trust a valuable opportunity to review our services and make improvements. The Patient Experience and Complaints service is an integral part of the corporate patient safety team. The team act as a single point of contact for members of the public who wish to raise complaints, concerns, and compliments. The service is responsible for coordinating the process and managing the responses once the investigations and updates are received from the relevant clinical business units. They are contactable by telephone, email, via the Trust web site, in writing or in person.

The Trust took the step to implement a Patient Advice and Liaison Service (PALS) to offer help to our patients and families, which went live to the public in September 2020. PALS is dedicated to the frontline response of information requests and concerns raised. They are located near the front entrance of Southport hospital and have a telephone link from Ormskirk hospital. An enhanced PALS role was also implemented in the Accident and Emergency Department between Dec- 21 – May 22 to support in response to high levels of activity.

PALS offer advice and support to patients and families and help to resolve problems or concerns about health services as quickly as possible, which can help improve and develop the services we provide.

"Having to visit your Treatment Centre for a colonoscopy, I feel I must contact you to express my thanks and appreciation for the amazing care I was given. From the initial reception, preparation for, through to, during the procedure and afterwards, every member of staff showed a high level of professionalism, offering endless support with a caring and in a friendly manner. I cannot speak highly enough of your staff and, although it is hoped that I will not need to visit again, I would not hesitate to attend in the knowledge of knowing of the welcome, treatment and care I would receive. Please pass on my thanks and appreciation to the department."

Treatment Centre, Ormskirk Hospital

The PALS service has had a positive impact on formal complaints. The Trust received 272 formal complaints of which 84 have been responded to by the PALS service. This has been completed verbally and the complainant has been satisfied with the outcome and a formal written response has not been required, thus reducing the number of formal complaint responses to 213.

Lessons Learned

- This year has continued to emphasise how our communication with relatives and carers is even more important during a pandemic when visiting is restricted. The lack of opportunity for visiting can create worry and angst amongst relatives when they are unsure of patients' current prognosis. The Trust continued to support proactive enhanced communication with families/carers. Including staff to support Zoom calls and Letters to Loved Ones where an email can be sent and delivered to the patient.
- To improve communication in response to restricted visiting, a communication care plan has been successfully piloted across a number of medical wards.

- The Integrated Governance Team have introduced governance learning bulletins which includes learning from complaints, and these are shared amongst all staff including at clinical business unit and at ward level to share learning.
- We have produced a new standardised discharge checklist which is now in use across the organisation.

Parliamentary Health Service Ombudsman (PHSO) Complaints

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Investigation: not upheld	3	3	1	2	0	**2**
Investigation: fully upheld	0	0	0	0	0	**0**
Investigation: partially upheld	3	3	2	1	1	**2**
Complaints withdrawn by PHSO	1	1	1	3	0	**4**
No decision made yet: carried forward	5	4	4	6	5	**2**
Total	12	11	8	12	6	**10**

"I am writing on behalf of my mother, who visited the A&E Department at Southport hospital last Monday morning, 20th September with a broken wrist and knock to the head. She was taken care of by a male nurse called Ian and wishes to pass on her compliments to him. My mother said that Ian was very efficient, extremely kind and caring, and had great communication skills. She was very impressed, especially when a department such as A&E is naturally very busy and under pressure."

Southport Emergency Department

I brought my near 80 year old mother into the hospital today to the Orthopaedic department due to ongoing pain and to discuss a hip replacement. She was very fearful, so I was very nervous for her. We were dealt with brilliantly and Mr. Sangani and nurse Karen were so lovely and reassuring. His manner and how he dealt with my mum was wonderful, so I wanted to thank him and the team. Thank you.

1.6 Celebrating Success

Following a break due to the pandemic, the Trust was delighted to recognise and reward its staff commitment and dedication once again via its **Time to Shine** Awards. The Executive Team continue to be amazed by the absolute commitment of our staff member for improving patient care

This gives our staff a chance to nominate the teams and individuals they believe have demonstrated excellence across the year -ensuring that all our support teams and unsung heroes also gain recognition and reward alongside our clinical teams.

Congratulations to Marie Wallace, lead nurse and sexual health practitioner on winning the Learner of the Award at the 2021 Time to Shine Awards. Maria is pictured receiving her award from Dr Ghanem, Sexual health Consultant.

We continue to recognize the work of our outstanding teams with our **Thanks a Bunch** awards - Paediatric A&E and Southport A&E teams who have both been recognised for the high standard of care they provide to their patients. The team were presented with chocolates, biscuits and a Thanks a Bunch certificate from Managing Director, Anne-Marie Stretch.

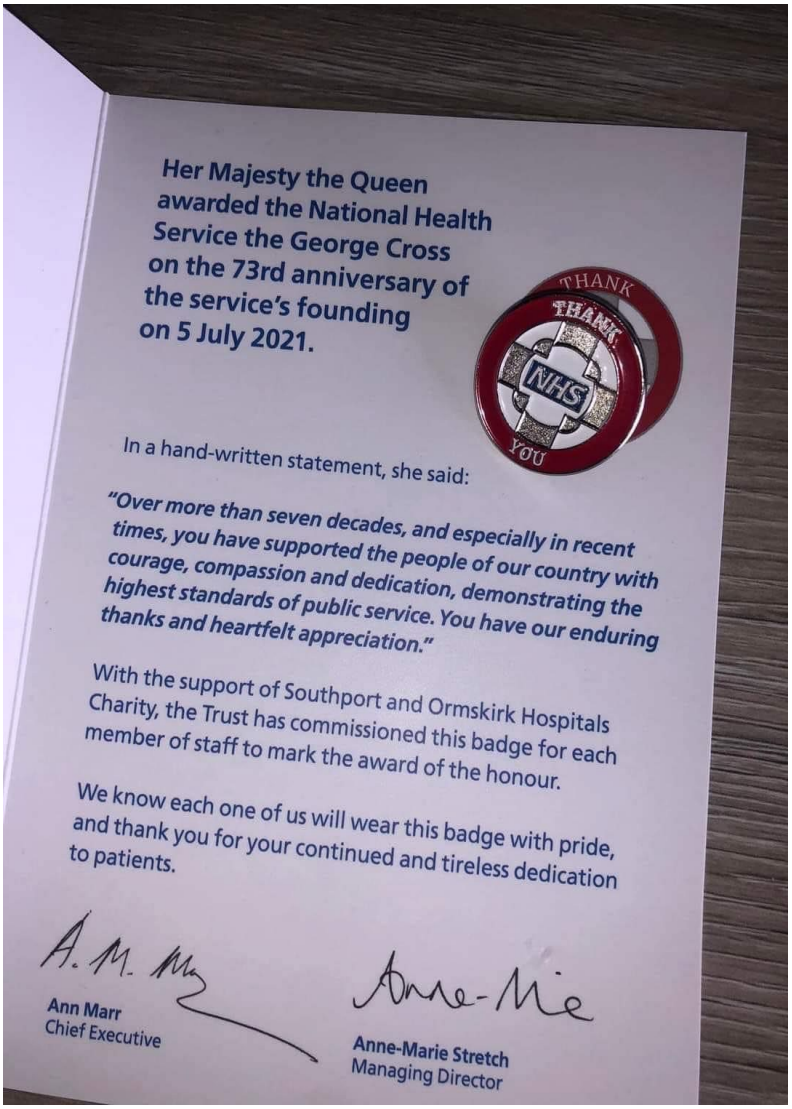
Individuals can be nominated for one of our **So Proud** awards by any other member of staff, as we feel it is important to give a voice to everyone in the Trust and encourage them to celebrate excellence wherever they find it.

Congratulations to the Sapphire Team who received their Thanks a Bunch certificate from Medical Director Kate Clark. The team were recognised for the high standard of care, they provide to their patients and families on the Maternity Ward and in the community.

Congratulations to the Ormskirk and Southport domestics teams who received their Time to Shine trophies as the winners of this year Non-clinical Team of the Year award at our 2021 awards ceremony .

A member of our HCA team designed a more permanent reminder of our contribution with his staff badge recognizing the George Cross Award given to the NHS, and a thank you card was sent with the badge for each member of staff to wear with pride.

Positive comments from patients are shared weekly throughout Trust News available to all staff and on our Trust Brief Live event every Thursday ensure we recognize qualifications gained by our staff by giving them a mention.
In addition, this year we held a Winter Wellness campaign, which along with our Random Acts of Kindness gifted over 200 staff in recognition of their ceaseless contribution during a challenging year.








I would like to take this opportunity thank all the staff/teams (A&E, wards, theatre, outpatients) who provided exemplary service to me during a recent period when I required urgent care and urology services at Southport and Ormskirk hospital. I was admitted to A&E, then hospital after experiencing acute pain ……. The way the operations were arranged by the admissions team, the communication/tests that were promptly sent, advice given, the seamless way the operations took place, every single member of staff who dealt with me, reassured me, explained clearly what was happening - ward staff, theatre staff, consultants all were outstanding in their professionalism and care. The very best of the NHS. Many thanks.

Various, SDGH & ODGH

Thank you to everyone who has collected their treat from Random of Kindness day last Thursday. This is the team from Ward 15A with theirs.

Those people who wanted their treat delivering to Ormskirk will be able to collect them at the Education Centre from Friday. Apologies for the delivery delay which is due to unplanned absence.

This is a list of all the winner. If you still haven't claim your treat, drop in or contact the Communication team at Corporate Management Office at Southport.

Would like you to pass on my thanks to Leslie in the PALS office, I spoke to her regarding trying to contact my mum who had been in A&E since last night. I had been unable to contact anyone to find out how she was or what injuries she had sustained, Leslie kindly went down to A&E to find out for me and rang me back almost straight away. Thanks, Leslie for your help and caring and kindness its much appreciated

PALS
Service

1.7 Promoting Health

The Trust appreciate the huge impact that the pandemic has had on all our staff both at work and at home. As a special thank you to staff the Trust has provided a range of activities and opportunities to show staff how much they are appreciated and valued. This included:

- Supporting home working and blended working,
- Free breakfasts,
- Free lunches,
- Soup and sandwiches,
- Thanks a Bunch,
- So Proud nominations,
- Hug in a Mug.
- Promotion of wellbeing using social media
- EAP programme providing 24hrs 365 days per week mental health advisory support.
- Dedicated staff access virtual platform able to be access off site signposting to a wide variety of sources including handling bereavement, domestic abuse.

In December we launched our 'winter wellness' campaign to help support staff at the most stressful time of the year. We wanted to show staff they were valued and offer them a small boost offering different challenges and rewards which included:

December –Seasons Greetings

- Trust Award Ceremony
- Christmas Hamper Raffle throughout the month
- Days Raffle with a range of fabulous presents
- Days of free breakfasts
- 'You have been socked' nominations from staff in recognition of colleagues that have gone the 'extra mile'
- Festive 'bake off'
- Free soup and sandwiches for night staff – given out by our Executive Team
- Free drink and cake for weekend staff
- Best dressed ward
- Executive team visit all area with free cake and drink
- Christmas sock day
- 25th and 26th December free breakfast
- Giving Back – staff donated to the local 'food bank'

January – Beat the Blues

- Free breakfast throughout January
- Blue Monday-Fresh fruit and water to all wards
- Free soup and sandwiches for night staff- given out by our Executive Team
- Launch of 'Growth Mindset Modules'
- Promotion of World Religion Day
- Celebration of Buddhist New Year

Feel Good February

- Introduction of yoga
- Meditation and Mindfulness sessions
- Random Acts of Kindness
- Celebration of Chinese New Year
- Drink Less Campaign
- Promotion of Apprenticeships – Apprenticeship Week

Occupational Health & Wellbeing

In addition to the above staff continued to have access to Occupational Health 7 days a week. The Occupational Health team provide a range of supportive services including:

- COVID-19 helpline – providing specific advice to staff on any COVID-19 related issues
- COVID-19 vaccination hub'
- 'Making Every Contact Count'
- Self-referral to offer advice and support
- Attendance Management
- Pre-employment screening
- Physiotherapy
- Counselling
- Staff Restoration Programme
- COVID-19 vaccinations
- Flu vaccinations

The team has since 2013 continued to maintain SEQOHS (Safe, Effective, Quality, Occupational Health Service) accreditation. In addition, the team won a Supporting Occupational Health and Wellbeing Professionals National Award for their outstanding contribution to Diversity and Inclusion, in relation to the support offered to Ethnic Minority colleagues who were vaccine hesitant.

Our Occupational Health & Wellbeing (OH&WB) team commenced the COVID-19-19 vaccination programme in January 2021, supported by a multidisciplinary team. Aware of a vaccine hesitancy from Black, Asian, and Minority Ethnic (BAME) communities, they wanted to ensure that BAME colleagues had priority access to the vaccine. Every BAME member of staff received a personal invitation. As part of the personal invitation, they were provided with a link to access the vaccination booking system, enabling them to book a convenient appointment time. In March 2021, the OH&WB team wanted to establish the impact of sending personal invitations and worked with the 'Business Intelligence' team to establish how many BAME colleagues had been vaccinated. Their data showed 17% (36) of BAME staff had not yet received their vaccination. To ensure that this group of staff felt supported, had access to the vaccination hub but more importantly had made an informed choice not to have the vaccination, the team telephoned all staff and offered an appointment to attend the vaccination hub at their own convenience. If they did not want an appointment, they were offered an appointment to speak to a clinician to discuss their concerns. This proactive approach increased the uptake from 77% to 93% winning them the " *Outstanding Contribution to Diversity and Inclusion*" award.

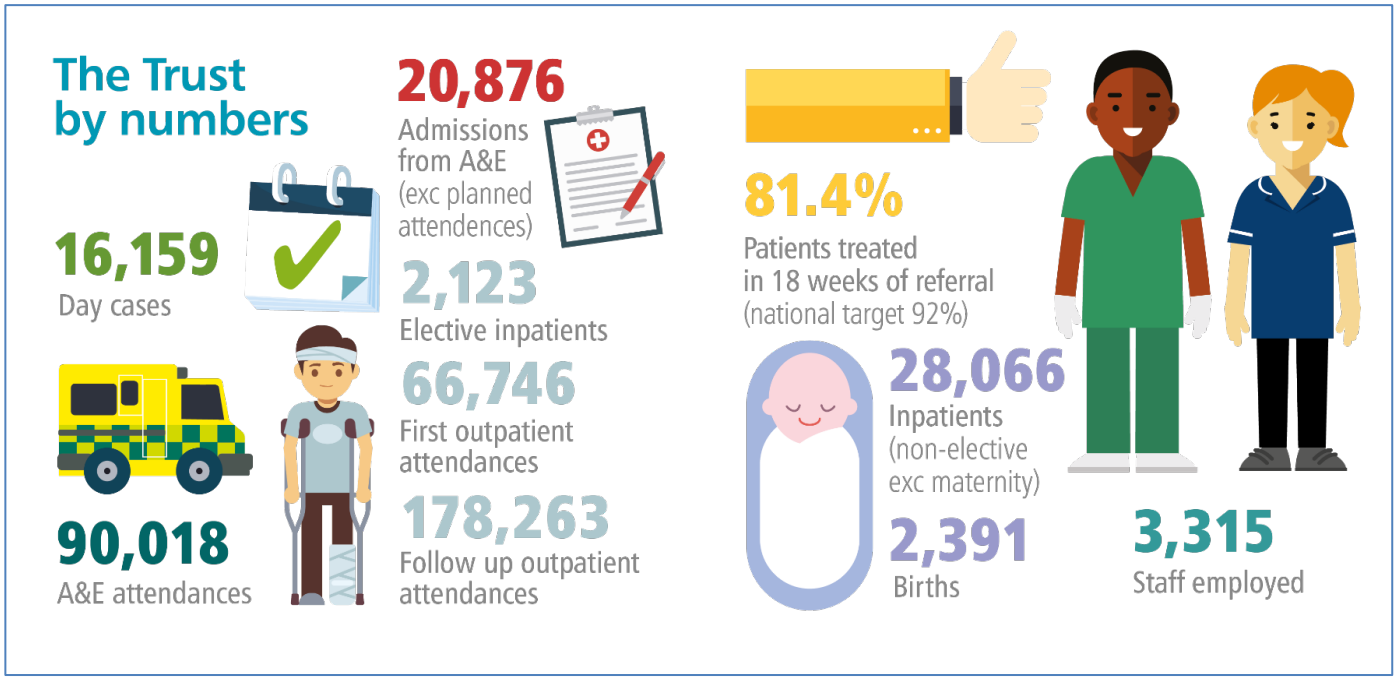
Ambassadors of Hope

The Trust has invested in training over ninety-five of our members of staff in Ambassadors of Hope (AoH) training which provides a baseline level of understanding of mental health, mental illness and what to do if you or somebody else needs help and support. The Trust continues to develop this role further providing a community base setting for AoH's, utilising this group as Champions of Wellbeing where up to date information on the latest incentives, offers of support and signposting are shared with the purposed of forwarding on within their areas to Leaders and colleagues.

Section 2

About Us

2.1 Our services



Southport & Ormskirk Hospital NHS Trust provides healthcare in hospital and the community to 258,000 people across Southport, Formby and West Lancashire. The Trust has over 480 overnight general and acute beds, with includes 360 beds on our Southport site, 59 adult beds on our Ormskirk site, 45 maternity beds, 21 pediatric beds and provides the majority of its services from two main sites at Southport and Ormskirk hospitals, both purpose-built facilities that are well-maintained. Southport Hospital houses the Adult Emergency Department, Critical Care and all acute care beds. Ormskirk Hospital houses day-case and elective surgery, women's, and children's services, including maternity, and the Paediatric Emergency Department are provided at Ormskirk hospital.

Acute care is provided at both Southport and Formby District General Hospital and Ormskirk District General Hospital. This includes adults' and children's accident and emergency services, intensive care, and a range of medical and surgical specialities.
The North West Regional Spinal Injuries Centre at Southport hospital provides specialist care for spinal patients from across the North West, North Wales, and the Isle of Man. The Trust also provides sexual health services for the Metropolitan Borough of Sefton.
The Trust Board is committed to continuing to deliver safe services and high-quality care, set within the context of the on-going increases in demand for urgent and emergency care, the backlog in the elective programme caused by the pandemic and the financial challenges facing the NHS.

Despite the ongoing management of COVID-19 normal hospital services were resumed or increased from their COVID-19 levels to restore normal levels of services, as far as possible to start the process of recovery and restoration.

- In the emergency departments, performance in 2021/22 against the four-hour standard for patients to be seen, discharged or transferred was 78.0% - just below national performance at 80.2%. In Cheshire and Merseyside, the Trust was the best performing non-specialist trust behind only Liverpool Women's at the end of the year.
- Ambulance handovers saw 79% completed in 30 minutes in 2021/22 compared to 86% the year before

The trust performed just above the 52+ week trajectory at March 2022. Challenges with COVID-19 demand and urgent and emergency care pressures meant a reduction in elective capacity with clinically prioritised (P2) patients. The Trust compare positively to peers across Cheshire & Merseyside with our 52+ week patients accounting for approximately 1.5% of our total waiting list, but Cheshire and Merseyside accounts for 5.5%. The Trust was the best non specialist trust across Cheshire and Merseyside.

Throughout 21/22 there has been a continued focus on gaining a full understanding of our fragile clinical services and development of actions plans to support the stablisation of these services. Workforce and service scale challenges remain key drivers for fragility which is a core reason for the development of the collaboration agreement with St Helens and Knowsley Teaching Hospitals. (STHK) The enthusiasm for collaboration shown by the teams has been a testament to their commitment to the patients and services and this has allowed us to stabilise two previously at-risk services and develop key work programs for the coming year. Alongside the Shaping Care Together work programme we have also seen support from the wider system, including the Cheshire and Merseyside Integrated Care Board to find and deliver the necessary actions to futureproof high quality services for our local population.

The pandemic has now been impacting on attendances and admissions for two years, making meaningful comparisons about activity difficult as illustrated in the table below. The North West has experienced 4 waves of COVID-19-19 since March 2020, the latest being the Omicron variant from December 2021 onwards. Each wave has impacted on the provision of the Trust's routine services and activities and the Trust has maintained as many services as possible for patients needing urgent, emergency, or elective treatment over that period.

	2019-20	2020-21	%change 2019-20 to 2020-21	2021-22	%change 2020-21 - 2021-22
Outpatient attendances (seen)	**258,575**	**212,863**	**-17.7%**	**247,538**	**16.3%**
Non-elective admissions	**35,044**	**26,030**	**-25.7%**	**30,711**	**17.9%**
Elective admissions	**2,271**	**1,266**	**-44.3%**	**2,126**	**67.9%**
Births	**2,340**	**2,095**	**-10.5%**	**2,391**	**14.1%**
Emergency Department attendances (as reported)	**88,161**	**62,833**	**-28.7%**	**90,260**	**43.7%**

The average length of stay for non-elective admissions was 7.0 days in 2020-21 and 7.0 days in 2021-22*

*Excluding 0 day length of stay (LOS)

2.1.1 Our staff and resources

The Trust's annual total income for 2021-22 was £264 million.

We employ more than 3,015 members of staff, providing acute healthcare for our population of 258,000 people. We are also the home of the North West Regional Spinal Injuries Centre.
The average staff turnover rate in the Trust for 2021-22 was 15% against the regional average of

10.6%. The Trust strives to meet the best standards of professional care whilst being sensitive and responsive to the needs of individual patients.

Our clinical services are organised in to 3 business units, Specialist Services, Planned Care and Medicine and Emergency Care, working together to provide integrated care.

A range of corporate services contribute to the efficient and effective running of all our services, including human resources, education and training, informatics, research and development, finance, governance, facilities, estates, and hotel services.

Significant national recruitment challenges remain within specific specialties and for specific roles, in particular, for nursing and medical staff. It is, however, notable, that in the last 12 months we have managed to recruit 100 international nurses, and this has had a significant positive impact. We will continue with overseas nursing recruitment as part of the Pan Mersey International Collaboration, and as part of that collaboration, we are exploring the possibility of extending this to fill some of our Allied Health Professional vacancies, as well as exploring further international recruitment activity for the medical workforce.

The Trust has also been proactively working towards ensuring there are no Healthcare Assistant vacancies through our regular recruitment events. This will be strengthened further with retention initiatives including the development of a bespoke induction and preceptorship programme, recognizing the need to ensure this group of staff are properly supported within the Trust. In addition, the Trust has collaborated with local Universities, formalising a partnership agreement with Edge Hill University, and securing its first jointly appointed Consultant Clinical Academic position. The Trust will build on these relationships further to strengthen the pipeline of students choosing the Trust as their preferred employer, as well as further opportunities to attract nursing and medical applicants to the roles we offer.

Medical vacancies are now at the lowest level the Trust has seen for at least 4 years, with the vacancy rate which is currently at 5.8% bringing it in line with the national average. Between April 2021 – March 2022 we have seen a gradual reduction in our medical vacancies, starting the year with 32.42 vacancies, and closing the gap to 22 vacancies by March 2022 . Whilst this seems like a small change it does represent a 3% improvement and we are currently mirroring the national average for medical vacancies. We also have a further 6 Consultant posts under offer which will again reduce our vacancy rate significantly.

Our main vacancies are across the medical specialities; however, we are attracting some applicants to these posts and have consultants posts under offer in acute medicine and respiratory medicine.

We are currently undertaking several pieces of work, with external support, to look at our medical numbers and ensure we have the best pathways in place. We are also utilising NHS England/Improvement (NHS E/I)support to engage with our clinical services to look at workforce re-modelling and the further integration of roles such as Physicians Associates, Anesthesia Associates and Advanced Clinical Practitioners

Workforce Plans

The Trust is aligning workforce plans to the NHS People Plan to ensure sustainable pipelines to attract and retain nurses, midwives, operating department practitioners (ODPs) and allied health professionals (AHPs), including:

- On-boarding and retention of new and existing staff including flexible working, internal staff transfer scheme, itchy feet discussions, assigning a buddy, welcome packs/information and encouraging retire and return
- An active recruitment programme for the nursing and midwifery workforce, ongoing throughout the year, both locally and internationally
- Delivering apprenticeship programmes, from local health care cadets at further education colleges through to part-time registered nurse degrees and Operating Department Practitioner apprenticeships
- Implementation of the nursing associate role with 15 trainees currently in training, and a total of 17 have now successfully completed this course. A further 106 people are being supported through a variety of apprenticeship programmes.
- Implementation of e-rostering and e-job planning for specialist nurses to ensure the
- most effective rostering and planning of work and extending e-rostering to non-clinical areas
- Launch of a new online appraisal and personal development plan system which includes an enhanced focus on health, wellbeing, and staff support

Nursing and midwifery safer staffing levels are reported externally, with details of the total planned number of hours for registered and care staff measured against the total number of actual hours worked to produce a monthly fill rate as a % for nights and days on each ward. Agency, bank, overtime, extra time hours, discharge coordinators and ward managers' supernumerary management days are included in the actual hours worked totals in accordance with the guidance. The safer staffing figure, however, does not analyse skill mix or the impact of temporary staff on a shift-by-shift basis, which can have an impact on the quality of care provided.

The acceptable monthly fill rate is 90% and over, which throughout the COVID-19-19 pandemic has been very challenging to achieve. Senior nurses, led by the Director of Nursing, Midwifery and Governance held twice daily staffing meetings at times of increased pressure to redeploy our staff across the Trust to maintain patient safety.

The Trust also reports Care Hours per Patient per Day (CHPPD), which is calculated from the total actual hours worked in a month divided by the monthly total inpatients in the ward at midnight. The Trust's position is reported monthly as part of the mandated safer staffing report. The Trust average for 2021-2022 was 8.85 hours, against a target of 9 hours. Our wards which are facing ongoing challenges with recruitment are generally the wards that are unable to meet the safer staffing 90% fill rate consistently. The rapidly increasing vacancy position will support the Trust drive to ensure that the target of 9 hours is consistently met.

This year, the Trust has worked incredibly hard to maintain patient safety during the pandemic, using a range of approaches to ensure available staff were deployed effectively across the whole Trust. The actions taken include:

- Identified staff from across the Trust redeployed for block periods to specialist areas needing additional capacity, including critical care and respiratory wards

- Ward managers cancelled management days to work clinically
- Matrons/specialist nurses worked clinical shifts where possible, including community staff wherever clinics were cancelled.
- Increased the daily Matron staffing meetings to twice daily, led by the Director of Nursing, Midwifery and Governance, with members of the temporary workforce resourcing team
- attending. Staffing levels across the Trust were reviewed at each meeting, with every area identifying any gaps identified for the following 24 hours and the number of patients requiring supplementary care (1-1 or bay tagging) on each ward. Staff moves were then jointly agreed to provide the safest care possible
- A plan for further moves, should this be required for unexpected absence, was communicated by the matrons covering the late shift to the operational managers and the general manager on call each day
- Deployed corporate staff to support in areas, such as A&E, during surges of demand.
- Worked with the Trust's staff bank and external agencies to provide a pool of staff to cover each shift for areas experiencing last minute gaps due to sickness
- Block booked agency staff to provide continuity where possible, whilst conscious of the move to utilise bank as our preferred option wherever possible
- Successfully secured £210k funding from NHS England/Improvement (NHSE/I) to support the fast tracking of international nurse arrivals
- 100 international nurses commenced their training for the national Nursing and Midwifery Council's (NMC) Objective Structured Clinical Examination (OSCE) test, and 81 have now successfully completed this and are in receipt of their NMC registration. This has supported an overall reduction in the qualified nurse vacancies from 13% down to 6.14%.
- Proactive support for staff who were absent to ensure they were able to return to work as soon as possible
- Ensuring safe staffing levels remained a priority for the Trust throughout the year, with concerns escalated to the thrice daily bed meetings, daily silver and gold command and our weekly Executive Committee meeting

Supporting our staff

The Trust understood the huge impact that the pandemic had on all of our staff and hosted a special winter wellness event with several activities and opportunities to show staff how much they are valued. This included random acts of kindness, with bouquets of flowers, gifts and lunches handed out to various groups of staff, including staff working from home, thank you messages and thank you videos posted on the intranet.

Our Trust Staff Zone website has specific wellbeing sections and improved wellbeing sections including self-help leaflets and advice. This is promoted to all our staff. In addition, staff continued to have access to our Health and Wellbeing Department who provide a range of supportive services, including Occupational Health and those listed below:

- E learning Mindset Modules with Coaching Culture
- Access to Wellbeing Apps and our Insight Wellbeing at Work programme includes the 24-hour confidential counselling and advice helpline
- Round the clock support through an employee assistance programme (EAP)
- Service provider and access to Boo Consulting for wellbeing support.
- Mindful Yoga Videos shared with staff weekly
- Visits from the Cheshire and Merseyside Resilience Hub Team

2.1.3 Our Communities

The Trust provides services to the communities of Southport, Formby and West Lancashire. The communities served by the Trust are not ethnically diverse but do have high levels of deprivation and a growing, ageing population, with over 25,000 people over the age of 75 which means a high number of them are deemed to be frail and there is a significantly higher number of care home beds in the region than in the UK population as a whole.

2.1.4 Our Partners

Many of the planned collaborative projects and work programmes across Cheshire and Merseyside have remained curtailed because of the pandemic. However, the Trust has continued to work closely with our health partners across the region and in social care in the response to the pandemic. The Trust has worked as part of the Cheshire and Merseyside Hospital Cell, which has coordinated the collective response of acute hospitals to ensure they were in the best position to cope with the peaks in demand for acute medical and critical care beds caused by the different waves of COVID-19-19 infections. This has involved providing mutual aid across the system, both in respect of critical care capacity and also in ensuring our most clinically urgent cancer patients continued to be seen and treated.

The Trust also worked very closely with social care, community, and primary care services throughout the period to ensure that patients received the care they needed in the most appropriate setting.

In September 2021 the Trust entered into a formal Agreement for Long Term Collaboration (ALTC) with St Helens & Knowsley Hospitals NHS Trust (STHK). The aim of the collaboration is to find a safe and sustainable solution for services in Southport and Ormskirk. The ALTC provides for STHK's

Board to provide strategic and operational management of the Trust. During the first 6 months a baseline assessment has been completed and work has been undertaken to stabilise a number of our fragile clinical services.

2.1.5 Technology and Information

This year we have made significant steps in improving our digital maturity in line with NHS plans to have fully digitised hospitals. The Electronic Paper Record (EPR) has been upgraded from 'Medway' to 'Careflow EPR' to enable the Trust to continue its digital programme in line with the Trust's IM&T strategy.

We are undertaking the biggest network overhaul the Trust has seen. After putting together, a successful business case, we were able to secure £1.7m funding to improve our server capability.

In conjunction with STHK, we are moving to a new Service Desk call logging system which will be able to log calls, record problems, log change controls, allow users to offer feedback and also have a catalogue function where users can order standard IT equipment.

In December 2021, the Trust was successful in a bid to support the improvement of the Maternity Digital programme and this will enable us to move towards a fully electronic record building on the strong foundations in place, moving towards the patients handheld record in 2023.

Achievements – System Development

Medway was implemented in October 2014 and development of the system has since been the focus of the Clinical Systems Team with an upgrade in June 2021 to '**Careflow EPR'**. **Bluespier Theatre System** was implemented early April 2021 saw full integration to Electronic Patient Record and enables the clinical team to track and detail the patients journey from listing to procedure. The system enables the post op notes to be recorded electronically and the soon to be implemented mobile functionality will ensure that the 'electronic record' can commence on the ward.

Careflow Connect has been implemented within several teams and the roll out brings the ability to record patient handover details electronically, add tasks and supports the increased roll out of electronic internal orders thereby reducing paper.

The implementation of other systems giving us greater visibility of clinical records across trust boundaries supports nation standards of care and improve our digital capability. In addition, our software estate and external links were upgraded to improve the performance of our systems for patients and staff.

COVID-19 Vaccination Centres-IT support

The Trust provided First Dose Vaccinations for staff from 2020 with second doses completed in 2021. The Informatics and PMO teams supported the implementation of both the staff vaccination site at Southport Hospital and at the Ormskirk Hospital site. Staff were able to work with clinicians to deliver 10556 vaccinations and boosters across the year to not only our own staff but Primary Care staff and locally vulnerable patients.

The team continued to support the vaccination sites including changes to booking slots and systems, providing support and guidance for staff using these systems and helping with administrative

responsibilities for the sites until the last vaccination took place at the end of March 2022.

"I'd just like to express my thanks for the excellent treatment and care shown by Darren Hallinan during my ongoing physio consultations despite this having to take place via video conferencing. Obviously, there's nothing better than face-to-face physiotherapy sessions but so far it has worked out quite well for me."

Technology-Physiotherapy Department SDGH

"Dear Dr Shami, Dr Avendes and Mr. Nicholson: I am writing to thank you and all your colleagues who treated me with such professional skill and kind care during my recent gastroscopy and colonoscopy and subsequent CT scan ...
The supportive care of your nursing colleagues prior to and during the procedures could not have been any more gentle, kind and reassuring and the technical skills and expertise demonstrated by Dr Avades, Mr. Nicholson and the CT scanner operator were all extremely impressive and further reassuring.
The procedures were then followed by Dr Shami's explanation of the results which I found to be very full and clear and detailed. I do not take your very high standards for granted and consider myself very fortunate to have been treated by such expert and caring professionals."

Gastroenterology Department

2.1.6 Business Intelligence

We often put all the attention on the importance of our front-line clinical staff to ensure we deliver safe care. However, Performance and Business intelligence (BI) is a key enabler in allowing us to record and process the wealth of data which is stored in every ward and office of our hospital, without it clinicians would be unable to do their job. The data produced by our BI Team gives our Trust the data to diagnose and treat their patients, it provides our senior leaders with the information about their wards or departments, and it provides our executives and healthcare partners with the intelligence to understand how the hospital is performing.

Achievements

The Performance and Business Intelligence team, along with Informatics colleagues in IT and the Project Management Office, have been accredited with Level 1 in Excellence in Informatics by the Informatics Skills Development Network. This nationally recognised standard demonstrates the departments and Trust's commitment to this discipline and offers assurances to the quality of service and also the care and development of the staff within. In addition to this the Trust has been asked to consult on multiple occasions on the accreditation of several regional partners, demonstrating the high regard to which our service is held in the region.

Performance

The Trust is a key partner for NHSI in championing their best practice performance reporting methodologies. Working closely with national and regional partners to create a suite of intelligence reports covering 'Ward to Board reporting' to ensure key decision makers have not just access to data but credible intelligence which covers all the Trust's strategic objectives.

2.2 Summary of how we did against our 2021-22 Quality Account Priorities

Every year, the Trust identifies its priorities for delivering high quality care to patients, which are set out in the Quality Account. The section below provides a review of how well the Trust did in achieving the targets set last year.

2.2.1 Progress in achieving 2021-22 quality goals

Objective	Measurement	Status
Improving Safety Culture	• Total Number of Incidents • % of Patient Safety Incidents Resulting in Harm	Progressing to Plan
Safe Staffing	• International Recruitment • Real Time Staffing – Staffing Against Minimum Compliance • Number of Nursing Vacancies – Non-Registered %	Partially achieved – to be incorporated into Trust Strategic objectives for 2022-23
Improving Medicines Safety	• Administered Controlled Drugs signed for as per Trust Policy • Incidence of Missed Doses Critical Medicines	Partially achieved improvement through year

Objective	Measurement	Status
Deteriorating Patient	• National Early Warning Score (NEWS) 2 Observations with Score 5+ - % on time	Partially achieved – improvement through year
Improving End of Life Care	• % Of in Hospital Deaths from Patients with a Gold Standard Framework Alert • Carer to Receive Bereavement Follow Up and Card Following Death of Relative in Hospital •	Progressing to Plan
Improving Do Not Attempt Cardiopulmonary Resuscitation order (DNACPR) Compliance	• % Where Evidence of Discussion with Patient for Do Not Attempt Cardiopulmonary Resuscitation Decision	Partially achieved
Facilitating Safe Discharges	• Number of Section 42s Received • Number of Complaints Received in Relation to Discharges • Number of Complaints Received via Discharges Email Account	Progressing to Plan
Falls & Pressure Ulcers	• Number of Pressure Ulcers Grade 2+ • Number of Patient Falls – Moderate/Major/Death (Related) •	Partially achieved
Nutrition & Hydration	• Timeliness of Malnutrition Universal Screening Tool (MUST) Assessments •	Partially achieved – improvement through year
Family & Friend Test	• Friends and Family Test Responses as % of Discharges – Trust • Friends & Family - % That Would Recommend – Trust •	Progressing to Plan

2.3 Quality Priorities for improvement for 2022-23

The impact of the second year of the pandemic led to a number of business-as-usual activities being suspended so that resources could focus on providing an effective response, in line with national directions. This led to limited and delayed progress in achieving the quality objectives and, therefore, the Board took the decision in agreement with partners to roll forward some of the Quality Priorities to 2022/23 while also recognizing that the Ockenden Report played such an important part in the care of mothers and babies and is vital to include as a priority for our Trust.

Quality Domain - Patient Safety
Strategic Objective 1.1

Objective	Measurement	Lead Director	Governance Route
1. Reduction in Falls	Reduce all falls by at least 10% and falls resulting in harm by at least 20% compared to 2021/22 Ensure all patient harm incidents are reported and investigated	Director of Nursing Midwifery & Therapies	• Report to Quality & Safety Committee • Review via Reducing Harm Panel
2. Reduction in Pressure Ulcers	Reduce number hospital acquired pressure ulcers with lapses in care by 10% compared to 2021/22 Ensure all patient harm incidents are reported and investigated	Director of Nursing Midwifery & Therapies	• Report to Quality & Safety Committee • Review via Reducing Harm Panel

Objective	Measurement	Lead Director	Governance Route
3. Acute Kidney Injury: Nutrition and Hydration	• Achieve compliance with AQUA Acquired Kidney Injury (AKI) standard for US within 24hrs and urinalysis. • Reduce Hospital Acquired AKI compared to the 2021/22 baseline • Implement and report hydration and nutrition performance metrics • Undertake NEWS2 observations at the correct intervals 95% of the time • Audit compliance with the sepsis bundle and reduce incidents related to late detection • Achieve CQUIN standard for unexpected admissions to critical care	Director of Nursing Midwifery & Therapies / Medical Director	• Report to Quality & Safety Committee • Review via Nutrition / Hydration & Mouth Care Group • AKI Steering Group

Quality Domain- Patient Experience
Strategic Objectives
1.3, 1.5, 2.2

Objective	Measurement	Lead Director	Governance Route
4. To improve communications with families prior to discharge or End of Life	• Improve feedback from patients and relatives evaluated via PALs/Complaints/patient survey results • Learning from complaints and focussing on improving communication between staff, patients and their	Director of Nursing Midwifery & Therapies / Medical Director	• Report to Quality & Safety Committee • Monitoring at Quality Improvement Programme Board

	relatives • Reporting and learning from incidents with SMART actions • Increase in FFT scores for patients having a positive experience • Reduction in patient complaints • Increase in complaint case resolution.		

Quality Domain- Patient Experience
Strategic Objective
1.6

Objective	Measurement	Lead Director	Governance Route
5. Compliance with the Immediate and Essential Actions of the Ockenden 2 enquiry	Delivery of the recommendations of the second Ockenden Report Standards compliant & outstanding	Director of Nursing Midwifery & Therapies	• Report to Quality & Safety Committee

2.4 Statements of Assurance from the Board

The following statements are required by the regulations and enable comparisons to be made between organisations, as well as providing assurance that the Trust Board has considered a broad range of drivers for quality improvement.

2.4.1 Review of Services

During 2020-21, the Trust provided and/or sub- contracted 240m NHS services.

Southport and Ormskirk Hospital NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2020-21 represents 96% of the total income generated from the provision of NHS services by Southport and Ormskirk Hospitals NHS Trust for 2020-21.

The above figures relate to income from patient care activities. The remaining total operating income mainly arose from NHS North West Deanery for the education and training of junior doctors, services provided to other organisations, mainly for Estates and Facilities, Income for support of International Nurses, and Private Finance Initiative (PFI) support funding.

2.4.2 Participation in Clinical Audit

Annually NHS England publishes a list of national clinical audits and clinical outcome review programmes that it advises Trusts to prioritise for participation and inclusion in their Quality Account for that year. This will include projects that are ongoing and new items. During 2021-22, 44 national clinical audits and 3 national confidential enquiries covered relevant health services which Southport and Ormskirk Hospitals NHS Trust provides.

During that period, Southport and Ormskirk Hospitals NHS Trust participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The table below shows:

- The national clinical audits and national confidential enquiries that Southport and Ormskirk NHS Trust was eligible to participate in during 2021-22
- The national clinical audits and national confidential enquiries that Southport and Ormskirk Hospitals NHS Trust participated in during 2021-22
- The national clinical audits and national confidential enquires that Southport and Ormskirk

Hospitals NHS Trust participated in, and for which data collection was completed during 2021-22, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry

No.	National clinical audits and clinical outcome review programmes	Eligible	Participated
1.	Case Mix Programme (ICNARC)	Yes	Yes
2.	Chronic Kidney Disease registry	No	No
3.	Cleft Registry and Audit Network Database	No	No
4.	Elective Surgery (National PROMs Programme)	Yes	Yes
5.	Emergency Medicine QIPs • Pain in Children (care in Emergency Departments)	Yes	Yes
6.	Falls and Fragility Fracture Audit Programme a. Fracture Liaison Service Database	No	No
7.	b. National Audit of Inpatient Falls	Yes	Yes
8.	c. National Hip Fracture Database	Yes	Yes
9.	Inflammatory Bowel Disease Audit	Yes	Yes
10.	Learning Disabilities Mortality Review Programme	Yes	Yes
11.	National Adult Diabetes Audit a. National Diabetes Core Audit	Yes	Yes
12.	b. National Pregnancy in Diabetes Audit	Yes	Yes
13.	c. National Diabetes Footcare Audit	Yes	Yes
14.	d. National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms	Yes	Yes
15.	National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme a. Paediatric Asthma Secondary Care	Yes	Yes
16.	b. Adult Asthma Secondary Care	Yes	Yes
17.	c. Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Yes
18.	d. Pulmonary Rehabilitation-Organisational and Clinical Audit	Yes	Yes

19.	National Audit of Breast Cancer in Older Patients 1, 2	Yes	Yes
20.	National Audit of Cardiac Rehabilitation	Yes	Yes
21.	National Audit of Cardiovascular Disease Prevention	Yes	Yes
22.	National Audit of Care at the End of Life	Yes	Yes
23.	National Audit of Dementia	Yes	Yes
24.	National Audit of Pulmonary Hypertension	No	No
25.	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	Yes
26.	National Cardiac Arrest Audit	Yes	Yes
27.	National Cardiac Audit Programme a National Audit of Cardiac Rhythm Management	No	No
28.	b. Myocardial Ischaemia National Audit Project	Yes	Yes
29.	c. National Adult Cardiac Surgery Audit	No	No
30.	d. National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	No	No
31.	e. National Heart Failure Audit	Yes	Yes
32.	f. National Congenital Heart Disease	No	No
33	National Child Mortality Database	Yes	Yes
34.	National Clinical Audit of Psychosis	No	No
35.	National Comparative Audit of Blood Transfusion 3 : NHS Blood and Transplant a. 2021 Audit of Patient Blood Management & NICE	Yes	Yes

	Guidelines		
36.	National Early Inflammatory Arthritis Audit	Yes	Yes
37.	National Emergency Laparotomy Audit	Yes	Yes
38.	National Gastro-intestinal Cancer Programme a. National Oesophago-gastric Cancer	Yes	Yes
39.	b. National Bowel Cancer Audit	Yes	Yes
40.	National Joint Registry	Yes	Yes
41.	National Lung Cancer Audit	Yes	Yes
42.	National Maternity and Perinatal Audit	Yes	Yes
43.	National Neonatal Audit Programme	Yes	Yes
44.	. National Paediatric Diabetes Audit	Yes	Yes
45.	National Perinatal Mortality Review Tool	Yes	Yes
46.	National Prostate Cancer Audit	Yes	Yes
47.	National Vascular Registry	No	No
48.	Neurosurgical National Audit Programme	No	No
49.	Out-of-Hospital Cardiac Arrest Outcomes Registry	No	No
50.	Paediatric Intensive Care Audit	No	No

51.	Prescribing Observatory for Mental Health	No	No
52.	British Thoracic Society a. National Outpatient Management of Pulmonary Embolism	Yes	Yes
53.	b. National Smoking Cessation 2021 Audit	Yes	Yes
54.	Sentinel Stroke National Audit Programme	Yes	Yes
55.	Serious Hazards of Transfusion	Yes	Yes
56.	Society for Acute Medicine Benchmarking Audit Society for Acute Medicine Benchmarking Audit	Yes	Yes
57.	Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	Yes	Yes
58.	Trauma Audit & Research Network	Yes	Yes
59.	UK Cystic Fibrosis Registry	Yes	Yes
60.	British Association of Urological Surgeons a. Cytoreductive Radical Nephrectomy Audit	No	No
61.	b. Management of the Lower Ureter in Nephroureterectomy Audit	No	No
1	Mothers and babies: reducing risk through audits and confidential enquiries across the UK (MBRRACE – UK) – maternal infant and newborn	Yes	Yes
2	NCEPOD Transition for child to adult health services • Epilepsy • Crohn's disease	Yes	Yes

The reports of 44 national clinical audits were reviewed by the Trust in 2021-22 and Southport and Ormskirk Hospitals NHS Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Audit Title	Outcome/Actions
Emergency Department	
Severe Trauma: Trauma Audit & Research Network (TARN)	The Trust has a Trauma Group chaired by an A&E consultant which reviews reports and TARN dashboard. They are also continuously reviewed locally and by the Cheshire & Mersey Major Trauma Network / Operational Delivery Network.
General Medicine - Cardiology	
National heart failure audit	Improvements are being incorporated as part of our GIRFT plans going forward.
Myocardial ischaemia national audit project (MINAP)	Improvements are being incorporated as part of our GIRFT plans going forward.
Audit Title	**Outcome/Actions**
General Medicine – Care of the Elderly	
Sentinel Stroke National Audit Programme (SSNAP)	During 2021-2022 there has been an ongoing review of the Trusts stroke services to ensure the service will continue to be provided for local people. Performance has increase during the year with the most recent results indicating an improvement for a level D to a level C.
Sentinel Stroke National Audit Programme (SSNAP) – Stroke Mortality Reporting April 2019 – March 2020	This report indicated the Trust is not an outlier for stroke mortality when compared with other Trusts.
National Dementia Audit	The COVID-19-19 pandemic delayed the piloting and rolling out of any national data collection for Round 5 of the National Audit of Dementia. An optional round of case note data collection was offered to all hospitals in England and Wales wishing to have an updated local data set to compare with the last available national dataset, round 4. The Trust participated in this optional audit project as we had established a dementia and delirium team in the previous year. The results demonstrated and improvement and the impact the positive impact the team have had. -88% of patients had an initial assessment for delirium compared to the previous audit 34% -Cognitive testing using a validated tool has increased from 14.6% to 64% -86.7% of patients had a named person co-ordinating discharged comparted to 78.9% previously
National Inpatient Falls facilities audit	Following publication if this audit the Trust has appointed a dedicated falls lead who is reviewing our current falls training and increasing risk of falls identification. This improvement work is fed back through our Trust falls steering group.

National Audit of Care at End of Life	The Trust participated in the third round of this audit which is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death. The results demonstrated the Trust is above average in the majority of areas.
Audit Title	**Outcome/Actions**
Paediatrics	
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	The report contained data for the patient care received during 2019 – 2020 and this includes care provided during the COVID-19-19 pandemic and was published in July 2021. The Trust has reviewed all the recommendations and a full-time epilepsy specialist nurse has been appointment to take forward further improvement work.
National Paediatric Diabetes Audit	Healthcare Quality Improvement Partnership (HQIP) have created benchmarking from the 2021 report which reflects data collected April 2019 to March 2020. The benchmarking report indicates we are not an outlier in any area and 84.7% of patients receive all the required key processes annually.
Audit Title	**Outcome/Actions**
Maternity	
National annual report MBRRACE – Rapid report 2021: Learning from SARS-CoV-2 related and associated maternal deaths in the UK	This report included lessons identified from the care of all women who died following a positive test for SARS-CoV-2 infection, or in whom SARS-CoV-2 infection was diagnosed at autopsy, and from the deaths of women whose care or engagement with care was influenced by changes as a consequence of the pandemic. The results were shared with our maternity team to ensure local learning took place.
National Maternity and Perinatal Audit	The report was published in September 2021 based on births between April 2017 – March 2018. The report indicates the Trust has a higher than expected rate of induction – 48.34% compared with the national average of 32.6%. There is currently local quality improvement underway to monitor induction rates. Positivity the report indicates the Trust has a lower than expected rate of SGA (small for gestational age) born by 40 weeks – 30.1% comparted to 50.8% nationally.
National Pregnancy in Diabetes Audit	The national pregnancy in diabetes audit measures the quality of care and outcomes for women with a pre-gestational diabetes who are pregnant. This most recent report covers the audit years 2018 – 2020. We are above the national average for the following measures: • Babies born to type 2 diabetic mums admitted to the neonatal unit • Preterm deliveries for type 1 diabetic mums • Preterm deliveries for type 2 diabetic mums • Babies born to Type 2 mums that were large for gestational age
Audit Title	**Outcome/Actions**
Orthopaedics	
National Joint Registry	The focus on improvement this year which has resulted in both hospital sites being awarded data quality awards.

	An external review of the Trusts governance for the National Joint Registry recommended the establishment of peer review meetings, where orthopaedic surgeons could discuss openly difficult cases and learn lessons from hip and knee revisions. As a result, two forums for clinical review have been established: -Orthopaedic complex cases peer review meeting (bi-monthly) -National Joint Registry Annual Peer Review meeting
Audit Title	**Outcome/Actions**
General Surgery	
National Emergency Laparotomy Audit	The Trust is below expected ranges for 1 (out of 6) measure – crude proportion of patients aged 80 or frail who were assessed by a geriatrician. To improve compliance a geriatrician has now been appointed within the Trust to review patients.
NCEPOD: (National Confidential Enquiry into Patient Outcome and Death)/Child Health Programme	
The Trust has participated in all eligible studies. During 2021-22, 0 studies were completed in this year and 1 report was received and disseminated from a previously participated study: **Current Studies:** • Epilepsy • Transition from child health to adult health	
Audit Title	**Outcome/Actions**
Report received: NCEPOD: Dysphagia in Parkinson's disease	The project was a review of the quality of dysphagia care provided to patients with Parkinson's disease aged 16 years and over who were admitted to hospital when acutely unwell. The Trust is please to say that a Parkinson's disease nurse has been appointed to develop our services further.
NCEPOD (Surgical & Medical) & NCEPOD (Child Health) have the following studies planned for 2022-23 • Prison Healthcare Study • Community Acquired Pneumonia	

Local Clinical Audit Information

The reports 32 local clinical audits were reviewed by the Trust in 2021-22 and Southport and Ormskirk NHS Trust have taken and intends to take the following actions to improve the quality of healthcare provided:

Audit Title	Outcome/Actions
Emergency Department (ED)	
Transfer Documentation Audit	An audit was developed to review documentation from nurse handover. Audit was conducted using the evolve system to review patients notes. A sample of 53 patients transferred within the Emergency department between February 2021 and April 2021 was audited and reported full compliance with 52 (98%) of cases having clearly documented nurse transfer.

Insect bites and stings: antimicrobial prescribing	Audit was created to measure the departments compliance to the NICE guidelines on management of insect bites. The audit found we are good at assessing and commenting on bites and good at prescribing the correct antibiotic, however areas for improvement were identified in relation to patient information which are being addressed
General Surgery	
Audit of Minimum Data Set in documentation of operative findings in diagnostic laparoscopy	This re-audit was undertaken following the development of a new pro-forma to improve documentation. The audit indicated that when the pro-forma is used documentation improves, areas for improvement have been identified
General Medicine	
Re-audit antibiotic prescriptions in COVID-19 19 infection	Project measured compliance with patients being prescribed and initiated on antibiotics in accordance with Trust guidance. A revised training / education programme has been developed for all staff.
Advanced care planning and palliative care in liver cirrhosis audit	The aim of the audit was to find out how well liver cirrhosis patients were being registered for Gold Standard Framework (GSF) and to review referrals for palliative care. Action to improve practice include introducing an Multidisciplinary Team (MDT) every month and training session to be conducted jointly with palliative care consultant and medical consultants.
Audit Title	**Outcome/Actions**
Pharmacy	
Medicines Reconciliation Audit	Guidance from the National Institute for Health and Clinical Excellence (NICE) recommends that medicines reconciliation should be performed as soon as possible and have agreed that reconciliation should be undertaken for all patients within 24 hours of admission to hospital. As a Trust we audit this monthly, and the results are fed back via the pharmacy clinical audit meeting. Our results are variable and are affected by staffing levels, sickness, and pharmacy cover over the weekends. This is being addressed through staff consultation
Re-audit of storage of medicines in community clinics	This audit aims to ensure that there is safe storage and handling of medicines in accordance with standards set out in the Duthie Report 2005. Overall compliance was excellent with the one area requiring improvement being stocks being in date, which has been addressed
Pharmacist Contributions	This audit is undertaken every 6 months where the pharmacists record their contributions at ward level and in the dispensary. The number of contributions has steadily been decreasing indicating safer prescribing. Any severe intervention is recorded on the Trusts incident reporting system. There is also targeted feedback to consultants to improve prescribing.

Controlled drugs audit	This audit is undertaken regularly within the Trust and has demonstrated a steady improvement. There are however areas we wish to improve and plan to do this through more regular monitoring using the Tendable system. Another positive change is that training on controlled drugs is provided by pharmacy staff for all clinical staff within medicines management training which is now mandatory.
Microbiology	
Re-audit of Appropriateness of antibiotics for MRSA (Methicillin resistant staphylococcus aureus) treatment	Re-audit was undertaken following the introduction of a yellow sticker which is put in notes of all colonized patients to alert team if patient is MRSA positive. The change had led to an improvement as the audit is now achieving significant assurance with 100% compliance for antibiotic review at 48 hours.
Palliative Care	
Re-audit of the documentation of syringe driver checklists	This 5th cycle of audit achieved significant assurance and demonstrated an improvement in a number of areas and overall, the majority of checklists were completed fully.
Healthcare Assistants / Nurses Confidence in Managing Dying Patients	Oasis Ward was a ward opened in Southport Hospital during the COVID-19 19 pandemic, to specifically support patients thought likely to be dying who also had a COVID-19-19 diagnosis. Following the closure of Oasis ward, this audit was undertaken as a snapshot of how confident Registered nurses, Healthcare Assistants, TNAs, and Student nurses felt supporting dying patients. Audit results indicated further education for Registered Nurses and Healthcare Assistants around End-of-Life Care is required, a revised training / education programme has been developed for all staff.
Audit Title	**Outcome/Actions**
Paediatrics	
Neonatal hypoglycaemia audit	There are a number of criteria which should be followed when a baby is born with the risk of hypoglycaemia. This audit was initially undertaken in 2019 and demonstrated very limited assurance. A revised hypoglycaemia care pathway was introduced, and the re-audit reported in 2021 demonstrated significant assurance.
Audit of the Quality of Child Protection Medical Documentation within Paediatrics	The assurance level is Significant for this re-audit which demonstrates a clear improvement on the original audit and indicates that the recommendations, additional training, and discussions around the importance of the process have been beneficial.
Obstetrics & Gynaecology	
Audit on prophylactic antibiotics following operative vaginal delivery	The audit found that 77% of women who had an instrumental delivery received antibiotic prophylaxis. This can be attributed to a new guideline being issued only a few months before the audit was undertaken and the subsequent implementation of change in practice.

	The action implemented was to include a note to act as an aide memoire on the electronic documentation for assisted vaginal delivery on the maternity information system.
Colposcopy service audit	Since introduction of NHS cervical screening, the programme has helped halved the number of cervical cancer cases. The national recommended timeline for reporting biopsy results to the patients is as following. 1. >90% patient receive result in 4 weeks 2. 100% patient receive result in 8 weeks This audit indicated we were meeting these targets and providing a timely service for our patients.
Maternity Services	
Audit of undiagnosed small for gestational age (SGA)	This audit measures 6 standards and reported significant assurance.
Antenatal risk assessment audit	This audit measured 7 standards including risk assessment completed at booking and subsequent risk assessments being undertaken
Re-Audit of routine antenatal blood/urine results	An annual audit has been developed, to provide assurance that systems and processes put in place for the management of blood results are sufficient to ensure compliance with the standard operating procedure. The audit provided full assurance with 100% of booking bloods and urine being followed up by the midwife within 10 working days. 91% of 28-week bloods were followed up by the midwife within 5 working days.
Sexual Health	
Audit of under 18's service delivery	This re-audit demonstrated improvement; however, it was agreed further improvement was required in ensuring there is a discussion about contraceptive options and encouragement to participate in the national HPV programme. The action agreed was to review the electronic notes to ensure there is a prompt in place for both of these areas.
Audit Title	**Outcome/Actions**
Orthopaedics	
COVID-19-19, DVT incidence and ambulatory DVT care in the Trust	This audit was measuring against NICE guideline 89 and report full assurance with 100% of patients with suspected DVT risk assessment and appropriate investigations undertaken.
Re-audit of orthopaedic operative notes	The audit was undertaken to determine if our orthopaedic operative notes complied with the Royal College of Surgeons standards for operative notes. The first round of this audit reported limited assurance and the re-audit reported significant assurance. The improvement has been achieved by the introduction of a standardized electronic operation notes.
Audit Title	**Outcome/Actions**
Anaesthetics	

Assessing adequacy of the anaesthetic consent process	To assess whether the anaesthetic consent process meets the standards required for ACSA (Anaesthesia clinical services accreditation). This audit measured against 8 standards and achieved significant assurance. However, it was noted that patient understanding side effects of pain relief and risk associated with anaesthetic procedure could be improved. The actions for improvement include talking about and asking, double check, the patient if they understand drug side effects and risks with anaesthetic
Cappuccini test audit	The Cappuccini Test is a simple six-question audit designed to pick up issues relating to supervision of anaesthetists in training and Non-Autonomous SAS grades (NASG). This audit indicated improvement in 3 areas with further improvement still required in 3 areas. Actions include establishing a set method of contact, set a time to discuss any issues with a list.
Urology	
Audit of pre-op urine culture for endourology procedures	This re-audit was undertaken to measure status following previous audit. The re-audit achieved significant assurance and there was an improvement in the number of patients where we considered microscopy and culture of midstream urine sample before surgery if the presence of a urinary tract infection would influence the decision to operate.
Intravesical BCG	This project was a re-audit looking at the management of high risk non muscle invasive bladder cancer patients. A number of improvements have been made following previous audit including: -New checklist implemented -Updated prescriptions -Better documentation of BCG administration is uploaded on Evolve -Urology CNSs in charge of booking and follow up for patients with high-risk non-muscle invasive bladder cancer that require intravesical BCG instillations. The project illustrated some improvement.
Audit Assessing the Investigations and Treatment of Newly presenting Multiple Sclerosis Patients	This re-audit achieved significant assurance and improvement in 3 of the 4 standards: -100% QoL impact quantified & sexual function -1000% baseline serum renal function -93% formal PVR measured -73% urinalysis performed (previous audit achieved 9%)
Maxillofacial	
Regional re-audit of validity of orthodontic referrals.	This audit found that 98% of patients achieved the target of being seen within 18 weeks of referral. It also demonstrated compliance with the BOS (British Orthodontic Society) guidance and all demographics were entered appropriately.
Regional audit of orthodontic clinical coding	This project was undertaken regionally to measure compliance with recommendations made by GIRFT. The results for this Trust indicated 98% of orthodontic patients had clinical coding

	completed with 86% accuracy of the clinical coding by the clinicians.
Radiology	
Audit of BTA (British Thyroid Association) classification of thyroid nodules	This re-audit was undertaken to assess the current practice of recording a “U” score in reports on thyroid ultrasound scans performed in our Trust, and to compare our results against the Royal College of Radiologists guidelines. Following the first audit a poster was put up in each examination room explaining thyroid node classification. This re-audit demonstrated an improvement from 51% to 81% in the documentation of "U" scores on reports of thyroid ultrasound scans performed in our Trust.
Re-audit of Chest X-ray confirmation of NG tube placement	This re-audit indicated that 3/4 standards achieved over 90% compliance which provides significant assurance. The standard requiring improvement is ensuring there is documentation around the appropriate action being taken by the radiographer in the case of tube malposition. To improve a flyer was developed and distributed throughout the department.
Use of alert codes on the TMC, 4 ways & Trust radiology reports	This project was undertaken to review the use of radiology alert codes by TMC and 4-ways, which are the external companies contracted to review radiology reports out of hours. The alert codes measured against were from the Royal College of Radiologists standards for interpretation and reporting of imagery investigations. It was found that the correct codes were used in 80% of cases audited and the wrong code in 20%. The action agreed to ensure full compliance was that all 4 way and TMC alerts will be reviewed by a Trust radiologist and the correct code added where appropriate.

2.4.3 Participation in Clinical Research

Participation in research brings many benefits for the NHS. Through advances, the quality of care and health outcomes is improved for our patients. Since 2020, the COVID-19-19 pandemic changed the landscape of research as we know it.

The Trust has responded at speed to setting up COVID-19-19 Urgent Public Health (UPH) studies investigating new treatments and preventions. According to the NIHR, this ground-breaking research is helping to save lives in the UK and around the world. It is informing government policy and providing NHS doctors and nurses with the tools they need to prevent and treat COVID-19-19.

We are extremely proud of both our staff and patients who have continued to support us through a difficult and unprecedented period. During 2021-22 we have continued to recruit to and follow-up many patients and staff who are taking part in COVID-19-19 research contributing greatly to the national effort. Since March 2020, the research teams have worked diligently to support these studies whilst maintaining some non-COVID-19-19 important research.

Now that the COVID-19 vaccination programme has reached the highest risk groups in the population and has helped drive down the effects of the pandemic, we are increasingly focusing on managing the recovery of research into other conditions, building on the lessons learnt during the pandemic. We will continue to work on COVID-19 studies, including the long-term consequences of COVID-19-19, some vital vaccine and antiviral studies, alongside other studies.

Key Achievements

The Trust is pleased that we surpassed the recruitment target set for 2021/22, we have successfully recruited 627 participants against a target of 407. This was a great achievement, and it also reinforces our commitment to offering patients and public the opportunity to take part in research. This is especially impressive given the high workload involved in follow-up visits for research participants who joined the COVID-19-19 studies last year.

The RECOVERY Trial was launched as an emergency response in March 2020 and discovered three effective treatments for COVID-19-19 and likely saved many thousands of lives. During 2021-22 the Trust have recruited a further 91 participants to this study (251 overall). This represents a significant contribution to the overall study and as such we were recognised by the Study Team for our participation.

Nearly a third of our staff took part in the SIREN study. When SIREN reported its first analysis, the study showed that 83% of people infected with COVID-19-19 had some protection against reinfection, and this was part of the evidence demonstrating that individuals with a previous COVID-19-19 infection are likely to be protected against reinfection for several months. As the rollout of vaccines began, the study was rapidly updated to include information about whether the participant had been

vaccinated. The Trust was one of 131 sites in England which continues to contribute to this important study

The Trust was recognised as one of the top 20 recruiters for the GENOMICC Study in October 2021 (this is a study which helps us understand and find new treatments for COVID-19, sepsis, influenza, and other forms of critical illness).

The Trust collected data for the ISARIC study. The aim being to collect vital information and samples on those people who have severe COVID-19-19 symptoms. This study will assist in understanding the clinical features, response to treatment, transmission, and clinical outcomes with the aim of improving clinical management of patients who with severe acute respiratory infections. A tremendous amount of effort was put into this study by the Research team who collected data on 1066 patients over the last two years.

The Trust was also recognised as site of the Month for SNAP2 (Smoking, Nicotine and Pregnancy Trial) in July 2021.

BronchSTART - This multi-centre prospective observational cohort study uses a well-established research network (Paediatric Emergency Research in the UK and Ireland, PERUKI) to report in real time cases of RSV infection in children under two years of age attending emergency departments across the UK and Ireland and examine the impact on timing, age, and severity of clinical presentations as Non-Pharmaceutical Interventions (NPI) restrictions are reduced throughout the UK and Ireland in 2021. The data is collected and displayed in real time via Microreact.org web base. Out of 58 sites Southport & Ormskirk NHS Trust are leading the recruitment with over 800 data sets recorded so far.

For the second year running, the Trust qualified for £20k Research Capability Funding, allocated by the Department of Health, for recruiting 500 or more participants to non-commercial research. This will be reinvested back into the department to help with capacity building
The NIHR also places emphasis on the Patient Research Experience Survey (PRES) High Level Objective, which opened in November 2020 and ran until 31 March 2021. The Trust was ranked sixth out of 21 CNR NWC partner organisations. The feedback was extremely positive, with 95% (n91) of respondents stating that they would consider taking part in research in the future, and the same number reporting that the research staff always treated them with courtesy, their comments are below:

“My fortnightly visits to the Siren study clinic have been a positive experience, the staff have always been welcoming, friendly, efficient and explained everything to me”
“Knowing that I was doing my bit to help understand COVID-19 and how well the vaccines were working.

To know, especially in the beginning, whether or not I had ever had COVID-19. Being part of the research study made me feel useful”

International Clinical Trials Day is an annual event that takes place on the 20 May where we raise awareness of clinical trials to encourage patients, carers, and the public to get involved in research. We also celebrate our achievements and take time to be grateful for the improvements made to public health. In May 2021 the research team celebrated with a stall promoting the campaign.

Promoting International Clinical Trials Day 2021

These achievements are only possible because of the continued support from the committed consultants, who take the role of chief and principal investigators, the research nurses, research administrative teams, support services and, most importantly, our patients, who give up their time to take part in clinical trials

Research Aims for 2022-23

The Trust's aim is to maintain and increase recruitment activity and thereby secure our income. The RDI manager will work with health care professionals' divisional managers and other interested parties across the Trust; this will enable us to maximise research opportunities in all specialties, but particularly in areas where there is currently either no or minimal research activity

Support Life Sciences Industry (commercially funded research) as this is one of the Department of Health's primary research objectives. We aim to supplement our research income by working with the pharmaceutical industry and increasing our participation in of commercial studies.

We will work in partnership with the Clinical Research Network North West Coast (CRN NWC) to ensure that we align with their priorities and that of the NIHR. We will also encourage healthcare professionals to apply for speciality research lead opportunities within the CRN NWC

The Trust will continue to strive to qualify for the minimum £20k Department of Health Research Capability Funding (recruiting 500 or more participants to non-commercial research) and ensure that there are robust structures in place to initiate, deliver and manage research, thus increasing opportunities for patients to participate in high quality clinical research

We will also promote research by increasing the use of social media and regularly posting good news stories on Facebook and Twitter. We will also promote research to patients and the public by liaising with the patient experience manager and the Trust's communication team. In addition to this we will explore new ways of promoting and increasing engagement in Trust research, i.e., using new methods to target patients and carers.

We will continue to promote the Patient Research Experience Survey; this is one way in which we can offer participants an opportunity to tell us about their experience of research. We will embed this as part of the research journey and report both positive and negative findings

The trust also aims to strengthen and support strong partnerships with Universities, the Academic Health Science Network and the Clinical Research Network Northwest Coast in the adoption and spread of research and innovation across the Trust Invest in training our research staff, as it is imperative that they possess an understanding of the important issues that underpin research

practices. This will include advertising GCP throughout the Trust to encourage as many staff as possible to participate in research.

We will encourage more staff to take part in the NIHR Associate Principal Investigators scheme with the aim of them becoming principal investigators in the future

There is an aim to set up a Research Development & Innovation Advisory Group to help shape the direction of research going forward (first meeting scheduled for March 2022) and to develop a robust Research Development & Innovation Strategy for our Trust.

2.4.4 Clinical Goals agreed with Commissioners

In normal circumstances, a proportion of Southport and Ormskirk Hospital NHS Trust's income in 2021-22 would have been conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body with whom we entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework (CQuIN). However, the COVID-19-19 pandemic resulted in NHS England/NHS Improvement (NHSE/I) suspending the operational delivery of CQuIN schemes for all NHS providers during the whole of the 2021-22 financial period (1st April 2021 – 31st March 2022). Instead, NHS providers were awarded full payment of their CQuIN allowance. Financial sanctions associated with the delivery of all NHS national operational standards and national quality requirements were also suspended for the whole of 2021-2022 financial period.

CQuIN Proposals 2022-23

Details of the 2022-23 CQuINs agreed with Commissioners are shown in the table below

2022-23 CQuINs agreed with CCG
Flu vaccinations for frontline healthcare workers
Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
Treatment of community-acquired pneumonia in line with British Thoracic Society BTS care bundle
Supporting patients to drink, eat and mobilise after surgery
Malnutrition screening in the community

2.4.5 Statements from the Care Quality Commission (CQC)

The CQC is the independent regulator for health and adult social care services in England. The CQC monitors the quality of services the NHS provides and takes action where these fall short of the fundamental standards required. The CQC uses a wide range of regularly updated sources of external information and assesses services against five key questions to determine the quality of care a Trust provides, asking if services are:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-led

If it has cause for concern, the CQC may undertake special reviews/investigations and impose certain

conditions.

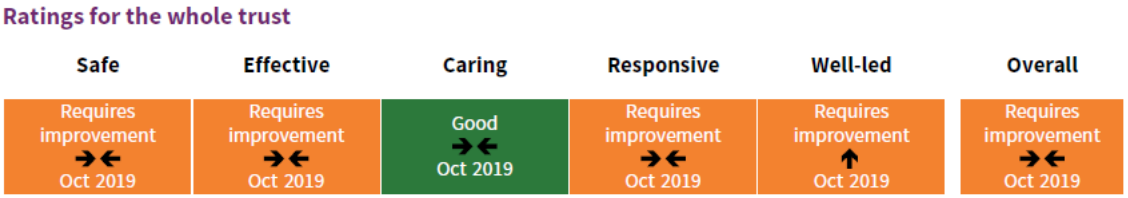
The latest comprehensive CQC inspection took place in July/August 2019 and covered the following areas:

- Use of resources
- Surgery
- Urgent and emergency care
- End of Life Care
- Sexual Health
- Outpatient Services
- Critical Care
- Children & Young People
- Medicine
- Well-led domain

The final report was published on 29th November 2019 and the overall Trust rating was **Requires Improvement**, this rating remains in place.

CQC ratings table for Southport and Ormskirk Hospital NHS Trust, November 2019:

Following the publication of the Southport & Ormskirk Hospital Trust Inspection Report (29 November 2019), the ratings for the whole Trust are:



An unannounced CQC inspection of the Medicine Core Service was undertaken from 3rd to 5th March 2021 and during this inspection, the Trust was inspected but not rated. Inspectors reported 'significant improvements' across all the reviewed areas with no regulatory breaches or 'must do' actions noted.

The Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions. The CQC has not taken enforcement action against the Trust during April 2021–March 2022. As part of the CQC's transitional regulatory approach to monitoring, the Trust completed and submitted a monitoring template for Maternity Services in September 2021 and for Medicine Core Services in November 2021. There were no concerns raised as a result of these reviews.

2.4.6 Learning from Deaths

Number of Deaths

During Quarters 1-4 2021-22, 850 of Southport and Ormskirk Hospitals NHS Trust's patients died (in hospital). This comprised the following number of deaths which occurred in each quarter of that reporting period:

180 in the first quarter 226 in the second quarter 204 in the third quarter 240 in the fourth quarter.

Learning from Deaths Report under development to be presented to Quality & Safety Committee in June 2022

Mortality

The Government's preferred measure for mortality is the Summary Hospital-level Mortality Indicator (SHMI). The latest published data is for the 12 month period December 2020 to November 2021. The Trust's SHMI for this period is 100.91, which is as expected.

For the same time period, the Trust's mortality is also within expected levels for the other commonly used measure with the Hospital Standardised Mortality Ratio (HSMR) at 76.92

National Audit of Care at the End of Life (NACEL)

NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute, community hospitals and mental health inpatient facilities in England, Wales, and Northern Ireland.

2.4.7 Priority clinical standards for seven-day hospital services

The Seven Day Hospital Services (7DS) Programme aimed to ensure that patients requiring emergency admission received high- quality care every day of the week through early, consistent senior decision-making as outlined in the 10 7DS Clinical Standards (CS). Trust performance against the priority CS defined by NHS England (NHSE) was previously audited and reported to the Trust Board and NHSE to provide assurance of progress towards the target of full compliance with the standards. Previously it was noted that for a small organisation our Trust is able to provide access to many of the services identified

Monitoring of 7DS has been paused during the COVID-19-19 pandemic in line with national guidance. In February 2022, updated guidance was published by National Health Service England /Improvement (NHSE/I) with recommendation that providers should assess delivery against the four priority 7DS clinical standards by using the Board Assurance Framework at least once a year to monitor progress and compliance.

The Trust is currently in the process of reviewing compliance against the four priority standards, this work was commenced at the Medical Leadership team in March 2022.

The two priority standards are:

- CS2: Time to first consultant review - all emergency admissions must have a clinical assessment by a suitable consultant within 14 hours of the time of admission to hospital.

- CS8: Ongoing daily review by consultant (or their delegate)

In addition, two other standards were considered to be key:

- CS5: Access to diagnostics and reported results every day

- CS6: Emergency and urgent access to consultant-directed interventions

Following completion of a gap analysis an improvement plan will be developed aligning the previous action plan to current position referencing collaboration with STHK and GIRFT principles and will be reported to our Board.

"I would like to thank all the staff that were on ward E between 16 September and 19 September. I thought it was a very happy and friendly ward. All the staff were very kind and helpful. I would like to say "thank you" especially to Dr Rauf Ghani for doing a very good job. I feel I am healing very well. Once again thank you to you all."

E Ward. Ormskirk

2.4.8 Information Governance and Toolkit Attainment Levels

Information Governance (IG) is the way in which the Trust manages its information and ensures that all information, particularly personal and confidential data is handled legally, securely, efficiently, and effectively. It provides both a consistent way and a framework for our employees to deal with the many different information handling requirements in line with Data Protection legislation.

Information Governance is underpinned by the following legislation and standards.

- The Computer Misuse Act 1990
- The Data Protection Act 2018
- The General Data Protection Regulation (GDPR)
- The common law duties of care and confidentiality
- The Human Rights Act 1998
- The Freedom of Information Act 2000
- The Privacy and Electronic Communication Regulations 2003
- The rights and pledges made to patients within the NHS Constitution
- The Confidentiality NHS Code of Practice
- The Information Security NHS Code of Practice
- The first Caldicott Report and Information: To Share or Not to Share? The Information Governance Review (the Caldicott 2 Report)

The Information Governance Team, based at Southport and Ormskirk Hospital NHS Trust, is comprised of the Head of Information Governance and the Information Governance Officer.

The Trust uses the Data Security and Protection Toolkit (DSPT) to benchmark its IG controls, also known as the IG Assessment Report. The DSPT is an annual online self-assessment tool that allows health and social care organisations to measure their performance against the National Data Guardian's 10 Data Security Standards (covering topics such as staff responsibilities, training, and continuity planning) and reflects legal rules relevant to IG. The Trust must address all mandatory requirements within the DPST in order to publish a successful assessment.

The submission date for the 21/22 DSPT submission is the 30th of June 2022, currently the Trust is on target to submit by this date.

For the 20/21 DSPT submission the Trust received a 'Standard's Met' rating for the DSPT with the Mersey Internal Audit Agency (MIAA) independent audit providing the Trust a 'substantial' rating in respect of the veracity of the self-assessment and 'moderate' assurance for the Trust's compliance to the 10 Data National Data Guardian Standards. Before the submission of the 21/22 DSPT it will be audited by the MIAA.

To understand the evolving cyber-threat landscape, vulnerabilities and risks the Trust Board attended the National Cyber Security Centre approved training provided by NHS Digital. The training covered learning about staff personal and corporate responsibilities and how the Trust demonstrates compliance with cyber security legislations and regulations.

21/22 also saw the Trust again partake in NHS Digital's Simulated Phishing Exercise. The Exercise simulated a phishing email being sent to all staff to test how they would deal with a phishing email. Following on from the event new awareness material has been distributed and the exercise has been increased from an annual to a quarterly event to provide the Trust with the assurance necessary that staff are confident with spotting dealing with phishing emails.

Adherence to Information Governance is actively monitored through regular information governance audits and looks at both physical and technical controls. Results of these audits are fed back to the appropriate managers and, if trends are noted, directly impacts on the information governance awareness material.

The Trust has a Data Breach Management Procedure in place which is adhered to when a personal data breach/incident occurs.

There have been no reportable incidents for 2021-2022 for the Trust.

2.4.9 Clinical Coding Error Rate

Due to COVID-19 there have been delays in the auditing process, the Trust was last audited in May 2021 and the results are as below. Our Trust will be audited again in 2022.

'Clinical data must be accurately and consistently recorded to well defined national standards to enable it to be used for statistical analysis. Information drawn from accurate clinical coding better reflects the pattern of practice of clinicians and provides a sound basis for the decision-making process.

The 2021/2022 DSPT Audit was undertaken by two Terminology and Classifications Delivery Service (TCDS) Approved Experienced Auditors.

DSPT Clinical Coding Audit Findings 2020-21				
Measure	**Primary Diagnosis**	**Secondary Diagnosis**	**Primary Procedure**	**Secondary Procedure**
Coding Accuracy – Error Rates	3.5%	3.25%	4.08%	4.11%

2.4.10 Data Quality

NHS number and General Medical Practice code validity

The Trust submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99.9% for admitted patient care
- 99.9% for outpatient care
- 99.6% for accident and emergency care

Which included the patient's valid general medical practice code was:

- 99.9% for admitted patient care
- 100.0% for outpatient care
- 100.0% for accident and emergency care

Southport and Ormskirk Hospital NHS Trust submitted records during 2020-21 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data which includes the patient's valid NHS number and registered GP practice contributes to the overall Data Quality Maturity Index (DQMI) scores, which are shown in the table below:

The Trust performed better than the national average, demonstrating the importance the Trust places on data quality.

2.4.11 Benchmarking Information

The Department of Health specifies that the Quality Account includes information on a core set of outcome indicators, where the NHS is aiming to improve. All Trusts are required to report against these indicators using a standard format. NHS Digital makes the following data available to NHS Trusts. The Trust has more up-to-date information for some measures; however, in the main only data with specified national benchmarks from the central data sources is reported, therefore, some information included in this report is from the previous year or earlier and the timeframes are included in the report. It is not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

Benchmarking Data

Indicator	Source	Reporting Period	SOHT	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
SHMI	NHS Digital	Dec-20 to Nov-21	1.0005	1	0.716	1.195	
SHMI	NHS Digital	Nov-20 to Oct-21	1.009	1	0.719	1.186	
SHMI	NHS Digital	Oct-20 to Sep-21	1.009	1	0.713	1.191	
SHMI	NHS Digital	Sep-20 to Aug-21	0.999	1	0.716	1.185	

Indicator	Source	Reporting Period	SOHT	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
SHMI Banding	NHS Digital	Dec-20 to Nov-21	2	2	3	1	
SHMI Banding	NHS Digital	Nov-20 to Oct-21	2	2	3	1	
SHMI Banding	NHS Digital	Oct-20 to Sep-21	2	2	3	1	
SHMI Banding	NHS Digital	Sep-20 to Aug-21	2	2	3	1	
% of patient deaths having palliative care coded	NHS Digital	Dec-20 to Nov-21	50%	39%	11%	64%	
% of patient deaths having palliative care coded	NHS Digital	Nov-20 to Oct-21	49%	39%	11%	64%	
% of patient deaths having palliative care coded	NHS Digital	Oct-20 to Sep-21	49%	39%	12%	63%	
% of patient deaths having palliative care coded	NHS Digital	Sep-20 to Aug-21	49%	39%	12%	64%	
Q18d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2021	52.8%	66.9%	43.6%	89.5%	
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2020	58.4%	74.3%	49.7%	91.7%	
Q21d. If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust.	NHS staff surveys	2019	55.3%	70.6%	39.8%	90.5%	
% experiencing harassment, bullying or abuse from other colleagues in last 12 months	NHS staff surveys	2021	21%	19.5%	27.2%	12.3%	Low scores are better performing Trusts
% experiencing harassment, bullying or abuse from other colleagues in last 12 months	NHS staff surveys	2020	21.8%	19.8%	26.4%	12.2%	
% experiencing harassment, bullying or abuse from other colleagues in last 12 months	NHS staff surveys	2019	18.7%	19.5%	26.5%	11.8%	
% Believing there are opportunities for me to develop my career in this organisation	NHS staff surveys	2021	44.4%	52.1%	38.8%	64.6%	
% Believing there are opportunities for me to develop my career in this organisation	NHS staff surveys	2020	Not available	Not available			
% Believing there are opportunities for me to develop my career in this organisation	NHS staff surveys	2019	Not available	Not available			

Southport and Ormskirk Hospital NHS Trust

Indicator	Source	Reporting Period	SOHT	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Friends & Family Test – A&E – Response Rate	NHS England	Mar-22	N/A	N/A	N/A	N/A	Response rates no longer published
Friends & Family Test – A&E – Response Rate	NHS England	Feb-22	23.43%	N/A	N/A	N/A	
Friends & Family Test – A&E – Response Rate	NHS England	Jan-22	23.83%	N/A	N/A	N/A	
Friends & Family Test – A&E – Response Rate	NHS England	Dec-21	23.17%	N/A	N/A	N/A	
Friends & Family Test – A&E – % recommended	NHS England	Mar-22	Not yet avail.	N/A	N/A	N/A	
Friends & Family Test – A&E – % recommended	NHS England	Feb-22	87%	77%	29%	100%	
Friends & Family Test – A&E – % recommended	NHS England	Jan-22	87%	79%	56%	100%	
Friends & Family Test – A&E – % recommended	NHS England	Dec-21	88%	80%	54%	100%	
Friends & Family Test – Inpatients – Response Rate	NHS England	Mar-22	Not yet avail.	N/A	N/A	N/A	
Friends & Family Test – Inpatients – Response Rate	NHS England	Feb-22	31.55%	N/A	N/A	N/A	
Friends & Family Test – Inpatients – Response Rate	NHS England	Jan-22	32.69%	N/A	N/A	N/A	
Friends & Family Test – Inpatients – Response Rate	NHS England	Dec-21	28.7%	N/A	N/A	N/A	
Friends & Family Test – Inpatients – % recommended	NHS England	Mar-22	Not yet avail.				
Friends & Family Test – Inpatients – % recommended	NHS England	Feb-22	95.1%	94%	77%	100%	
Friends & Family Test – Inpatients – % recommended	NHS England	Jan-22	93.6%	94%	69%	100%	
Friends & Family Test – Inpatients – % recommended	NHS England	Dec-21	93.5%	94%	78%	100%	
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 3 2019-20	98%	95.3%	71.6%	100%	All data is for Acute Providers only
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 2 2019-20	98%	95.4%	71.7%	100%	
% of patients admitted to hospital who were risk assessed for VTE	NHS England	Quarter 1 2019-20	97.8%	95.6%	69.8%	100%	Data for Q4 2019-20 onwards is suspended

Indicator	Source	Reporting Period	SOHT	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-20 to Mar-21	45.5	41.1	0	161.3	Please note this includes Hospital Acquired, HOHA & COHA as per Trust reporting. STHK includes Hospital Acquired Only
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-19 to Mar-20	40.5	34.7	0	136	
C Difficile rates per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	GOV.UK	Apr-18 to Mar-19	21.5	31.1	0	180.3	
Incidents per 1,000 bed days	Internal	Apr-21 to Mar 22	Not yet avail.				Based on acute (non-specialist) Trusts with complete data
Incidents per 1,000 bed days	NHS England	2020-21 (Reporting changed to annual)	55	58.4	27.2	118.7	
Incidents per 1,000 bed days	NHS England	Oct 19 – Mar 20	62.4	50.7	15.7	110.2	
Incidents per 1,000 bed days	NHS England	Apr 19 to Sep-19	59.6	49.8	26.3	103.8	
Incidents per 1,000 bed days	NHS England	Oct-18 to Mar-19	51.4	46.1	16.9	95.9	
Number of incidents	Internal	Apr-21 to Mar-22	Not yet avail.				
Number of incidents	NHS England	2020-21 (Reporting changed to annual)	6222	12502	3169	37572	
Number of incidents	NHS England	Oct-19 to Mar-20	4205	6502	1271	22340	
Number of incidents	NHS England	Apr-19 to Sep-19	3970	6276	1392	21685	
Number of incidents	NHS England	Oct-18 to Mar-19	3598	5841	1278	22048	
Number of incidents resulting in severe harm or death	Internal	Apr-21 to Mar-22	Not yet avail.				
Number of incidents resulting in severe harm or death	NHS England	2020-21 (Reporting changed to annual)	15	55.1	4	261	

Indicator	Source	Reporting Period	SOHT	National Performance			Comments
				Average	Lowest Trust	Highest Trust	
Number of incidents resulting in severe harm or death	NHS England	Oct-19 to Mar-20	6	19.7	0	93	
Number of incidents resulting in severe harm or death	NHS England	Apr-19 to Sep-19	5	19.4	0	95	
Number of incidents resulting in severe harm or death	NHS England	Oct-18 to Mar-19	9	18.8	1	72	
Percentage of patient safety incidents that resulted in severe harm or death	Internal	Apr-21 to Mar-22	Not yet avail.				
Percentage of patient safety incidents that resulted in severe harm or death	NHS England	2020-21 (Reporting changed to annual)	0.2%	0.5%	0%	2.8%	
Percentage of patient safety incidents that resulted in severe harm or death	NHS England	Oct-19 to Mar-20	0.1%	0.3%	0%	1.5%	
Percentage of patient safety incidents that resulted in severe harm or death	NHS England	Apr-19 to Sep-19	0.1%	0.3%	0%	1.6%	
Percentage of patient safety incidents that resulted in severe harm or death	NHS England	Oct-18 to Mar-19	0.3%	0.4%	0%	1.8%	
Southport & Ormskirk Hospital NHS Trust considers that this data is as described for the following reasons: The Trust actively promotes a culture of open and honest reporting within a just culture framework. The data has derived from NHS England using National Reporting and Learning System (NRLS) and Health and Social Care Information Centre (HSCIC) figures. The latest data to be published is up to March 2020. The Trust's overall percentage of incidents that resulted in severe harm or death was 0.2%.							

Performance against national targets and regulatory requirements

The Trust aims to meet all national targets. Performance against the key indicators for 2020-21 is shown in the table below:

Performance Indicator	2019-20 Target	2019-20 Performance	2020-21 Target	2020-21 Performance	Latest data
Cancelled operations (% of patients treated within 28 days following cancellation)	100.0%	Not Achieved 98.3%	100.0%	97.3%	Apr20-Mar21
Referral to treatment targets (% within 18 weeks and 95th percentile targets) – Incomplete pathways	92%	Not Achieved 90.3%	92%	70.6%	Apr20-Mar21
Cancer: 31-day wait from diagnosis to first treatment	96%	Achieved 97.1%	96%	97.5%	Apr20-Mar21
Cancer: 31-day wait for second or subsequent treatment:					

Performance Indicator	2019-20 Target	2019-20 Performance	2020-21 Target	2020-21 Performance	Latest data
- surgery	94%	Achieved 96.5%	94%	96.0%	Apr20-Mar21
- anti-cancer drug treatments	98%	Not Achieved 96.6%	98%	100.0%	Apr20-Mar21
Cancer: 62-day wait for first treatment:					
- from urgent GP referral	85%	Achieved 86.2%	85%	86.5%	Apr20-Mar21
- from consultant upgrade	85%	Achieved 87.4%	85%	88.8%	Apr20-Mar21
- from urgent screening referral	90%	Achieved 92.5%	90%	94.8%	Apr20-Mar21
Cancer: 2 week wait from referral to date first seen:					
- urgent GP suspected cancer referrals	93%	Not Achieved 91.0%	93%	94.3%	Apr20-Mar21
Emergency Department waiting times within 4 hours – all types	95%	Not Achieved 83.9%	95%	86.8%	Apr20-Mar21
Percentage of patients admitted with stroke spending at least 90% of their stay on a stroke unit	83%	Achieved 89.3%	83%	90.4%	Apr20-Mar21
Clostridium Difficile	48	Achieved 42 avoidable	48	26 (43 total, 15 appealed, 2 outstanding)	Apr20-Mar21
MRSA bacteraemia	0	Not Achieved 1 contaminant	0	2	Apr20-Mar21
Maximum 6-week wait for diagnostic procedures: % of diagnostic waits waited <6 weeks	99%	Achieved 99.7%	99%	67.6%	Apr20-Mar21

3.1 Equality, Diversity, and Inclusion Strategy

The Trust remains committed to ensuring that its staff and service users enjoy the benefits of a healthcare organisation that respects and upholds individuals' rights and freedoms. Equality and human rights are at the core of our beliefs and the Trust strives to ensure that people with protected characteristics, as defined by the Equality Act 2010, and those individuals from traditionally hard to reach groups are not disadvantaged when accessing the services the Trust provides.

It is acknowledged that positive actions to support Equality, Diversity and Inclusion underpin the principles of positive staff engagement. The Trust has developed objectives to address the areas of shortfall identified, these will be reviewed & updated in 2022. The current objectives are monitored through the Valuing Our People through Inclusion Group and Workforce Committee which is a subcommittee of the board of directors.

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

Specific training on cultural and unconscious bias will continue to be rolled out, and career development opportunities and support will be aimed at staff from Black and Minority Ethnic group staff. For example, a bespoke offer is being developed 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 BAME backgrounds 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, developing the staff networks to identify initiatives or help prioritise areas for improvement and involvement in process review groups such as Recruitment and Selection and policy development

Improving access and outcomes for patients and communities who experience disadvantage

Learning Disability

The Trust has a Learning Disability and Autism Practitioner who supports care of patients with a Learning Disability and/or Autism in several ways;

- The Trust has purchased several beds through its charitable funds that can be accessed by family/carers who wish to stay overnight to support the hospital admission.
- Patients with a learning disability and/or Autism can be assessed to have their own funded carer to stay with them throughout admission.
- The use of Medway alerts allows us to identify patients who have a learning disability and/or Autism and benefits the patient by allowing the communication of any necessary reasonable adjustments.
- The use of the LD health/hospital passport also supports the sharing of information of the needs of the patient.
- The service also has a strong relationship with both West Lancashire and Sefton Community LD teams which enhances care and communication for both planned and unplanned admissions of a patient with a learning disability and/or Autism.

Accessing Trust Services

The Trust offers the following interpretation and translation services and will provide other services as requested:

- Foreign language translation of Trust documents
- Braille translation of Trust documents
- Face-to-face and telephone interpretation
- British Sign Language interpreting
- Easy-read or large font translation of Trust documents
- Moon Literacy

Patients with Mental Health Needs

- Within the Accident and Emergency department there is a designated room for mental health patients under 136 mental health section.
- The clinical team in the department work closely with Mersey Care NHS Foundation Trust to ensure timely assessments and plans for care are implemented.
- The frail elderly unit have an in-reach service from a mental health practitioner to support/advise on the care of patients on the ward.
- The wards work closely with the mental health liaison nurses from Mersey Care completing timely referrals for mental health assessments.
- The mental health liaison nurses are integral part of the MDT when best interest meetings are held.
- Patients are assessed as individual and care is tailored to their needs, additional support with close or continuous supervision is available. Side room facilities are available, with open visiting for relatives / families to support the patient as required.

Carer Support

- The Trust continues to promote John's Campaign to welcome carers whenever they are needed (this is currently risk assessed in line with COVID-19 restrictions).
- Pre-pandemic the Trust purchased several beds through its charitable funds that can be accessed by family/carers who wish to stay overnight to support the hospital admission.
- There are also several areas in the Trust which have facilities for carers to utilise to have some quiet space away from the patient bedside.
- There is a relative's room on critical care and Ward 15a has developed a room for carers to rest and make refreshments.
- There is the OASIS room to support family members of patients who are receiving end of life care.
- For patients on the Regional Spinal Unit, carers who are not residents are supported in finding local accommodation, for individual cases the Spinal Unit Action Group may also offer an amount of financial support towards this.
- On the Paediatric unit there is a parent's room where they store food and make refreshments. Comfort bags are available with showering facilities for parents who have children admitted as an emergency

3.2 Our Workforce Strategy 2021-2022

The Trust's workforce strategy **'Our People Plan'** has been developed in line with the ambitions of the national NHS People Plan that we need more people, working differently, in a compassionate and inclusive culture. It is designed to be flexible enough to respond to the lived experience of our staff and our shared hopes for the Trust over the coming years. Our People Plan describes how we will support our staff to recover from our response to the pandemic, reset to a post-COVID-19 19 world and cope with changes in demand and delivery of services to patients across Southport and Ormskirk. At the same time, ensuring that staff feel empowered, valued, developed, trusted, and motivated to move towards the future, embracing change and the introduction of technology and new ways of working and endeavouring to improve the quality of care they provide.

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. This overarching strategy is aligned to the NHS People Plan and will be supported by detailed annual plans covering key aspects of the four enabling pillars identified below:

1. **Looking after our people**
2. **Belonging to the NHS**
3. **New ways of working and delivering care**
4. **Growing for the future**

The delivery of Our People Plan affects every one of our colleagues, and its impact will be monitored by the Trust's Workforce Committee over the next two years.

The key **Our People Plan** achievements during 2021-22 were:

- An agile, adaptive, and robust approach to risk assessing all staff – agile working guidance and alternative approaches to working arrangements developed to support the workforce responding to the ongoing COVID-19 restrictions
- Additional staff wellbeing support to help with the recovery and reset from the pandemic, including pilot of individual restoration programmes
- Ongoing international recruitment
- Re-established the Trust's Valuing Our People through Inclusion Group to drive retention and staff engagement initiatives
- Staff Winter Wellness programme to support attendance through the winter period
- Implementation of Place based Schwartz Rounds, in collaboration with our partners across the Sefton borough
- Commenced our Just and Learning culture journey
- Launched our first Equality and Diversity calendar recognizing the diverse range of significant events and festivals celebrated by our staff
- Made significant improvements to our workforce systems, introducing digitized ways of working

3.2.1 Freedom to Speak Up

All staff members across the organisation, including sub-contracted staff, have access to the Trust's newly appointed Freedom to Speak Up (FTSU) Guardian, and deputy to raise concerns. The Guardian and trained FTSU champions are representative of various staff groups and backgrounds. They provide an alternative way for staff to discuss and raise concerns and act as an independent and impartial source of advice to staff at any stage of raising a concern. The Guardian has also forged strong links with staff side and staff side lead.

National Guardian

The work of the Guardians has a direct impact on continuously improving safety and quality for our patients, carers, and families, as well as enhancing the experience of our staff, by acting on the concerns raised. The Guardians have continued to engage with staff members who have raised a concern, in a manner that is supportive, whilst ensuring that there are no repercussions for the person raising a concern. The Guardians have received very positive feedback on the help offered.

During COVID-19-19, accessibility to information about speaking up was made available through staff briefings and IT systems. Staff members were encouraged and supported to raise concerns, either personal or service-related to the Guardian or to use alternative raising concerns routes available. Improvements and changes have been made based on the concerns raised.

The Trust works in partnership with the National Guardian's Office and North West Regional Network of Freedom to Speak Up Guardians to enhance staff experience with raising concerns.
The Trust recorded a mean Freedom to Speak Up index score of 77.0% in 2020 (published in 2021) an increase from 74.6% for the previous year.

The Trust score is slightly below the national average being 2.2% lower than the national mean score for acute Trusts of 79.2%%, confirming the continuing need for growth in promoting a positive culture for raising concerns.

MIAA undertook a FTSU review 2021/22 (date of issue 21st September 2021). The overall objective of the audit was to select a random sample of Freedom to Speak Up cases and for each the following sub-objectives were to be confirmed:

- An independent investigator was appointed where required (per policy)
- Confirmation of observation of anonymity and importance of protection (per policy)
- Ensured that rights to access information had been adhered to.

The opinion offered is that there is High Assurance. Their executive comment is:
"There was a strong system of internal control which had been effectively designed to meet the system objectives, and that controls were consistently applied in all areas reviewed. "

The Trust continues with its commitment and support to ensure a culture where all staff feel empowered to speak up or raise concerns. The Trust SCOPE values include being open and honest and supportive and professional. There are a number of supportive facilities in place

across the Trust for staff to raise concerns, including:

Speak Up, Listen up, Follow up

The Trust has continued to provide staff members with access to a dedicated speaking up email address, to which only the Guardian, Deputy and specialist administrator has access, to encourage "Speak up" in confidence, which supports all staff, irrespective of their role, to raise concerns and indicate that do not wish their identity disclosed. The guardian on receipt of the concern is able to support and provide a response to the concern, to request further information and/or to provide assurances of actions taken to mitigate the risks associated with the concern raised via the online system. The system has been used by staff members to raise concerns, which have been addressed.

Raising concerns

The Trust also has a telephone line, and direct mobile number to access the Guardian which provides access to report any concerns, which are reviewed and actioned by the FTSU specialists administrator and Guardian. This system has been utilised by staff members to raise concerns, which have been addressed.

FTSU Champions

The Trust has a group of 12 FTSU champions across the organisation, we are currently recruiting a further cohort of 10 champions to support staff in speaking up. The FTSU champions attend the Trusts local network group for peer support, and to enhance staff experience with raising concerns.

Health, Work and Wellbeing

Staff members have access to a dedicated helpline, to provide advice and support regarding health and wellbeing aspects relating to work or impacting on the individual. Bespoke support can be offered dependent on the needs and circumstances. Concerns about the workplace can be raised through the hotline.

Policies and Procedures

There are a number of Trust policies and procedures that facilitate the raising of staff concerns as follows: Grievance Policy and Procedure, Respect and Dignity at Work Policy and Being Open Policy. Staff are also encouraged to informally raise any concerns to the FTSU Champions, their manager, nominated HR lead or their staff-side representative, as well as considering the routes above.

3.2.2 Staff Survey Key Questions

The national staff survey provides a key measure of the experiences of the Trust's staff, with the findings used to reinforce good practice and to identify any areas for improvement. 1,335 completed questionnaires were returned from 3,218 questionnaires sent to staff for the latest survey reported in 2022. This provided a 41.8% response rate (1,335 responses from a usable sample of 3,197), which is a slight reduction compared to last year (45.4%).

It is important to note that this year saw some significant changes to the questionnaire content and the results present the results in the form of People Promises, Themes and question scores. This provides

an indication of how well the Trust is performing over time and within its benchmarking group.

People Promises/Themes can be considered as summary scores for groups of questions which, when taken together, give more information about a particular area. They are presented as scale scores (on a scale of 0 to 10). Individual question scores are expressed as percentages.

There are seven People Promises and two Themes within the report, which are:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team
- Staff engagement
- Morale

This year, the majority of staff told the Trust they feel proud of the difference they make to our patients, and they feel trusted in their job to perform their role. These positive results reflect the Trust's vision of delivering the best care to every patient, every time.

Staff also told the Trust that there is a mutual respect and a strong sense of teamwork among colleagues. Despite all the challenges of recent years, this demonstrates that the Southport and Ormskirk values continue to underpin everything we do. There are, of course, areas for development, building on strengths and working together with staff to make Southport and Ormskirk an even better place to work and provide care. Over the coming months, a staff engagement programme will continue with colleagues from the Executive Team dropping into staff meetings and huddles to hear views first-hand.

3.2.2 Clinical Education and Training

Nurse and AHP Education

During this current financial year, the non-medical education team have primarily focused upon the development of post-registration education which included the review and implementation of clinical skills, preceptorship, care certificate and international nurse development.

The Trust embarked upon the integration of overseas nurses through education and training, which involved in a Pan Mersey collaboration of OSCE preparation to support acquisition of NMC registration status.

The clinical skills programme is currently undergoing a full review of all teaching resources to support the upskilling development of staff, in line with the NMC Standards of Proficiency. This has resulted in the expansion of additional clinical skills training and the creation of the clinical skills planner to support staff engagement. Training is available up to 3-6months in advance to support staffing and attendance to teaching.

The preceptorship has undergone a full review, and this has resulted in a new preceptorship

handbook (which incorporates holistic staff development), a core skills workbook (focusing on non-technical skill attainment) and preceptorship workshops (peer support/ action learning sets). All which align with national standards and recommendations. Communications surrounding preceptorship are growing on the Trust's social media platforms to support recruitment.

The Care Certificate programme has gained greater traction from the Trust with an increase in compliance from healthcare support workers. Communications on how to gain compliance and access to all training materials are now available on the intranet.

Plans for Nursing and Allied Health Professional (AHP) Education for 2022/23

To improve resus training compliance across the organisation and access to training. Communication of training available in 2022, will be shared via the clinical skills planner in advance to support release from practice to attend training. Training sessions available, exceeds organisational need.

To create a multi-professional preceptorship programme to include allied health professionals. Work has begun:

- To improve compliance with the Care Certificate, including a review of classroom delivery, as well as implementing career development for healthcare support workers within the Trust.
- A pilot of a pre-preceptorship programme to support the transition from pre-registration nurse to newly qualified nurse. Preceptorship accreditation status.
- Increase pre-registration adult nursing capacity to an additional 30 placements by August 22 to support the national drive to have an additional 50,000 nurses by 2024.

"I attended the treatment centre at Ormskirk hospital yesterday for a colonoscopy. I just wanted to say that the whole experience was made so much better because every member of staff, from reception to the preparation area, to the treatment room were fantastic. Their team spirit was obvious and their attitude to patients was impeccable. Thanks for all you are doing"

Treatment Centre, Ormskirk Hospital

"Originally, my procedure was for a day case on Ward F. They were professional, in a warm and friendly manner, thank you. I was moved on to Ward G for an overnight stay. The entire team showed dignity, best practice care, and a smile. This wasn't just for myself; I could hear the same kindness being delivered all around me. NHS at their best, thank you all!"

F & G Wards, Ormskirk

3.3 Patient Safety

One of the Trust's Quality Priorities in 2021-22 was to improve safety culture from a "Just and Learning" perspective in order for staff to feel safe in speaking up when incidents arise. This programme has involved joint work with both Integrated Governance and Human Resource Teams to reduce the number of safety incidents resulting in harm. Progress has been made in the roll out of support and training for staff and improvement in patient investigation times to complete and Trust quality improvement events on improving safety culture in January 2022.

I would like to thank all the staff at the eye clinic at Southport hospital and in particular Dr Nishat. I attended the clinic today for emergency laser treatment. The clinic seemed busy, but I was seen very promptly. The staff were all kind and efficient. Dr Nishat was very professional, of course, but also friendly and reassuring. He made the experience much more relaxing than it might have been. Thank you again to everyone.

Ophthalmology Department

3.3.1 Pressure Ulcers

The reduction of Hospital Acquired Pressure Ulcers was one of the Trust's quality priorities in 2021-22. During the previous 12 months the Trust had 862 patients who presented at the Accident and Emergency department with a pressure ulcer and Southport and Ormskirk continue to focus on both the prevention of hospital acquired pressure ulcers and management of existing wounds. Whilst there was an overall reduction of all hospital acquired pressure ulcers in 2021-22, the Trust recorded 18 category 3 / deep tissue injuries/ upgradeable wounds in 2021-22. Each patient pressure ulcer underwent a root cause analysis investigation and was presented to the Trust's Harm Free Care Panel to identify learning, common themes and inform the Trust action plan on pressure ulcers. During the year, the Trust have begun piloting wound photography via the patient electronic information system to promote assessment and validation of wounds.

The numbers of patients with hospital acquired category 2 pressure ulcers with lapses in care reduced in 2021-22 from 62 to 46 with a focus on education for staff on assessment and care planning to reduce pressure ulcers as well as the reinstatement of Tissue Viability Link ward nurse meetings following a suspension of meetings due to COVID-19-19.

3.3.2 Falls

The Trust recruited to a Trust Falls Lead in Q4 2021-22 to coordinate the ongoing work and support education of staff to minimise the risk of inpatient falls.

All falls resulting in severe harm had root cause analysis investigations presented to the Trust's Serious Incident Review Group and a review of the Trust's falls action plan was undertaken in December 2021. This was to ensure any new themes, such as reduced visiting access due to infection prevention and control measures, could be added to the existing plan.

Improvement work continued during 2021-22 with key areas of work . The strategy focuses on seven key areas for improvement:

- Promotion of visual cues for staff and patients at risk of falls.
- Estates work to ensure falls sensors are installed in bathrooms and are in use

- Enhance the role of the ‘Falls Champions’ on each ward and providing more in-depth training.
- Increased education sessions for both ward-based staff and on staff inductions on use of falls alarm equipment.

A review of the documentation and risk assessments used within AED to ensure consistent planning to reduce risk of falls.

3.3.3 Medicine Safety

EPMA in 2022/23 will now be supported by STHK with a collaborative approach moving forward with go live dates delayed until STHK upgrade. The product will be the latest offering from Careflow Medicines Management and will allow enhanced capability for the prescribing and administration of medicines.

The Pharmacy Team have continued to maintain a clinical and medicines supply service throughout the pandemic. Building on the ward-based Technician role in the previous year with three wards now receiving a discharge service where medicines are reconciled, and patients/ carers are counselled on medicines use by Pharmacy Technicians leaving Nursing staff more time to care.

The successful implementation of Omnicell dispensing cabinets in AED and ITU will be enhanced by adding cabinets to Paediatric AED and replacing the Pharmacy Controlled drug cabinets.

The Medicines Management Quality improvement priorities for missed doses for critical medicines and Controlled Drug administration documentations show overall improvement.

Drug and Therapeutic, Medicines Safety, Medical Gases, Pharmacy Governance Committees and Controlled Drug Oversight Group have met regularly through the year reporting to the Clinical Effectiveness Committee and CDU Governance Committees. The management of incidents, Policies, Patient Group Directions, and new drugs have been controlled with sharing information, relevant safety bulletins, action plans and escalations in place. This includes the running of a Quality Improvement event for medicines management

Benchmarking data shows the Trust in reporting medication errors is consistent with 20/21 having 531 reports and 21/22 569 demonstrating a small increase of less than 2%. The pattern of incidents for storage, dispensing and prescribing are also consistent, but with more low risk incidents in 21/22.

3.3.5 Being Open – Duty of Candour

Our Trust is committed to ensuring that we tell our patients and their families/carers if there has been an error or omission resulting in harm. This duty of candour is a legal duty on Trusts to inform and apologise to patients if there have been mistakes in their care that have, or could have, led to significant harm (categorised as moderate harm or greater in severity).

The Trust has achieved 100 % compliance in providing both a verbal apologies and written apologies when Duty of Candour applied in 2021-22.

Year	No of applicable incidents	Evidence of verbal conversation/apology within 10 days	Compliance with verbal conversation/ apology within 10 days	Evidence of letter sent within 10 days	Compliance with letter sent within 10 days
2021/22	62	62	100.00%	62	100.00%

3.3.6 Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. In 2021-22, Southport and Ormskirk did not have any reported incidents which met the definition of a Never Event.

3.3.7 Coroner's Regulation 28 Prevention of Future Deaths Reports

Between April 2021 – March 2022 one Regulation 28 report was issued by the Coroner to the Trust. The Coroner gave 2 actions for the Trust to take to prevent future deaths. The 2 actions attributed to the Trust where on the communication to both patients' families and with communication with other providers when there is a transfer of care following referral. The Trust has worked closely with other providers in developing a network where care which is shared across organisations can be reviewed as well as how we communicate information to patients and their families

3.3.8 Infection Prevention and Control (IPC)

The Health and Social Care Act 2008 requires all Trusts to have clear arrangements for the effective prevention, detection and control of healthcare associated infection (HCAI). The Director of Nursing and Midwifery is the Trust's Director of Infection Prevention and Control (DIPC), with board level responsibility for infection control.

The Trust's Infection Priorities are:

- C.diff – reduction in hospital acquired cases
- Catheters - associated UTIs/reduction in use/monitoring/documentation
- Cannulae – associated devise infections/ reduction in use/monitoring/documentation

The Infection Prevention Team carry out a series of rolling audits of each ward and department and raise actions required with managers and teams to ensure action is taken. During the period April 2021 to March 2022 the Trust reported the following;

- MRSA Bacteremia's (MRSAb)- 2 bacteraemia cases
- Clostridium Difficile Infection (CDI)- 44 cases.
- Methicillin Sensitive Staphylococcus Aureus bacteraemia (MSSAb)- 15 cases.

Lessons learned from the PIRs of these cases are shared with the Trust via a monthly Infection Prevention report which is also shared with CCGs.

Key Achievements for 2021-22 were:

- Working with the Trusts C Difficile Action Plan to deal with issues arising, monitoring trends, and presenting their C Diff review to the CCG and NHSEI for feedback
- Action Plan for Medicine and Emergency Care MRSA screening on admission.
- Daily Outbreak/Bronze meetings with Sefton Quality Manager, with actions swiftly escalated via Silver and Gold Command structure.
- Consistently Good rates of asymptomatic carriage screening for COVID-19-19, thereby enabling

quick identification and isolation of positive patients.

- 2122 staff received their flu vaccination, 64% of our workforce of 3315 people.

COVID-19 -19 Response IPC

Members of the infection Prevention Team (IPC) were responsible for advising the Trust via Silver and Gold Command and ensuring the continued education of staff in how to best provide care for COVID-19 patients while protecting themselves, auditing availability of Personal Protection Equipment
(PPE) and Hand Gel and working closely with the Procurement Team to ensure the provision of PPE was effective and that the equipment itself was fit for purpose. In addition to IPC precautions the Trust purchased 37 air purifiers with HEPA filters and integrated UVC light disinfection, also CO2 monitors are installed in multi patient rooms which are reliant on natural ventilation.

They took responsibility for communication to the wider Trust any changes in PPE requirements issued by Public Health England and NHS England, also any changes to testing of inpatients and staff and visitors. IPC team members continued to work 365 days a year to support with issues continuing from the pandemic.

We had 1,272 inpatient spells during the year compared to 1,685 in the previous year.

74 cases of Hospital -Onset Definite Healthcare Associated (HO-dHA) were reported where the first positive specimen date was 15 or more days after admission. There were 60 cases of Hospital Onset Probable Healthcare Associated (HO-pHA) reported where the first positive specimen date was 8-14 days after admission.

The Trust was pleased to report that 2153 of staff received their third booster vaccination. 95.6% of staff received at least one dose.
A massive 25,784 vaccines were administered to families, local NHS, and Social Care via our hubs at both hospital sites.

3.3.9 Safeguarding

The Trust has a dedicated Safeguarding Team covering two sites and is responsible for ensuring that robust and effective systems are in place to support the Trust in working effectively to safeguard the un-born, children, young people and adults who are at risk of abuse or neglect. An Independent sexual health advisor (ISVA) employed through the Lancashire ISVA programme is placed within the safeguarding team. In August 2021, a Learning Disability and Autism Practitioner has been employed through National Health Service Professionals (NHSP) and this post is awaiting the outcome of a business case and then formal recruitment. The safeguarding team is a multi-functional team providing both the daily operational management of safeguarding referrals and concerns raised, while undertaking the corporate responsibilities regarding training, supervision, policy development and deployment. The team work closely with both Sefton and Lancashire County Councils and other partners and support the work of the Local Safeguarding Boards for Merseyside and Lancashire.

A quartile key performance indicator (KPI) report is submitted to South Sefton CCG, after which the CCG provide an assurance feedback report for the Trust. The Assistant Director of Safeguarding undertakes business meetings with the Designated Nurse and Designated

Practitioner for South Sefton CCG. The KPI assurance feedback report is an agenda item at the Trust Contract & Clinical Quality Review Meeting (CCQRM).

The Trust has a Safeguarding Assurance Group (SAG). To provide external scrutiny the meeting provides invites for representatives from the Local Authority, and Designated Nurses from South Sefton and Lancashire CCG's. An advice, alert, assure (AAA) report from the meeting is submitted to the Trust Safety and Quality Committee. A safeguarding annual report is approved by the Trust Board and shared with external safeguarding boards.

The Trust is represented at Sefton and Lancashire Local Safeguarding Board meetings and provides attendance at Board sub-group, task and finish groups, strategy meetings, case conferences, core groups, domestic homicide reviews, learning events, practice review meetings and steering groups.

Safeguarding Training Compliance

The Trust has an overall compliance for all safeguarding training of 93.1% (against a target of 90%). Compliance has now been achieved in all 6 levels of safeguarding training.

Overall Trust Compliance 2021/22	Oct	Nov	Dec	Jan	Feb	March
Safeguarding Adults Level 1	93.1%	94.3%	93.7%	94%	93.2%	93.7%
Safeguarding Adults Level 2	91.99	90.9%	91.5%	93.3%	92.8%	91.3%
Safeguarding Adults Level 3	90.33%	100%	100%	100%	96.6%	96.4%
Safeguarding Children Level 1	93.8%	94.4%	94.2%	94.5%	94.5%	93.9%
Safeguarding Children Level 2	89.5%	88.3%	89.7%	90.6%	91%	90.7%
Safeguarding Children Level 3	72.1%	74.4%	78.4%	82.4%	82.4%	92.8%

By the end of Quarter 4, children's level 3 training has achieved >90% making the Trust compliant against all levels of safeguarding training.

3.4 Clinical Effectiveness

The Clinical Effectiveness Meeting meets monthly and monitors key outcome and effectiveness indicators, including national clinical audit, application of National Institute for Health and Care Excellence (NICE) guidance.

3.4.1 National Institute for Health and Care Excellence Guidance

Southport and Ormskirk Hospitals NHS Trust has a responsibility for implementing NICE guidance to ensure that:

- Patients receive the best and most appropriate treatment
- NHS resources are not wasted by inappropriate treatment
- There is equity through consistent application of NICE guidance/quality standards

The Trust must demonstrate to stakeholders that NICE guidance/quality standards are being implemented within the Trust and across the health community. This is a regulatory requirement that is subject to scrutiny by the CQC. The Clinical Audit and Effectiveness Team are responsible for supporting the implementation and monitoring NICE guidance compliance activity.

There is a system in place to ensure all relevant guidance is then distributed to the appropriate clinical lead to assess its relevance and the Trust's compliance with the requirements. This is then reported to the Clinical Business Units Governance meetings. Action plans are produced for any shortfalls to ensure compliance is achieved. Compliance will be rigorously assessed by mandatory departmental compliance audits reportable through the Trust audit meetings. Below is a table highlighting the Trusts current compliance levels for all NICE products produced.

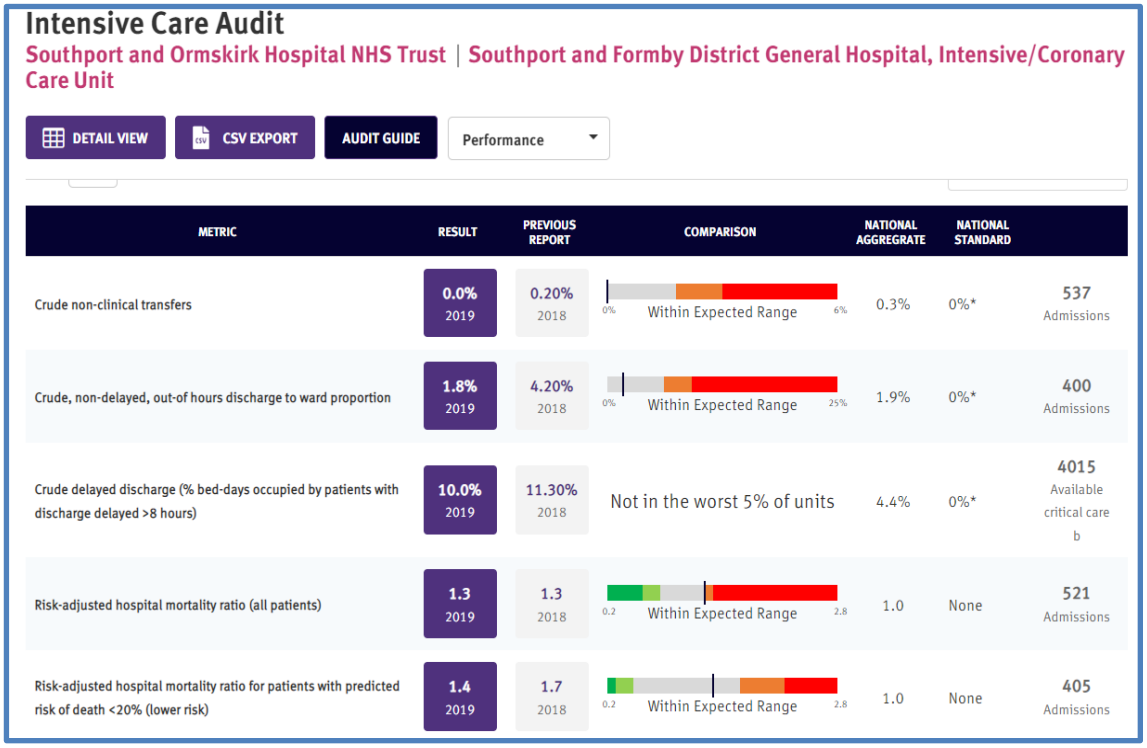
Compliant	643 / 743 (86.5%)
Working towards compliance	96 / 743 (13%)
Not compliant	4 / 743 (0.5%)

3.4.2 Clinical Audit

The Trust has an active clinical audit programme and is an active participant in required national audits where performance is robust. Details of the work undertaken this year are contained in section 2 above.

3.4.3 Intensive Care National Audit & Research Centre (ICNARC)

The Trust's Critical Care Unit performs well in the patient centred quality indicators, as externally



Intensive Care Audit

Southport and Ormskirk Hospital NHS Trust | Southport and Formby District General Hospital, Intensive/Coronary Care Unit

DETAIL VIEW | CSV EXPORT | AUDIT GUIDE | Performance

METRIC	RESULT	PREVIOUS REPORT	COMPARISON	NATIONAL AGGREGRATE	NATIONAL STANDARD	
Crude non-clinical transfers	0.0% 2019	0.20% 2018	0% Within Expected Range 6%	0.3%	0%*	537 Admissions
Crude, non-delayed, out-of hours discharge to ward proportion	1.8% 2019	4.20% 2018	0% Within Expected Range 25%	1.9%	0%*	400 Admissions
Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	10.0% 2019	11.30% 2018	Not in the worst 5% of units	4.4%	0%*	4015 Available critical care b
Risk-adjusted hospital mortality ratio (all patients)	1.3 2019	1.3 2018	0.2 Within Expected Range 2.8	1.0	None	521 Admissions
Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	1.4 2019	1.7 2018	0.2 Within Expected Range 2.8	1.0	None	405 Admissions

benchmarked by the Intensive Care National Audit and Research Centre (ICNARC), which collects data from 100% of all Intensive Care Units in the country (https://www.icnarc.org).

The most recent annual report and HQIP benchmarking reporting demonstrates good performance from the Trust as we are not an outlier for any of the measures.

3.6 Clinical Business Unit Summary (CBU)

3.6.1 Medicine & Emergency Care CBU

The Trust experienced the most challenging year ever known in the NHS in 2020-21, which continued in 2021 across all areas of the Medicine and Emergency Care CBU, encompassing emergency care, medicine, and therapies.

We have continued to provide care for COVID-19-19 with emergency admissions and ongoing care in dedicated COVID-19-19 wards and where appropriate, specialist wards, with staff demonstrating flexibility and commitment to the service and their patients. In addition, we have managed additional escalation areas to increase the acute bed base to manage the demand, LOS and COVID-19-19 care pathways. We have faced unprecedented challenges as a result of the need to safely manage both new patients presenting with COVID-19-19 and patients presenting with other acute and chronic illnesses requiring medical admission and intervention.

Over the course of the year, we have regularly reviewed our processes in terms of visiting due to the restrictions and have therefore developed innovative ways to keep patient's families informed about their care. This included creating a team of Patient Information Communication Officers (PICOs) who would call families and provide updates and providing a service whereby zoom calls were facilitated

for patients themselves to speak to their families giving them reassurance and precious visible contact time. The teams have also implemented a new communication care plan to further strengthen the communication with patients and families as we continued to adhere to visiting restrictions.

The CBU faced a great challenge in the drive to try to recover activity which was paused and therefore reduced as a result of the pandemic including a range of medical and therapy outpatient services, rehabilitation, staff training, quality improvement programmes, staff well-being and governance. The focus on restoration of activity such as seeing and treating those patients waiting for appointments and tests and reducing administrative backlogs has required a significant adjustment in working practice with clinical and managerial staff working together to ensure recovery is achieved and sustained and developing new innovative ways of working such as increased utilisation of telehealth and virtual appointments.

"I am writing on behalf of my mother, who visited the A&E Department at Southport hospital last Monday morning, 20th September with a broken wrist and knock to the head. She was taken care of by a male nurse called Ian and wishes to pass on her compliments to him. My mother said that Ian was very efficient, extremely kind and caring, and had great communication skills. She was very impressed, especially when a department such as A&E is naturally very busy and under pressure."

Southport Emergency Department

Despite the significant challenges, our CBU services have continued to develop, with notable areas including:

- Reviewing of and redesign of the estate specifically in the Emergency Department to facilitate appropriate isolation and mitigating the risk of COVID-19-19 transmission.
- Developing and progressing plans for the enhanced discharge lounge to support improvements in discharge performance and flow.
- Working collaboratively with NWAS to trial new pathways and methods of ensuring fast handover and release of crews back into the community.
- Continued development of the frailty services within the Trust including the progression of the designing of frailty SDEC pathways and recruitment to key clinical positions to support this service and recruitment to the Consultant Pharmacist post.
- Significant progress and improvement in reducing the use of premium rate agency nurse staffing, with a shift towards bank and significantly reduced vacancy rate through continued active involvement in the recruitment of international nurses.
- Reviewing of areas with significant challenges in recruitment, to determine new ways of working and models such as ACP and ANP posts and recruiting to improve stability and quality of service provision in challenged areas such as speech and language therapy and dietetics, increased dietetic nurse provision and implementing additional positions within the discharge team to deliver safe, timely discharges.
- The Medical Day Unit Team has demonstrated resilience and adaptability in managing their service being moved from the Southport to the Ormskirk site to minimise the risk to their vulnerable patient group.
- Therapies have developed new ways of working to support outreach into the community working with system partners and supporting earlier discharge and a rehabilitation provision for patients who require this before being able to return home.

- The CBU has continued to progress the stroke service transition as part of the service redesign with colleagues across North Mersey.
- Teams have continued to deliver excellent patient care with areas achieving significant improvements in their accreditation scoring (SOCAAS).
- The teams have continued to deliver on the investigation, reporting, management and responses to incidents and complaints.
- There have been sustained improvements in compliance with training, with senior staff attending AQUA Quality Improvement Training and many specialist CPD opportunities supported to maximise the development of the workforce.
- There have been multiple opportunities to celebrate with national recognition of services and local awards and commendations for a variety of staff in the CBU.

The teams in Medicine and Emergency Care have during the most difficult year been through some of the hardest days, made the toughest decisions and faced extreme challenges. Through all this they have found reasons to smile every day, always put our patients first, never gave up and displayed a fighting spirit. The teams have gone above and beyond demonstrating commitment and dedication to deliver excellent care, for every patient, every time and we are **SO proud** of each and every member of the teams

3.6.2 Planned Care CBU

As we continue to work within the COVID-19 restrictions our main focus is to re-establish pre-pandemic activity across the CBU and deliver on the elective restoration plan.
This year endoscopy has commenced a wider transformation of the service offered.

There has been the opening of the admissions area within the department as discussed earlier in this document. This has enabled the delivery of mixed sex lists within the department which has had the positive impact of ensuring a timelier management of patient pathways. Whilst continuing to work within COVID-19 guidance, the team have also opened an additional scoping room to enable us to increase the number of patients we are able to see. The trust has successfully implemented the Surveillance FIT testing programme with monies awarded by Cheshire and Mersey Cancer Alliance. This piece of work offers safe screening of all the patients overdue their surveillance colonoscopy due to the COVID-19 pandemic. The test looks to risk assess patients and triage them into an appropriate ongoing pathway.

I attended the Urology Department at Ormskirk Hospital yesterday morning. Could I ask you to pass on a big thank you to everyone who dealt with me from the receptionist, the lady who booked me in, Dr/Mr. Reddy and the two ladies who assisted him and finally the lady who discharged me. I appreciate that the NHS has been overworked for a while now, but the service I received yesterday was fantastic. Everyone introduced themselves, sorry I can't remember all of their names, they were all very polite and very professional.

Urology Department ODGH
Planned Care

As part of the work with the Cancer Alliance all overdue surveillance scopes have been transferred over onto the patient tracking list for ongoing timely management.

Our outpatient services have continued to work with the blended appointment model commenced during the COVID-19 pandemic. We continue to offer telephone, virtual and face to face appointments as part of this offer to our patients. The trust has commenced work in the implementation of patient initiated follow up (PIFU). This model will vary slightly to suit the needs of each clinical speciality to ensure a safe and effective offer to our patients.

The opening of 4 bedded Post Operative Critical Care Unit (POCCU) on the Southport site has been successful in ensuring we have been able to continue to offer surgery to our cancer and most clinically urgent patients throughout the whole pandemic.

We have made fantastic moves in nurse recruitment across the CBU but especially in our hard to recruit to areas, of 14A and Spinal Injuries Unit, international nurses have been welcomed into teams which has filled their qualified nurse vacancies.

We have employed a practice development facilitator for planned care wards on the Southport site, which reflects the support in other areas of CBU.

To support patient flow and utilisation of acute beds on Southport site we have reviewed the Orthopaedic Rehabilitation ward, on Ormskirk site, and relaunched the service as Post Operative Care Ward. As a result, the pathway has been reviewed to support surgical and urology transfers as well as orthopaedic and additional training in place to support the speciality changes.

In our theatres suites we have continued to maximise the capacity and productivity whilst working within the COVID-19 restrictions. We have also utilised the independent sector to ensure that clinically appropriate patients' procedures could proceed.

3.6.3 Specialist Services CBU

Maternity Services

The last two years have presented many challenges for the NHS and in particular Maternity services, with the uncertainty that COVID-19 presented and the more recent findings of the Ockenden report. We have been flexible and responsive as a team to ensure our mothers and babies had the best possible experience and that we continued to deliver timely and responsive care. This included remote booking service and telephone and virtual appointments so that patients need to travel for appointments was kept to a minimum whist still ensuring clinical needs were met. The service submitted a bid for monies following the Ockenden review which was successful and have recruited 6 Midwives and 0.6 WTE Consultant to deliver against the report's recommended actions. We also continue collaboratively work with colleagues across the region to continue to improve our maternity services

"I had outpatient procedure on Thursday 29 July with the gynaecology team. I can't express how great this team of women were. They were reassuring, extremely emotionally warm, efficient, and caring. Everything was explained to me, and at unpleasant stages in the procedure they reinforced key messages and advised that the discomfort would be short-lived. I asked if I could chat to distract myself (I was very nervous). All four women chatted and relaxed the atmosphere and my tension (whilst getting the job done.
I was emotional when I left, as I was touched by their kindness and friendliness. One lady held my hand the whole time (and at points I realised I had squeezed her hand quite hard). I would appreciate this feedback going back to the team. For them, it was probably 20 minutes out of a busy day, but recognition should be given to people that go above and beyond their job role and who can do it so effortlessly"

Gynaecology & Sexual Health

We have implemented virtual appointments within several Gynaecology services which has maximised our ability to maintain both in and out-patient activity and are currently delivering all menopause services virtually which has freed nursing capacity to support additional capacity in other areas.

The team has developed non-medical staff skills and competencies to deliver enhanced roles to support delivery in menopause, colposcopy and smear clinic and are working with key stakeholders
to develop a plan for service delivery in both primary and secondary care including active participation with the following:

- Shaping care together
- C&M Cancer Alliance
- C&M Gynaecology Network
- Local Commissioning teams

Key achievements in Sexual Health include the introduction of online testing enabling patients to access STI screening from home and reducing footfall in the clinics as well as bringing the service in-line with the service specification. This will support reduction in the likelihood of onward transmission and reduced the pool of infection in the wider community. Improving the health outcomes of the wider heath economy.

In 2020 the service achieved a rate 32.02 per 1000 LARC (long-acting reversible contraception) fitting which was 138.2% above the National average. The service was able to maintain and further increase delivery of LARC and have been able to continue to accommodate all requests throughout 2021/2022 resulting in no waiting lists for Implants or Coils which has had to be implemented by other Sexual Health services both regionally and nationally.

Clinical Support - Radiology

Through innovative working the radiology team was one of the only Trusts in the region who continued to provide a CT Colons service throughout COVID-19, by ensuring stringent infection prevention rules were followed, home reporting workstations were implemented for some of the Consultant Radiologists and the Lead Plain Film Reporting Radiographer, which enabled the continuation of reporting

Despite challenges nationally the team have successfully recruited 7 International Radiographers, and 2 Consultant Radiologists from overseas and will provide support as they complete their CESR.

As part of the team working towards reducing the referral back log, they have been able to utilise additional support in CT/MRI and Ultrasound Scanning from some of the local hospitals; Renacres, St Helens & Knowsley and the Walton Centre. The team have also been able to perform in house additionality in these modalities as part of this work and to keep up with the increase in demand.

The team have also been successful in a bid to secure NHS England funding for software upgrades on both the GE and Philips MRI Scanners, this will improve image quality and reduce scan times, therefore increasing patient throughput.

"We had our second baby at Ormskirk on the 16 July. I would like to express how grateful we are for the care and expertise we experienced for both of our children. Throughout the whole pregnancy absolutely everyone I came into contact with from sonographers, consultants, midwives and admin support staff have been great. We are so grateful for the support to bring our second baby safety here. I would also like to say how professional all the students were. I saw a lot of students and each and they all were brilliant. Thank-you".

Maternity Department, Ormskirk

Paediatrics and Neonates

The Paediatric Emergency Department has undergone extensive refurbishment to increase the number of cubicles available in order to isolate patients at the earliest opportunity to prevent the spread of infection. Included in this refurbishment was Paediatric Emergency Department Resus enabling the team to be able to safely deliver care for additional patients in separate cubicles

Where appropriate Paediatric outpatient clinics continued throughout pandemic either through virtual/telephone clinics or face-to-face where clinically indicated, this has enabled the service to maintain strong performance against 18-week targets.

The team now have a very robust Paediatric Network across Cheshire and Mersey. Initially MS Team meetings were held very regularly and reduced as the situation changed. The team are able to escalate through the introduction of Daily Network Status Reports which indicates whether a particular Unit is Red /Amber / Green and therefore able to ask for mutual support in case of emergency gaps / lack of beds.

The Children's Community Nursing and Outreach Team (CCNOT) for West Lancs has been commissioned providing equity to all our patients as this service was only previously offered to North Sefton patients. This has helped facilitate early discharge and provide care closer to home.

Alongside the extended CCNOT service, a Respiratory nurse for West Lancs has also been appointed. The aim of the role being to reduce Emergency Department attendances with Respiratory conditions and supporting the GPs to manage these patients at home by improving management of their condition.

The Neonatal Unit has secured significant funding to increase their staffing levels to meet BAPM standards and this has enabled us to support the delivery of Transitional Care keeping the babies with their mums.

Cancer

The team has been successful in securing a significant amount of funding for various projects and posts that will provide improvements to our cancer pathways and enhance patient experience. The aim of the team over the coming year will be to evidence these benefits in order make the roles sustainable for the below services:

- Rapid Diagnostic Services – including a Senior programme manager
- Non-site-specific primary cancer
- High Risk FIT testing
- Early Diagnostic Support Workers
- OG Dietitians

3.7 Summary of national patient surveys reported in 2021-22

The full results for all the latest Care Quality Commission's national patient surveys can be found on their website at www.cqc.org.uk

3.7.1 National Inpatient Survey

The Trust participated in the annual National Inpatient Survey 2020 coordinated by the Care Quality Commission. The results from the survey are used in the regulation, monitoring and inspection of NHS Trusts in England and were published in January 2022.

The Adult Inpatient 2020 survey was significantly different to previous years' surveys with regards to methodology, sampling month and questionnaire content, therefore, the results are not directly comparable to previous years' data and trend data is not available. In future years, trend data will be incorporated into the reports.

In addition, this year the CQC amended its analysis and reporting, in an attempt to provide Trusts with a higher level of feedback from the survey, by including additional levels for the bandings. Previously all questions were banded as either 'better', 'about the same' or 'worse', with the addition of 'much worse', 'somewhat worse', 'somewhat better' or 'much better' bandings for the 2020 survey.

Other changes to the Adult Inpatient Survey in 2020 included the transition from a paper only method to a 'push-to-web' method, offering an online option. This had a slight impact on the Trusts response rate with a decrease of 1% to 42%. The survey was sent to those who were inpatients during the month of November 2020.

Section	Theme	2020 score	2020 Band
Section 1	Admission to Hospital	7.3	About the same
Section 2	The hospital and ward	7.8	About the same
Section 3	Doctors	8.9	About the same
Section 4	Nurses	8.6	About the same
Section 5	Care and Treatment	8.2	About the same
Section 6	Operations and procedures	8.3	About the same
Section 7	Leaving hospital	6.8	Somewhat worse
Section 8	Respect and dignity	9.1	About the same
Section 9	Overall	8.1	About the same
Section 10	Feedback on quality of care.	1.3	About the same

The Trust's results were:

- Somewhat better than most Trusts for 1 question relating to self-medication.
- Same than most Trusts for 39 questions
- Worse than most Trusts for 2 questions related to leaving hospital.
- Somewhat worse than most 4 questions related to leaving hospital

Themes for improvement have been identified including:

- supporting patients to achieve a good night's sleep.
- patients being told why they are being moved to a different ward another ward
- Improved communication with patients when they are given information about their condition and treatment
- Improving information regarding medications
- Supporting patients with nutrition and hydration
- Supporting patient privacy and dignity
- Supporting patients understanding of their condition and treatment
- Supporting patients regarding their anxieties or fears
- Improved communications with patients and their families regarding their discharge and afterwards

An action plan has been developed to support improvement in the above areas.

3.7.2 National Maternity Survey 2021

The NHS Maternity Survey is carried out by the Picker Institute every other year with 66 Trusts commissioning the survey. Its purpose is to understand what women think of Maternity Services and provide each Trust with a comparison to the average of other Trusts as a benchmark. The survey is also reported to the Quality Care Commission.

This information refers to the Maternity Survey report received September 2021 which surveyed women who gave birth in February 2021.

- 296 women were eligible to complete the survey
- 146 (49%) women completed the survey This was an improvement from 25% in 2019
- The majority who responded had previously given birth (89%)
- The average response rate for other Trusts was 54%

Results

• Top 5 scores vs Picker Average	• Trust	• Picker Avg
• C19. Felt concerns were taken seriously (during labour and birth)	• 84%	• 78%
• C25. Able to ask questions afterwards about labour and birth	• 82%	• 77%
• B12. Given enough support for mental health during pregnancy	• 86%	• 82%
• F16. Received help and advice about feeding their baby (first six weeks after birth)	• 89%	• 86%
• C10. Involved enough in decision to be induced	• 86%	• 83%

Most improved scores	Trust 2021	Trust 2019
D2. Discharged without delay	63%	48%
F16. Received help and advice about feeding their baby (first six weeks after birth)	89%	84%
F12. Staff asked about mental health (postnatal)	98%	95%

Areas Identified for Improvement	Trust	Picker Avg	Trust Score 2019
B5. Given enough information about where to have baby	63%	76%	89%
B7. Felt midwives or doctor aware of medical history (antenatal)	73%	83%	89%

Areas Identified for Improvement	Trust	Picker Avg	Trust Score 2019
D7. Found partner was able to stay with them as long as they wanted (in hospital after birth)	23%	33%	91%
F15. Given enough information about their own physical recovery	77%	85%	95%
B3. Offered a choice of where to have baby	72%	80%	76%

So what are we doing?

Involving Staff:

- Findings discussed at senior midwives meeting and improvement plan has been developed which includes:
    - Discussing with the MDT team about improving doctors and midwives awareness of medical history
    - Review of patient information with support of the Maternity Voices Partnership to include choices for birth
    - Midwife Led beds identified on the Delivery Suite
    - Implementing ethos of continuity of carer in line with Better Births

Involving Women

- Maternity Ward Walkabouts to enquire about women's views which are shared with staff
- Tell the Midwives' events – where women are invited to discuss their maternity care experience
- Maternity Voices Partnerships – Joint working with women, CCG's and Cheshire & Mersey partnership to improve maternity care locally and regionally.

3.7.3 National Cancer Patient Experience Survey 2020

The 2020 survey was run on a voluntary basis and was sent to eligible participants in late April 2021. The average patient overall rating of care scored from very poor to very good has increased from 8.8/10 to 8.9/10. Themes recognised for improvement are:

- Involving patients and families in their care.
- Access to information regarding treatment and support.

Section 4 Statement of Directors' responsibilities in respect of the Quality Account

The Trust Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2012) to prepare a Quality Account for each financial year.

The Department of Health issues guidance on the form and content of the annual Quality Account, which has been included in this Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered 2020-2021
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with Department of Health guidance.

The Trust Board of Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Trust Board

Neil Masom OBE Chairman

Ann Marr OBE, Chief Executive

Section 5
Written statements by other bodies

5.1. Amendments made to the Quality Account following feedback and written statements from other bodies

To follow after event 10th June 2022

Section 6
Appendices

Section 7
Abbreviations

ACE	Angiotensin-converting enzyme
ACP	Advance care planning
AF	Atrial fibrillation
AHPs	Allied Health Professionals
AI	Artificial Intelligence
AKI	Acute Kidney Injury
AMD	Age-related Macular Degeneration
AMU	Acute Medical Unit
ANTT	Aseptic Non-Touch Technique
App	Application
AQuA	Advancing Quality Alliance
BAF	Board Assurance Framework
BAME	Black, Asian and minority ethnic
BAPEN	British Association of Parenteral and Enteral Nutrition
BAUN	British Association of Urology Nurses
BAUS	British Association of Urological Surgeons
BBA	Born before arrival
BC	Blood culture
BPH	Benign prostatic hyperplasia
BSI	Blood stream infection
BSL	British Sign Language
BTS	British Thoracic Society
CaSH	Contraception and Sexual Health
CBT	Cognitive behavioural therapy
CCGs	Clinical Commissioning Groups
CCS	Clinical Classification Service
CCU	Coronary Care Unit
CDI	Clostridium difficile infection
CHPPD	Care Hours per Patient per Day
CMPA	Cow's milk protein allergy
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Airways Disease
CP	Chest Pain
CPAP	Continuous Positive Airway Pressure
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
CQuIN	Commissioning for Quality and Innovation
CRAB	Copeland Risk Adjusted Barometer
CRN / NWC	Clinical Research Network, North West Coast Research
CS	Clinical standards
CT	Computerised tomography
CTG	Cardiotocography
DAP	Digital Aspirant Programme

Datix	Integrated Risk Management, Incident Reporting, Complaints Management System
DIPC	Director of Infection Prevention and Control
DKA	Diabetes keto-acidosis
DNA	Did not attend
DNACPR	Do not attempt cardiopulmonary resuscitation
DQMI	Data Quality Maturity Index
DSPT	Data Security and Protection Toolkit
DVLA	Driver and Vehicle Licensing Agency
DVT	Deep vein thrombosis
EAP	Employee Assistance Programme
ED	Emergency Department
EDS or EDS2	Equality Delivery System
EoLC	End of life care
ePMA	Electronic Prescribing and Medicines Administration
ePR	Electronic Patient Record
eTCP	Electronic Transfer of Care to Pharmacy
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends & Family Test
FFP3	Filtering Face Piece
FIT	Faecal Immunochemical Test
GAP SCORE	Growth Assessment Protocol Standardised Case Outcome Review and Evaluation
GI	Gastrointestinal
GIRFT	Get It Right First Time
GMC	General Medical Council
GNBSIs	Gram-negative bloodstream infections
GORD	Gastroesophageal reflux disease
GP	General Practitioner
GPSI	GP with special interest
GPwER	GP with Extended Role
HASU	Hyper-acute Stroke Unit
HCA	Healthcare Assistant
HCAI	Healthcare associated infections
HES	Hospital Episode Statistics
HF	Heart Failure
HNA	Health Needs Assessment
HR	Human Resources
HSCIC	Health and Social Care Information Centre
HSJ	Health Service Journal
HSMR	Hospital Standardised Mortality Ratio
HSRC	Hyper-acute Stroke Research Centre
HST	Higher Specialist Trainees
HWWB	Health, Work and Well-being
IBD	Inflammatory Bowel Disease
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
IDDSI	International Dysphagia Descriptor Standardisation Initiative
IG	Information Governance

IMT	Internal Medicine Trainee
IPR	Integrated Performance Report
IQILS	Improving quality in liver services
IT	Information Technology
IV	Intravenous Therapy
JAG	Joint Advisory Group
LARC	Long-acting reversible contraception
LGBT	Lesbian, gay, bisexual, transgender
LGBTQ+	Lesbian, gay, bisexual, transgender, and questioning
LocSSIPs	Local Safety Standards for Invasive Procedures
LSCB	Local Safeguarding Children Board
LUTS	Lower urinary tract symptoms
MAMMA	Mastitis and mammary abscess management
MARAC	Multi-Agency Risk Assessment Conferences
MBRRACE- UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the
UK MDT	Multi-disciplinary Team
MEOWS	Modified Early Obstetric Warning System
MET	Medical Emergency Team
MINAP	Myocardial Ischaemia National Audit Programme
MLU	Midwife-led Unit
MMU	Manchester Metropolitan University
MOP	Medicine for Older People
MR	Magnetic Resonance
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant staphylococcus aureus
MSSA	Methicillan - sensitive staphylococcus aureus
MTI	Medical Training Initiative
MUST	Malnutrition Universal Screening Tool
MVC	Mass Vaccination Centre
NABCOP	National audit-breast cancer in older patients
NACAP	National asthma (adults) and COPD audit programme
NAOGC	National Audit Oesophago-Gastric Cancer
NBOCAP	National Bowel Cancer Audit Programme
NatSSIPs	National Safety Standards for Invasive Procedures NCAA National Cardiac Arrest Audit
NCAP	National Cardiac Arrest Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCPES	National Cancer Patient Experience Survey
NDA	National Diabetes Audit
NELA	National Emergency Laparotomy Audit
NEWS	National Early Warning Score
NG	Naso-gastric
NHSE	National Health Service England
NHSE/I	National Health Service England/Improvement
NHSI	National Health Service Improvement

NHSX	National Health Service X - joint unit of NHS England and the Department of Health and Social Care
NICE	National Institute for Health and Care Excellence
NIPE	Newborn and Infant Physical Examination
NIHR	National Institute for Health Research
NIV	Non-Invasive Ventilation
NJ	Naso-jejunal
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NMC	Nursing and Midwifery Council
NMPA	National Maternity and Perinatal Audit
NNAP	National Neonatal Audit Programme
NPDA	National Paediatric Diabetes Audit
NOAC	New oral anticoagulant
NoF	Neck of femur
NPCA	National Prostate Cancer Audit
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
NSTEMI	Non-ST-segment elevation myocardial Infarction
NWAS	North West Ambulance Service
OBE	Order of the British Empire
ODPs	Operating Department Practitioners
OHCA	Out of hospital cardiac arrests
OT	Occupational Therapist/Therapy
OSCE	Objective Structured Clinical Examination
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PBS	Patient Booking Services
PCN	Primary Care Networks
PCNL	Percutaneous Nephrolithotomy
PE	Pulmonary Embolus
PEG	Percutaneous Endoscopic Gastrostomy
PEWS	Paediatric Early Warning Score
PFI	Private Finance Initiative
PHE	Public Health England
PI	Principal Investigator
PIR	Post infection review
PLACE	Patient-Led Assessments of the Care Environment
PMRT	Perinatal mortality review tool
PN	Parenteral Nutrition
PoCT	Point of Care Testing
PPD	Preferred place of death
PPE	Personal Protective Equipment
PRES	Patient Research Experience Survey
PROMs	Patient Reported Outcome Measures

QCAT	Quality Care Accreditation Tool
QICA	Quality Improved Clinical Audit
QIP	Quality Improvement Project
QOF	Quality Outcomes Framework
QSI	Quality Standard for Imaging
RACPC	Rapid Access Chest Pain Clinic
RAG	Red, Amber, Green
RCA	Root Cause Analysis
RCEM	Royal College of Emergency Medicine
RCM	Royal College of Midwives
RN	Registered Nurse
SALT	Speech and Language Therapy Team
SAMBA	Society for Acute Medicine (SAM) Benchmarking Audit
SAU	Surgical Assessment Unit
SDEC	Same Day Emergency Care
SEQOHS	Safe Effective Quality Occupational Health Services
SCR	Summary Care Record
SHMI	Summary Hospital-level Mortality Indicator
SHOT	Serious Hazards of Transfusion
SIREN	SARS-COV2 Immunity and Reinfection Evaluation
SIRO	Senior Information Risk Owner
SJR	Structured Judgement Review
SLA	Service level agreement
SMR	Standardised Mortality Ratio
SSI	Surgical Site Infection
SSNAP	Sentinel Stroke National Audit Programme
ST	Specialty Trainee
STEMI	ST-segment elevation myocardial infarction
STI	Sexually Transmitted Disease
STP	Sustainability and Transformation Plan
SUS	Secondary Uses Service
TARN	Trauma Audit & Research Network
ToP	Termination of pregnancy
TPN	Total Parenteral Nutrition
TWOC	Trial without catheter
UKAS	United Kingdom Accreditation Services
UPH	Urgent Public Health
US	Ultrasound
VTE	Venous Thromboembolism
WALANT	Wide-Awake Local Anaesthesia, No Tourniquet
2WW	Two week waits
7DS	Seven day hospital services

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Please direct any queries relating to the Quality Account to the following email:

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGIC & OPERATIONS COMMITTEE**	**Date**	**01 June 2022**
Agenda Item	**SO105/22**	**FOI Exempt**	**NO**
Report Title	**MATERNITY REPORT INCLUDING OCKENDEN II SELF-ASSESSMENT**		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Lynne Eastham, Associate Director of Midwifery/Nursing		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To receive updates and assurances on:

- Ockenden Report/Actions
- CNST
- Quality & Safety
- Workforce

Executive Summary

Ockenden Final Report (March 2022)

The Independent Review of the Maternity Services at Shrewsbury & Telford NHS Trust commenced in 2017 by Donna Ockenden and was published in March 2022. An interim report was published in December 2020 (Ockenden One) in response to initial findings so that immediate actions could be taken. Final report published March 2022.

Benchmark completed of S&O Maternity Services against the 92 actions in the report using the Cheshire & Mersey Local Maternity & Neonatal Network (LMNS) standardised self-assessment template with a view to working to full implementation. This self-assessment will also be shared with the LMNS to support oversight and scrutiny and prioritisation of actions required regionally. A peer review has been completed in partnership with StHK.

A regional Insight Visit is planned for the 10 June 2022. This is an assurance visit by the regional maternity team. This will have an MDT approach and MVP involvement. The assurance visit will give opportunity to review any gaps within the Trust's report against the immediate and essential actions and discuss progress made to date.

The Chief Midwifery Officer is also meeting with members of the maternity team and Board members on 20 June for a Maternity Safety Executive meeting.

CNST Year 4

In December 2021, in recognition of pressures in Maternity Services and the NHS, there was a temporary pause in the reporting procedure for Year 4 CNST Safety Actions. On the 06 May 2022, the CNST scheme was relaunched with extension for compliance now being the 05 January 2023.

In light of the Ockenden report some of the safety actions have been reviewed and new requirements added. These are included in Midwifery Staffing (safety action 5), Maternity Voices Partnership (safety action 7), and Safety Champions (safety action 9). The revised actions are being reviewed

by the Team. It is proposed that Trust Board is updated on progress accordingly.

Quality & Safety
A national recommendation from the Ockenden Report was the proposed introduction of a Perinatal Quality Surveillance Model (PQSM). The regional NHSE/I team and the LMNS reviewed its governance framework and reporting processes. A monthly Quality and Safety Surveillance Group has now been developed and will report to the LMNS Assurance Board.

In May 2022, in response to a serious incident in Maternity, a S&O Quality Review meeting was held attended by Cheshire & Mersey Regional Team and key representatives from the Trust. This was to review the incident and actions being taken both immediately and longer term. Further supportive meetings are proposed to monitor progress.

Perinatal Mortality
Eligible cases and reviews are undertaken using the Perinatal Mortality Review tool on the regional reporting template. There has been one STEIS incident for this reporting period. CNST Safety Action 1 states that the Trust Board receive a quarterly report including details of deaths reviewed and consequent action plans.

Saving Babies Lives Care Bundle
We have demonstrated full compliance with Saving Babies Lives Care Bundle 2, except for undertaking uterine dopplers at 20 weeks gestation. Plans for implementation have been delayed due to scan capacity and agreeing Consultant Obstetric lead. Expected date for implementation is June 2022

Safety Champions
The Terms of Reference for the Safety Champions meetings have been revised and there has been an agreement for alternate monthly Safety Champions walkabouts to speak with staff and women and their families The first walkabout took place in May 2022.

Maternity Staffing
Staffing update provided including Neonatal and medical workforce. The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing which is an immediately available resident Tier 2 practitioner dedicated solely to the neonatal service between 0900 – 22.00hrs during the working week Monday to Friday. However, at weekend during the long day shift the doctor covers Paediatrics as well and therefore does not currently meet CNST Safety Action 4 CNST requirements.

Recommendations

The Strategy and Operations Committee is asked to receive the Maternity Report including Ockenden II Self-Assessment.

Previously Considered By:

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

Southport and Ormskirk Hospital NHS Trust

☐ **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:**
Lynne Eastham Associate Director of Midwifery/Nursing	Lynne Barnes, Director of Nursing, Midwifery and Therapies

Southport and Ormskirk Hospital NHS Trust

Maternity Services

May 2022

Title:	Maternity Services Quarterly Update
Responsible Director:	Lynne Barnes, Director of Nursing & Midwifery
Presented by:	Lynne Eastham, Associate Director of Midwifery/Nursing

Introduction

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

This report will give an update on:
To provide updates and assurances on:

- Ockenden Report/Actions
- CNST
- Quality & Safety
- Workforce

Despite competing priorities and demands within the Trust such as A&E targets and pressures, impact and ongoing issues of Covid-19 and other key priorities, Maternity Services is high on the agenda and KPI's are presented monthly, and the quarterly report is received quarterly

1. Ockenden Report

Ockenden Final Report (March 2022)

The Independent Review of the Maternity Services at Shrewsbury & Telford NHS Trust commenced in 2017 by Donna Ockenden and was published in March 2022. An interim report was published in December 2020 (Ockenden One) in response to initial findings so that immediate actions could be taken.

The review commenced with 23 cases of concern but grew considerably to 1,486 families having their maternity care investigated, the majority who were maternity patients between 2000 and 2019.

This final report identified new themes to be shared across the maternity system as well as building upon the immediate and essential actions of the first interim report.

The findings of this report have resulted in a further 15 overarching immediate and essential actions, subdivided into 92 actions, to support service improvements for women and their families which every Trust, ICS and LMS must consider and act upon.

15 overarching immediate and essential actions,	
Workforce Planning	Preterm Birth
Safe Staffing	Labour and Birth
Escalation & Accountability	Obstetric Anaesthesia

Clinical Governance (Leadership)	Postnatal Care
Clinical Governance (Investigation and Complaints)	Bereavement Care
Learning from Maternal Deaths	Neonatal Care
Multidisciplinary Training	Supporting Families
Complex Antenatal Care	Specific Action on Continuity of Carer

S&O Immediate Response to the Report

Following receipt of the Ockenden report S&O Maternity team have responded as follows:

- Have reviewed the report and provided an overview and presentation at Trust Quality & Safety Committee and Strategy Operations Committee in April 2022.

- Completed a benchmark of S&O Maternity Services against the 92 actions using the Cheshire & Mersey Local Maternity & Neonatal Network (LMNS) standardised self-assessment template with a view to working to full implementation. ***(attached as Appendix 1)*** This self-assessment will also be shared with the LMNS to support oversight and scrutiny and prioritisation of actions required regionally.

  Whilst the self-assessment has not yet been reviewed by the LMNS we have assessed ourselves as 'Red' in the following actions:

  - **Essential Action – Training** All Trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers.
  - **Safe Staffing -** In Trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload
  - **Escalation & Accountability -** Trusts should aim to increase resident consultant obstetrician presence where this is achievable
  - **Complex Antenatal Care -** Women with pre-existing medical disorders must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have

These actions will be discussed with the LMNS with a view to sharing or contributing to developing best practice across Maternity Units in Cheshire & Merseyside

Additional responses have been as follows:

- The Clinical Director for Obstetrics and Associate Director for Midwifery/Nursing have completed presentations and briefings for Maternity staff on Ockenden findings and actions taken to date
- In May 2022, the Associate Director for Midwifery/Nursing presented at the Trust Team Brief and how learning from Ockenden can be applied to learning for all clinical services
- Suspended plans for Continuity of Carer until we are assured staffing levels are safe and meet recommendations outlined in report
- Exploring the role and expectations of a Maternity Patient Safety Specialist as recommended by Ockenden
- Focusing on implementing 24 hour 7 days a week bereavement support for families
- Undertaken a peer review with StHK with regard to benchmarking against the 92 actions and looking to opportunities on working together and to share practice

The actions taken to date are the first stage in response to the report. The next stage will be to look to costing up implementation of the actions to become compliant with local actions at the Trust, and also working with the LMNS and other providers in the region to look at the wider footprint

Ockenden One - Interim Report (December 2020)
Compliance with the Immediate and Essential Actions (IEAs)

In June 2021, to assess compliance with the 12 urgent clinical priorities set out in the interim Ockenden report, a national portal was opened to submit evidence against each criterion. The evidence was reviewed by the national and regional teams following which, a template which was 'RAG' rated showing areas of non-compliance. The Trust's final report published in December 2021.

An action plan has been developed in response to this ***(attached as Appendix 2)*** with key leads identified and is monitored via the Maternity Improvement Plan with evidence logged in Smartsheets

Work has progressed against the plan with expected completion date of August 2022

Ockenden Report - Oversight and Scrutiny

- A regional Insight Visit is planned for the 10 June 2022. This is an assurance visit by the regional maternity team. This will have an MDT approach and MVP involvement. The assurance visit will give opportunity to review any gaps within the Trust's report against the immediate and essential actions and discuss progress made to date.
- Bi-weekly support meetings with the LMNS are in place and attended by the Director of Nursing & Midwifery and Associate Director of Midwifery/Nursing. This meeting includes representatives from all maternity units in Cheshire & Mersey to support sharing lessons and collaborative working
- Direction from regional team is awaited regarding key priorities for providers and regionally (expected to be June 2022 following the East Kent report)

2. Maternity Incentive Scheme (MIS)

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

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

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

On the 06 May 2022, the CNST scheme was relaunched with extension for compliance now being the 05 January 2023

In light of the Ockenden Report some of the safety actions have been reviewed and new requirements added. These are included in Midwifery Staffing (safety action 5), Maternity Voices Partnership (safety action 7), and Safety Champions (safety action 9).

The scheme's conditions have also been reviewed and strengthened. The new conditions include the following additional requirements:

- The declaration form to be submitted to Trust Board with an accompanying joint presentation detailing maternity safety actions by the Head of Midwifery and Clinical Director for Maternity Services
- The CEO of the Trust will ensure that the Accountable Officer (AO) for their Clinical Commissioning Group/Integrated Care System (CCG/ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution.

From a financial perspective, Trusts' contributions towards year 4 of MIS will not be collected in the 2022/23 financial year but will be collected in 2023/24 financial year. Year 4 results and payments will also be shared with Trusts at the earliest in point possible in 2023/24 to enable Trusts to make best use of the funds available to them.

The revised actions are being reviewed by the Team. It is proposed that Trust Board is updated on progress accordingly.

3 Quality and Safety

3.1 Perinatal Quality Surveillance Model (PQSM)

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

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

The five principles are:

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

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

In May 2022, in response to a serious incident in Maternity, a S&O Quality Review meeting was held chaired by Marie Boles, Director of Nursing NHSI/E, and attended by Cheshire & Mersey Regional Team and key representatives from the Trust. This was to review the incident and actions being taken both immediately and longer term. Further supportive meetings are proposed monthly to monitor progress.

3.2 Clinical Outcomes/ Dashboard

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

Where Maternity Services are outliers with their peers, this is challenged by the Local Maternity System. The LMNS are streamlining procedures for reviewing spikes or outliers on the Cheshire & Mersey regional dashboard to ensure Trusts are responsive to deadlines and there is a consistent approach to what is reported on

For this reporting period there is nothing to highlight.

3.3 Perinatal Mortality

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

There were three stillbirths in this reporting period and one early loss:

Feb 2022	37+6 weeks gestation	Attended with reduced fetal movements for 12 hours	Rapid review completed Presented at SIRG For PMRT review No Harm
April 2022	22 weeks gestation	Fetal demise seen on repeat anatomy scan	Currently being reviewed No Harm
	39+2 weeks gestation	Intrauterine death/maternal death	Rapid review completed Presented at SIRG External investigation
	36+6 weeks gestation	Admission at with absent fetal movements for 24 hours	Rapid review completed Presented at SIRG For PMRT review Moderate Harm

In January 2022, Cheshire & Mersey Local Maternity System agreed a standardised regional reporting template for reporting stillbirths to Board quarterly to ensure a standardised approach. This template has been utilised for reporting perinatal mortality for Q4 of 21/22 reporting period and can be found in Appendix 3.

3.4 Serious Incidents

Never Events
There have been no never events for this reporting period.

STEIS Reportable Incidents
Serious incidents (SIs) continue to be reported monthly on the regional dashboard by all maternity providers in Cheshire & Mersey and in Lancashire and South Cumbria. SIs are also reported to the LMNS by the Trust with the Quality and Safety Surveillance Group having further oversight of all SI's across the region.

Sadly, in April 2022 there was a maternal death and still born baby. This was Steis reported and is currently being investigated. Immediate actions have been implemented including introduction of a Standard

Operating Procedure for the management of caesarean sections, capacity and demand of elective and emergency maternity and theatre work and reviewing the emergency response team. Weekly support meetings are in place and chaired by the Trust's Medical Director.

Maternity Theatre
The need to open a second emergency theatre has not been required during this reporting period. Monitoring of its usage is via DATIX reporting and follow up via the weekly patient safety meeting. Both the elective and emergency section pathway has been recently reviewed. A business case is in development to improve the theatre capacity.

3.5 Health Care Safety Investigation Branch (HSIB)

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

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

Cases to date	
Total referrals	10
Referrals / cases rejected	2 (2003-1866, MI-003565)
Total investigations to date	8
Total investigations completed	6
Current active cases	2 (awaiting consent to proceed)
Exception reporting	0

3.6 Saving Babies Lives Care Bundle (Version 2)

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

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

We have demonstrated full compliance with Saving Babies Lives Care Bundle 2, with the exception of undertaking uterine dopplers at 20 weeks gestation. This monitors blood flow to the placenta for those pregnancies identified as having increased risks such as previous stillbirths, mothers with pregnancy induced hypertension and small babies. Plans for implementation have been delayed due to scan capacity and agreeing Consultant Obstetric lead. Expected date for implementation is June 2022

Due to impact of Covid-19 there has been delays in completion of audits to demonstrate compliance to some of the guidance and these are now being actioned

CNST Safety Action 6

CNST Safety Action 6 refers to compliance with all five elements of the Saving Babies Lives version 2. In view of the amended Safety Actions in the relaunch of CNST in May 2022, a more detailed report on any changes and compliance will be provided in the next quarterly Maternity Update once a review has taken place. The Northwest Coast Saving Babies Lives quarterly bundle survey has been re implemented as of May 2022 and will be completed by S&O as requested

3.7 Care Quality Commission CQC Review

Our current ratings are:

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

The CQC has completed the 'Maternity Relationship Management Relationship Questions' proforma and all evidence is being collected on SMART sheets as a central point of access. There is a plan for a SOCAS inspection on Maternity with external support from an external team currently being arranged.

3.8 Safety Champion Report

The aim of Safety Champions is to ensure seamless communication from 'floor to board' to ensure Board focus on Maternity issues and improving safety and outcomes. Our recently recruited Non-Executive Director Safety Champion attended her first Maternity Safety Champions meeting in February 2022.

The Terms of Reference have been revised and there has been an agreement for alternate monthly Safety Champions walkabouts to speak with staff and women and their families. The first walkabout took place in May 2022.

The Maternity Safety Champions are also completing a self-assessment toolkit designed for Maternity Services by NHSE/I to support and empower the role of Safety Champion and findings will be discussed at the Safety Champions meetings with a AAA Highlight Report of the outcome submitted to Clinical Effectiveness Committee

4. Workforce: Maternity and Neonatal Staffing

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

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

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge is notified. The midwife in charge will then determine whether midwifery staffing is the cause, and the action that is needed.

The following are the recommended red flags:

- Delayed or cancelled time critical activity.
- Missed or delayed care (delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (e.g., diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of two hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (e.g., sepsis or urine output). Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

S&O Maternity Services *'Standard Operating Procedure for Maternity Services Staffing'* reflects this recommended guidance. This data is collected via the DATIX incident reporting system. Any incidents are cross referenced against staffing levels and any incidents regarding staffing levels discussed at weekly patient safety meeting. For this reporting period the red flag data demonstrated an issue *Delay of 2 hours or more between admission for induction and beginning of process (2).* This related to high acuity and/or sub optimal staffing levels. These incidents have been reviewed and no harm was caused.

It has been noted that whilst DATIX reports have been completed for staffing levels these have focused on *'insufficient midwives' (5)* rather than specific red flag indicators. This has been discussed with the maternity team to ensure they have an understanding of requirements of completion.

Maternity Unit Closure
During this reporting period the Maternity Unit has not closed or requested a divert.

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

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

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

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

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

Birthrate Plus

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

Findings

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

Table 1

Category	Need	S&O Maternity Services Case Mix	
		2019	2021
1	Normal labour and outcome. These women are usually midwifery led care	4.1%	4.1%
2	This is also a normal outcome very similar to Category I, but may include perineal tear, longer labour or IV Infusion	14.1%	14.1%
3	Moderate risk/need such as Induction of Labour, instrumental deliveries, and continuous fetal monitoring.	30.8%	23.6%
4	More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight and women having epidural pain relief	23.2%	27.5%
5	This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy	27.8%	30.7%

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

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

The recommended establishment is based on a 'traditional' way of working and does not incorporate Continuity of Carer caseload teams.

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

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

Percentage for Provision of One to One Care in Labour
One to one care is when a woman is cared for by a Midwife who is looking just after her. Maternity services aim to achieve 100% one to one care in labour, and this is monitored via the Maternity Information System and where this cannot be provided a DATIX incident report is completed which is recorded as a 'red flag'. During the reporting period there have been no occasions when one to one care could not be provided

Continuity of Carer (Better Births)
Plans were in place to roll out two continuity of carer teams in May 2022, however in view of Ockenden (2022) the roll out has been postponed until we are assured that staffing levels are safe, consistent and we are in a position to commence

Consultant Obstetricians
The Consultant Obstetric & Gynaecology team are now fully established with 12 Consultants now in post however the medical model will need further review following the Ockenden 2 recommendations.

Neonatal Nursing Workforce
Neonatal staffing is aligned to BAPM standards and monitored by the Regional Neonatal Operational Delivery Network. Whilst staffing levels remain safe a dedicated supernumerary shift coordinator is not always able to be rostered. The Regional Neonatal Network has made a commitment to permanently funding neonatal nursing posts across the region where these do not meet the recommendations and so additional funding has been provided to recruit 4wte Band 6 neonatal nurses to meet this standard. 2wte nurses are commencing in post in June 2022 and 2wte Nurses will be commencing in post in September 2022. The Associate Director for Midwifery & Nursing and the Matron for Paediatrics continues to work collaboratively with the Neonatal Network

Next Steps/Priorities
The following are priorities for the next three months:

- Complete improvement plan for Ockenden 1 (2020)
- Work towards actions/recommendations of Ockenden Final Report (2022)
- Work towards completion of CNST Year 4 Safety actions
- Prepare for regional Insight Visit on the 10 June 2022
- Continue to work collaboratively with LMS and MVP's
- Await direction from regional team regarding key priorities (expected to be June 2022 following East Kent report)

Appendices:

Appendix 1 Gap Analysis **Ockenden Essential Actions - April 2022**	

1: WORKFORCE PLANNING AND SUSTAINABILITY				RAG Rating	Comments / Lead Progress
1: WORKFORCE PLANNING AND SUSTAINABILITY	The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	**1**	The investment announced following our first report was welcomed. However, to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.		Neonatal Service Staffing Review undertaken and bid for national monies successful for nursing. Tier 2 doctor allocated to NNU but at weekends long day doctor covers paediatrics as well. Anaesthetic staffing review to be undertaken: Medical & Anaesthetic staffing review to be undertaken: **Leads Clinical Directors**
		2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.		Birthrate Plus completed Year 3 CNST achieved TNA compliance to be agreed with LMNS. To include uplift in staffing levels review **Leads ADOM/Clinical Directors**
		3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.		Local uplift to be calculated and compared to BR+ staffing requirements. To be included in staffing review. **Leads ADOM/Clinical Directors**
		4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.		National review awaited of BR+ Tool.
Essential Action: Training					

	We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	**5**	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.		National Programme being developed
		6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.		In place supported by preceptorship package and regional Midwifery Retention Support post
		7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.		Shift Coordinators attend Human Factors training as part of mandatory training. National Programme awaited.
		8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.		Review orientation package with focus on individual needs. Work in collaboration with StHK to develop **Lead Matron for Maternity (In patients)**
		9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.		Core of Senior Midwives with competency in place In house training Need to look at external programme for training/competencies

		10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience		Gap analysis to be completed Succession planning programme to be developed and include reference to leadership roles. **Leads Workforce Leads/ Senior Maternity Team**
		11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.		Regional work re MMN ongoing with training available. National update awaited.
2: SAFE STAFFING					
2: SAFE **STAFFING**	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	**1**	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.		C&M Escalation &V Diver Policy in lace Escalation processes in place and any diverts are StEIS reported. Staffing related incident forms reviewed daily and when investigating incidents. Manager of the Day Helicopter role Staffing levels reported at least daily to Trust Staffing meeting and included in Trust Bed management meetings. Reported monthly with DON&M oversight. Staffing Levels included in Trust Board report attended by Safety Champions Daily Sit Reps provided to LMNS
		2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.		Escalation in-house at present therefore review whether SOP to be developed and agreed at Board to formalise process. **Leads: Clinical Director/AMD**

		3	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.		Specific job description in place with personal specification. JD has been through matching process. Role is Supernummary
		4	All trusts must review and suspend, if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.		Prior to Ockenden report planning to implement two COC teams. Until assured of safe staffing levels this has been suspended Requirement to review Continuity of Carer and ensure building blocks to support are in place with regards to safe staffing **To await staffing reviews and guidance from LMNS**
		5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction		Final position statement on this to be formalised nationally -
		6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.		Job plans review in progress **Leads ADO/AMD**
		7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.		Practice Development Midwife in post - guidance re what wte requirement and role for training required and skill mix **Leads Matrons for Maternity**
		8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.		Some Band 7 and Band 8 attending leadership course and have mentor Process not formalised and agreed within the Trust**.** Look to working with StHK **Lead Training & Development Lead**

		9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.		Engagement, listening events in progress, communication pathways and guidelines in place Rotational posts between unit and community setting Senior midwife meeting joint with all leads.
		10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.		To check RCOG guidance for management of locums to confirm current process is robust **Leads ADO/DM**
3: ESCALATION AND ACCOUNTABILITY					
3: ESCALATION **AND ACCOUNTABILITY**	Staff must be able to escalate concerns if necessary. There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	**1**	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals		Guidance needs review and development of robust process. **Leads Maternity Triumvirate**
		2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role		Mechanisms in place need review to ensure robustness **Leads Clinical Director**
		3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable		Ward rounds take place at weekend, twice daily however resident consultant presence not in place 24/7. Needs further review to decide future mode and agreement at Trust Board. **Leads Clinical Director/AMD**
		4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit		Guidance in place: Responsibilities of the Consultant on call (MSOP 94) Responsibilities of Consultant of the Week (MSOP 95)

		5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.		Partial guidance in place including Maternity Escalation & Divert Policy and Helicopter Manager of the Day role and bleep holder Currently no dedicated maternity on call rota in place - to be reviewed - refers to Trust 1st and 2nd on call **Leads ADOM**
4. CLINICAL GOVERNANCE - LEADERSHIP					
4 : CLINICAL GOVERNANCE-LEADERSHIP	Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	**1**	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans		3 monthly reporting to Board but needs further discussion regarding more robust oversight Standardised reporting template Exception reports to Board as required **Leads: DONM/MD & ADOM/CD**
		2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board		Self-assessment tool completed with actions in place not yet presented to Board as currently being reviewed following Ockenden. Updated self-assessment to go to Board in Aug 2022 **Leads ADOM/CD**
		3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services		To understand role and remit of patient safety specialist and recruit into position **Leads Associate Director for Governance**
		4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities		In self-assessment tool to include neonates and anaesthetists. Only obstetric time currently supported. **Leads Clinical Directors for each speciality**
		5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		Staff currently trained however review of staff groups is required and additional training to be identified as required **Leads: Associate Director for Governance/Training Leads**

		6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.		Multidisciplinary Leads in place for midwifery this is currently Matrons since retirement of Consultant MW. Consultant MW JD in AFC process then to recruit **Lead: ADOM**
		7	All maternity services must ensure they have midwifery and obstetric co-leads for audits		Audit plan in place/ Audit Leads identified Need to ensure midwifery attendance and involvement at audit meetings **Lead ADOM/Matrons**
5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATING AND COMPLAINTS					
5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	**1**	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.		Robust process for reviewing documents before they are sent to families. Meet with families and read through reports with them
		2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.		Training Needs analysis amended in response to lessons learnt and/or additional training implemented
		3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.		Any change in practice is recorded and included in Annual Audit Cycle to ensure embedding
		4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.		Learning put in place immediately. - evidenced on individual report
		5	All trusts must ensure that complaints which meet SI threshold must be investigated as such		Clear MDT process in place Includes discussion with family and Duty of Candour SIRG panel to support decision making
		6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent		Complaint response processes in place however MVP to review and to identify improvements to further strengthen the process **Lead Quality & Audit MW/MVP Chair**

		7	Complaint's themes and trends must be monitored by the maternity governance team.		Process for identifying themes and trends needs review and to be communicated to all staff. **Leads Associate Director for Governance/Quality & Audit MW**
6: LEARNING FROM MATERNAL DEATHS					
6: LEARNING FROM MATERNAL DEATHS	Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	**1**	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.		Guidance awaited nationally
		2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.		Guidance awaited nationally
		3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.		Process for learning from reviews in place and serious incidents shared with the LMNS Process for the LMNS sharing learning needs further embedding
7: MULTIDISCIPLINARY TRAINING					
7: MULTI- **DISCIPLINARY TRAINING**	Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG	**1**	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.		MDT Team attend Multidisciplinary training however gaps with Anaesthetic attendance. Midwifery and middle grades involved in audit - need to neonatal as well Attendance from midwifery team not formalised **Leads Audit Lead, Clinical Directors and Matrons**
		2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.		SBAR included all training including neonates. Audit of process on Annual Audit Plan. Need assurances that training included in MDT training **Leads Training Leads for Specialities**

	training and emergency skills training	**3**	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.		Human Factors training included in Skills Drills Guidance re content awaited from LMNS **Leads LMS**
		4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.		PROMPT includes all of these topics however all staff groups including neonatal staff to be included in PROMPT Difficulties with Anaesthetics attending for MDT training **Leads: Training Leads for Specialities**
		5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.		H&W have full package of support available and ability to purchase external support as required. PMA team in place in process of external OD support for Maternity Team
		6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.		Midwife Surveillance Lead and Obstetric Lead in place to facilitate training. Training monitored monthly. Midwives whose training has expired do not provide antenatal/delivery suite care
		7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory		Midwives whose training has expired do not provide antenatal/delivery suite care Clinical Director implementing same process **Leads Clinical Director/Matron (In Patient)**
8: COMPLEX ANTENATAL CARE					
8: COMPLEX ANTENATAL CARE	Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide	**1**	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.		Do not currently offer routine preconception care. Will discuss regionally at what can be offered - will look at what high risk team could provide. **Lead Clinical Director/ADOM**

	services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	**2**	Trusts must have in place specialist antenatal clinics dedicated to accommodating women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019		Currently being implemented pending job planning **Leads Clinical Director/Matron for OPD**
		3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.		Guidance in place. Need to include on Annual Audit Cycle to assure of compliance
		4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.		In place but need to include on Annual Audit Cycle to assure of compliance **Leads Diabetic Consultant & Midwife Leads**
		5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).		Guidance in place to support this practice - specific clinic allocation to be reviewed. **Leads Clinical Director & Matron for OPD**
9: PRETERM BIRTH					
9: PRETERM BIRTH	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the	**1**	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.		Guidelines in place with clear guidance. Pathways of care with tertiary centre

	management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	**2**	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.		Guidance discussed at time dependent on individual situation. Guidance in place re type of monitoring as per gestation of pregnancy. Pathways of care with tertiary centre. Inuterine transfer policy in place as required
		3	Discussions must involve the local and tertiary neonatal teams, so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.		Pathways of care in place with tertiary centre to support local discussions Need to review guidance to assure of process for discussion **Leads: Clinical Directors for Obstetrics & Neonatal Services**
		4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.		In utero transfers are reviewed at Patient Harm meeting. Need assurances regarding audit process and discussions **Lead Clinical Director for Obstetrics and Neonatal Services**
10: LABOUR AND BIRTH					
10: LABOUR AND BIRTH	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	**1**	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made		Guidelines in place supported by audit
		2	Midwifery-led units must complete yearly operational risk assessments.		Not Applicable - as no Midwifery Led Unit
		3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan		Not Applicable - as no Midwifery Led Unit
		4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times		Comprehensive information provided and procedure in place Requires review to include transfer times

			to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust		**Leads Matron for OPD & Community**
		5	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.		Guidelines in place Need to include escalation and accessing mutual aid **Lead Clinical Director**
		6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs		Purchase of system currently being undertaken. Procurement In progress. **Lead Maternity Matron for In patient**
11: OBSTETRIC ANAESTHESIA					
11: OBSTETRIC ANAESTHESIA	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.	**1**	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia		Some conditions generate DATIX incident report and review via Patient Safety Meeting Offer for debrief postnatally in place. Need to review guidance and process for referral **Lead Clinical Director for Anaesthetics**
		2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.		Currently being undertaken on ad hoc basis Need to review guidance to ensure all criteria included with audit of same. **Lead Clinical Director for Anaesthetics**
		3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC		Documentation is recorded in maternity record however need to review audit process. **Lead Clinical Director for Anaesthetics/Audit Lead**

	Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	**4**	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.		National guidance awaited.
	Obstetric anaesthesia staffing guidance to include:	**5**	**Obstetric Anaesthesia Staffing Guidance to include:**a) The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.		Obstetric anaesthesia staffing guidance to be reviewed to ensure inclusion of recommendation **Lead: Clinical Director for Obstetric Anaesthetics**
		6	b) The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.		Obstetric anaesthesia staffing guidance to be reviewed to ensure inclusion of recommendation **Lead: Clinical Director for Obstetric Anaesthetics**
		7	c) The competency required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments.		Obstetric anaesthesia staffing guidance to be reviewed to ensure inclusion of recommendation **Lead: Clinical Director for Obstetric Anaesthetics**
		8	d) Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		Participation of anaesthetists in Delivery Suite rounds included in guidance To ensure included in audit of compliance
12: POSTNATAL CARE					
12: POSTNATAL CARE	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant	**1**	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward		To ensure this is included in Standard Operating Procedure **Lead Maternity Matron for In patients/ Clinical Director**

	review. Postnatal wards must be adequately staffed at all times	**2**	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum		To ensure this is included in Standard Operating Procedure **Lead Maternity Matron for In patients/ Clinical Director**
		3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary		To ensure this is included in Standard Operating Procedure **Lead Maternity Matron for Inpatients/ Clinical Director**
		4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.		BR + assessment completed. Acuity tool in place. Staffing Levels monitored each day via 'Helicopter Role' Sub optimal staffing levels reported via DATIX Escalation procedure in place
13: BEREAVEMENT CARE					
13. BEREAVEMENT CARE	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	**1**	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.		Bereavement midwife in post but works Monday to Friday and not full-time hours Midwives trained to support including shift coordinators Need to explore option for increasing to 1.0wte cover and development of bereavement champions in teams. to cover available 24/7 **Lead ADOM**
		2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.		Need to assess numbers of staff trained and competent **Lead Bereavement Leads**
		3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome		Process in place
		4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National		Pathway in place and in use.

			Bereavement Care Pathway		
14: NEONATAL CARE					
14: NEONATAL CARE	There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	**1**	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.		Guidance in place from ODN
		2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.		Exception report requested by C&M Regional network but on ad hoc basis and not formalised Guidance awaited from LMNS **Lead LMNS**
		3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.		In utero procedure in place to support transfer of premature labours. Need to check if Audits completed If not to include on Annual Audit Cycle **Lead Audit Lead/Clinical Director/Matron for In Patients**
		4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example, senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.		Regional meetings in place re sharing of best practice however work to be developed on identifying secondment/s and shadowing with support from ODN **Lead ODN/Matron for Paediatrics/Clinical Director**
		5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.		Review being undertaken by ODN **Lead ODN**
		6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during		Evidence of this happening in practice to be confirmed and to be included in SOP

			the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required		**Lead Clinical Lead for Neonates**
		7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.		NLS Guidance in place Neonatal team to review guidance to assure on process **Lead Clinical Lead/Matron for Neonates**
		8	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.		Tier 2 doctor allocated to NNU but at weekends long day doctor covers paediatrics as well Action plan completed in line with CNST requirements **Lead Clinical Director for Paediatrics & AMD**
15: SUPPORTING FAMILIES					
15: SUPPORTING FAMILIES	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision. Maternity care providers must actively engage with the local community and	**1**	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.		Perinatal mental health team in post. Need to assess provision in place and what is required **Lead PMH Leads**
		2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.		Perinatal mental health team in post. Need to assess provision in place and what is required **Lead PMH Leads**

	those with lived experience, to deliver services that are informed by what women and their families say they need from their care	**3**	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care		Perinatal mental health team in post. Need to assess provision in place and what is required **Lead PMH Leads**

Appendix 2

SOUTHPORT & ORMSKIRK HOSPITAL NHS TRUST

Maternity Services – OCKENDEN IMPROVEMENT PLAN

RED	Little or No Progress Made
AMBER	Moderate Progress Made
YELLOW	Actions Almost Completed
GREEN	Completed

No	Current Situation	Key Actions	Lead Officer	Progress	Date for Completion	RAG
Immediate and Essential Action 1: Enhanced Safety						
Q1	Maternity Dashboard to LMS every 3 months	SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	LMNS	Procedure in place for managing regional maternity dashboard and process to be followed if provider is an outlier	**April 2022**	**Green**
Immediate and Essential Action 2: Listening to Women & Their Families						
Q11	Non-executive director who has oversight of maternity services	Evidence of how all voices are represented	NED/Safety Champions	Awaiting induction of MVP chair	**August 2022**	**Amber**
		Evidence of link into MVP and any other mechanisms	NED/Safety Champions	MVP chair engaged with Safety Matron	**August 2022**	**Amber**
		Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	NED/Safety Champions	Newly appointed NED Safety champion In post Feb 2022 Commenced maternity walkabouts in May 2022. Evidence of process and embedding still needed	**August 2022**	**Green**
Immediate and Essential Action 3: Staff Training & Working Together						
Q17	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	Associate Director of Midwifery	Quarterly reporting to LMS now in place	**Dec 2021**	**Green**
		Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	Associate Director of Midwifery	Quarterly reporting to LMS now in place	**Dec 2021**	**Green**

Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Evidence from Budget statements.	CBU Finance Lead	Report being prepared by Finance Lead to evidence ring fenced monies	**March 2022** Evidence sent from Finance to the LMS in May 2022	**Green**
		MTP spend reports to LMS	CBU Finance Lead	Report being prepared by Finance Lead to evidence	**March 2022** Evidence sent from Finance to the LMS in May 2022	**Green**
Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA. Issue with Anaesthetist and Obstetricians attending Newborn Life Support Obstetricians need to attend Preterm Birth & Personalised care	Associate Director of Midwifery/Clinical Director	Trajectories and compliance sent out via E Mails monthly to team by PDM Discussed at Mat Care Forum Action Plan for attendance of clinical team in place shared with LMNS	**March 2022**	**Green**
Q23	Joint multi-disciplinary training is vital - assurance that a MDT training schedule is in place	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	Associate Director of Midwifery/Clinical Director	Trajectories and compliance sent out via E Mails monthly by PDM to team Discussed at Mat Care Forum	**March 2022**	**Green**
Immediate and Essential Action 4: Managing Complex Pregnancy						
Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Agreed Pathways of care for Maternal Medicine Specialist Centres	LMS	Work ongoing but led by LMS Maternal Medicine Network went 'live' in April 2022 Referral process in place Regular MDT's that can be accessed by all Trusts	**March 2022**	**Green**
		Criteria referrals for Maternal Medicine Specialist Centres	LMS	Work ongoing but led by LMS Work ongoing but led by LMS Maternal Medicine Network went 'live' in April 2022 Referral process in place Regular MDT's that can be accessed by all Trusts	**March 2022**	**Green**
Immediate and Essential Action 5: Risk Assessment Throughout Pregnancy						

Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	Review and discussed and documented intended place of birth at every visit.	Associate Director of Midwifery	6 monthly Audit completed – Antenatal Risk Assessment Project Number 20-414	**Feb 2021**	**Green**
Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	Associate Director of Midwifery	VBAC clinic in place only at this time Women referred to Consultant team if required Need to extend offer to birth options clinic Lead Midwife identified Referral process needs including in guidance	**July 2022**	**Amber**
		Out with guidance pathway.	Associate Director of Midwifery	Standard Operating Procedure for Antenatal low risk women in place – needs amending	**June 2022**	**Amber**
		SOP that includes review of intended place of birth.	Associate Director of Midwifery	Standard Operating Procedure for Antenatal low risk women in place – needs amending	**June 2022**	**Amber**
Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	Associate Director of Midwifery	6 monthly Audit completed – Antenatal Risk Assessment Project Number 20-414 Separate dedicated clinics effective from June 2022 – Preterm labour, Rainbow, GROW and medical disorders – included in Consultant job plans	**Feb 2022**	**Green**
Immediate and Essential Action 6: Monitoring Fetal Wellbeing						
Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	Associate Director of Midwifery/Clinical Director	Evidence needs strengthening specifically from Obstetric lead	**July 2022**	**Amber**
		Incident investigations and reviews	Associate Director of Midwifery/Clinical Director	Leads attend patient safety meetings s required and are included on panel for incident reviews specifically from Obstetric lead	**May 2022**	

Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	Associate Director of Midwifery/Clinical Director	Evidence needs strengthening specifically from Obstetric lead	**May 2022**	**Green**
		Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	Associate Director of Midwifery/Clinical Director	Evidence needs strengthening specifically from Obstetric lead	**July 2022**	**Amber**
		Keeping abreast of developments in the field	Associate Director of Midwifery/Clinical Director	Evidence needs strengthening specifically from Obstetric lead	**July 2022**	**Amber**
Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	Associate Director of Midwifery/Clinical Director	Trajectories and compliance sent out via E Mails monthly to team Discussed at Mat Care Forum	**March 2022**	**Green**
Immediate and Essential Action 7: Informed Consent						
Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	Maternity Voices Partnership/ Associate Director of Midwifery	MVP chair resigned so no progress New chair appointed and meetings commenced in February 2022 to discuss way forward	**August 2022**	**Amber**
Q41	Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.	Audit Lead/Quality Midwife	On audit plan ready to progress	**August 2022**	**Amber**
Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	Audit Lead/Quality Midwife	On audit plan ready to progress	**August 2022**	**Amber**
Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy	Co-produced action plan to address gaps identified	Maternity Voices Partnership/ Associate	MVP chair resigned so no progress New chair appointed and meetings commenced in	**August 2022**	**Amber**

	and posted on the trust website.		Director of Midwifery	February 2022 to discuss way forward. Workplan in draft		
		Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	Maternity Voices Partnership/ Associate Director of Midwifery	MVP chair resigned so no progress New chair appointed and meetings commenced in February 2022 to discuss way forward	**August 2022**	**Amber**
Workforce						
	Birthrate Plus	Most recent BR+ report and board minutes agreeing to fund.	Associate Director of Midwifery	Birthrate Plus report completed to Board after Workforce Committee Report evidences full compliance with Birthrate Plus	**March 2022**	**Green**
	Midwifery Leadership	A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service	Associate Director of Midwifery/Director of Nursing & Midwifery	Associate Director of Midwifery in post No Director of Midwifery in post Job Description to be written and to AFC process	**August 2022**	**Amber**
		Deputy Head of Midwifery in post	Associate Director of Midwifery/Director of Nursing & Midwifery	No Deputy Head of Midwifery in post Job description in place Processed via AFC Not recruited into. To review September 2022	**August 2022**	**Amber**
		Consultant Midwife in post	Associate Director of Midwifery/Director of Nursing & Midwifery	Consultant Midwife recently retired from post JD being reviewed prior to recruitment process	**June 2022**	**Amber**
NICE Guidelines						
Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented	Audit to demonstrate all guidelines are in date. Evidence of risk assessment where guidance is not implemented.	Trust Audit Lead	CIRIS system records NICE compliance NICE status reported monthly via the CBU governance meetings This is then escalated to our clinical effectiveness committee where required If not compliant this is risk assessed	**March 2022**	**Green**

				Audit completed		

NHS
North West Coast
Clinical Networks

Cheshire and Mersey Maternity Quarterly Perinatal Board Report

Southport & Ormskirk Hospital NHS Trust

Contents

PROVIDER:	SOUTHPORT & ORMSKIRK HOSPITAL NHS TRUST
COMPLETED BY:	**CATHERINE BOYLE MIDWIFE**
DATE COMPLETED:	**16/05/2022**

NHS
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1. BACKGROUND and INTRODUCTION

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

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

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

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

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

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

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

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

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

2. EXECUTIVE SUMMARY: Key findings section

This report details the information in relation to the Perinatal Mortality for Quarter 4 2021-2022 (January-March)

Quarter 4 stillbirth rate (including termination of pregnancy)

During quarter 4 the stillbirth rate was 3.45 per 1000

This is inclusive of one case of a termination of pregnancy at 31 weeks gestation due to a fetal abnormality. This case is excluded from review using the Perinatal Mortality Review Tool.

Quarter 4 neonatal mortality rate is 0 /1000

There were no neonatal deaths at ODGH during this timeframe and therefore the neonatal mortality was 0.

Progress on PMRT Reports & Action Plans

Update on reviews for Quarter 3

- During Quarter 3 there were 3 reviews. All the PMRT meetings have taken place
- Two reports have been finalised and one report is nearing completion.
- During Quarter 3 feedback was received from one case reported to HSIB during May 2021. The HSIB report has been finalised and presented at the Trust SIRG meeting and the action plan agreed. The action plan in relation to this review has 2 outstanding actions identified including the update of Patient Information to include more detailed information about mode of delivery, and the facilitation of human factors training for the Maternity Team. Both actions are currently progressing on schedule.

Update on reviews for Quarter 4

- During Quarter 4 Southport & Ormskirk maternity team have inputted in to a Liverpool Woman's Hospital PMRT case review. The details on the actions identified can be found in section 3.

- During Quarter 4 there was one case reviewed and this report is currently being drafted as per table below

Date of Incident	Type of Incident	A/N Care Provider	Date Reported to MBRRACE	Date PMRT commenced	Date Report Published	Date Parent's Sent
11/02/2022	Antenatal IUD	ODGH	16/03/2022	Review meeting 06/04/2022	In progress	

- At the time of reporting there are no cases awaiting review from Quarter 4

3. DASHBOARD AND BENCHMARKING

Table. 1 Stillbirths and neonatal death dashboard

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	TOTAL
Total stillbirths						1	0	2	1	0	1	0	
Stillbirths (excluding terminations)						1	0	2	1	0	1	0	
Births						221	205	211	191	196	174	209	
Stillbirth Rate/1000 births													
Stillbirth Rate (excluding TOP)/1000													
	Apr-21	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Total**
Discharges						0	0	0	0				
Total Neonatal Mortality						0	0	0	0	0	0	0	
Deliveries						217	205	213	192	192	170	204	
Neonatal Mortality Rate/1000 deliveries						0	0	0	0	0	0	0	

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

Quarter	Stillbirth Rate	NMR
Q1		
Q2		
Q3		
Q4	1.73	0

Table 3: Stillbirth and Neonatal Mortality by Cause (*Quarter 4 21/22*)

We are awaiting availability of information to complete this section for Quarter 4.

Update from Quarter 3

Please see table below for the cause of death from the cases in Quarter 3 for completed reviews

Overall 3 cases in Quarter 3

(Overall cases for Quarter 4 will be reported on next quarter)

Reported cause of death (based on CESDI 2018)	No.	In-utero transfers
Stillbirth		
Termination of pregnancy for fetal abnormality		
Fetal abnormality	1	
Pre-eclampsia		
Antepartum haemorrhage		
Medical disorder		
Multiple pregnancy		
IUGR		
Mechanical		
Infection		

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

4. MORTALITY REVIEWS AND KEY THEMES

At the PMRT panel review all areas of care are graded for the mother and baby up to the point of antenatal / intrapartum death.

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

Grading

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

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

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

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

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

Nil applicable for Quarter 4

Table 5. Reasons for review panel grading C&D *(example reasons given below)*

Review panel grading	Reason for grading	Level of investigation (StEIS/Level 2/Level 1/PMRT with external)	HSIB (yes/no)	Learning	QI plan aligned to theme
Nil cases where grading C & D were applicable					

5. PMRT PANEL ATTENDANCE

Case	External Obstetrician	External Midwife	External Neonatologist
Case 1 06/04/2022	✓	x	N/A
% external representatives	100%	0%	N/A

6. INTRAPARTUM & TERM STILLBIRTHS

- There were 0 intrapartum stillbirths in Quarter 4
- There was 1 term stillbirth in Quarter 4

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

- There were 0 term neonatal deaths in Quarter 4

8. SAFEGUARDING/UNBOOKED AND LATE BOOKERS

- One woman in Quarter 4 had safeguarding issues identified. In this case, the woman was booked for care and delivery at Ormskirk DGH. This woman had a history of domestic abuse and there was referral to Children's Social Care and input and support from the Named Midwife for Safeguarding due to a number of non-attendances for antenatal appointments.

9. SOCIO-DEMOGRAPHICAL

1. Birth at ODGH	G2P1 34 years BMI 28.3 Booked for Consultant Led Care due to previous history of preterm birth.

10. LANGUAGE BARRIER

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

11. SMALL FOR GESTATIONAL AGE

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

12. FETAL ABNORMALITIES DEATHS (known and unknown)

- In one case there was a diagnosis of Zellweger Syndrome and following review in both the local Fetal Medicine Clinic and the Liverpool Woman's Hospital, the woman made the decision for a termination of pregnancy which was undertaken at 30+6 weeks gestation.

13. LEARNING FROM DEATHS

Update on learning from Quarter 3 report – completed reviews

Issue	Action	Implementation plan
Intrauterine death due to a sacro-coccygeal tumour - delivered at 24+0 weeks gestation		
Ineffective communication of management between LWH and the Trust	Update to the Maternity Standard Operating Procedure 55: Referral for Fetal Abnormality	Screening Midwife to update the MSOP 55
	Communication of update to the Maternity Standard Operating Procedure 55: Referral for Fetal Abnormality to the Fetal Medicine Team at LWH	Screening Midwife to communicate the update to the Fetal Medicine Team at LWH

Issue	Action	Implementation
LWH PMRT Twin pregnancy referred to LWH due to fetal abnormality in 1 twin – birth at LWH		
The chorionicity was not documented on all the ultrasound scan reports	Lead Sonographer to advise all ultrasound practitioners that the documentation of chorionicity to be reported in the free text section of all ultrasound reports for multiple pregnancies.	Importance of documentation highlighted to all staff undertaking ultrasound scans
As above	Lead Sonographer to advise if the sonographer cannot determine chorionicity at 1st trimester ultrasound scan then the woman should be referred to the Fetal Medicine Clinic	Importance of determining chorionicity and referral to the Fetal Medicine Clinic if unable to do so highlighted to all staff undertaking ultrasound scans

As above	To provide regular training about assessment of chorionicity	Staff training implemented
As above	To conduct regular clinical audit to evaluate the accuracy of determining chorionicity and amnionicity	Audit identified on the audit forward plan

14. LEARNING / GOOD PRACTICE.

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

15. HORIZON SCANNING

As part of intelligence gathering the following sources were used for horizon scanning: CQC, NCEPOD,NHS Digital, NHSE/I (includes LMS), NHSR, PHE, RCOG, RCM, MBRRACE-UK, HSIB, Ockenden, CNST Maternity Incentive Scheme

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ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Workforce Committee
MEETING DATE:	24 May 2022
LEAD:	Lisa Knight

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

N/A

ADVISE

PDR Compliance
PDR rates have reduced again in month. For assurance, the Committee were advised that an entirely new approach will be adopted to increase compliance as current methods are not working.

Medical Vacancies
Vacancies in the Medical staff group are improving. This is testament to the Recruitment Team, Nurses and Medical staff. Work continues for the 'hard to fill' posts.

HCA Vacancies
There remains a gap in HCA vacancies. Recruitment events and open days have been arranged to specifically hire HCA's. There is a national pay issue related to HCA's as the NHS salary for these staff members is lower than competitive companies. The Trust's aim therefore is to advertise the HCA role as a career pathway.

CQC Insight Report
The members were advised of the March 2022 CQC Insight intelligence report, detailing the metrics specifically related to workforce.

ASSURE

Staff Story: International Recruit
The Workforce Committee heard from Ms Sanjumol Yohannan, Band 6 Sister, presenting her story on joining the organisation through the International Nurse Recruitment programme. Ms Yohannan explained the high amount of support she received when joining the Trust and to complete her OSCE exam. She noted a few areas the Trust could improve upon such as housing issues and skill mix. The membership were energised and uplifted by the positive story and thanked Ms Yohannan for her honesty.

Listening Plan
The members were assured by the presentation.

CORP 19 – Policy for Recruitment and Management of Volunteers
The Workforce Committee approved the policy.

New Risks identified at the meeting: None

Review of the Risk Register: Yes

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Finance, Performance, and Investment Committee
MEETING DATE:	23 May 2022
LEAD:	Jeff Kozer

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Due to the overall national position for 2022/23 a further plan submission is required by the 20 June by NHSE/I with a potential ICS submission being due before that date. This submission falls pre the next FP&I and SOC and therefore will require delegation to the Chief Executive and Chairman to sign off the revised plan.
- A&E performance in April 2022 improved compared with March 2022 but below the national standard. Compares positively to peers and top quartile nationally. The Trust has continued to see improvement with 12 hour duration breaches.
- Whilst still below the standard, the Trust has seen improvements across all cancer metrics.

ADVISE

- The month 1 financial position is £1.8m deficit, which is in line with plan. Given the methodology for calculating ERF has not been finalised the Trust has assumed full achievement of the financial target. The CIP target for month 1 is £650k. This is showing as being achieved though £370k of the target has been met through mitigations. Work is underway to develop plans to meet the target. The current cash position is £12.5m with BPPC performance at 97%.
- Improvements to the network are being planned, pending the longer-term network replacement. The cross-site switches are going to be replaced with like for like switches and the current VPN will be replaced. Detailed plans are being drawn up to be able to agree the dates, but the aim is to have this completed by the end of June. Some pre switch replacement work is planned the week commencing 23 May to improve the resilience of the network.
- A peer review was undertaken of the costings systems between Southport and Ormskirk and St Helens and Knowsley which concluded there was a mapping issue with regard to non-elective care at Southport and Ormskirk which will be rectified in the next submission. The likely outcome is that it will increase the Trust index.
- Model Hospital has been updated with the 2020 National Cost Collection (NCC) data. Services that continue to flag holding efficiency opportunities are Trauma & Orthopaedics, General Surgery, Rheumatology and Ophthalmology, which require further investigation.
- The number of Covid19 positive patients continues to decrease and were reported at 15, 9,5% of non-elective admissions 1+ day LOS vs plan of 1.5%.
- A copy of the recommendations from the recent ECIST visit were presented to the Committee. Further updates will be shared with the committee in future meetings.
- The Orthodontic service is in the process of safely transferring all patient groups. The Trust continued to work with NHSE to support the smooth transition of these patients to alternative patients, the in-treatment cohort is expected to have been moved by end of June. The service has received an increased number of patient complaints and letters from local MPs.

ASSURE

- Orders have been placed for the fire alarms and compartmentation to continue the fire safety work at both Southport and Ormskirk. Work has commenced on the theatre storage scheme as part of the Ormskirk fire safety work.
- The Cyber security service transferred to StHK as of 01 May and the process is under way to transfer Information governance to StHK.
- The Data Security Protection Toolkit update was presented. 106 of the 110 items have been submitted. PEN tests are due 06 to 13 June, but no issues anticipated. The only issue is in relation to training compliance and being able to achieve 95% compliance by the end of June.
- An implementation date of the 19 September 2022 has now been agreed for the North Mersey Acute Stroke Pathway. It has also been agreed that should there be any unexpected issue with the consultant availability between now and September at S&O this would be supported by LUHFT.
- Improvements reported last month in endoscopy continued in April 2022, achieving 119% plan, 143% 2019/20 levels.

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:	May 2022
LEAD:	Anne-Marie Stretch

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Petition to change Children's A&E Opening Times – 03.05.22

A petition had been instigated by a parent who is a local resident about the opening times of Children's A&E at Ormskirk. In addition, the local MP, NHSE/I and the DHSC are also requesting a timeline for the Paeds ED to reopen 24/7. The department currently closes at midnight. An assessment is currently underway to understand what resource would be required to reopen the department in a safe and sustainable way and whether this is achievable.

Elective Restoration Update – 16.05.22

Ahead of the committee meetings the COO presented the latest performance from an elective restoration perspective. Challenges with delivering 104% activity in April, attributed to continued UEC pressure and covid demand (9.5% of beds vs plan 1.5%). Mitigating actions at speciality levels were discussed.

Cancer Improvement Plan – 03.05.22

Ahead of the Committee meetings the COO presented the latest performance from a cancer recovery and restoration perspective. Challenges with cancer are multi factorial however some levels of actions were leading to some improvements with March 22 position improved on February's position.

Key actions included:

- Robust validation of the PTL with daily and weekly monitoring with COO oversight
- Recruitment of 3.0 WTE vacant cancer navigator posts to be progressed
- Funding agreed through Cheshire & Mersey Cancer Alliance (CMCA) to support recruitment for additional trackers and cancer manager post.
- Agree a plan with StHK for mutual peer review
- Continued development of comprehensive action plans with improvement trajectories for all tumour groups to be presented at the next QSC.
- The trust has just gone live with High-Risk FIT which will have a positive impact on pathways for our colorectal patients

ADVISE

Capital Bids – 09.05.22

LN provided the Executive Committee with an update on capital bids and secured funds.

Available Funding Streams include:

- Targeted Investment Fund (TIF)
- JAG accreditation
- Community Diagnostic Centres (CDC)

Additional CT Scanner for any trusts that currently only have one

The region has not allocated S&O monies via the JAG accreditation funding stream as it has been secured via the TIF and CDC routes which will provide full JAG accreditation across both sites.

Jubilee Weekend – 16.05.22

The COO presented a plan for Jubilee weekend for celebrations for staff and patients. This was supported by League of Friends. Plans include ward decorations and a Jubilee menu for staff and patients.

2021/22 Draft Quality Account – 16.05.22

LB presented the Executive Committee with an update on the progress of the Draft 2021/22 Quality Account. The Quality Team had worked closely with colleagues from StHK to ensure a consistent format was produced and reflected the partnership with StHK. The Draft Quality Account will be presented at Quality & Safety Committee in May 2022 and SOC in June 2022 and will be uploaded onto NHS Choices by 19th June 2022.

Maternity Services Quarterly Update – 16.05.22

LB provided a summary of the report, she noted the report included a lot of information which from a finance and HR perspective was important to share. The report provided an update and assurances on:

- Ockenden Report / Actions
- CNST
- Quality & Safety
- Workforce

A regional Insight Visit is planned for the 10 June 2022. This is an assurance visit by the regional maternity team.

Policy Management Update – 16.05.22

NB provided an update on the management of Trust policies and assured the Executive Committee on the work that is currently being undertaken to improve the position. Policy management is a CQC 'must do' and would require continued focus. The report that had been circulated would form the basis of a monthly report to the EC.

Staff Voice Partnership (Listening Plan) – 16.05.22

JR provided a summary of the Listening Plan which had been developed in response to the recent staff survey feedback and final Ockenden report, and as part of the continued drive for culture change articulated in Trust's Our People Plan.

ASSURE

Major Incident Plan & Major Incident Action Cards – 03.05.22

The recommendation was for the Executive Committee to approve the Major Incident Plan and Major Incident Action Cards which had been updated. The Executive Committee approved the MIP which would now need to be signed off by Ann Marr.

New Risk identified at the meeting	None

Review of the Risk Register