Southport and Ormskirk Hospital NHS Trust

AGENDA
STRATEGY AND OPERATIONS (S&O) COMMITTEE
To be held at 0930 on Wednesday 04 May 2022

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0930***
SO071/22 (P)	**Patient Story** *Purpose: To **receive** the patient story*	*No*	*L Barnes*	15 mins
SO072/22 (V)	**Chair's welcome and note of apologies** *Purpose: To **record** apologies for absence and confirm the meeting is quorate.*	*No*	*Chair*	
SO073/22 (D)	**Declaration of interests** *Purpose: To **record** any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
SO074/22 (D)	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 06 April 2022.*	No	*Chair*	10 mins
SO075/22 (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**
SO076/22 (D)	**Audit Committee AAA Highlight Report** *Purpose: To **note** the Audit Committee Report*	*No*	*I Clayton*	10 mins
INTEGRATED PERFORMANCE REPORT				**1005**
SO077/22 (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				**1025**
SO078/22 (D)	**Quality and Safety Committee AAA Highlight Report** *Purpose: To **receive** the Quality and Safety AAA Highlight report*	*No*	*R Thind*	5 Mins
SO079/22 (D)	**Ockenden II Report Briefing** *Purpose: To **receive** the Ockenden Report Briefing*	*No*	*L Barnes*	10 mins
SO080/22 (D)	**CQC Registration Annual Declaration** *Purpose: To **receive** assurance the Trust continues to be registered with the CQC.*	*No*	*L Barnes*	10 mins
WORKFORCE				**1050**
SO081/22 (D)	**Workforce Reports** a) Committee AAA Highlight Report *Purpose: To **receive** the Workforce reports*	*No*	*L Knight*	20 mins
SO082/22 (D)	**2021 Staff Survey Results and Action Plan** *Purpose: To **receive** the Staff Survey Results and **approve** the Action Plan*	*No*	*J Royds*	15 mins
SO083/22 (D)	**Freedom to Speak Up Report – Quarter 4** *Purpose: To **approve** the Freedom to Speak Up Report*	*No*	*L Barnes*	5 mins
SO084/22 (D)	**Guardian of Safe Working Report** *Purpose: To **receive** the Guardian of Safe Working Report*	*No*	*K Clark*	5 mins
FINANCE, OPERATIONS AND INVESTMENT				**1135**
SO085/22 (D)	**Finance, Performance and Investment Reports** a) Committee AAA Highlight Report b) Final 2022/23 Financial & Operational Plan *Purpose: To **receive** the Finance, Performance and Investment Reports*	*No*	*J Kozer* *J McLuckie*	10 mins 5 mins
CORPORATE				**1150**
SO086/22 (D)	**Executive Committee AAA Highlight Report**	*No*	*K Clark*	5 Mins

*Purpose: To **receive** the Executive Committee AAA Highlight Report*

CONCLUDING BUSINESS			**1200**
SO087/22 (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*
SO088/22 (V)	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*	*Chair*	*5 mins*
	Date and time of next meeting: 0930 Wednesday 01 June 2022		***1215 close***

RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC

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

Chair: Richard Fraser

Minutes of the Strategy and Operations Committee
Held on Microsoft Teams
Wednesday 06 April 2022
(Approved at the Strategy and Operations Committee on 04 May 2022)

Present

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

In Attendance

Name	Initials	Title
Geoffrey Appleton	GA,	Board Advisor, STHK
Tony Ellis	TE	Communications and Marketing Manager *(Part 1 only)*
Cassandra Garner	CG	Colorectal Nursing Team *(Item SO043/22 only)*
Stephen Mellars	SM	Deputy Director of Nursing *(Item SO043/22 only)*
Alan Sharples	AS	Board Advisor, STHK
Juanita Wallace	JW	Assistant to ADCG (minute taker)

Apologies

Name	Initials	Title
Paul Growney	PG	Non-Executive Director, STHK
Gareth Lawrence	GL	Director of Finance, STHK
Rowan-Pritchard-Jones	RPJ	Medical Director, STHK

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
SO043/22	**Patient Story** SM introduced the patient story video which was provided by a patient who had taken part in the National Bowel Screening Programme in September 2019 and, despite having had no prior symptoms and following further investigation, had received a diagnosis of a cancerous	

polyp in his colon. The patient had surgery in November 2019 and has remained under the care of the Colo Rectal Cancer team during his programme of surveillance. The patient spoke about his experience, emotions and fears and the support that he had received from the team throughout his care.

GB commented that the story had highlighted the importance of the link between the patient and the cancer support nurse throughout the patient's care as the impact of the disease is both physical and psychological. She also was impressed by the patient's comments around the joint analysis of positives and risks going forward.

AM commented that the story had highlighted the importance of the role of specialist nurses and support workers in supporting patients and that this should not be underestimated. She thanked the team involved for contributing to the patient's positive experience.

RF reflected that it served as reminder to everyone of the importance of cancer screening for early detection of the disease, often before there was any symptoms. RF also thanked the team for presenting such an important patient story.

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

SO044/22 Chair's Welcome and Note of Apologies

RF welcomed all to the meeting and in particular welcomed John Williamson, a member of the public who was in attendance.

RF advised that GB had now been appointed as a Non-Executive member of the Board for Southport and Ormskirk NHS Trust.

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

SO045/22 Declaration of interests

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

SO046/22 Minutes of the previous meetings

The Committee reviewed the minutes of the previous meeting held on 02 March 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 02 March 2022

SO047/22 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

SO048/22 2022/23 Trust Objectives

AMS presented the 2022/23 Trust Objectives and advised:

- The Executive team had developed proposals for Trust Objectives for 2022/23 to support the delivery of the six strategic goals of the organisation.
- These objectives incorporated the quality improvement priorities for 2022/23 as agreed as part of the Quality Account.
- The approved Trust Objectives would be launched at a "Start of the Year Conference", with a simplified version being distributed to every ward and department so that staff would be aware of the Trust's priorities for the coming year and could develop their service and personal objectives in support of these.
- Each objective was aligned to a Committee for regular oversight and assurance whilst the Executive Committee would performance manage delivery.
- A formal mid-year review of progress would be presented at the Strategy and Operations Committee in October.

IC welcomed the objectives but commented that he felt there should be more balance between those supporting strategic objective 4 and 5, to reflect this issues that were emerging from the staff survey results in particular staff morale. AMS agreed with this comment and undertook to rebalance the objectives before they were published.

LB advised that, following the recently published Ockenden report, the continuity of carer plans would be paused for this year in line with national guidance and the objectives would be amended to remove this.

GB asked if, in light of the current pressures, would it be possible to move ahead with the planned ward refurbishment programme and AMS advised that the refurbishment had been progressing well but had been impacted by the fourth wave of Covid-19 and current system pressures as the decant wards were being used as escalation areas. It was important to provide a better environment for both patients and staff and

the situation was under review to find a way forward.

GA commented that in relation to proposed objective 6.3 the Trust would be a leading member of the Place Based Partnerships in at least two areas.

RESOLVED:
The Strategy and Operations Committee **approved** the 2022/23 Trust Objectives subject to the amendment of objectives aligned the the strategic aims 4 and 5

SO049/22 Board Assurance Framework

NB presented the Board Assurance Framework (BAF) which provided assurance that the principal risks to achieving the Trust's Strategic Objectives (SO) were identified, regularly reviewed and systematically managed.

NB advised that the BAF had been reviewed by the Executive team and that actions had been updated and noted that this was a work in progress and additional work was still required. The BAF had been presented at the S&O Trust Board and members had been assured that the BAF had been updated.

NB recommended that a new strategic risk be included on the BAF relating to the condition of the estates and the backlog maintenance issues faced by the Trust.

IC asked in relation to SO2, whether the Cancer Improvement Plan element should be amended to reflect that updates are provided at the Finance Performance and Investment (FP&I) Committee as well as the Quality and Safety (Q&S) Committee. LN advised that the FP&I was briefed as part of the Operational Update, but she would update the BAF to reflect this.

AS felt that the score of SO4 appeared to be low, given the issues the Trust was facing in accessing the required workforce. JR advised that the SO4 had been reviewed based on the success of the recruitment of international nurses as well as the assurance around medical vacancies but agreed to review this.

The BAF had been updated to include a new risk reflecting the specific Information Management and Technology (IM&T) and cyber security threat to the Trust (SO7) and CW undertook to review the risk as

additional assurance that all the expected controls and actions had been identified.

ACTION **N Bunce**

BAF to be updated at the next quarterly review 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

RESOLVED:

The Strategy and Operations Committee **approved** the Board Assurance Framework.

SO050/22 Corporate Risk Register

KC presented the Corporate Risk Register which provided an update on the current open risks and advised that enhanced training support had been provided to the CBU governance teams. KC highlighted that, following the recent Risk and Compliance Group meeting:

- work was ongoing to update the Risk Register to include risks relating to the Trust estate.
- Two additional risks had been raised, one related to staff vacancies within some of the already fragile services and the second related to patient flow and capacity on the Southport site. It was noted that these were not new risks but had been re-escalated through the Clinical Business Units as a result of the increased pressures, as well as the increase in the number of 12 hour breaches and increased ambulance handover times.

It was noted that risk 2411, Major and sustained failure of essential IT systems, had been reviewed for its controls and the actions were being delivered. CW suggested that target completion dates for each action would strengthen the action plan. Additionally CW recommended that the Business Continuity Plan (BCP) be reviewed to provide assurance that, if the risk materialised, there would be confidence that the Trust would continue to deliver clinical services. AMS agreed with CW's comments and advised that the replacement parts needed to improve system resilience had been ordered and that a date for the installation needed to be finalised.

ACTION: **J McLuckie**

Action plan in relation to risk 2411 to be updated to reflect firm dates as well as additional information around mitigations and the BCP to be updated to provide increased assurance.

GB advised that she and RT had visited the Ormskirk maternity unit whilst the Trust had been experiencing network issues and had been advised by LB that the BCP had been activated. She commented that it was good to see the BCP in operation from a NED's point of view and had been assured by her observations on the day. LN thanked GB for her feedback and advised that the Trust was developing an internal critical incident plan for the IT Teams and that this would include a review of the BCP as well as the involvement of the Emergency Preparedness, Resilience and Response team.

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

SO051/22 Terms of Reference

a) Assurance Committees

NB presented the Terms of Reference (ToR) for the Assurance Committees and advised that the ToRs had been reviewed by the committee chairs and lead Director(s) and the changes were agreed at the March Committee meetings. The proposed changes reflected the terms of the Agreement for Long Term Collaboration (ALTC) with St Helens and Knowsley Hospitals NHS Trust (STHK) and had removed duplication between committees. The governance diagram had also been updated.

b) Executive Committee

NB presented the Terms of Reference for the proposed Executive Committee as a sub-committee of the Strategy and Operations Committee (SOC) and advised that the Executive Committee would be the final arbiter on all operational issues within the Trust. The draft ToR outlined the principal duties of the proposed Committee as well as the membership. It was noted that formalising the Executive Committee as a sub-committee of the SOC would strengthen the governance structure and would align with other meetings within the organisation.

RESOLVED:
The Strategy and Operations Committee **received and approved** the Terms of Reference and **approved** the establishment of the Executive Committee

SO052/22 Charitable Funds Committee AAA Highlight Report

JMcL presented the Charitable Funds Committee AAA Highlight Report which was presented to the SOC for information and advised that:

- the issues around the database and administrative support had now been rectified.
- an Expenditure Strategy was being developed and areas of focus for fundraising, which included spinal and fragility, had been discussed.

RF, GB and AS commented on the importance of fundraising and the added benefits which included an appreciation of the hospital by the local population as well as the improvements made for both patients and staff. The importance of having a dedicated Charity Manager was also highlighted. AMS advised that a professional Charity Manager had been appointed, and during his 12 months in the role, he had implemented several ideas that had contributed to fundraising. Additionally, the Charity Managers from both S&O and STHK Trusts were now planning shared events across both sites.

IC noted that the Charitable Funds Committee was statutory and remained a committee of the Board under the ALTC arrangements, however it was important for the SOC to be aware of the decisions made.

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

INTEGRATED PERFORMANCE REPORT

SO053/22 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 February 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 standards. It was noted that:

- The frequency of the Harm Free Care Panels had been reviewed and one panel per month had been stood down to allow for there to be a focus on learning.
- There had been a reduction in the number of falls and pressure ulcers reported with two category 3 and 4 category 2 pressure ulcers reported in February and one fall resulting in harm.
- There had been a slight improvement in the Patient Friends and Family Test, however, this remained below target.
- The second Ockenden Report had been published and included 15 new immediate actions for maternity services. It was noted that the

report contained learning for all specialities. A briefing on the findings would be prepared for the next meeting and to be shared with staff and families currently using the service who might have anxieties about their care.

- An extra-ordinary meeting with the Local Maternity Service had been arranged to discuss the final Ockenden report recommendations and a self-assessment template had been developed for all maternity units to complete. This will be presented at the June SOC meeting for review ahead of the submission deadline.

SR asked if the Health Care Assistants (HCA) fill rates included supplementary care for the increased number of patients with cognitive needs and LB advised that this was not included as these requirements are in addition to the base staff establishment for each ward. LB advised that a review of the current establishment had been undertaken and it was noted that an additional 11 or 12 HCAs were required. The senior nursing teams across S&O and STHK were working together to address the challenges of HCA recruitment and retention..

SR reported that the two trusts were also working together as critical friends to support the response to Ockenden 2.

GB asked if the plan to set up a robust recruitment programme to reduce reliance on international nursing recruitment was in place and LB advised that this was in development currently and work was on going with local colleges to encourage students to apply for vacancies at S&O Trust. The Trust was also in the process of recruiting to 50 HCA posts via a training programme and was planning to run something similar to the Preceptorship programme for unqualified staff. JR also noted that work was being carried out with the international nurses to support their career progression at the Trust.

RT asked why the caesarean section metric had been withdrawn and for any explanation as to why induction of labour rates remained so high.. LB explained that Ockenden 2 had highlighted the need to improve choice for women and therefore “artificial” targets for caesarean sections were no longer felt to be an effective measure of safe or effective care. Similarly a low induction of labour rate was also not now considered as a good indicator. KC advised that work was being carried out, in partnership with STHK, around induction and caesarean rates to review clinical criteria and documentation to ensure that clinical criteria and patient choice were documented, and decisions were subject to senior review.

KC advised that 40 Covid-19 hospital onset cases had been recorded for February 2022 and noted that this was on par with other trusts. A

number of these cases were felt to be linked to the relaxation of visiting restrictions.

One case of Clostridium difficile (C.diff) had been recorded and a Root Cause Analysis (RCA) had been completed which had identified no lapses in care.

RT noted that only 6% of Transient Ischaemic Attack (TIA) patients were seen within 24 hours and requested clarity around whether this referred to inpatients or both inpatients and outpatients. Additionally, she asked if the referrals were appropriate and whether the delay increased the risk around stroke management and prevention. KC advised that Stroke was one of the services that has been escalated as non-compliant and identified as a fragile service. However all patients presenting at ED were triaged and referred to the Walton Centre if clinically indicated. AM commented that, as part of the discussions around fragile services with the Integrated Care System (ICS) and Liverpool University Hospitals NHS Foundation Trust (LUFT), stroke services had been escalated as a service that required urgent intervention and the current proposal was that the target date would now be July 2022.

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:

- There were currently 65 Covid-19 patients being cared for over three wards and accounted for 14% of the Trust's bed base which was impacting operational delivery.
- Staff sickness peaked at 9% in February of which 3% was Covid-19 related.
- ED performance remained challenged at 74.8% against the four hour standard of 95%, however, the Trust was the best performing adult ED department in Cheshire and Merseyside.
- The challenges of patients waiting in excess of 12 hours remained, however, the latest performance data indicated an improvement against the six-week average. There had also been 192 ambulance handover breaches with 98 delayed longer than 60 minutes.
- There has been a decline against the Elective Recovery Restoration plan with performance down to 82% of the baseline in February against a target of 89%, however, the Trust still compared favourably with neighbouring trusts.
- 52-week waits were slightly above trajectory and accounted for 1%

of the Trust's total waiting list.

- Cancer performance indicated that two of the three standards were not being achieved in January although all had shown improvement on the December figures.
- The opening of the new Endoscopy unit at the Ormskirk Hospital had allowed the service to deliver on mixed sex lists as well as increasing the list capacity, which was very welcome.

GB asked about the impact of the reduction in national funding for the hospital discharge programme of super stranded and stranded patients and LN advised that a senior leadership workshop exploring discharge options was being arranged. Additionally, the challenges around staffing with community partners and carers remained unchanged and this was all impacting on discharges.

RF noted some of the excellent performance relative to other local trusts and commended the operational and clinical teams on their efforts. LN would relay this thanks to the staff involved.

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 highlighted that:

- The Trust was now forecasting financial breakeven from M11 following the confirmation of additional System Top-Up Funding secured for 2021/22.
- The Trust had secured a further £6m of system allocations for 2021/22 to support surge costs experienced during Q4 as well as year-end accounting estimates.
- Cash flow risks that had been previously highlighted had been mitigated.

JMcL advised that assurance had been provided at the IM&T Steering Group as well as from Estates and Facilities that all capital schemes would be delivered by 31 March 2022 to complete the £13.5m programme.

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

d) Workforce Performance Report

JR presented the Workforce Performance report and advised that:

- The completion rate of Personal Development Reviews (PDRs) had been impacted by the ongoing operational pressures and was 75.6% in February against the 85% target.
- Mandatory training remained ahead of target at 89.2%.
- There was a reduction in the sickness absence rate in February to 7.1% however, rates continued to show special cause for concern and support was ongoing.
- There has been a reduction in the medical vacancy target which was now below target but it was noted the Nurse vacancy rate had increased to 11%, which was primarily impacted by 33 vacancies for HCAs. The rolling 12 month staff turnover rate was 15.7% in February against the annual target of 10%, however the in month rate for February had reduced to 0.9%.
- GB asked for clarification in relation to "unadvertised vacancies" and JR explained that these were posts that were either vacant following multiple attempts to fill substantively or were being held as training posts and filled with bank/agency or locum staff on a temporary basis.
- JR reported that the calibre of consultant staff currently being appointed was high, which indicated the Trust was offering exciting and attractive posts.

RESOLVED

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

QUALITY AND SAFETY

SO054/22 Quality and Safety Report

a) Quality and Safety Committee AAA Highlight Report

GB presented the AAA Highlight report and advised the following:

- There were no issues escalated to the SOC as alerts.
- The Acute Kidney Injury (AKI) team had demonstrated the progress being made and a business case for additional equipment as well as the employment of a second consultant was in development to support this as a quality priority in 2022/23.
- The Quality Accounts and Quality Improvement Priorities – assurance had been provided on the achievements made in 2021/22 and the proposals for 2022/23 had been agreed.

RESOLVED:

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

SO055/22 CQC Progress Update

LB presented the report which provided an update in relation to the Care Quality Commission (CQC) progress, actions, engagement and Well-Led Improvement Journey.

IC commented that he had previously questioned the Well Led element of the report as it did not capture the progress against actions clearly. Additionally, he raised a concern about the pace of progress in certain areas.

Following a discussion around the 2019 CQC Inspection and that most of the team had changed since then, it was agreed that there needed to be evidence that the actions from the last inspection had been delivered and a new focus on evidence of continued or sustained performance improvement. GA commented that the focus should now be on the journey to "outstanding".

It was noted that a well led self-assessment was currently being undertaken and this would generate a new action plan.

LB also reported that the annual assessment of the Trust's ongoing compliance with the CQC regulations and fundamental standards was being undertaken.

RESOLVED:
The Strategy and Operations Committee **received** an update on the CQC Progress, Actions, Engagement and Well Led Improvement Journey

WORKFORCE

SO056/22 Workforce Reports

a) Workforce Committee AAA Highlight Report

LK presented the AAA Highlight report and advised the following:

- There were no issues escalated to the SOC as alerts.
- The Trust has continued to try and appoint a Guardian of Safe Working (GoSW) and STHK has offered that their GoSW to meet with senior clinicians to make the role more attractive.
- The Annual Staff Survey 2021 Trust results were presented and a presentation around the themes identified as well as improvements and deteriorations were identified.

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

b) People Plan – Quarterly Progress Report

JR presented the People Plan which provided a quarterly update on the progress.

The themes from the 2020 Staff Survey had helped to inform the key *Our People Plan* deliverables for 2021/22 and progress has been made against the 23 key deliverables. However, a few of the deliverables had been impacted by winter pressures and limited capacity. An Integrated Performance Report (IPR) has been developed which will measure the impact of the programmes of work and would highlight areas that required focused attention.

GB asked about how staff could informally engage around the People Plan and JR advised that information was gathered from several sources which included the annual Staff Survey and the Freedom to Speak Up reports. Additionally, the 'back to the floor' days as well as the Executive Team Open Door policy provided opportunities for staff to interact with Executives.

The target for time to recruit had been amended and GB asked what changes would be made in the meantime to reduce this. JR advised that candidates had been requested to present identifying documentation at their interviews so that these checks could be completed as part of the interview. There was also a push to ensure that offer of employment letters were sent out quickly.

AS noted that the establishment of staff networks, which had been completed in September 2021, was now being reported as in progress. JR advised that additional work was being carried out to ensure that the Trust was hitting the targets, but this had been affected by absence in the HR team.

RESOLVED:
The Strategy and Operations Committee **received** the People Plan Update

SO057/22 Freedom to Speak Up Annual Self-Assessment 2022

LB presented the Freedom to Speak Up Annual Self-Assessment and advised that a recent MIAA review had provided High Assurance. The

Trust was reporting compliance with all 11 standards.

RESOLVED:
The Strategy and Operations Committee **approved** the Freedom to Speak Up Annual Self-Assessment 2022

FINANCE, OPERATIONS AND INVESTMENT

SO058/22 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 significant increase in Covid-19 admissions, which had accounted for 21% of the bed base, had impacted on operational delivery.
- A&E performance in February 2022, whilst significantly below the national standard, had compared positively to peers.
- Both 62 and 14-day cancer standards were not achieved in January 2022 and upper and lower GI and Head and Neck continued to be the most challenged pathways.
- Elective activity for February 2022 was below the 89% Elective Recovery Fund (ERF) target at 82%.
- The draft financial plan for 2022/23 was presented with an overall deficit of £28m.
- Following the visit by the Lancashire Fire Safety Officer on 07 March 2022 an action plan had been produced to address the safety concerns raised
- Following a concern about the four boiler house chimneys at Southport and an inspection by our Combined Heat and Power (CHP) provider, two of the chimneys had been removed to be inspected offsite. If these chimneys needed to be replaced due to age the liability would rest with the Trust and this would be an additional backlog maintenance pressure.

The report also advised that:

- The groundworks for the discharge lounge had been completed and the modular build was onsite. It was expected that work would be completed by end April 2022.
- Work was ongoing to see how the IT network replacement programme could be completed as soon as possible.
- Work on the endoscopy upgrade at Ormskirk had been completed and there had been an improvement in Endoscopy performance.

The Committee had been assured that the £13.5m capital programme would be fully delivered in 2021/22.

JMcL advised that the Fire Safety Officer had been made aware of the

work taking place at the Ormskirk site and was assured by the progress already made and the timescales for delivery of the remainder of the remedial action. The most pressing issue had been storage in theatres, and this was being addressed.

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

b) Draft Financial Plan 2022/23

JMcL presented the 2022/23 Draft Financial Plan and advised that:

- The Trust's draft financial plan for 2022/23 projected a deficit of £28m of which £15.2m related to income shortfalls, and £20.6m related to cost pressures. These would be partly offset by an assumed CIP of £7.8m (3.5% of turnover).
- Financial arrangements were still being discussed with the Cheshire and Merseyside Integrated Care System (ICS) and mechanisms for all partners to break even were still to be agreed.
- The 2022/23 financial plan included fixed planned income available for elective activity via a block contract mechanism.
- The Trust had submitted an indicative capital expenditure plan of £34.6m, which included £26m critical backlog maintenance. System capital allocations remained subject to ICS approval ahead of Final Plan submission.
- Systems had been asked to develop fully triangulated plans across activity, workforce and finances for the 2022/23 financial year and the Trust's final operational plan would be submitted to NHSEI on 28 April 2022.

RESOLVED:
The Strategy and Operations Committee **received** the AAA Report from the Finance, Performance and Investment Committee and **approved** the 2022/23 expenditure budget and **noted** the draft financial plan.

CORPORATE GOVERNANCE

SO0059/22 Executive Management Team Report

AMS presented the AAA highlight report that detailed the activity and reports considered by the ETM during March and alerted the Committee to the Major Incident Network Outage on 15 March which lasted over eight hours. One of the mitigations will be an agreed process for the Trust's IT engineers to contact STHK network on-call colleagues out of hours to strengthen the incident response and management.

AMS advised that, following a bidding process, it had been confirmed that the Trust would receive elective restoration capital.

The NHS Estates Review Report had been received and reviewed by the EMT.

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

CONCLUDING BUSINESS

SO060/22 Questions from Members of the Public

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

SO061/222 Any Other Business

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12.16.

The next meeting would be held on **Wednesday 04 May 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 April 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.	Green
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

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	Status
SCO021/21	03-Nov-21	**Board Assurance Framework**	A BAF training session to be arranged which would be beneficial when conducting reviews of the BAF	~~S Katema~~ N Bunce	03-Nov-21	~~February 2022~~ April 2022	**November Update**: A training session on BAF is planned for January / February 2021. All members will sent invites to the session. **Feb 2022:** Whilst there's been a slight delay to arranging the session, it is expected that the session would be scheduled during Q4 **March Update:** Session to be arranged for March 2022 **March Update:** Due to operational pressures and annual leave amongst the Exec Directors it was not possible to identify a dedicated session in March, however NB has worked with each of the Directors individually to update the BAF risks for which they are the lead. A development session is still planned when time allows. **Action completed**	Completed

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
SCO021/21	03-Nov-21	**Board Assurance Framework**	SK and LN to arrange an NHSEI facilitated session on Statistical Process Controls (SPC) methodology.	S Katema and L Neary	03-Nov-21	~~February 2022~~ ~~March 2022~~ June 2022	**November Update**: A training session on SPC Charts is planned for February 2021. All members will sent invites to the session. **January Update:** We are waiting on NHSEI to advise their availability to present the training. **February Update:** A session has been arranged for 01 June 2022 and invites will be sent. **March Update:** MS Teams invite has been sent. **Action completed**	**Completed**
SO007/22	02/02/2022	**Board Assurance Framework**	RF commented that the BAF was a live document which required input from numerous specialist areas and requested that the updated BAF be presented at the meeting in April 2022.	EMT	02/02/2022	Apr-22	**February Update**: EMC will attend a workshop in March 2022 to review the BAF and an updated BAF will be presented at the S&O Committee meeting in April 2022 **March Update:** Item included on Agenda. **Action completed**	**Completed**

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	AUDIT COMMITTEE
MEETINGS HELD:	20 April 2022
LEAD:	Ian Clayton

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- None

ADVISE

- 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 trajectory of improvement to address the backlog of policies that were out of date by the end of December 2022.
- The Committee reviewed the Mobile Computing and Lessons Learnt Internal Audit Reports with Moderate assurance. A summary Lessons Learnt report that identified changes to clinical practice would be presented at the Quality and Safety Committee. There was assurance that the other actions had been completed or were in process.
- It was confirmed that a review of the underlying data for Cancer Pathways reporting had been included in the draft Internal Audit Plan for 2022/23 as a part of the data quality assurance programme.
- The Committee recognised that the new cleaning standards were wider than previously experienced, and this was potentially a new or increased risk. The Committee was raising it to ask where it will be reported and monitored, and which assurance sub-committee(s) would need to be involved. The Committee could, if necessary, add it 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 appeared to be short of action/evidence to provide assurance that it was being addressed and the Committee was looking for assurance as to where this would be picked up in the governance structure e.g. Workforce Committee, S&O Committee
- 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.

ASSURE

- The Audit Committee was 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 Trusts systems of internal control.

New Risks identified at the meeting	National Standards of Cleaning compliance

Review of the Risk Register? No

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**IN UPPER CASE**	**Date**	**04 May 2022**
Agenda Item	**SO077/22**	**FOI Exempt**	**NO**
Report Title	**INTEGRATED PERFORMANCE REPORT (IPR)**		
Executive Lead	Executive Management Team		
Lead Officer	Michael Lightfoot, Head of Information Katharine Martin, Performance and Delivery Manager		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

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

Executive Summary

The performance report includes the Trust indicators relating to the NHS Constitutional standards, the 21/22 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 has a Statistical process Control (SPC) chart and commentary. Whilst this executive summary provides an overall view of the organisational improvements and risks, some indicators are also included as improvement measures for the four QI priorities and are covered in detail in the relevant reports.

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 proposal for the IPR reporting for 2022/23 was approved through Executive Committee and the Assurance Committees in April. The key points to note are:

- Reduction in the number of metrics being reported to Strategy & Operations Committee from 100 to 40
- Changes to some of the metrics or targets, based on National Priorities and local and national benchmarking data
- The re-basing of the SPC charts to look at the last 12 months, rather than 26 months
- The addition of matrices to identify metrics by their level of assurance/variation and to identify which metrics require action plans

These changes will be in place for reporting from April 2022, to be received at Strategy and Operations Committee in June 2022.

Recommendations

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

Southport and Ormskirk Hospital NHS Trust

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 and Delivery Manager	The Executive Management Team

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;

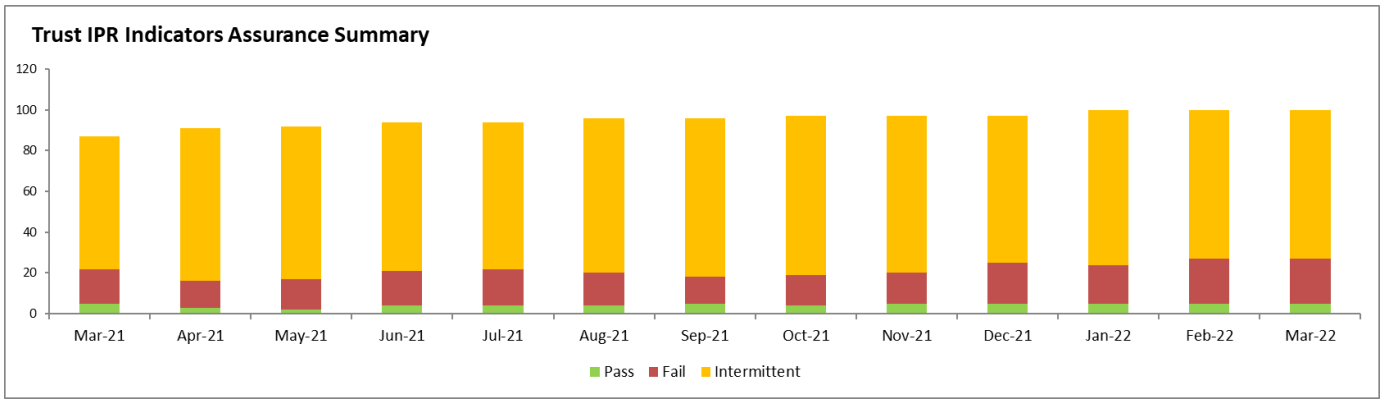
Quality - reflects those metrics aligned to Strategic Objective **S01** – *Improve clinical outcomes and patient safety to ensure we deliver high quality services*.

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 majority of indicators in this month's IPR are still classed as intermittent. Only Care Hours Per Patient Day, Patient Safety Incidents (Moderate & Above), HSMR, Friends and Family Test - Patients - % Response Rate and Mandatory Training are fully assured.



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 were no Never Events in March 2022. (2021/22 = 0).
There were no cases of MRSA March. (2021/22 = 2).
There were three Hospital Onset Hospital Acquired C. Difficile (CDI) positive cases reported in March 2022.
There were 30 reported Hospital Acquired Covid infections reported in March.
The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for March 2022 was 92.8%. This is based on 100.4% for Registered Nurses and 83.8% for Un-Registered Nurses. The 2021-22 rate is 89.4%.
The Trust remains ahead of target for VTE Prophylaxis Assessment at 96.3% for March and 97.8% for the year.
There were 5 category 3 and 6 category 2 hospital acquired pressure ulcers reported in March.
There were 89 patient falls in March of which 3 resulted in moderate harm in March. All pressure ulcers and falls with harm are managed through the Harm Free Care panel.
Induction of labour rates remain above plan and have increased by 1.7% in March to 44.1% (42.8% for the year).
The SHMI remains as expected at 100.9 (latest data Oct 21) and the HSMR continues to be ahead of plan at 73.9.
The mortality screening rate continues its improving trajectory and was 98.7% in March.
The Patient Friends & Family Test - % that would recommend declined to was 86.5% in March, from 90.4% in February, against a response rate of 25.6%.
The % of complaints responded to within timescales has improved again in March to 70.8% but remains below the 80% target.

Operational Performance

Overall Accident and Emergency performance for March 2022 was 74.5% and 78% for the year. (Adults ED 52.2%, Paeds ED 95.9% in March). Total attendances for March 2022 were 10,494 compared to 8,575 in February. 170 Ambulance Handovers were 30-60 mins in March compared to 192 in February, with 104 delayed for longer than 60 mins, an increase of 6 on the previous month.

Performance against the 62-day cancer standard was below the target of 85.0% in month (February 2022) at 58.9%. YTD 66.2%. This is a decrease on January which was 67.7%. The Trust achieved the 96% 31-day target in February 2022 with 96.8% performance in month (January 100%), YTD remains ahead of target at 98%. The 2-week rule target was not achieved in February 2022 with 77.1% in month and 81% YTD against a target of 93.0%. Performance in January 2022 was 82.4%.

The average daily number of stranded patients in March 2022 decreased marginally to 180 from 187 in February. The number of super-stranded patients also decreased, from an average of 69 in February to 63 in March. Both 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 March 2022 with 78.1% compliance, 1% lower than the previous month, and 81.4% for the year (Target 92%). The Trust continues to perform well in comparison to peers. There were 182 52+ week waiters, an increase on the 159 reported in February. The diagnostic target was not achieved in March 2022 with 44.2% patients waiting longer than 6 weeks, a deterioration on the previous month (43.3%) against a target of 1%.

The Covid19 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 has achieved the 2021/22 financial plan – and has delivered services at a £81k surplus following successful bids for additional system funding.

Income & Expenditure - The reported position is consistent with the risk highlighted as part of H2 planning, driven by £1.0m ERF income risk, and a £4.2m gap in system allocations – partly reduced by £0.5m UEC funding as previously reported – mitigated by successful bids for System Top up allocations.
The Trust secured a further £6m system allocations in 2021/22 to support the following whilst ensuring delivery of breakeven:

- Surge costs experienced during Q4 which were originally to be funded from surge funding
- Year-end accounting estimates

CIP - The Trust has delivered schemes totalling £6.6m during 2021/22.
It should be noted that £3.8m is identified as delivered non-recurrently. The potential recurrent nature of schemes identified across CBUs and Corporate budgets is being assessed as part of 2022/23 Financial Planning.

Cash - The cash balance at the end of March was £18.5m – which offers a healthy starting point moving into early 2022/23.

BPPC – The Trust's recovery plan submitted to NHSEI set out an improvement trajectory to achieve 95% on a monthly basis by the end of March 2022. The Trust continues to maintain a 90% YTD to the end of March.

Capital - The Trust has achieved its statutory Capital Resource Limit with an underspend of only £1k meaning the Trust has been able to fully invest all of its capital into Estates, IT and equipment and improve the delivery of healthcare.

In addition, the Trust continues to pursue capital funding of £68m in order to address High Risk Critical Backlog Maintenance.

Southport and Ormskirk Hospital NHS Trust

Workforce

Personal Development Review compliance has reduced in March to 74.3% against the 85% target. Performance in February was 75.6%. Mandatory training compliance remains ahead of target and was 89.1% in March.

In March overall sickness increased to 7.9% from 9.1% reported in February. The rolling 12-month figure is 7%. The medical vacancy rate continues to be ahead of plan at 5.8% (target 7.4%), although this is an increase on the previous month. The Nursing vacancy rate has decreased to 9% in March (11% in February). In-month Staff turnover has increased to 1.5% in March from 0.9% in February (target 0.75%)., impacted by a large number of retirements. The rolling 12-month figure is 16.2%, against a target of 10%.

NHS
Southport and Ormskirk Hospital
NHS Trust

Integrated Performance Report
Strategy and Operations Committee Report

March 2022

Guide to Statistical Process Control

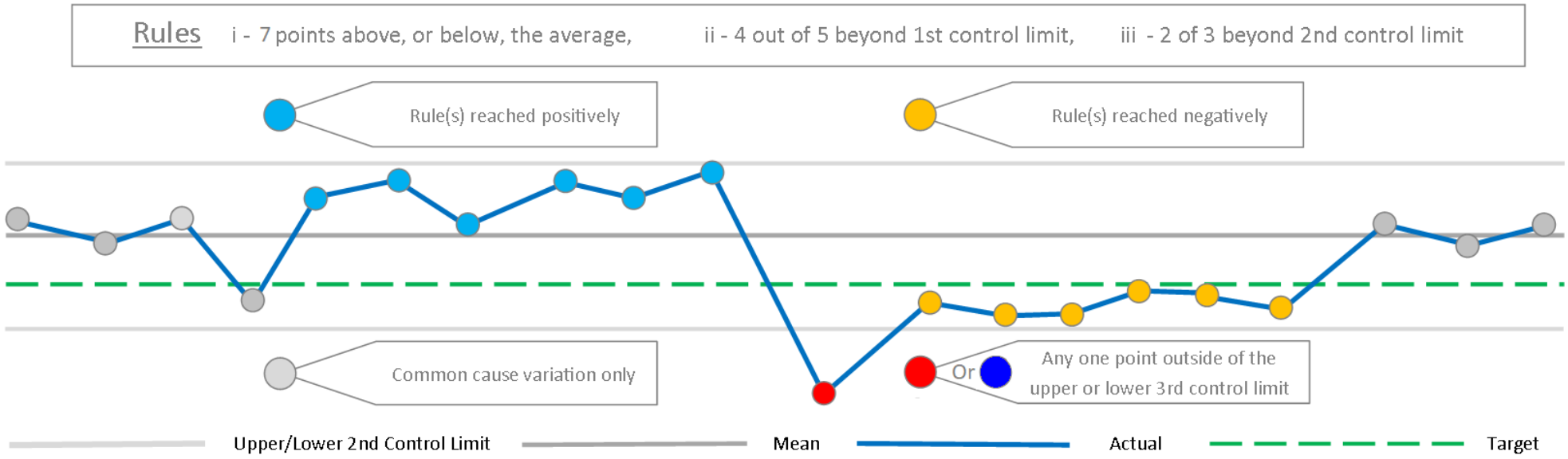
Southport and Ormskirk Hospital NHS Trust

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	Mortality	1	1	2	0	0	1	2	1
	Patient Experience	1	1	6	0	2	2	0	4
	Maternity	0	0	11	0	0	1	1	9
	Infection Prevention and Control	0	0	6	2	0	0	0	4
	Harm Free	0	2	11	2	1	2	1	7
Operations	Cancer	0	0	3	0	2	0	0	1
	Access	8	0	5	8	2	0	0	3
	Productivity	1	0	9	4	0	3	2	1
Finance	Finance	5	0	12	6	0	1	3	7
Workforce	Organisational Development	1	1	1	0	0	2	0	1
	Sickness, Vacancy and Turnover	5	0	7	5	0	0	2	5

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

Issues
• Safer staffing has shown improvement in month, achieving 92.8% against the 90% target with a year-to-date figure of 89.4%. The number of staff isolating due to covid infection has reduced.
• Overall rate continues to be impacted by care staff fill-rate. Registered Nurses achieved 100.36% with Care Staff 83.79%.
• Care Hours per Patient Day (CHPPD) remains ahead of target and is assured due to the effect of improved staffing levels and reduced vacancy levels on all wards. This is despite increased demand and acuity of services.

Management Action
• Work remains focused on the scrutiny of daily rosters to ensure safe staffing across the whole organisation.
• Recruitment of both RN and HCA remains focused and on course to support the workforce with a robust plan for the year ahead already underway.
• Close month on month monitoring of the vacancy rate will provide assurance following the current nurse staffing establishment reviews.

Patient Falls/Patient Falls– Moderate/Severe/Death

Issues
• The number of patient falls increased significantly in March, and although not statistically significant, was higher than any point in the last 2 years.
• Three falls with harm were reported in March, which is above average but statistically as expected.
• 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, funding has been agreed to implement a toilet sensor/falls alarm on every ward across both sites to provide a better balance between safety and dignity.
• Enhance the role of the ‘Falls Champions’ on each ward including providing more in-depth training.
• Additional training on falls alarm equipment to be undertaken in early May.
• 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.

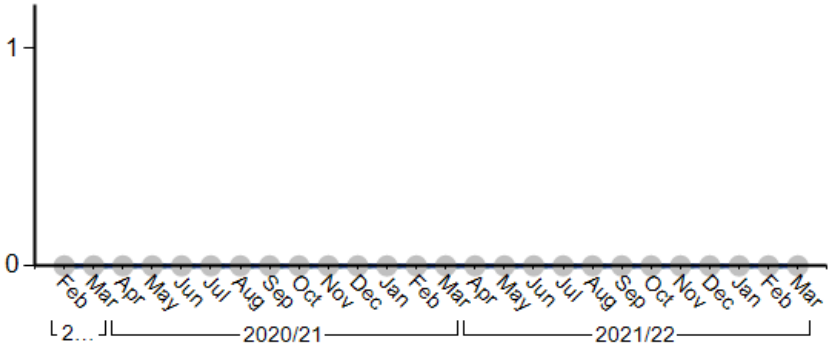
Hospital Acquired Pressure Ulcers

Issues
• Both metrics are performing statistically as expected, although there has been an increase in both the number of category 2 and category 3 HAPU’s reported in March.
• Hospital Acquired Category 3 pressure ulcers have breached the target and second upper control limit, with 5 reported in March.

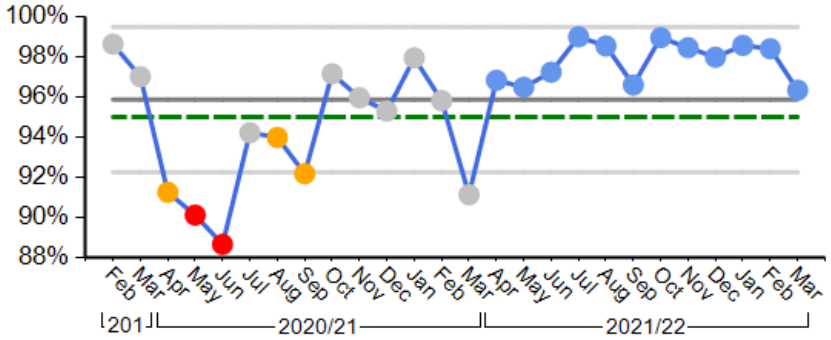
Management Action
• All hospital acquired pressure ulcers are subject to root cause analysis which is presented at the Harm Free Care Panel.
• Themes from investigations have resulted in a renewed focus on the importance of accurate and timely risk assessment, as this results in patients having the right 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	0	0	Mar 22		0	0	Feb 22	0	0	
VTE Prophylaxis Assessments	95%	96.3%	138	Mar 22	H	95%	98.4%	Feb 22	95%	97.8%	
Fractured Neck of Femur - Operated on within 36Hours	85%	80%	5	Mar 22		85%	72.7%	Feb 22	85%	69.9%	
WHO Checklist	100%	100%	0	Mar 22	H	100%	100%	Feb 22	100%	100%	
Safe Staffing	90%	92.8%	N/A	Mar 22		90%	91.7%	Feb 22	90%	89.4%	
Care Hours Per Patient Day (CHPPD)	7	9	N/A	Mar 22	L	7	8.7	Feb 22	7	8.9	P
StEIS	0	0	0	Mar 22		0	2	Feb 22	0	19	
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days	0.45	0.5	6	Mar 22		0.5	0.2	Feb 22	0.45	46	
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days	0.1	0.4	5	Mar 22		0.1	0.2	Feb 22	0.1	24	
Percentage of Patient Safety Incidents - Moderate/Major/Death(related)	2.1%	0.8%	8	Mar 22	L	2.1%	0.1%	Feb 22	2.1%	0.6%	P
Patient Falls - Trust	50	89	89	Mar 22		50	59	Feb 22	600	809	
Falls - Moderate/Severe/Death	0	3	3	Mar 22	H	0	0	Feb 22	0	27	
Patient Falls - Moderate/Severe/Death - per 1,000 bed days	0.1	0.2	3	Mar 22	H	0.1	0	Feb 22	0.1	0.2	

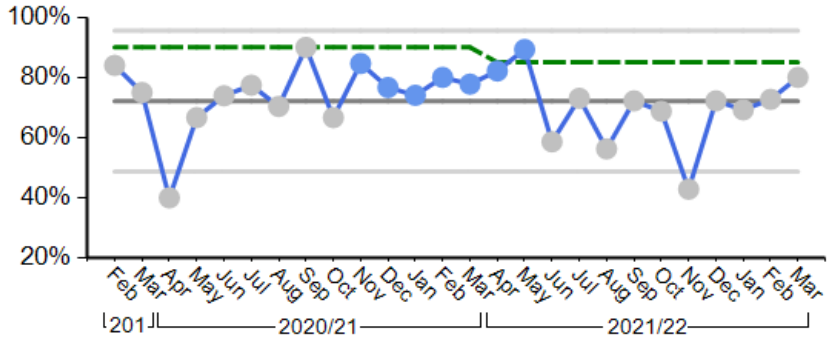
Never Events



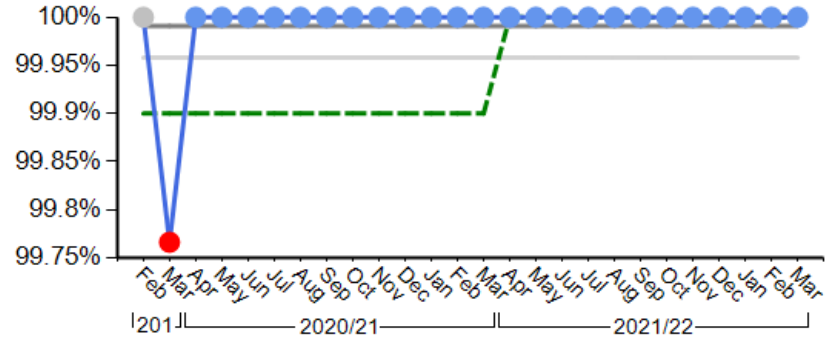
VTE Prophylaxis Assessments



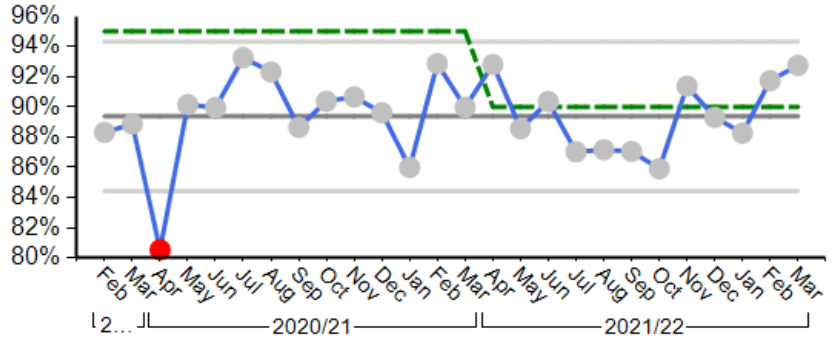
Fractured Neck of Femur - Operated on within 36Hours



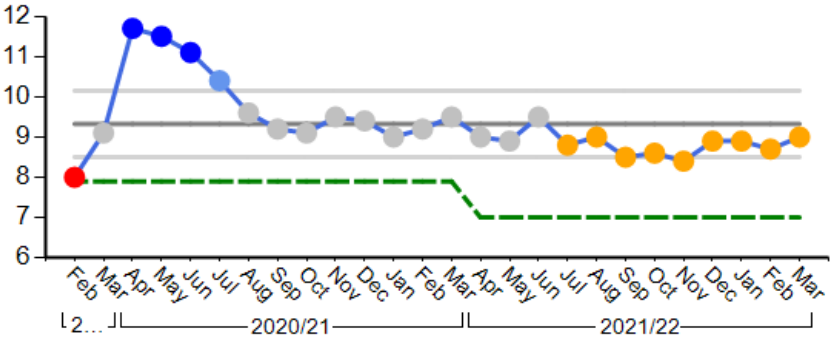
WHO Checklist



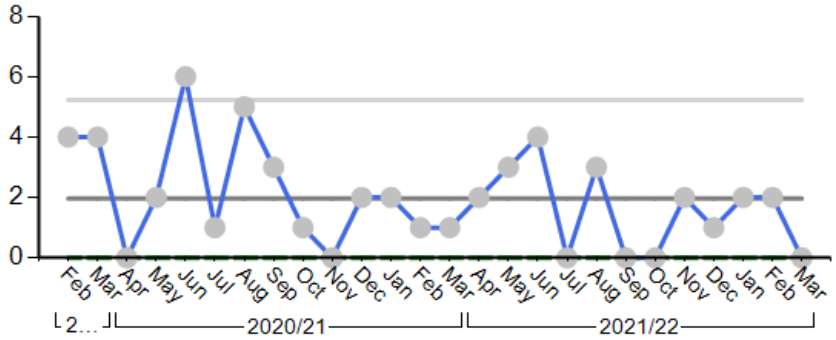
Safe Staffing



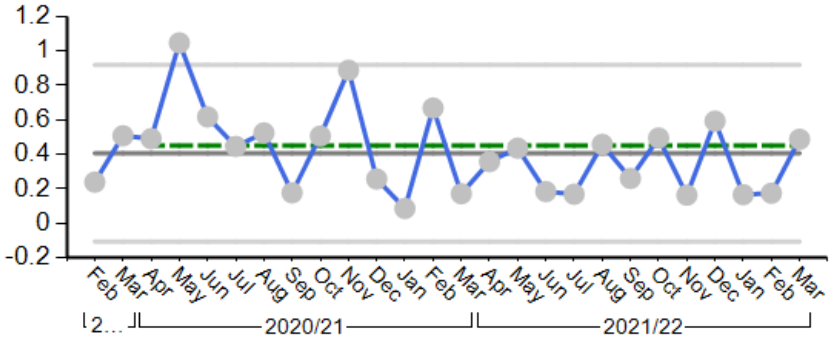
Care Hours Per Patient Day (CHPPD)



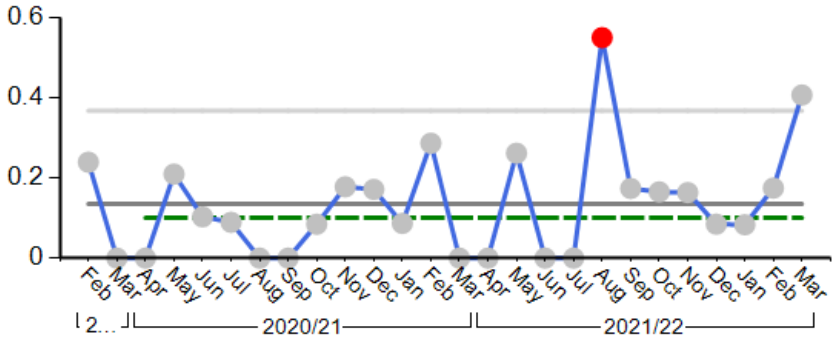
StEIS



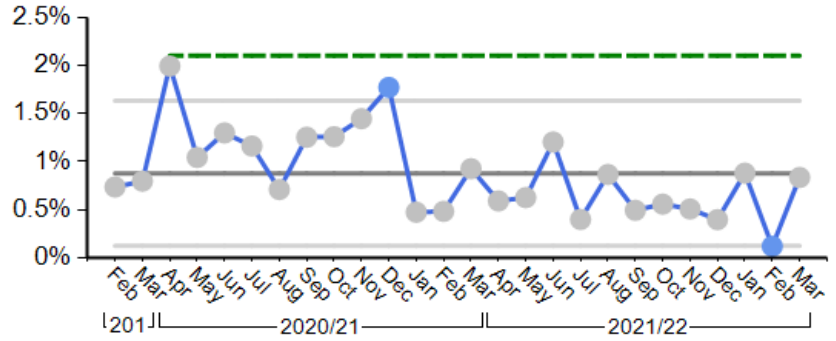
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days



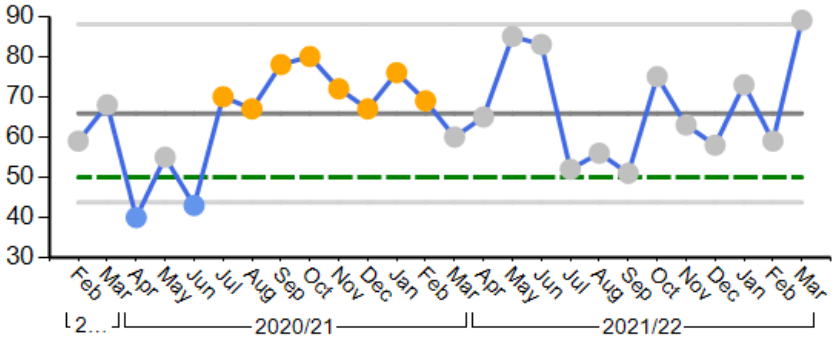
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days



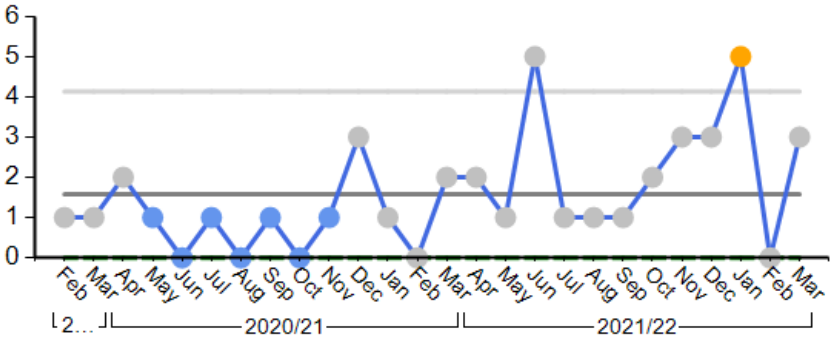
Percentage of Patient Safety Incidents - Moderate/Major/Death (related)



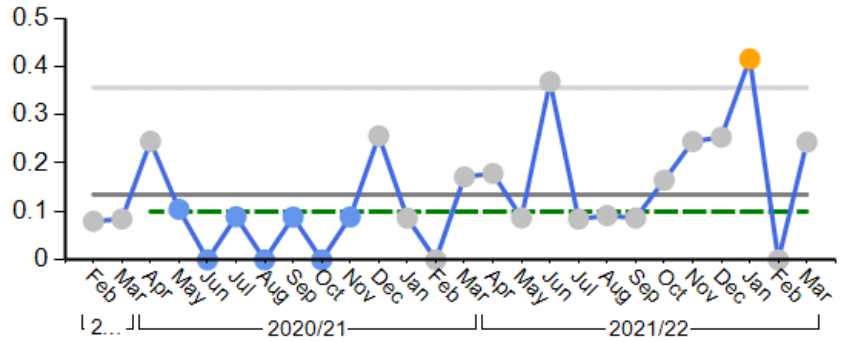
Patient Falls - Trust



Falls - Moderate/Severe/Death



Patient Falls - Moderate/Severe/Death - per 1,000 bed days



Quality

Infection Prevention and Control

C.diff

Issues
• Three Hospital Onset Hospital Acquired cases were reported in March. This is above the target but in-line with the average and statistically as expected.

Management Action
• Each of the patients are reviewed by the IPC team, Microbiologist and the clinical team at the time of the positive result and then are followed up on the C diff ward round.
• RCAs are conducted on each of the cases.
• Lessons learned are disseminated to all clinical colleagues through the RCA actions and are overseen by the CCG.
• The Trust continues to have IPC Bronze meetings to report significant infections and review actions.

E-Coli

Issues
• 6 cases were reported in March; 4 Hospital Onset Hospital Acquired and 2 Community Onset Hospital Acquired. This is an increase of 1 on the previous month.
• The metric is showing special cause concern with 4 consecutive data points above average.

Management Action
• Each of the patients were appropriately reviewed and treatment prescribed in collaboration with the Consultant Microbiologist.
• On review by the IPC team there were no apparent lapses in care.

MSSA

Issues
• 2 reported cases of Hospital Onset Hospital Acquired MSSA in March.
• This is a reduction on the previous month but although not statistically significant, remains above average.

Management Action
• Each of the patients with MSSA bacteraemia were reviewed by the Microbiologist and the patients clinical team.
• Both patients were treated appropriately - this was very evident with the apparent hospital acquired infections.

Covid

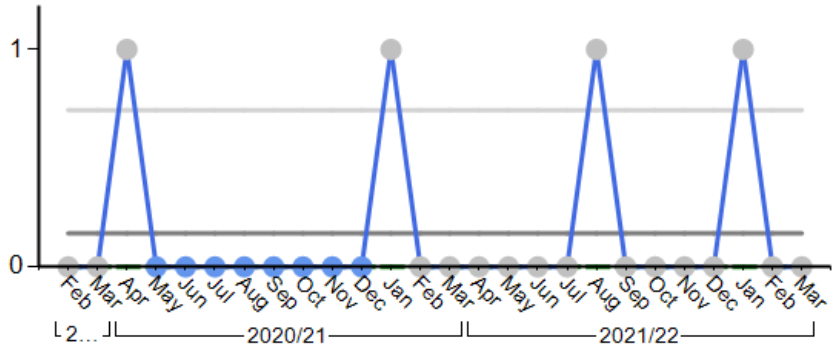
Issues
• There were 30 reported hospital acquired Covid cases in March (18 definite and 12 probable), this is a decrease on the previous month but the metric continues to show special cause concern.
• The issues apply as were noted in last month except that fewer clusters identified, for example visitors or contact with asymptomatic Covid positive patients.
• It is apparent that the hospital cases increase when the 0-2 and 3-7 day positives increase and that these cause onward transmission.

Management Action
• The Trust continues to work hard in maintaining patient flow while also maintaining patient safety.
• All areas continue to be disinfected using chlorine dioxide solution and as an adjunct UVC light or H2O2 disinfection.
• The Trust is well supported by the CCG Quality Manager who attends the IPC Bronze meetings.
• The IPC team continues to work weekends and bank holidays to support the continuing issues caused by the pandemic.

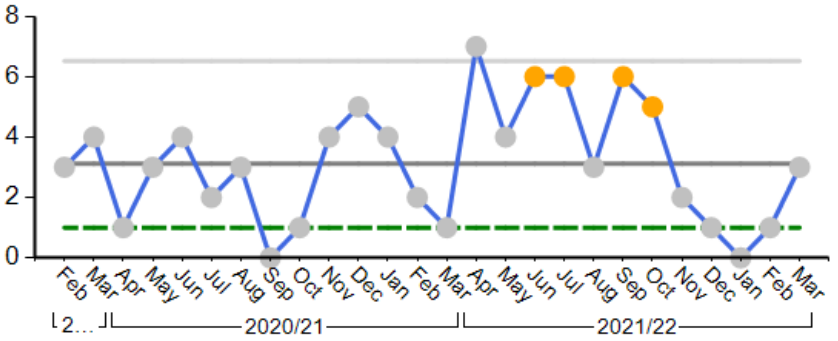
There were no MRSA cases reported in March.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
MRSA	0	0	0	Mar 22		0	0	Feb 22	0	2	
C-Diff	1	3	3	Mar 22		1	1	Feb 22	15	44	
Clostridium Difficile - per 100,000 bed days	26.5	24.4	3	Mar 22		26.5	8.7	Feb 22	26.5	31.5	
E. Coli - per 100,000 bed days	20.6	48.7	6	Mar 22		20.6	43.6	Feb 22	20.6	38.6	
MSSA - per 100,000 bed days	8.8	16.2	2	Mar 22		8.8	34.9	Feb 22	8.8	15.7	
Number of Hospital Acquired Covid Infections - Trust		30	30	Mar 22			40	Feb 22		134	

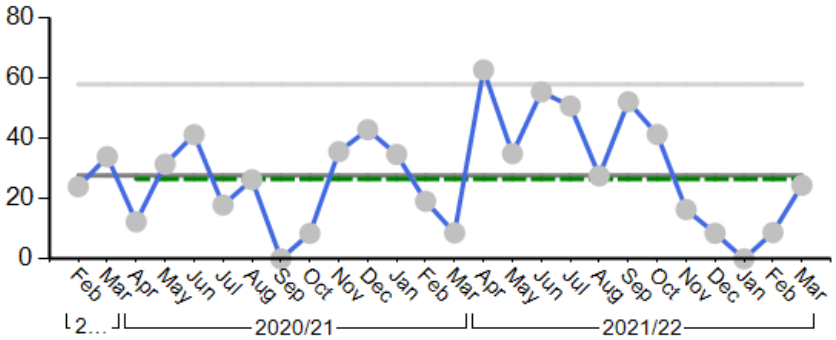
MRSA



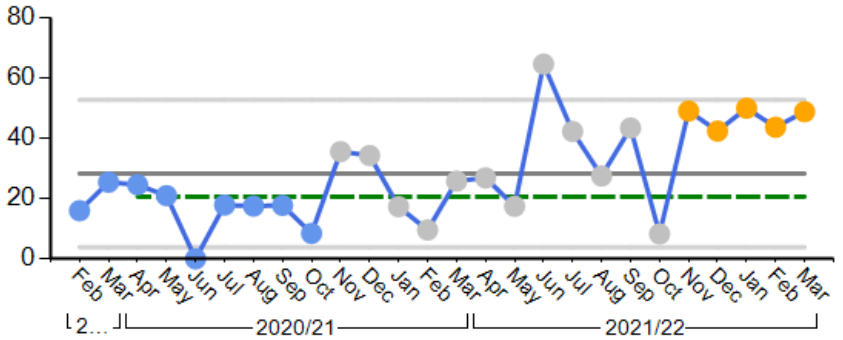
C-Diff



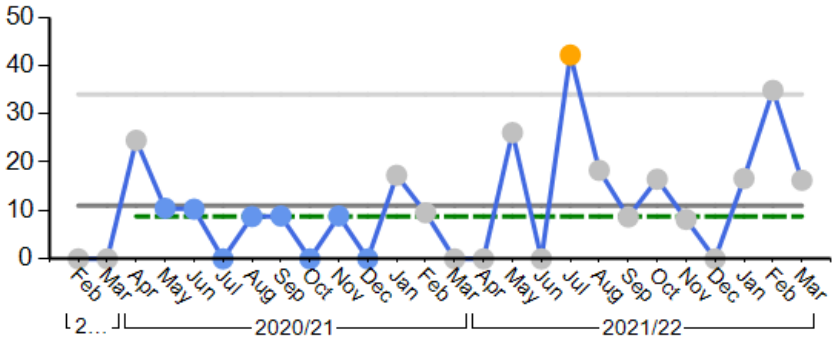
Clostridium Difficile - per 100,000 bed days



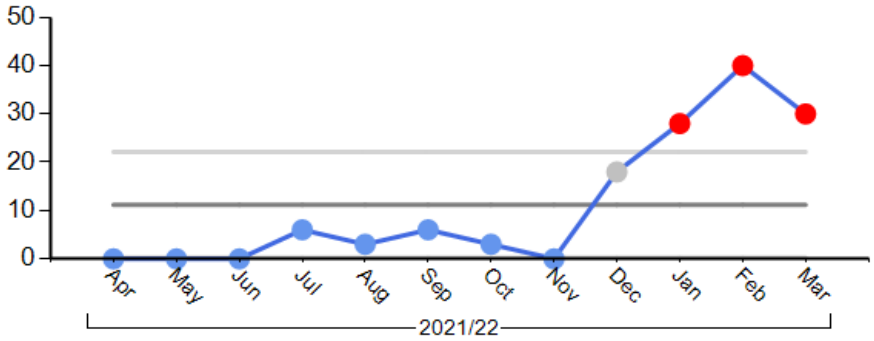
E. Coli - per 100,000 bed days



MSSA - per 100,000 bed days



Number of Hospital Acquired Covid Infections - Trust



Quality

Maternity

Induction Rates

Issues
• Performance remains statistically as expected. A further increase in March with performance above the average.
• The Trust remains an outlier for induction rates.
• As a part of Saving Babies Lives (SBL), increased awareness of poor outcomes associated with reduced fetal movements (RFM) and slow growth (RGV) have been responsible for an increased IOL rate across the region. In Ormskirk hospital these indications accounted for nearly 40% of inductions in the latest audit.
• The audit found Consultants were involved in IOL decision in under 50% of cases/not documented in the notes, majority of patients were not offered Bishop's score/not documented and no current guideline for management of Large for Gestational Age (LGA) in pregnancy.

Management Action
• Induction rates discussed at Governance meetings.
• LGA Guidance is now implemented
• Consultant to lead on lowering our IOL rate as a quality improvement project – the lead consultant will be regularly updating the Clinical Director on the progress re measures to reduce our IOL rate.

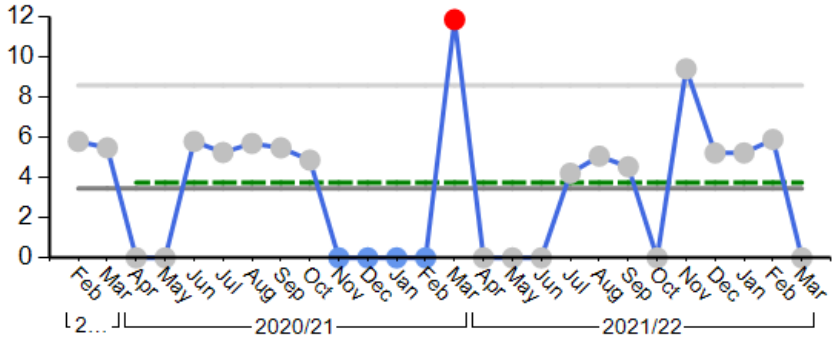
3rd and 4th Degree Tears

Issues
• Whilst there has been an increase in March for tears in Assisted Vaginal Births, this is not statistically significant and it remains below target.
• The Trust is doing better in comparison to our peers and has been asked to share practice regionally.

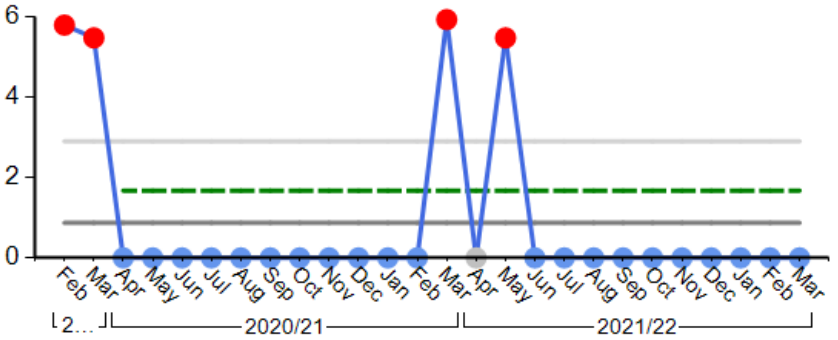
Management Action
• All cases are reviewed at the Patient Safety Meeting to ensure care/management appropriate.
• No themes with midwife conducting births OASI (Obstetric anal sphincter injury).
• Quality improvement care bundle implemented.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Stillbirth Rate (per 1,000 births)	3.74	0	0	Mar 22		3.7	5.9	Feb 22	3.74	3.4	
Neonatal Mortality Rate (per 1,000 births)	1.67	0	0	Mar 22	L	1.7	0	Feb 22	1.67	0.4	
Number of Maternal Deaths	0	0	0	Mar 22		0	0	Feb 22	0	0	
Caesarean Rates	28.5%	35.3%	60	Feb 22		28.5%	30.7%	Jan 22	28.5%	35.3%	
Induction Rate	38%	44.1%	90	Mar 22		38%	42.4%	Feb 22	38%	42.8%	
Breastfeeding Initiation	62%	61.5%	75	Mar 22	H	62%	63.3%	Feb 22	62%	63.5%	
Percentage of Women Booked by 12 weeks 6 days	90%	92.5%	18	Mar 22		90%	91.6%	Feb 22	90%	91.5%	
Number of Occasions 1:1 Care Not Provided		0	0	Mar 22			0	Feb 22	0	12	
Maternity Complaints as % of Deliveries	0.7%	0.5%	1	Mar 22		0.7%	0.6%	Feb 22	0.7%	0.6%	
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Births	1.5%	0.9%	1	Mar 22		1.5%	2.4%	Feb 22	1.5%	2%	
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births	11%	10.5%	2	Mar 22		11%	0%	Feb 22	11%	4.1%	

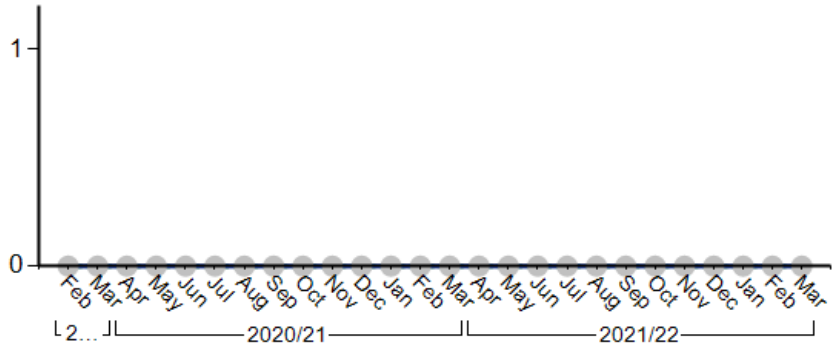
Stillbirth Rate (per 1,000 births)



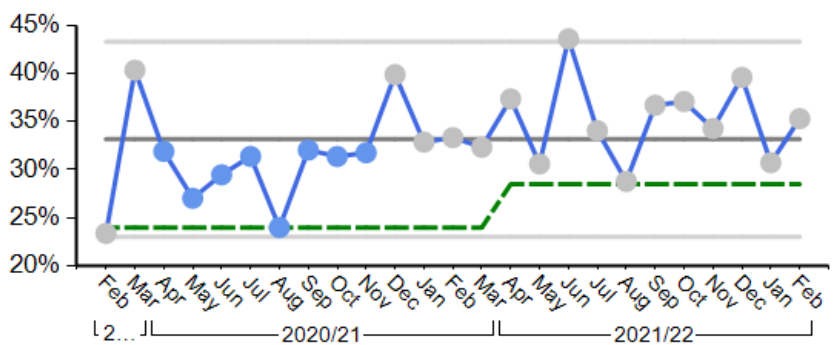
Neonatal Mortality Rate (per 1,000 births)



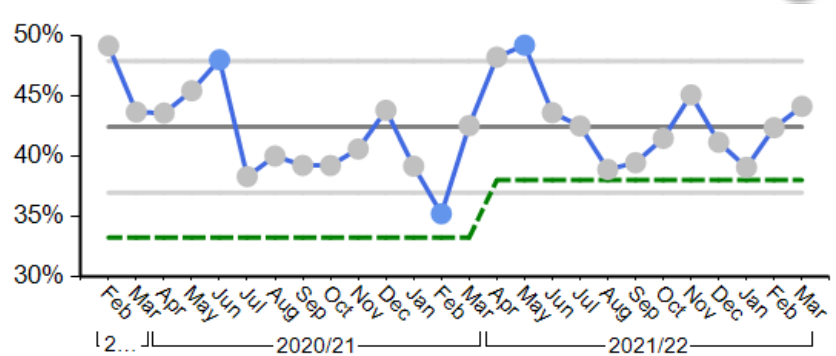
Number of Maternal Deaths



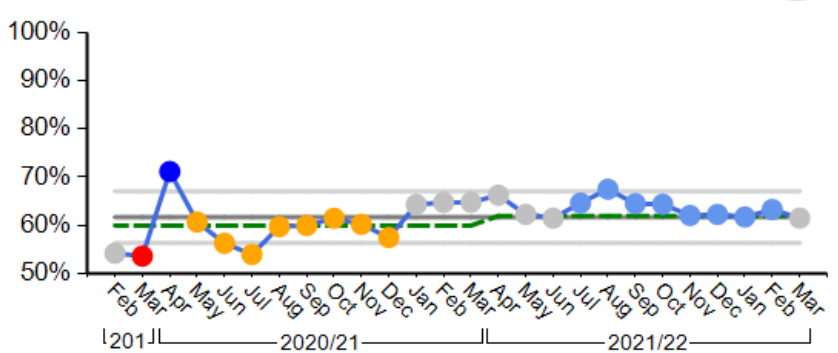
Caesarean Rates



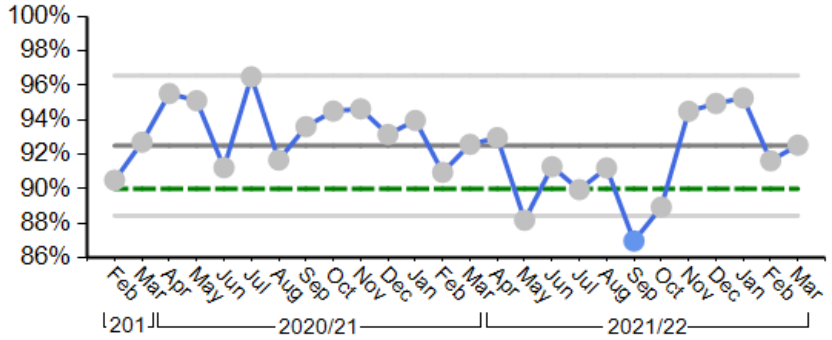
Induction Rate



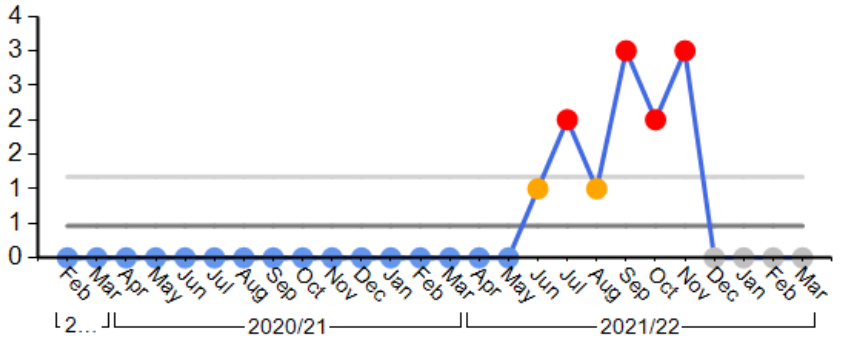
Breastfeeding Initiation



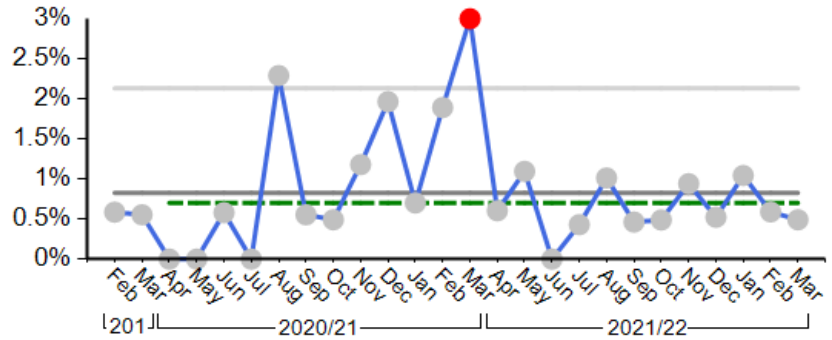
Percentage of Women Booked by 12 weeks 6 days



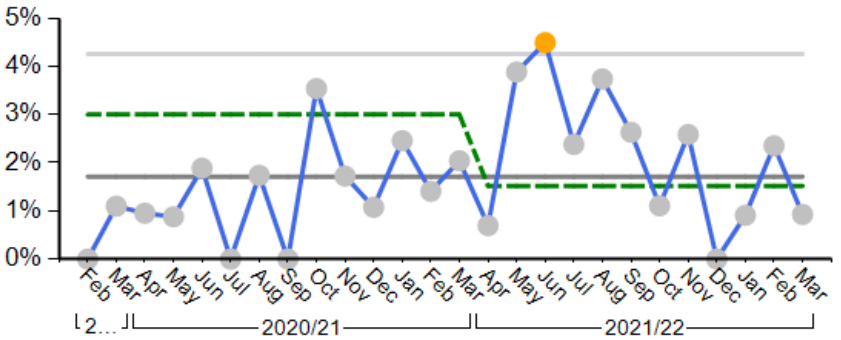
Number of Occasions 1:1 Care Not Provided



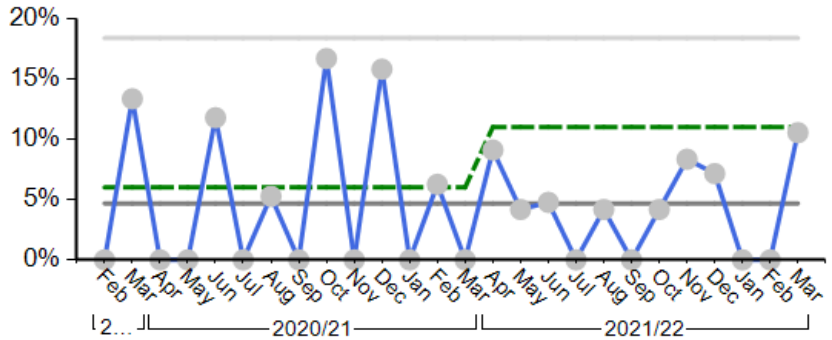
Maternity Complaints as % of Deliveries



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



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



Quality

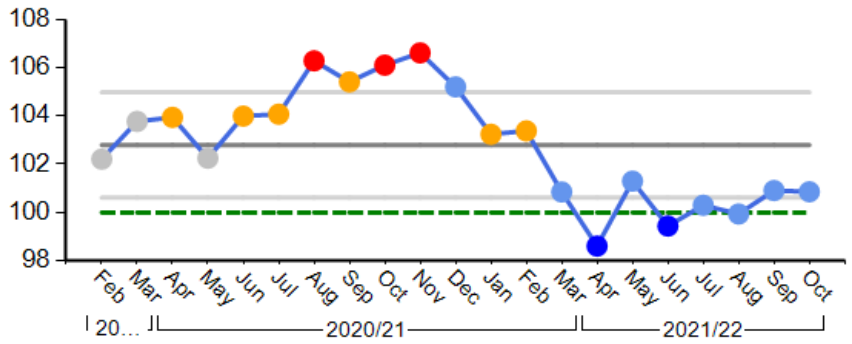
Mortality

Issues
- Both the HSMR and SHMI are showing special cause improvement.
- The HSMR continues to be assured with performance well below target.
- SHMI 100.86 for 12 month period ending October 2021. Continues to remain ‘around’ 100 but is always ‘as expected’
- All local SMR’s remain below 100.
- The Percentage of Deaths screened continues to show special cause improvement.

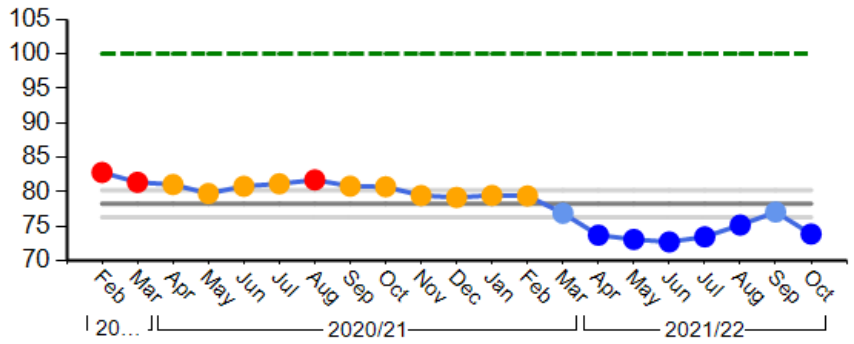
Management Action
- The Mortality Operational group continues to meet monthly to review the Mortality dashboard.
- The Mortality Screening falls under the Medical Examiner’s Office, with a resulting increase in compliance with screening.
- The outcome of completed structured judgement reviews (SJR’s) into deaths are discussed at Mortality Operational Group with learning disseminated as required.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
SHMI (Summary Hospital-level Mortality Indicator)	100	100.9	N/A	Oct 21		100	100.9	Sep 21	100	100.2	
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	73.9	N/A	Oct 21		100	77.1	Sep 21	100	73.9	
Percentage of Deaths Screened	100%	98.7%	1	Mar 22		100%	96.6%	Feb 22	100%	62.9%	
Perinatal Mortality Rate	5.4	0	0	Mar 22		5.4	5.8	Feb 22	5.4	3.7	

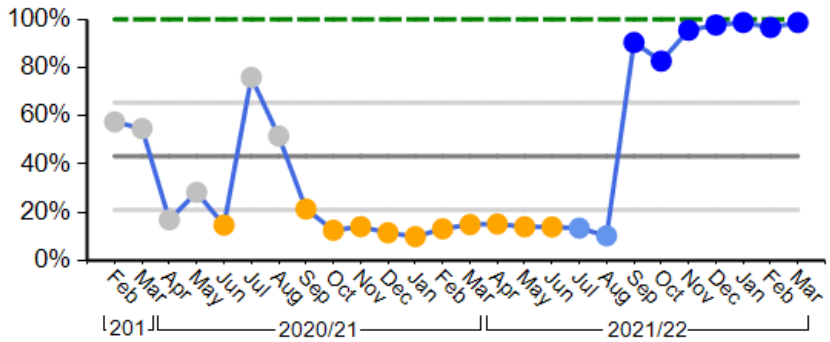
SHMI (Summary Hospital-level Mortality Indicator)



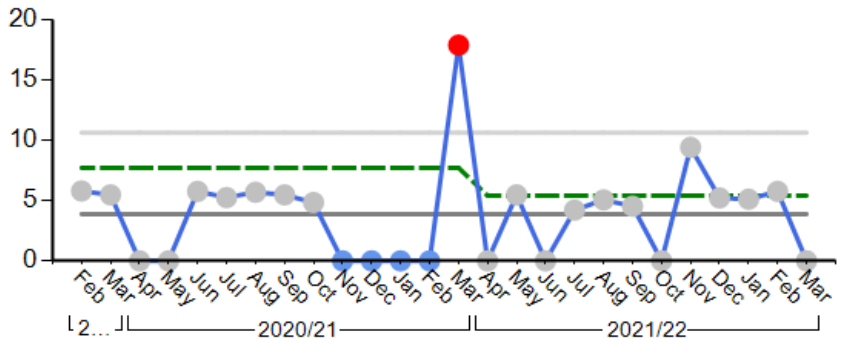
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)



Percentage of Deaths Screened



Perinatal Mortality Rate



Quality

Patient Experience

Complaints - % closed within 40 working days

Issues
• There has been a 23.2% improvement in March to the highest level of compliance since February 2021.

Management Action
• The new Complaints Manager continues to work closely with the CBU's to improve the timeliness of complaints response and explore alternative methods of complaint resolution, this includes improved complaints monitoring and reduction of any bottlenecks within the quality assurance processes.

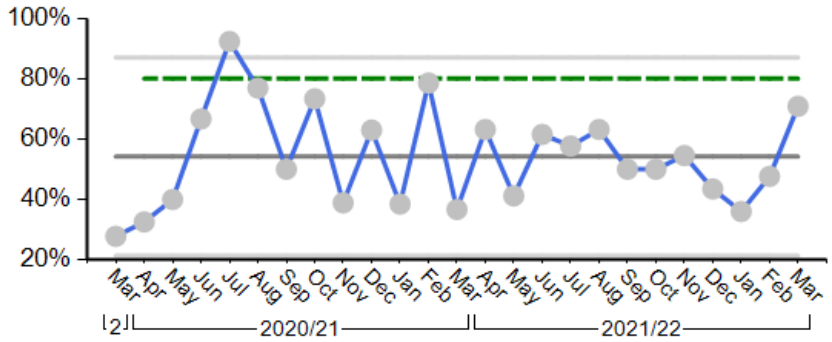
Friends & Family Test

Issues
• Overall Trust score for those that have rated their experience as 'very good/good' continues to show special cause concern and has breached the third lower control limit, achieving 86.5% against the 94% target in March. This is against a response rate of 25.6% which is above the 15% target.
• Medicine and Emergency Care have decreased from 88.4% to 82.8% and Planned Care have decreased from 95.6% to 92.3%.
• Low response rates within Maternity settings continue to impact.
• FFT within the Adult Accident and Emergency department has decreased to 77.94% from 84.89%. The main themes from ratings of 'poor/very poor' are waiting times and environment.

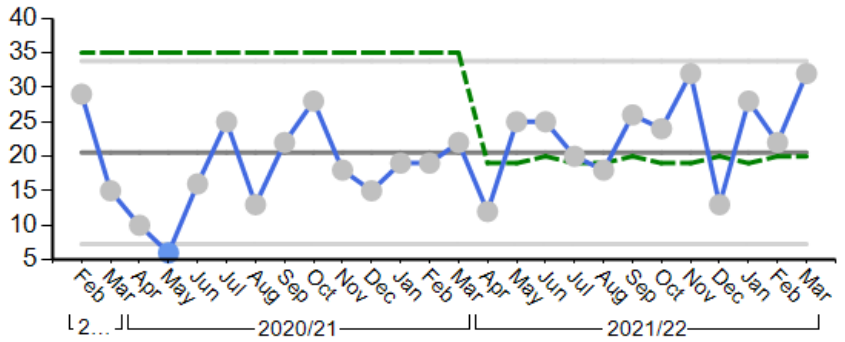
Management Action
• Focused work continued in March to improve response rates in Antenatal and Post- Natal community settings including implementation of QR codes, use of Maternity Social Media platforms to promote the FFT and consideration of automating FFT for the postnatal community settings.
• To improve the patient experience within Adults A&E, the Trust has added an enhanced PALS Officer, recruited to Housekeeper roles, re-introduction of volunteers in A&E with a further 3 in the recruitment process and a Patient Experience Facilitator supporting communication between patients who are awaiting admission and their families.
• Monthly FFT summaries are shared with CBU's and FFT is identified as a quality priority with all CBU's participating in the current working group.
• Ward /Dept managers have access to view their own live FFT data to inform a 'You said.. We did" approach.
• FFT is 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%	70.8%	N/A	Mar 22		80%	47.6%	Feb 22	80%	53%	
Written Complaints	20	32	32	Mar 22		20	22	Feb 22	233	277	
Friends and Family Test - Patients - % Response Rate	15%	25.6%	6140	Mar 22	H	15%	25.4%	Feb 22	15%		P
Friends and Family Test - Patients - % That Would Recommend - Trust Overall	94%	86.5%	285	Mar 22	L	94%	90.4%	Feb 22	94%	88.6%	
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	68%	49.4%	N/A	Jan 22	L	68%	53.8%	Oct 21	68%	53.8%	F
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	0	5	5	Mar 22		0	0	Feb 22	0	46	
Duty of Candour - Evidence of Discussion	100%	100%	0	Mar 22		100%	100%	Feb 22	100%	100%	
Duty of Candour - Evidence of Letter	100%	100%	0	Mar 22	H	100%	100%	Feb 22	100%	100%	

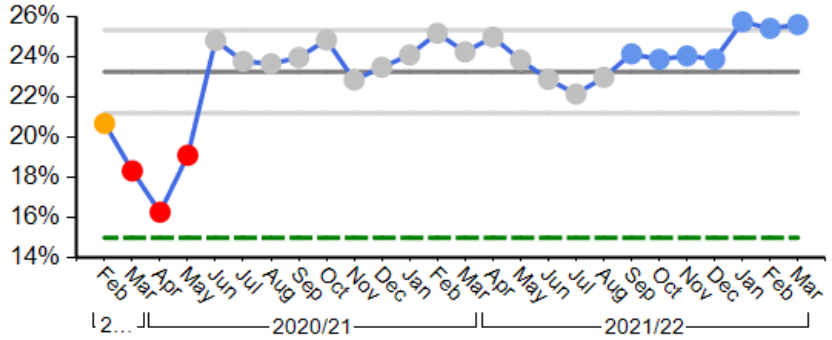
Complaints - % closed within 40 working days



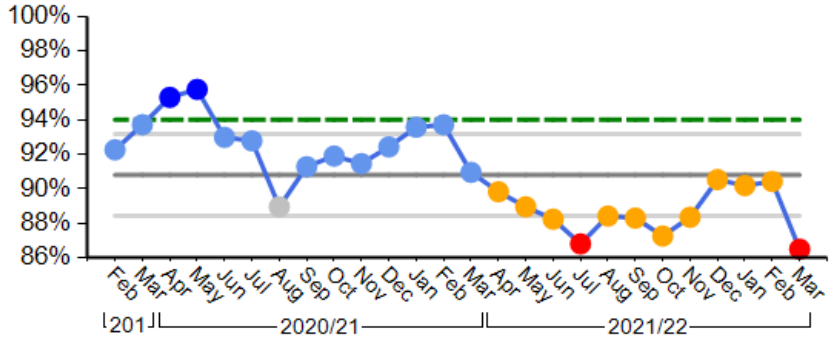
Written Complaints



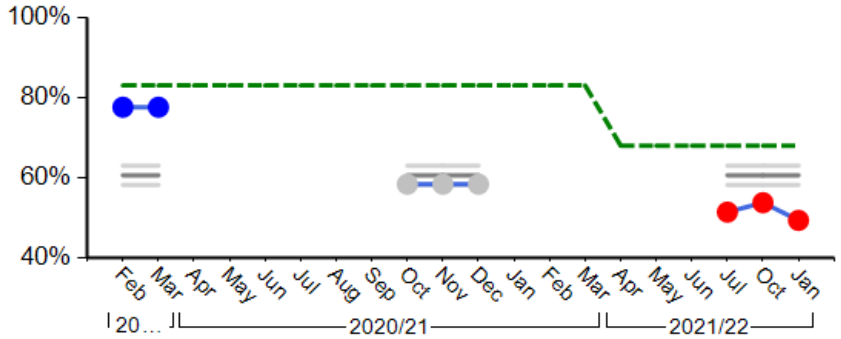
Friends and Family Test - Patients - % Response Rate



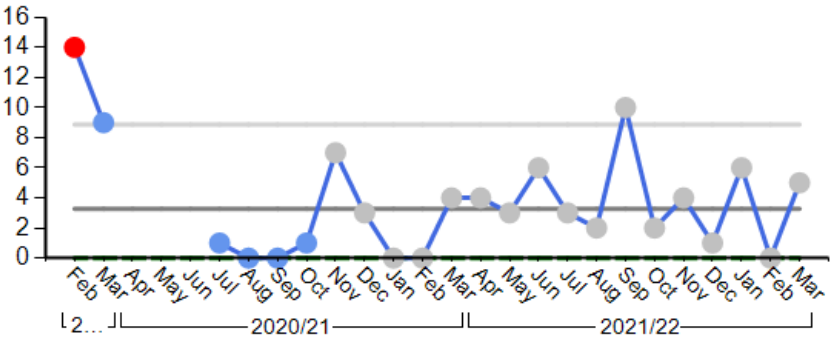
Friends and Family Test - Patients - % That Would Recommend - Trust Overall



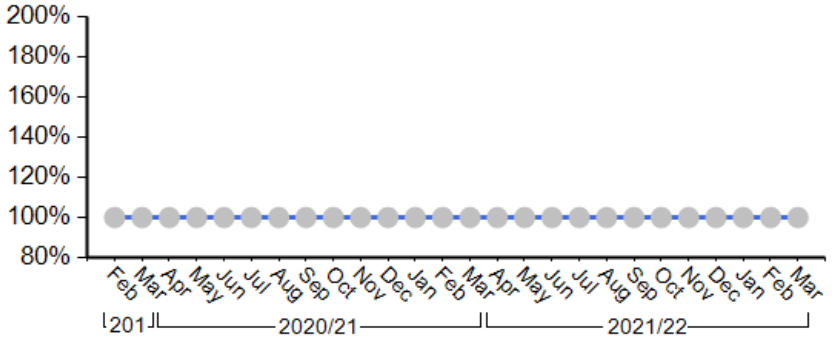
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



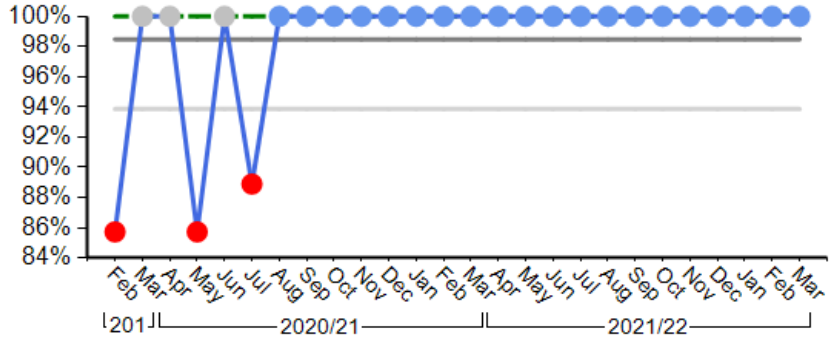
DSSA (Delivering Same Sex Accommodation) Breaches - Trust



Duty of Candour - Evidence of Discussion



Duty of Candour - Evidence of Letter



Operations

Access

Stroke

Issues
• Performance against the 90% stay on a Stroke ward continues to be challenged and has declined in February to 42.3%.
• Compliance in February 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 February 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.
• Thirdly, compliance has been challenged by late referrals to the Stroke team and late diagnosis. These accounted for 3 of the 15 breaches. 1 was avoidable.

Management Action
• The Stroke Operational Group continues to focus on quality and pathway improvements
• Collaborative work with LUFT continues as part of the 'North Mersey Stroke Transformation'. 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 March data has not yet been validated to assess the number of 'non-TIA' referrals.
• Historical compliance continues to be challenged by a high percentage of non-TIA referrals which would therefore be inappropriate to be seen in a TIA clinic within 24hrs. This is the single factor in extremely low performance.
• When reporting against validated TIA referrals only, this metric has demonstrated consistently higher compliance.

Management Action
• Reporting to be done on appropriate TIA referrals only (this excludes those who are receiving the requiring interventions, on appropriate medication, or referrals which are not appropriate for a TIA clinic appointment).
• Additional narrative is included on the monthly submission to include the information which has been excluded.

A&E

Issues
• A&E 4hr compliance, the number and proportion of patients spending more than 12 hours in ED and Ambulance Handover 30-60mins are all failing their assurance measures and showing special cause concern.
• Significant pressures remain across all ED's with Cheshire & Mersey reporting 71.2%, North West 68.5% and National 71.6%.
• High bed occupancy at SDGH in March resulting in patients being bedded in ED and CDU overnight.
• ED performance impacted by patient flow, with RFD numbers rising through the month due to delays with care packages, pressure on community teams and multiple Covid outbreaks in care homes, in addition to bed closures within the Trust.

Management Action
• Maintain Clinical Decision Unit in ED as flow area to see and treat patients.
• Major ambulatory stream developed in Ambulatory Care Unit (ACU) to manage demand and reduce 12-hour breaches.
• Eliminate corridor care with use of capacity in surge plans for covid capacity.
• ESCIT QI events for ED and discharge commenced, improvements will form part of operational plan objectives for SDEC and discharge processes.
• Additional medical support in ED and ACU to manage demand.

• Ward 1 used as an escalation ward
• Continued review of covid capacity, surge plan expedited and covid capacity now on three wards to meet demand.
• All reviews of 12-hour breaches demonstrate good standards of care, timely reviews and commencement of plans, and no instances of harm despite the significant time spent in ED.
• ED continues to work closely with NWAS on opportunities to drive down handover times and continue to keep NWAS updated on activity levels (either via the ALO or directly to NWAS Regional Operations Centre).

Diagnostics

Issues
• Diagnostic waits continues to fail its assurance measure and show special cause concern and performance has deteriorated in March to the highest % since June 2020.
• The Trust overachieved against the target of 89% of 19/20 activity in month, achieving 118% for scopes and 93% for scans.

Management Action
• Gastroscopy and colonoscopy account for the highest number of diagnostic waiters over 6 weeks.
• Reconfiguration of Endoscopy ward has supported over-delivery of against elective restoration target for second consecutive month.

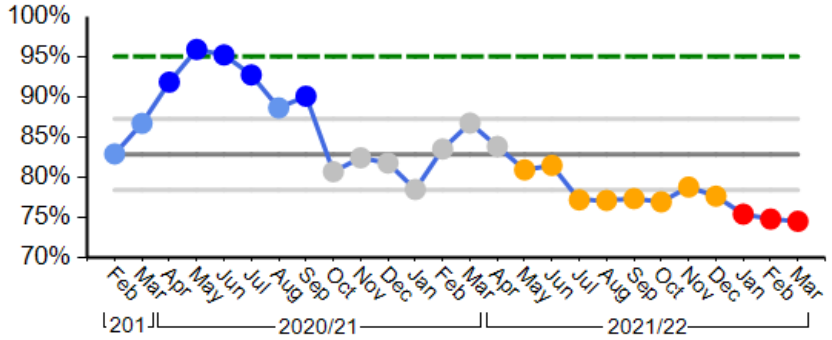
RTT

Issues
• The Referral to treatment: on-going metric continues to fail the assurance measure but performance in month is statistically as expected at 78.1% against the 92% target.
• Against the ERF target to achieve 89% of 19/20 activity, the Trust achieved 82% for RTT – Admitted and 97% for RTT – Non-admitted. The overall RTT ERF position was 94.89%.
• The 30-, 42- and 52-week waiter indicators are all showing recent negative variation. All long-waiters have increased in March.
• Covid continues to have a significant impact on elective restoration plans due to bed capacity and staffing challenges with Covid occupying 3 wards throughout March.
• The Trust continues to perform well compared to peers: 52 week waiters at S&O accounted for 1.5% of the total waiting list compared to Cheshire & Mersey 5.5%.

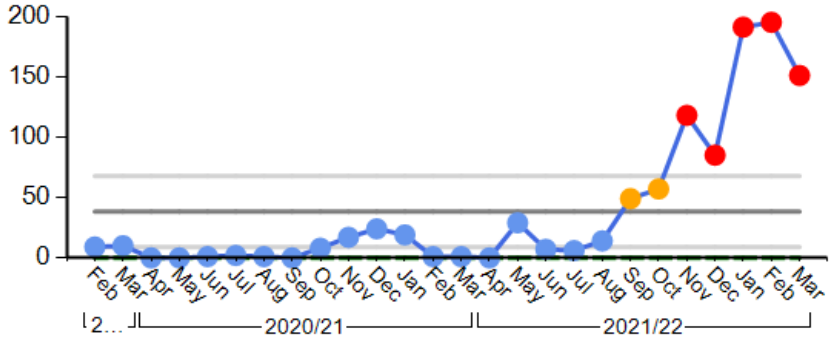
Management Action
• Continued risk stratification of the waiting list.
• Maximise the utilisation of the independent sector to reduce long waiters.
• Enhanced speciality management as the Trust manages Covid absence.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Accident & Emergency - 4 Hour compliance	95%	74.5%	2696	Mar 22		95%	74.8%	Feb 22	95%	78%	
Accident & Emergency - 12+ Hour trolley waits	0	151	151	Mar 22		0	195	Feb 22	0	902	
Number of Patients spending 12+ Hours in ED - Trust	0	1010	N/A	Mar 22		0	832	Feb 22	0	7201	
% of Patients spending 12+ Hours in ED - Trust	0%	12.3%	N/A	Mar 22		0%	12.6%	Feb 22	0%	8%	
Ambulance Handover 30-60 Mins	0	170	170	Mar 22		0	192	Feb 22	0	1162	
Ambulance Handover Over 60 Mins	0	104	104	Mar 22		0	98	Feb 22	0	504	
Diagnostic waits	1%	44.2%	3272	Mar 22		1%	35.6%	Feb 22	1%	32.8%	
Referral to treatment: on-going	92%	78.1%	2639	Mar 22		92%	79.1%	Feb 22	92%	81.4%	
Total RTT Waiting List - Trust		12038	12038	Mar 22			11815	Feb 22		12038	
Total 52 week waits – completed	0	42	N/A	Mar 22		0	37	Feb 22	0	775	
52 Week Waits	0	182	182	Mar 22		0	159	Feb 22	0	242	
Stroke - 90% Stay on Stroke Ward	80%	42.3%	15	Feb 22		80%	43.3%	Jan 22	80%	58.1%	
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	60%	21.1%	15	Feb 22		60%	6.9%	Jan 22	60%	23%	

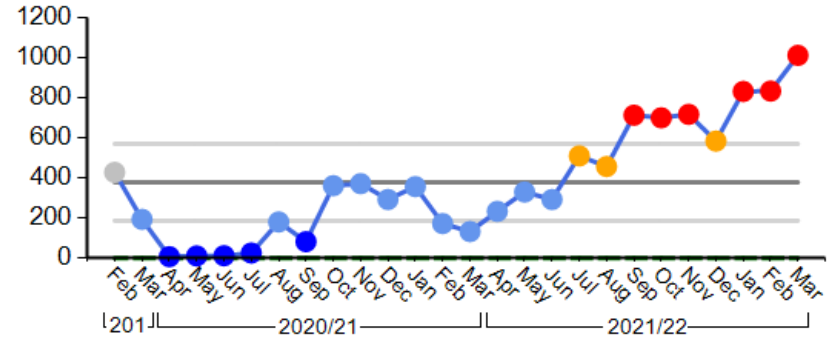
Accident & Emergency - 4 Hour compliance



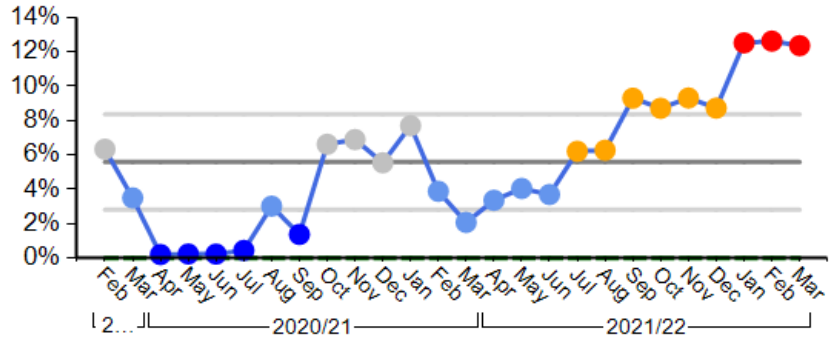
Accident & Emergency - 12+ Hour trolley waits



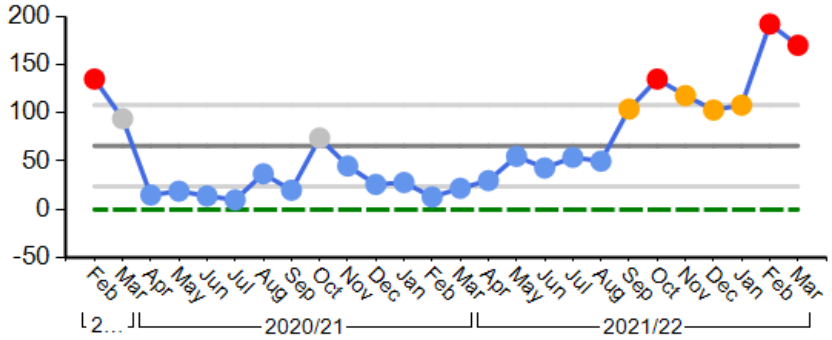
Number of Patients spending 12+ Hours in ED - Trust



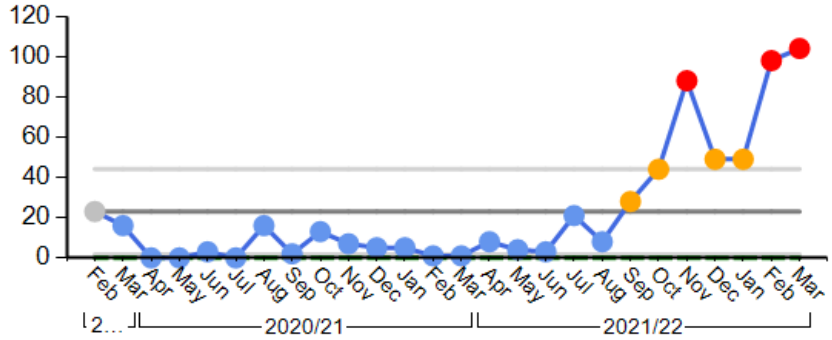
% of Patients spending 12+ Hours in ED - Trust



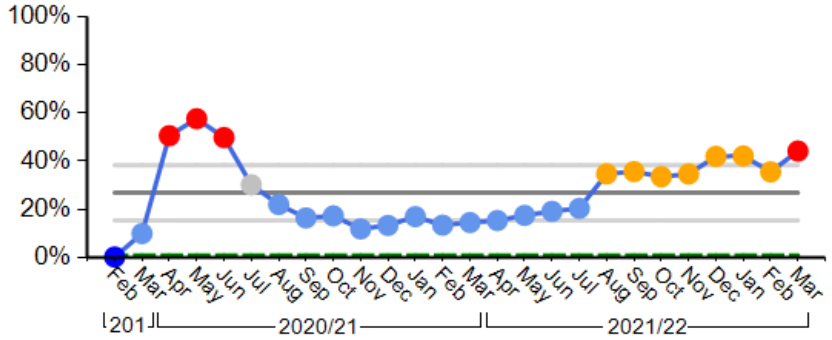
Ambulance Handover 30-60 Mins



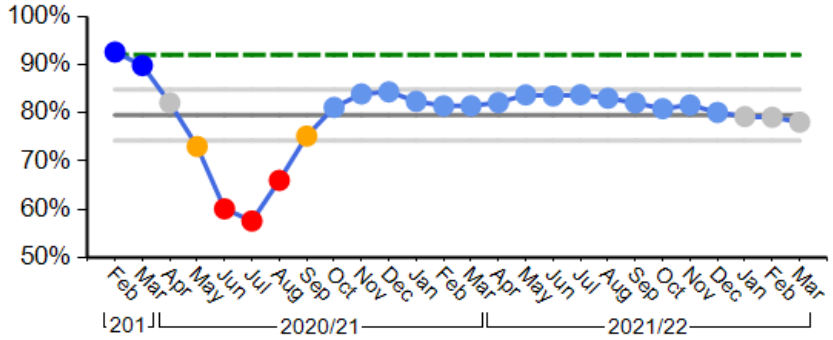
Ambulance Handover Over 60 Mins



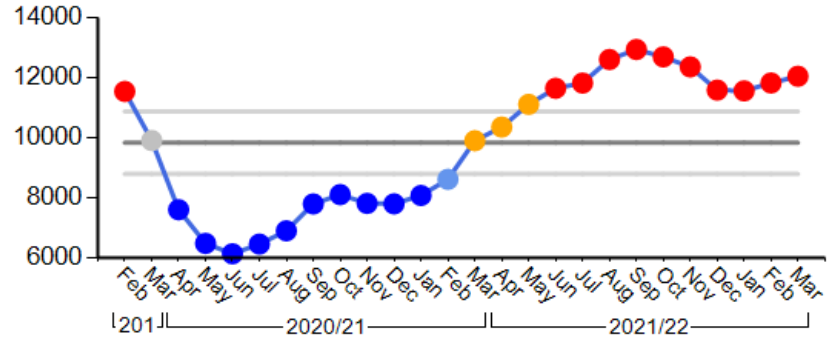
Diagnostic waits



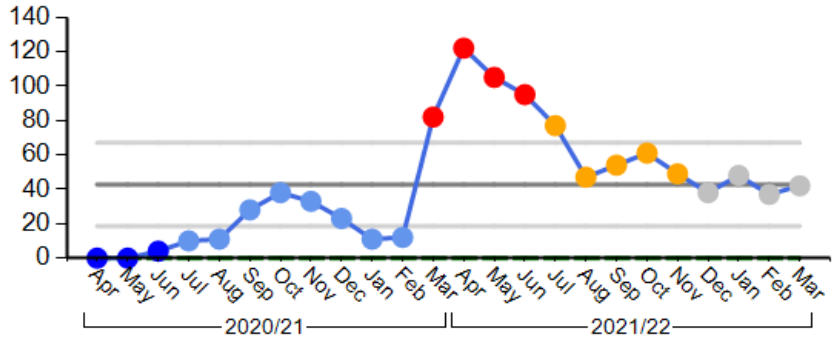
Referral to treatment: on-going



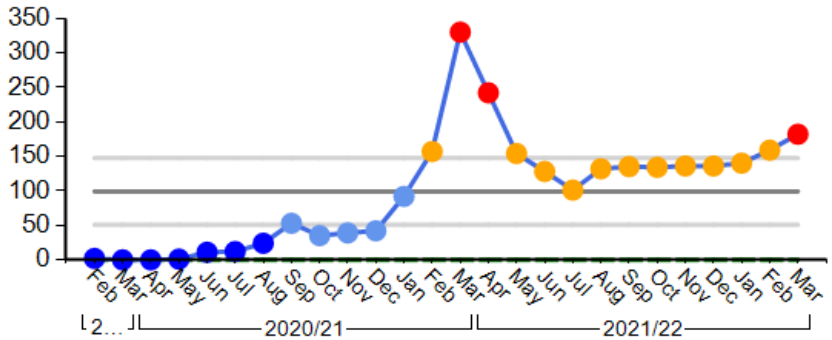
Total RTT Waiting List - Trust



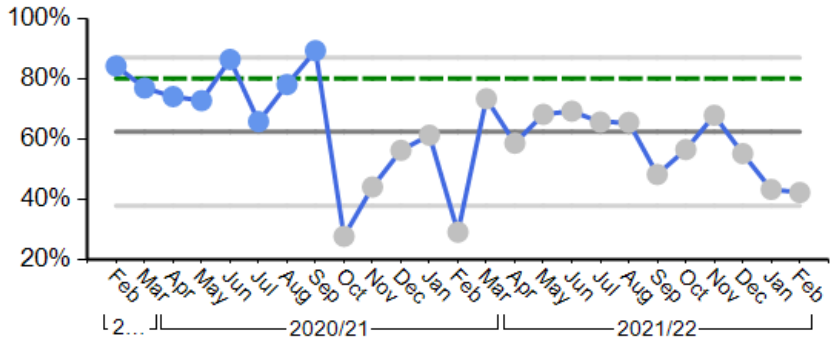
Total 52 week waits – completed



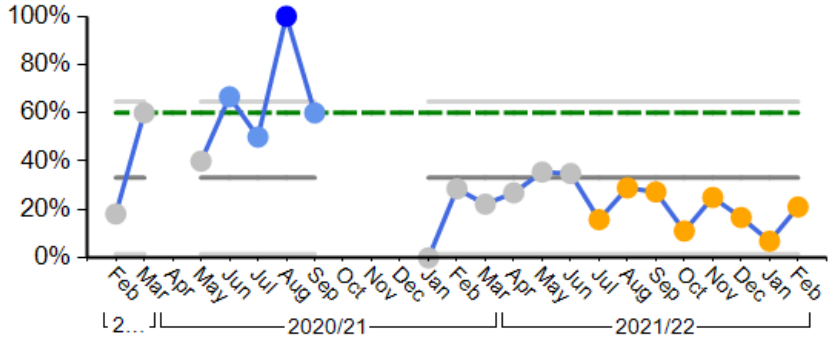
52 Week Waits



Stroke - 90% Stay on Stroke Ward



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



Operations

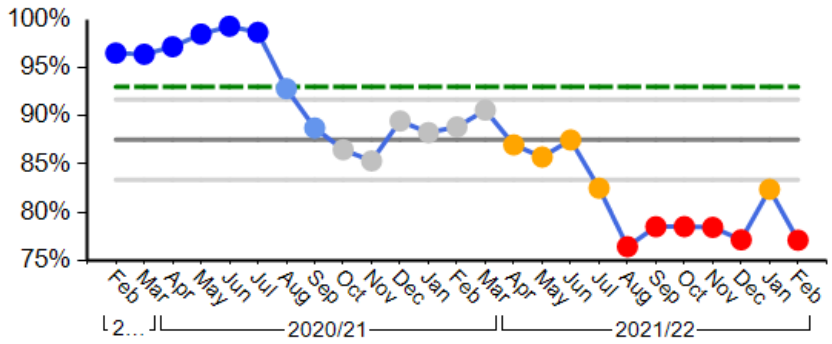
Cancer

Issues
• Performance against the two week wait standard continues to show special cause concern and has decreased to 77.1% against the 93% target.
• The 14-day performance was impacted by ongoing issues in endoscopy, which resulted in upper and lower GI compliance levels of 27.9% and 44.8% respectively. Lung and gynaecology were also non complaint.
• The Trust maintained compliance against the 31-day target, with only two breaches due to lack of capacity in colorectal theatres.
• Challenges remain for the Trust around the 62-day target, with performance against this target falling. Only skin and haematology met this target in February.

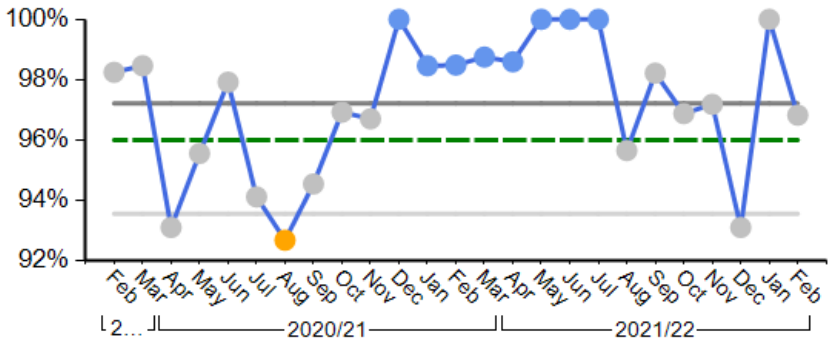
Management Action
• Newly appointed staff in the cancer tracking team are working to reduce the backlog of patients on the cancer PTL.
• Themes that test the Trust ability to deliver against the cancer targets are identified in the robust cancer improvement plan, which is managed by the operational teams.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
14 day GP referral to Outpatients	93%	77.1%	217	Feb 22		93%	82.4%	Jan 22	93%	81%	
31 day treatment	96%	96.8%	2	Feb 22		96%	100%	Jan 22	96%	98%	
62 day GP referral to treatment	85%	58.9%	19.5	Feb 22		85%	67.7%	Jan 22	85%	66.2%	

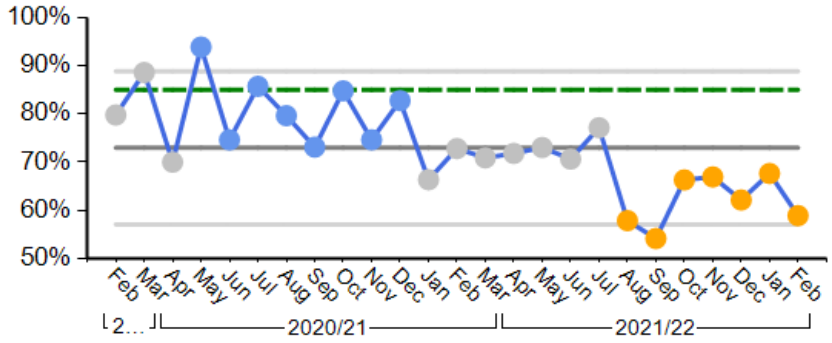
14 day GP referral to Outpatients



31 day treatment



62 day GP referral to treatment



Operations

Productivity

Stranded/Super-Stranded Patients/RFD

Issues
• The number of stranded patients has breached the third upper control limit for the second consecutive month, continuing to show special cause concern although has declined marginally in March.
• The number of super-stranded patients has also decreased but continues to show special cause concern.
• RFD and Stranded patients continue to be impacted by significant delays for care packages, high acuity within community teams and community beds running at near 100%. There were also multiple Covid outbreaks in care homes.
• As many as 80+ patients at a time have been reported as being Ready for Discharge across the wards contributing to high bed occupancy levels, and high numbers of patients bedded in ED and CDU awaiting admission to wards.

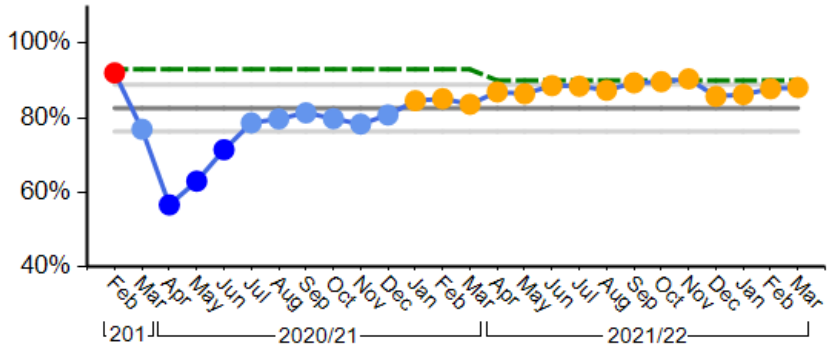
Management Action
• Discharge lounge extended hours to accommodate discharge. Progress being made on new discharge lounge to open April 2022.
• Continued nursing and therapy recruitment as per agreement following FP+I.
• Continued command & control, Point Prevalence, MADE due to internal and ED pressures.
• BI Team working with Patient Flow Matron to provide enhanced reporting relating to Criteria to Reside and RFD.

Length of Stay

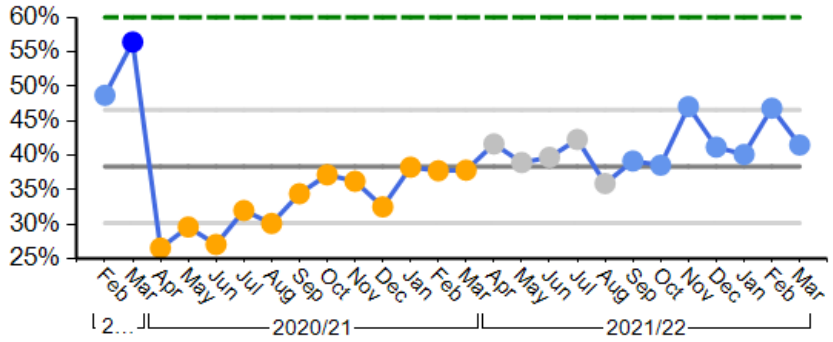
The Trust Average Length of Stay has increased in month and is showing special cause concern. This has been impacted by the discharge of a small number of long stay patients (over 150 days).

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Bed Occupancy - SDGH	90%	88.1%	N/A	Mar 22	H	90%	87.8%	Feb 22	90%	87.9%	?
Bed Occupancy - ODGH	60%	41.5%	N/A	Mar 22	H	60%	46.8%	Feb 22	60%	41.1%	F
Stranded Patients (>6 Days LOS)	163	180	180	Mar 22	H	163	187	Feb 22	163	1980	?
Super Stranded Patients (>20 Days LOS)	53	63	63	Mar 22	H	53	69	Feb 22	53	646	?
OP Slot Utilisation	95%	89.1%	N/A	Mar 22	H	95%	90.6%	Feb 22	95%	92.2%	?
New:Follow Up	2.63	2.2	N/A	Mar 22	L	2.6	2.5	Feb 22	2.63	2.4	?
DNA (Did Not Attend) rate	7%	6.9%	1634	Mar 22	H	7%	7%	Feb 22	7%	6.8%	?
Theatre Utilisation - SDGH	75%	65.3%	N/A	Mar 22		75%	71.6%	Feb 22	75%	66.3%	?
Theatre Utilisation - ODGH	75%	67.4%	N/A	Mar 22	H	75%	67.6%	Feb 22	75%	70.4%	?
Southport A&E Conversion Rate	28%	20.1%	1009	Mar 22	L	28%	21.8%	Feb 22	28%	21.1%	?

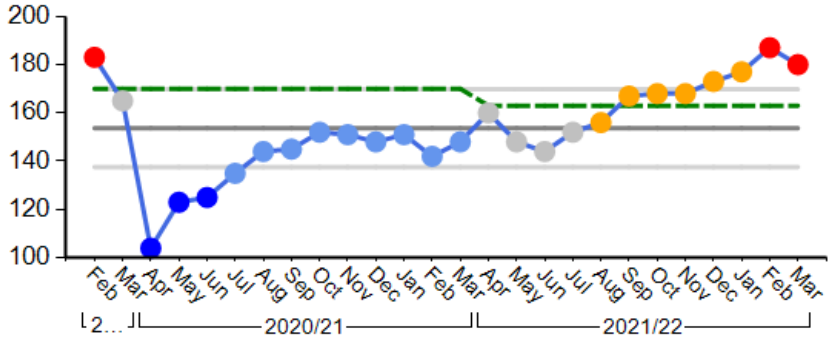
Bed Occupancy - SDGH



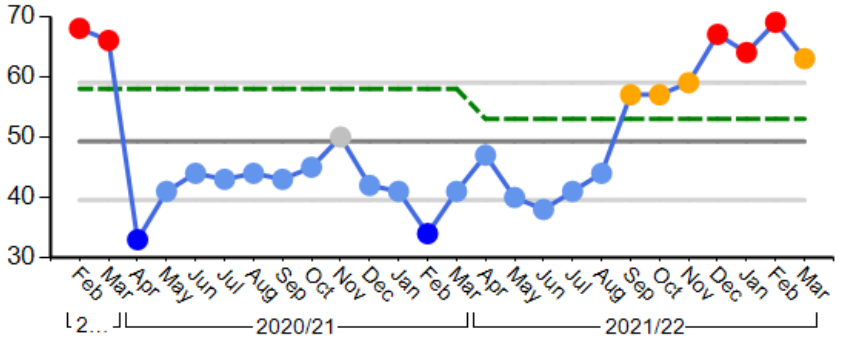
Bed Occupancy - ODGH



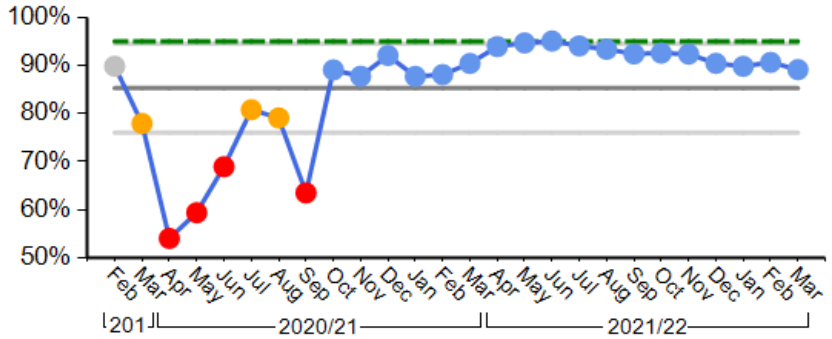
Stranded Patients (>6 Days LOS)



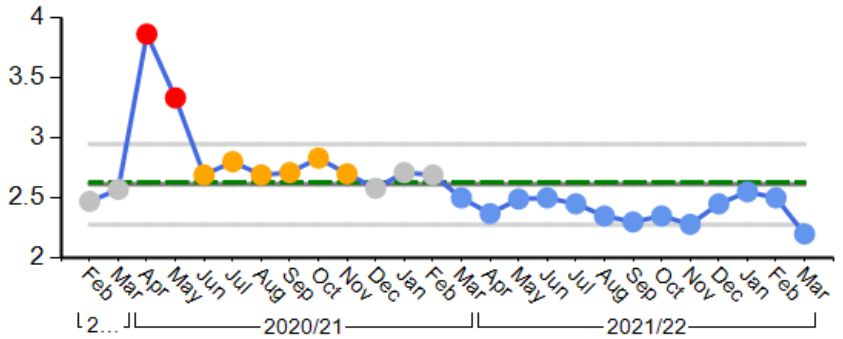
Super Stranded Patients (>20 Days LOS)



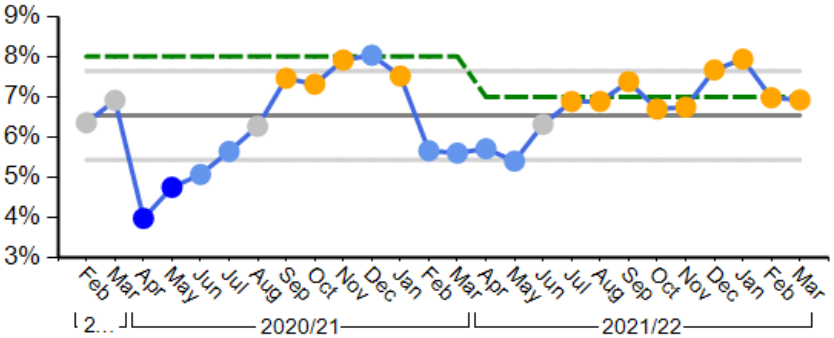
OP Slot Utilisation



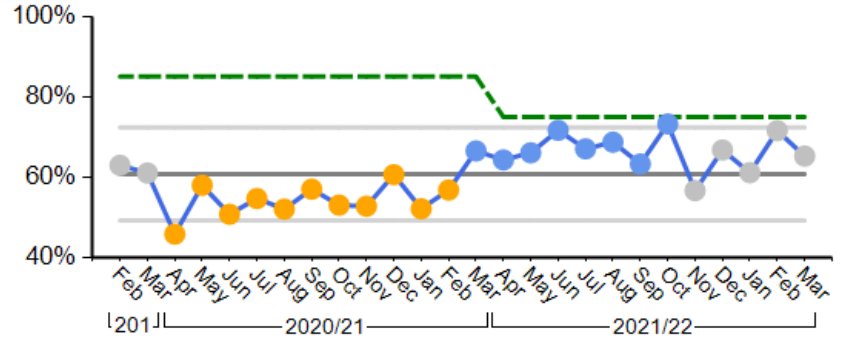
New:Follow Up



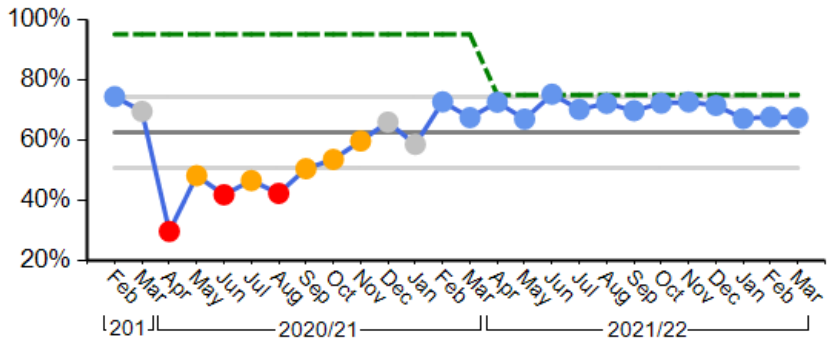
DNA (Did Not Attend) rate



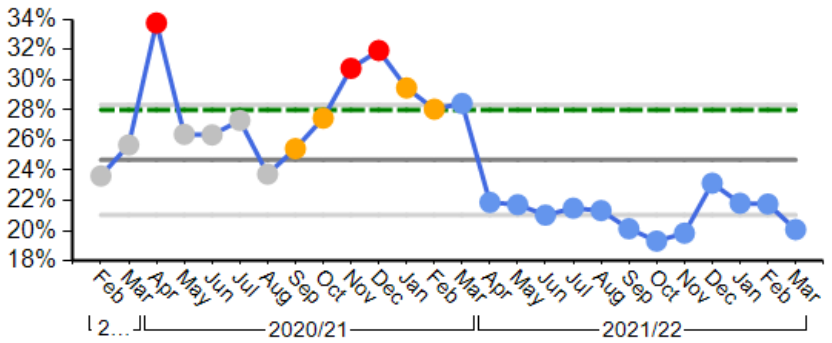
Theatre Utilisation - SDGH



Theatre Utilisation - ODGH



Southport A&E Conversion Rate



Finance

Finance

The Trust has achieved the 2021/22 financial plan – and has delivered services at a £81k surplus following successful bids for additional system funding.

Income & Expenditure - The reported position is consistent with the risk highlighted as part of H2 planning, driven by £1.0m ERF income risk, and a £4.2m gap in system allocations – partly reduced by £0.5m UEC funding as previously reported – mitigated by successful bids for System Top up allocations.
The Trust secured a further £6m system allocations in 2021/22 to support the following whilst ensuring delivery of breakeven:
 Surge costs experienced during Q4 which were originally to be funded from surge funding
 Year-end accounting estimates

CIP - The Trust has delivered schemes totalling £6.6m during 2021/22.
It should be noted that £3.8m is identified as delivered non-recurrently. The potential recurrent nature of schemes identified across CBUs and Corporate budgets is being assessed as part of 2022/23 Financial Planning.

Cash The cash balance at the end of March was £18.5m – which offers a healthy starting point moving into early 2022/23.

BPPC – The Trust's recovery plan submitted to NHSEI set out an improvement trajectory to achieve 95% on a monthly basis by the end of March 2022. The Trust continues to maintain a 90% YTD to the end of March.

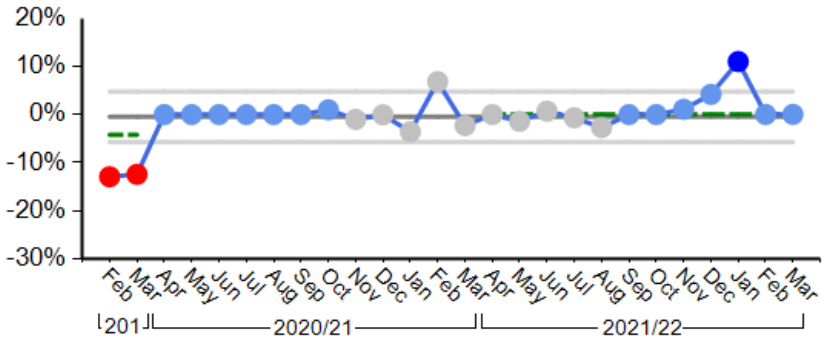
Capital - The Trust has achieved its statutory Capital Resource Limit with an underspend of only £1k meaning the Trust has been able to fully invest all of its capital into Estates, IT and equipment and improve the delivery of healthcare.

In addition, the Trust continues to pursue capital funding of £68m in order to address High Risk Critical Backlog Maintenance.

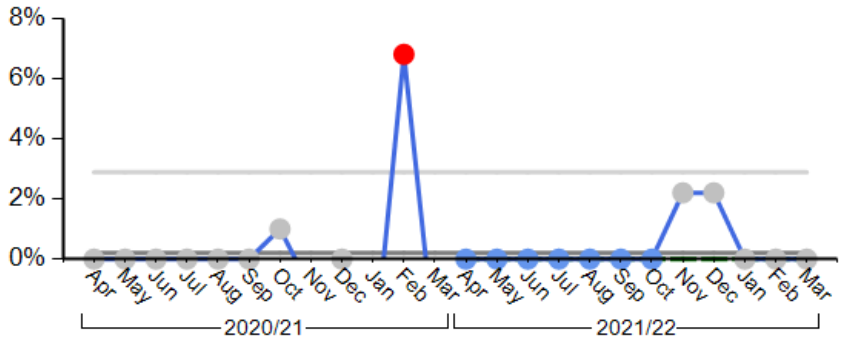
	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
I&E surplus or deficit/total revenue	0%	0%	N/A	Mar 22	H	0%	0%	Feb 22	0%	0%	?
Finance - I&E Surplus or Deficit/Total Revenue – Forecast Outturn	0%	0%	N/A	Mar 22		0%	0%	Feb 22	0%	0%	?
Pay Run Rate - Trust	£14,400K	£16500K	N/A	Mar 22	H	£14,300K	£14582K	Feb 22	£168,000K	£169,300K	F
Non Pay Run Rate - Trust	£5,800K	£9200K	N/A	Mar 22	H	£5,600K	£6030K	Feb 22	£67,380K	£72,500K	F
Year to date Budget in balance		Yes	N/A	Mar 22			Yes	Feb 22		Yes	?
Budget in balance - forecast year end		Yes	N/A	Mar 22			Yes	Feb 22		Yes	?
Bank & Agency Run Rate - Trust		£2900K	N/A	Mar 22	H		£2363K	Feb 22		£20,210K	?

Bank & Agency Staff Run Rate (%)		17.8%	N/A	Mar 22		16.2%	Feb 22		16.7%	
Agency Staff Run Rate (Cost)		£1030K	N/A	Mar 22		£800K	Feb 22		£9,500K	
% Agency Staff (cost)		6.2%	N/A	Mar 22		5.3%	Feb 22		5.6%	
Year To Date Reduction in Premium Rate pay		£500K	N/A	Mar 22		-£200K	Feb 22		-£50K	
CIP – Performance against Plan	£600K	£600K	N/A	Mar 22	£600K	£600K	Feb 22	£6,300K	£6,300K	
CIP – Forecast Outturn	£6,300K	£6300K	N/A	Mar 22	£6,300K	£6300K	Feb 22	£6,300K	£6,300K	
CIP on Target		Yes	N/A	Mar 22		Yes	Feb 22		Yes	
Capital Spend – Actual in Month	£5,500K	£5900K	N/A	Mar 22	£1,500K	£2900K	Feb 22	£13,700K	£13,700K	
Capital Spend – Forecast Outturn	£13,700K	£13700K	N/A	Mar 22	£13,500K	£13500K	Feb 22			
Cash Balance	£19,000K	£18400K	N/A	Mar 22	£18,900K	£13400K	Feb 22			

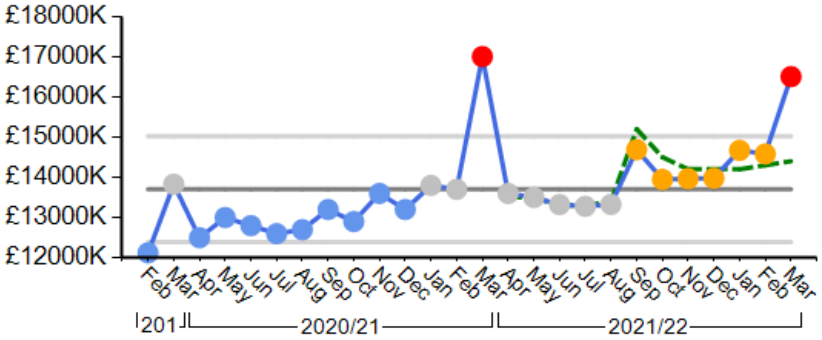
I&E surplus or deficit/total revenue



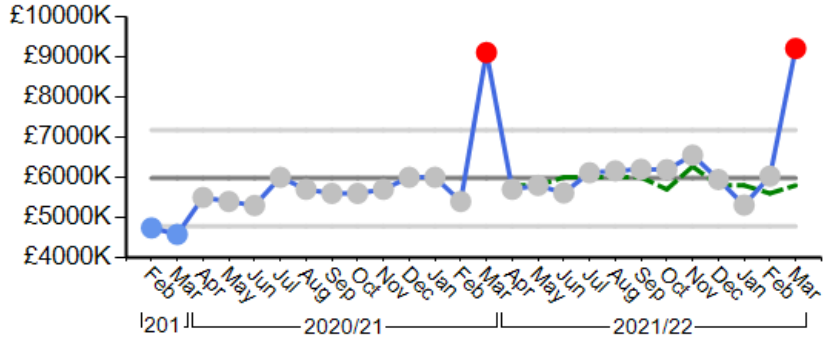
Finance - I&E Surplus or Deficit/Total Revenue – Forecast Outturn



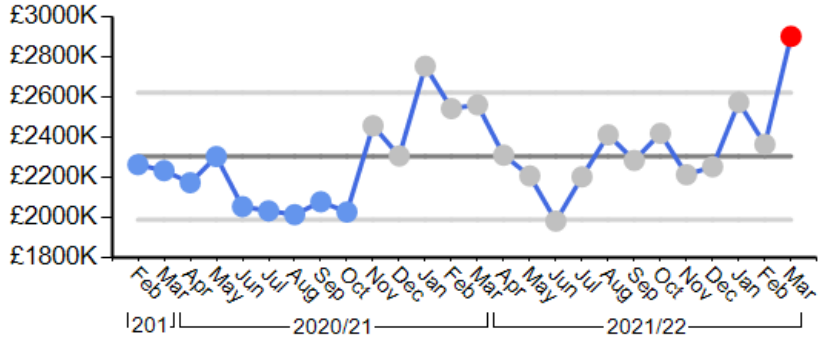
Pay Run Rate - Trust



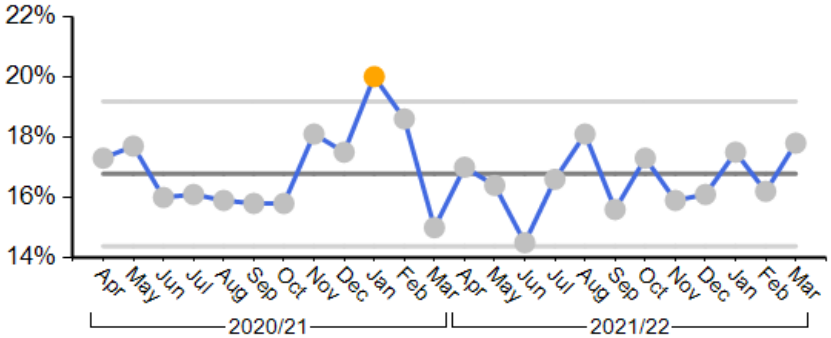
Non Pay Run Rate - Trust



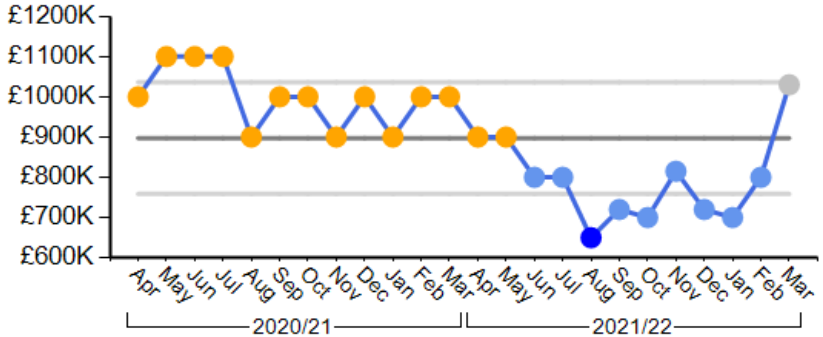
Bank & Agency Run Rate - Trust



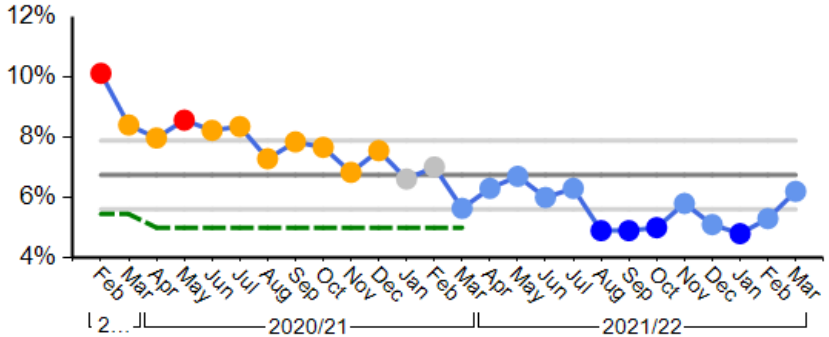
Bank & Agency Staff Run Rate (%)



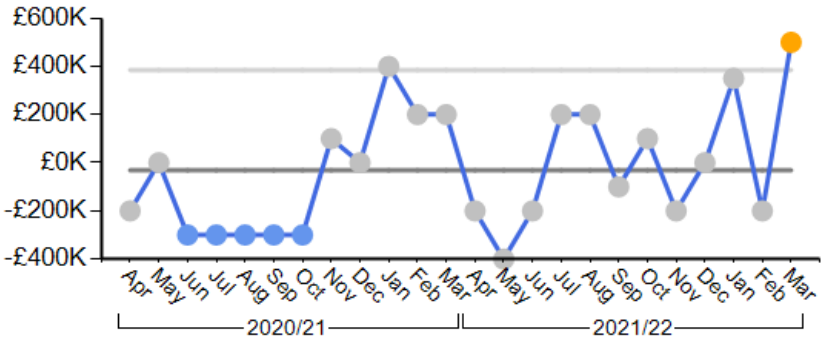
Agency Staff Run Rate (Cost)



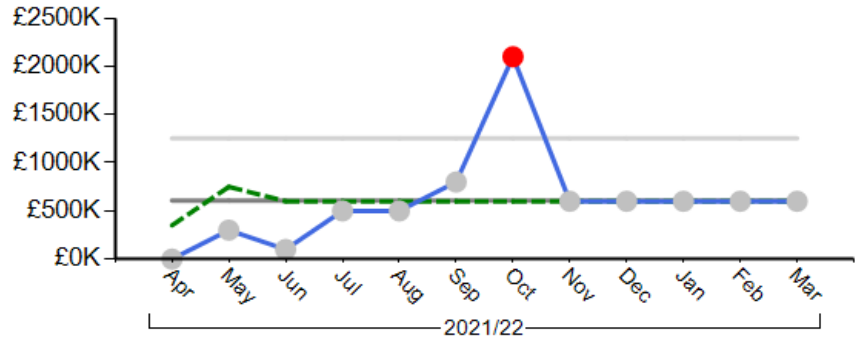
% Agency Staff (cost)



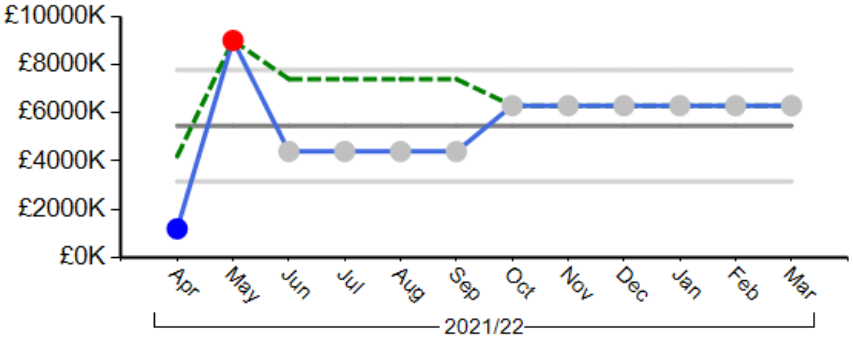
Year To Date Reduction in Premium Rate pay



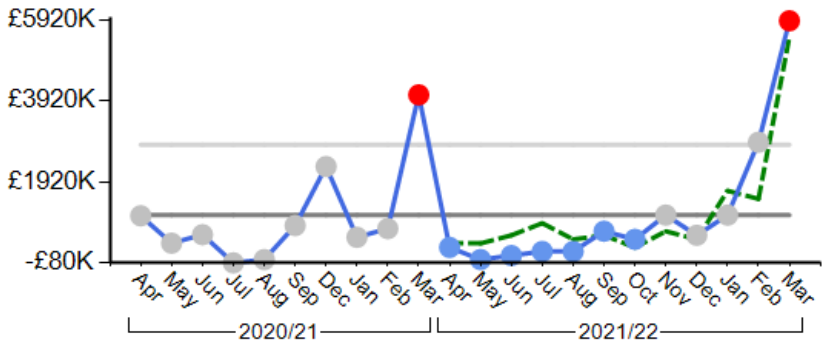
CIP – Performance against Plan



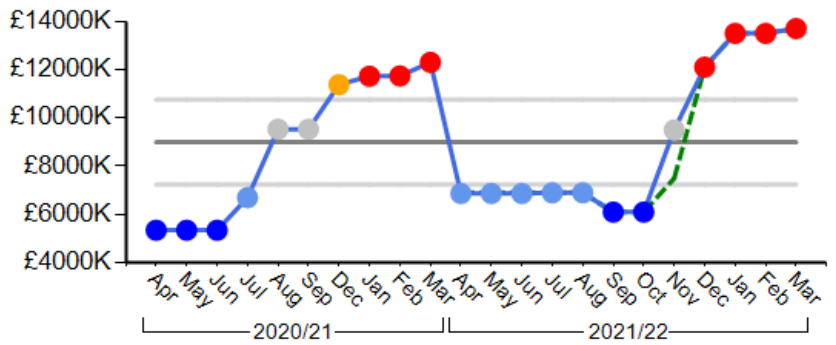
CIP – Forecast Outturn



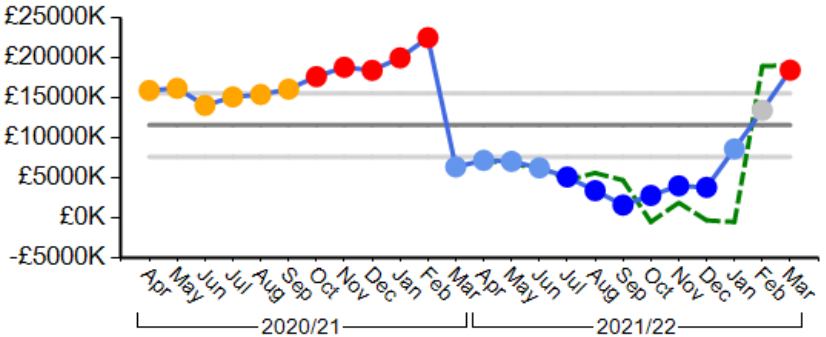
Capital Spend – Actual in Month



Capital Spend – Forecast Outturn



Cash Balance



Workforce

Organisational Development

Personal Development Reviews

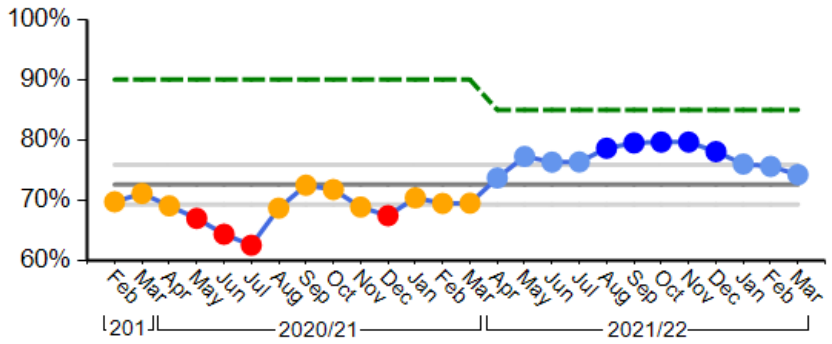
Issues
• The indicator continues to show special cause improvement although for the third consecutive month compliance has declined and is 1.3% lower than the February position.
• Performance in March continues to be impacted by the operational pressures experienced by the Trust.

Management Action
• Improvement trajectories from CBUs have been requested to show a 10% improvement in compliance by the end of April.
• Compliance records are being monitored closely by CBUs and Departments.
• Concentration in March has been on trying to ensure that any PDRs out of date in month are completed initially prior to any 'out of date' requirements.

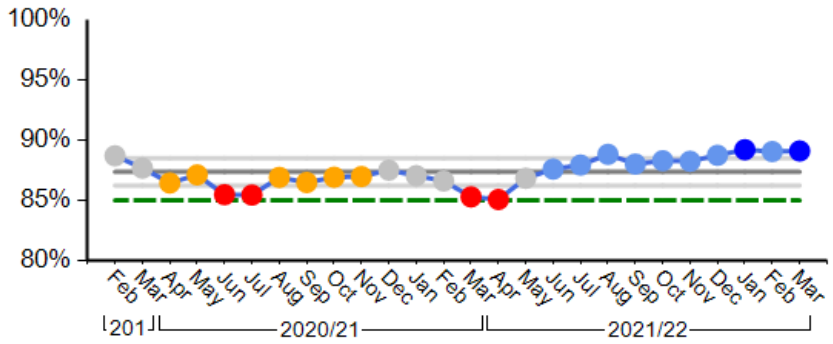
Mandatory training remains assured and is 4.1% ahead of target.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Personal Development Review	85%	74.3%	N/A	Mar 22		85%	75.6%	Feb 22	85%	77.1%	
Mandatory Training	85%	89.1%	N/A	Mar 22		85%	89.1%	Feb 22	85%	88.1%	
Staff Survey - I would recommend my organisation as a place to work	59%	49.2%	N/A	Jan 22		59%	53.9%	Oct 21	59%	53.9%	

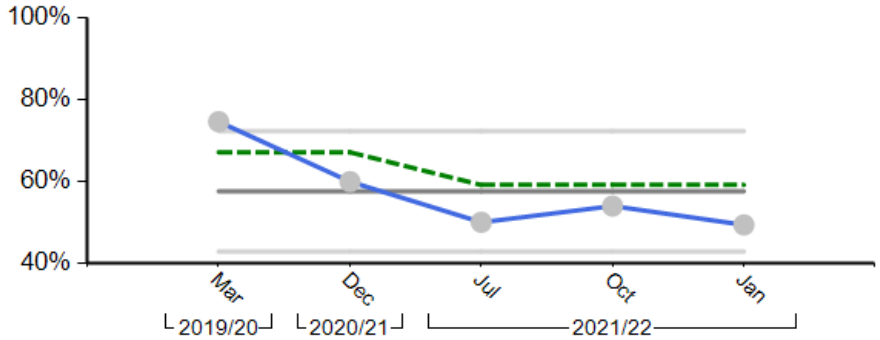
Personal Development Review



Mandatory Training



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



Workforce

Sickness, Vacancy and Turnover

Sickness

Issues
• Sickness rates in March continue to show special cause concern due to the spike in January. Whilst performance in month remains statistically as expected, it has increased by 0.8% on the previous month.
• The rolling 12-month sickness rate continues to fail its assurance measure and at 7% is the highest reported.
• Sickness rates for Nursing staff are failing their assurance measure and showing special cause concern due to the January spike, there has also been a 0.9% increase in March, although performance remains statistically as expected.
• Medical sickness rates remain consistent with the previous month and below the target.

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.
• Drill down into non-registered nurse absence has resulted in some early returns to work.

Vacancies

Issues
• Overall Trust vacancy rate continues to fail its assurance measure but there has been a 0.4% reduction in March.
• Medical vacancy rates are showing special cause improvement although have increased in March.
• Nursing vacancy rates have decreased in March and are showing special cause improvement. The rate is in-line with the target for the first time since April 2021.

Management Action
• The Trust continues to have a pipeline with 191 posts currently under offer.
• Based on our current time to hire of 52 days the evidence of this pipeline will be shown in significant increases in staff in post during the next two months.
• Recruitment team to continue to liaise with operational teams to identify unadvertised vacancies as this is producing good results.
• Rostering team to work through current agency usage, and support to reduce agency spend as we are aware we are utilising more agency than we have vacancies – timescale for this work – to be completed in April.
• The Medical Vacancy Rate continues to be under the planned level, and with a further 23 posts under offer will continue to improve during the year.
• The Nursing Vacancy Rate has seen a significant improvement due to increases in both Band 5 and HCA workforce.
• There are planned recruitment events to close the Nursing Vacancy gap further, with an emphasis on HCA recruitment. The nursing team is also putting together a preceptorship and induction programme for HCAs to ensure they are well supported and wish to remain with the Trust.

Turnover

Issues
• Overall staff turnover levels have increased in March but are statistically as expected.
• The rolling staff turnover is failing the assurance measure and shows special cause concern.
• The Nursing staff turnover has increased in March and whilst this is not statistically significant this is above target and average.

Management Action
• Turnover figures in March have been impacted by a high number of leavers due to retirement.
• It is notable that 14 of the leavers were flexible retirements and will be returning to the Trust shortly but there were an additional 12 retirements.

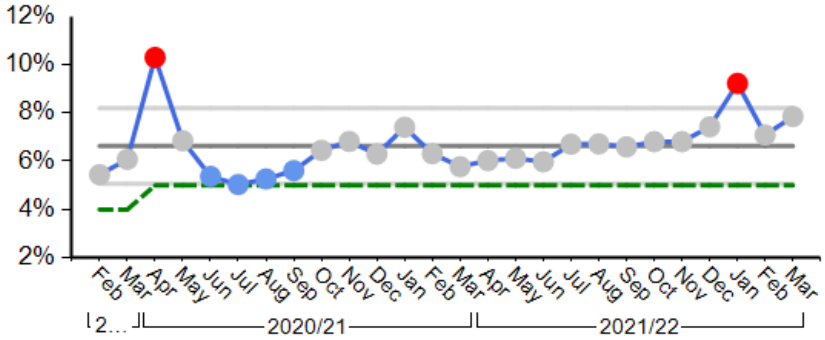
Time to Recruit

Issues
• Time to Recruit shows significant improvement in March.

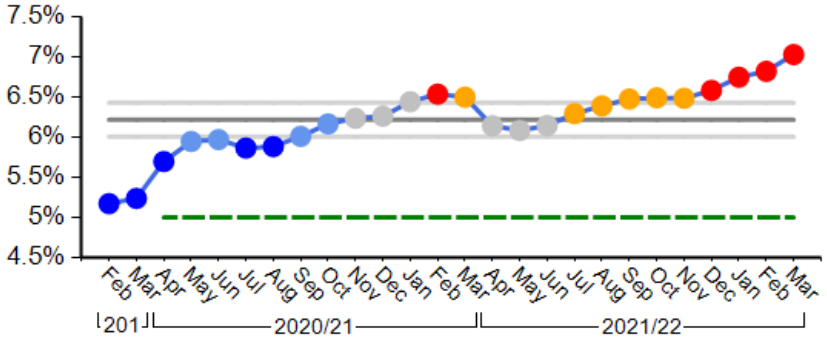
Management Action
• The work of Operation Green continues.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Sickness Rate	5%	7.9%	N/A	Mar 22		5%	7.1%	Feb 22	5%	7%	
Sickness Rate (Rolling 12 Month)	5%	7%	N/A	Mar 22		5%	6.8%	Feb 22	5%	6.5%	
Sickness Rate - Medical Staff	5%	4.4%	N/A	Mar 22		5%	4.4%	Feb 22	5%	2.7%	
Sickness Rate - Nursing Staff	5%	9.4%	N/A	Mar 22		5%	8.5%	Feb 22	5%	8.8%	
Sickness Rate (not related to Covid 19) - Trust		5.5%	N/A	Mar 22			5.3%	Feb 22		5.7%	
Trust Vacancy Rate – All Staff	6.8%	9.7%	N/A	Mar 22		6.8%	10.1%	Feb 22	6.8%	9.8%	
Vacancy Rate - Medical	7.4%	5.8%	N/A	Mar 22		7.4%	4.6%	Feb 22	7.4%		
Vacancy Rate - Nursing	9%	9%	N/A	Mar 22		9%	11%	Feb 22	9%		
Staff Turnover	0.75%	1.5%	N/A	Mar 22		0.8%	0.9%	Feb 22	9%	6.8%	
Staff Turnover (Rolling)	10%	16.2%	N/A	Mar 22		10%	15.7%	Feb 22			
Staff Turnover - Nursing	0.75%	1.5%	N/A	Mar 22		0.8%	0.5%	Feb 22	0.8%	1.3%	
Time to Recruit	55	54	N/A	Mar 22		55	63	Feb 22	55	57	

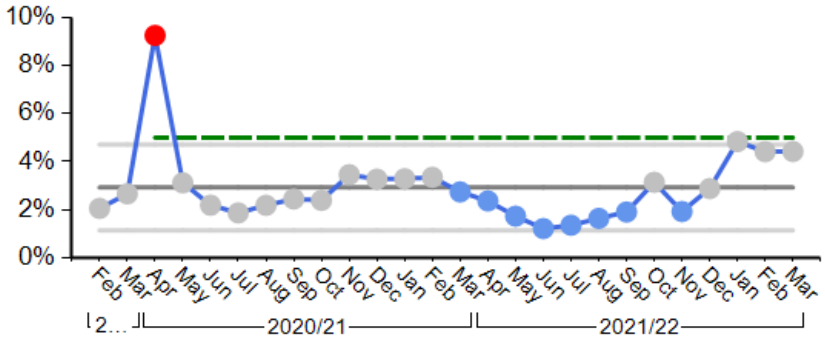
Sickness Rate



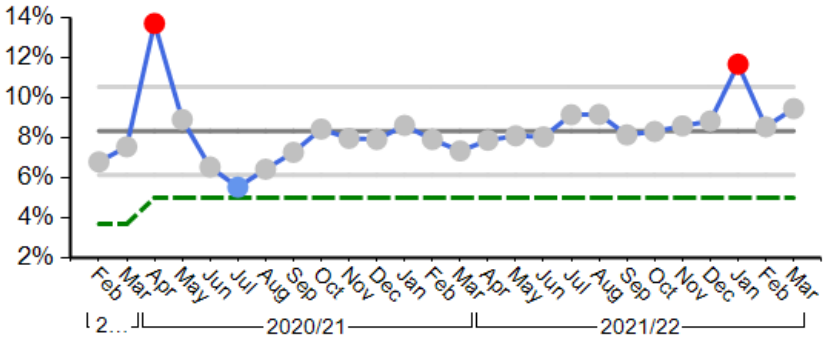
Sickness Rate (Rolling 12 Month)



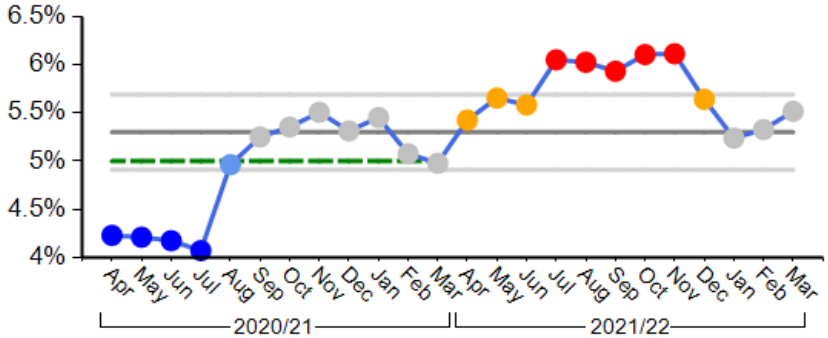
Sickness Rate - Medical Staff



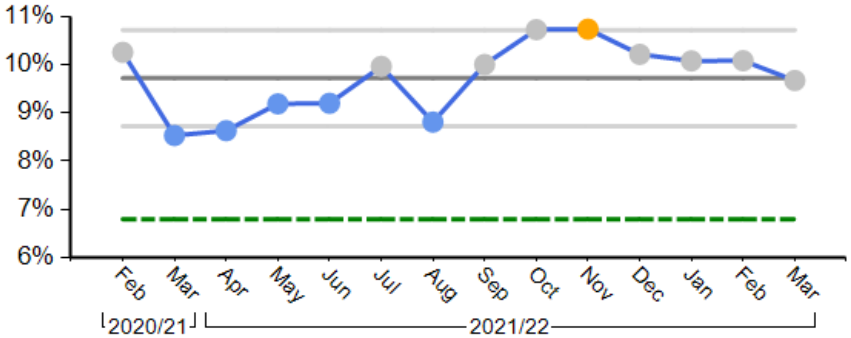
Sickness Rate - Nursing Staff



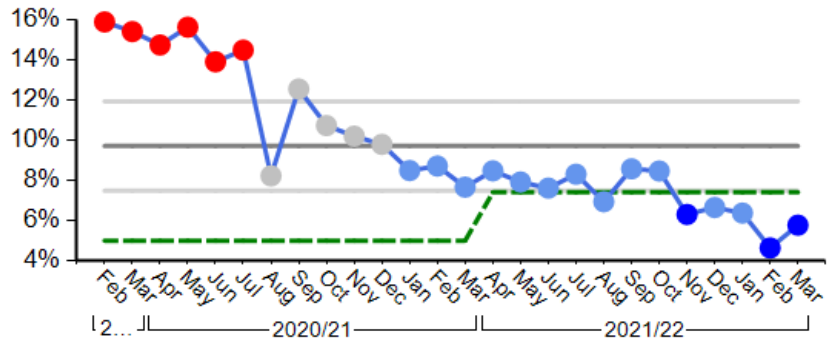
Sickness Rate (not related to Covid 19) - Trust



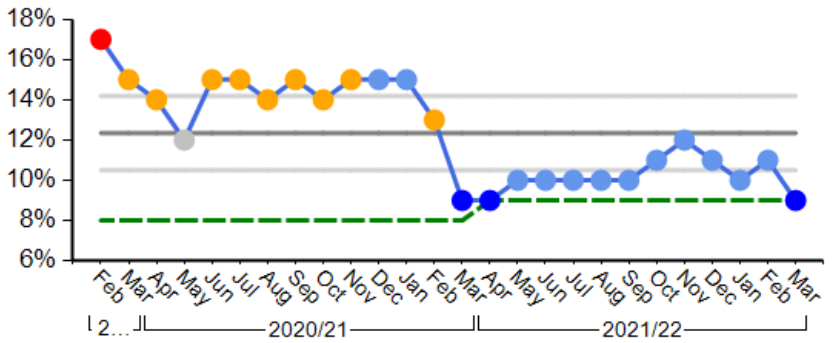
Trust Vacancy Rate – All Staff



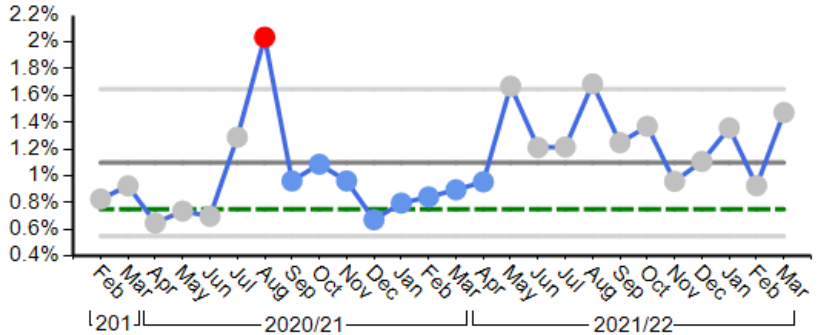
Vacancy Rate - Medical



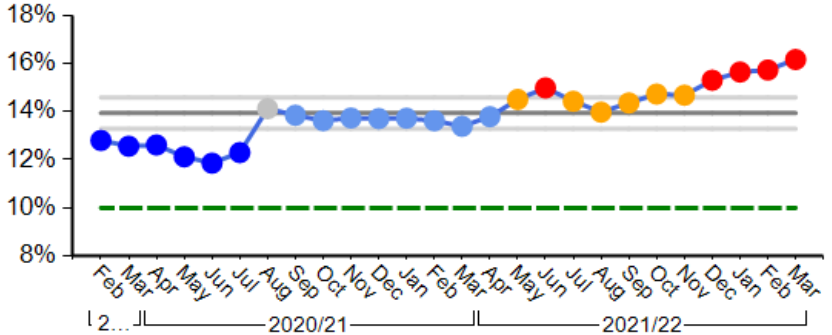
Vacancy Rate - Nursing



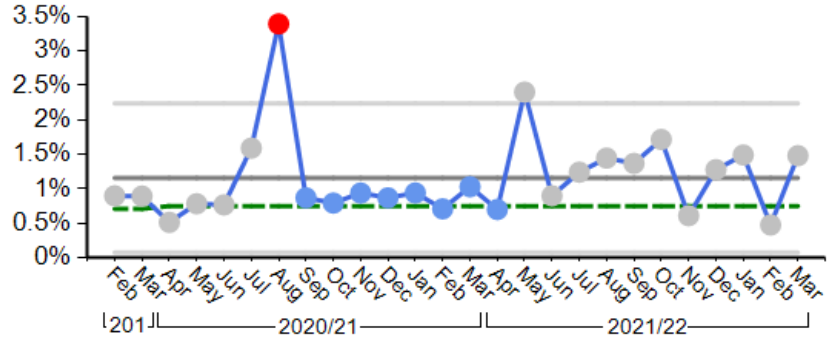
Staff Turnover



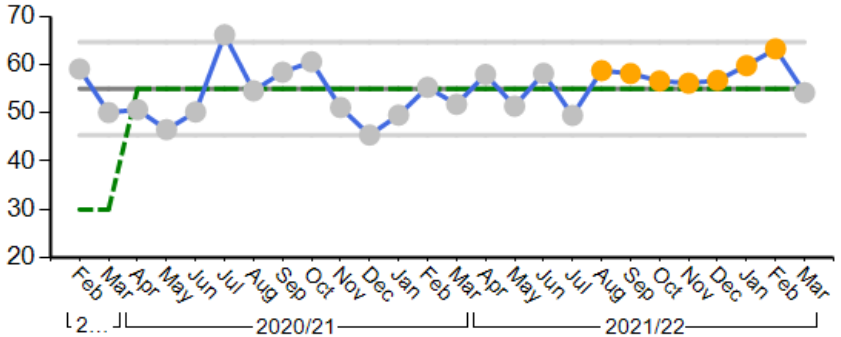
Staff Turnover (Rolling)



Staff Turnover - Nursing



Time to Recruit



ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Quality and Safety Committee
MEETING DATE:	25 April 2022
LEAD:	Gill Brown

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- **IPC AAA** noted concerns in compliance with hand hygiene and PPE compliance, referencing specific areas and norovirus outbreak. Mitigating actions in place. Situation being closely monitored
- **Patient Safety Update** noted work ongoing relating to falls and specific inpatient areas. Further work needed now. Falls Lead Nurse in place to support patients with cognitive impairment and raise staff awareness.
- **Cleaning Rosters** – business case being progressed to ensure cleaning rosters are substantively resourced to ensure the Trust can staff all necessary IP cleans to support patient flow.

ADVISE

- **Ockenden Final Report** – received summary of findings with immediate actions and next steps.
- **Operational Update** - Increased pressures relating to COVID and acuity noted impacting on elective recovery. Escalated as an alert in CEC AAA with ongoing actions. Engaging with Emergency Care Intensive Support Team. Good progress noted in endoscopy work
- **Orthopaedic Review** - Further support required from Royal College of Surgeons to agree risk stratification approach
- **New COVID guidance** - Reviewed at CRG and implementation plan in place
- **IPR Dashboard Review** - Approved changes to dashboard. Noted work relating to staff and patient experience. Incidence of hospital acquired Covid-19 noted, comparable across the North West. E.coli metric noted increased cases in beginning of year. Completed 21/22 below trajectory (57 against target of 70)
- **Core Mandatory and Essential Skills Training** - Core mandatory training remains above 85% target (89.1%). Essential skills compliance continues to improve (79.3%) but remains below trajectory (85%).

ASSURE

- **Patient Initiated Follow Up** – Presented by Laura Atherton demonstrating great progress in musculoskeletal services and intent to utilise across other specialties to generate additional outpatient capacity
- **Quality Priorities 2021/22 and Quality Account Priorities 2022/23** received
- **QSC Annual Cycle of Business –** received and approved.
- **AAAs received:**
  - Clinical Effectiveness Committee
  - Infection Prevention Assurance Group
  - Patient Experience and Community Engagement Committee

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

Review of the Risk Register
(Detail the risks on the committee's risk register that were reviewed in the meeting, including scores C&L and current actions)

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**04 May 2022**
Agenda Item	**SO0079/22**	**FOI Exempt**	**NO**
Report Title	**OCKENDEN II REPORT BRIEFING**		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Lynne Eastham, Associate Director of Midwifery and Nursing		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To present the findings of the Ockenden Review published March 2022

Executive Summary

- The Independent Review of the Maternity Services at Shrewsbury & Telford NHS Trust commenced in 2017 by Donna Ockenden and published in March 2022. An interim report was published in December 2020 in response to initial findings so that immediate actions could be taken.
- The review commenced with 23 cases of concern but has grown considerably to 1,486 families having their maternity care investigated, the majority who were maternity patients between 2000 and 2019
- The findings of the report have resulted in 15 immediate and essential actions, subdivided into 96 actions to support service improvements for women and their families which every Trust, ICS and LMS must consider and act upon.

Immediate Response to the essential actions

- Suspended plans for Continuity of Carer until we are assured staffing levels are safe and meet recommendations outlined in report
- Reviewing staffing levels to include headroom for sickness absence, MDT training and maternity leaves
- Explore expectations and role of Patient Safety Specialist
- Focus on provision of 24/7 bereavement support for our families
- Share finding of report Trust wide to share learning

Next Steps

- Focus on completion of 'Ockenden 1 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)
- Benchmark our services against essential actions using LMS standardised template

The committee is also asked to receive the letter dated the 01 April 2022, from the NHS Chief Executive, Chief Nursing Officer and National Medical Director regarding the responsibilities of the Trust Board

Southport and Ormskirk Hospital NHS Trust

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

Southport and Ormskirk Hospital
NHS Trust

OCKENDEN
Final Report (March 2022)

Independent Review of Maternity Services at Shrewsbury & Telford NHS Trust

Presented by Lynne Barnes Director of Nursing & Midwifery

April 2022

Southport and Ormskirk Hospital
NHS Trust

Introduction

Review originated from families raising concerns to the former Secretary of State for Health, Jeremy Hunt

Independent review commenced in 2017, initially of 23 families cases but grew to include reviews of nearly 1500 families experiences between 2000 and 2019

Initial report published in December 2020 which outlined immediate and essential actions to be implemented across all maternity providers and the wider system

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 report

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NHS Trust

Immediate & Essential Actions to Improve Care & Safety in Maternity Services across England

Key Learning:

15 overarching Immediate and Essential actions subdivided into 96 actions.

These are covered in 10 key areas:

1. **Safe maternity workforce -** financed appropriately with staffing levels agreed locally and nationally and adhered to
2. **Training –** sufficient protected time allocated and funding ring fenced
3. **Clear escalation and mitigation policy when agreed minimum staffing levels not met at all times** – Continuity of Carer model suspended unless this can be demonstrated

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NHS Trust

Immediate & Essential Actions to Improve Care & Safety in Maternity Services

4. **Trust Board oversight** – process of reviews and reporting with a patient safety specialist dedicated to Maternity Services

5. **Meaningful investigations** – with family involvement and evidence of change in clinical practice in 6 months after incident

6. **Mandatory joint review learning when a mother dies –** with joint review panel from all clinical settings involved

7. **Care of mothers with complex pregnancies –** care provided by specialists familiar with complex pregnancies

8. **Ensuring recommendations from the 2019 Neonatal Critical Care Review are introduced at pace –** work towards a position of 85% of births less than 27 weeks gestation take place with onsite NICU

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NHS Trust

Immediate & Essential Actions to Improve Care & Safety in Maternity Services

9. Improve postnatal care for unwell mothers – with a system to ensure consultant review of all postnatal readmissions

10. Care of bereaved families – with bereavement services available every day of the week

- Responsibility for these actions sits with every Trust, ICS and Local Maternity System
- Every Trust Board has a duty to prevent a repeat of the failings found at Shrewsbury & Telford NHS Trust as outlined in the NHS letter dated the 1st April 2022, from Amanda Prichard, NHS Chief Executive, Ruth May, Chief Nursing Officer and Professor Stephen Powis, National Medical Director

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NHS Trust

Immediate response to report:

- Suspended plans for Continuity of Carer until we are assured staffing levels are safe and meet recommendations outlined in report
- Reviewing staffing levels to include headroom for sickness absence, MDT training and maternity leaves
- Explore expectations and role of Patient Safety Specialist
- Focus on provision of 24/7 bereavement support for our families
- Share finding of report Trust wide to share learning

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What Next?

- Focus on completion of ‘Ockenden 1’ actions
- Prepare for regional Insight Visit on the 10th 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)
- Benchmark our services against essential actions using LMS standardised template

Official
Publication approval reference: B1523

To:

- NHS Trust and Foundation Trust:
  - Chief Executives
  - Chairs
  - Chief Nurses
  - Chief Midwives
  - Medical Directors
- ICS leads and Chairs
- LMNS/LMS leads
- CCG Accountable Officers

CC:

- Regional chief nurses
- Regional chief midwives
- Regional medical directors
- Regional obstetricians

Skipton House
80 London Road
London
SE1 6LH

1 April 2022

Dear colleagues

OCKENDEN – Final report

The Ockenden – Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March.

Donna Ockenden and her team have set out the terrible failings suffered by families at what should have been the most special time of their lives. We are deeply sorry for the loss and the heartbreak they have had to endure.

This report must act as an immediate call to action for all commissioners and providers of maternity and neonatal services who need to ensure lessons are rapidly learned and service improvements for women, babies, and their families are driven forward as quickly as possible.

NHS England and NHS Improvement are working with the Department of Health and Social Care to implement the 15 Immediate & Essential Actions (IEAs) and every trust, ICS and LMS/LMNS Board must consider and then act on the report's findings.

We have announced significant investment to kick-start transformation of maternity services with investment of £127 million over the next two years, on top of the £95 million annual increase that was started last year. This will fund further workforce expansion, leadership development, capital to increase neonatal cot capacity, additional support to LMS/LMNS and retention support. We will set out further information in the coming weeks.

Your Board has a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening at your organisation / within your local system. The Ockenden report should be taken to your next public Board meeting and be shared

with all relevant staff – we strongly recommend everyone reads it, regardless of their role. After reviewing the report, you should take action to mitigate any risks identified and develop robust plans against areas where your services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up. We expect every trust board to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events. A dedicated maternity listening event should take place in the coming months. We will soon publish a revised national policy and guidance on speaking up.

Staff in maternity services may need additional health and wellbeing support. Please signpost colleagues to local support services or national support for our people.

The report highlights the importance of listening to women and their families. Action needs to be taken locally to ensure women have the necessary information and support to make informed, personalised and safe decisions about their care.

It includes a specific action on continuity of carer: *'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.' (*IEA 2, Safe Staffing page 164)

In line with the maternity transformation programme, trusts have already been asked to submit their MCoC plans by 15 June 2022. In doing so, they must take into account this IEA in ensuring that safe midwifery staffing plans are in place. Trusts should therefore immediately assess their staffing position and make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Boards must also assure themselves that any recent reviews of maternity and neonatal services have been fully considered, actions taken, and necessary assurance of implementation is in place.

We expect there will be further recommendations for maternity and neonatal services to consider later this year given other reviews underway. We are committed to consolidating actions to ensure a coherent national delivery plan.

However, there can be no delay in implementing local action that can save lives and improve the care women and their families are receiving now.

In the 25 January 2022 letter we asked you to set out at a Public Board your organisation's progress against the seven IEAs in the interim Ockenden report before the end of March 2022. Your position should be discussed with your LMS and ICS and reported to regional teams by 15 April 2022. We will be publishing a detailed breakdown of these returns and compliance by Trust with the first Ockenden IEAs at NHSE/I public Board in May. Your trust also needs to provide reliable data to the regular provider workforce return, with executive level oversight.

For organisations without maternity and neonatal services, this report must still be considered, and the valuable lessons digested.

We know you will be as determined as we are to ensure the NHS now makes the changes that will prevent other families suffering such devastating pain and loss.

Yours sincerely

Amanda Pritchard

NHS Chief Executive

Ruth May

Chief Nursing Officer

Professor Stephen Powis

National Medical Director

			1: WORKFORCE PLANNING AND SUSTAINABILITY		
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.		
		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.		
		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.		
		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.		
			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.		
		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.		
		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.		
		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.		
		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.		
		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		
		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.		
			2: SAFE STAFFING		
		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.		
		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.		
		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.		
		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.		

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.	**5**	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction		
		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.		
		7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.		
		8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.		
		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.		
		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.		
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		
		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		
		3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable		
		4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit		
		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.		
4. Clinical governance and 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		
		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		
		3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services		
		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		
		5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		
		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.		
		7	All maternity services must ensure they have midwifery and obstetric co-leads for audits		
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.		
		2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.		
		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.		
		4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.		
		5	All trusts must ensure that complaints which meet SI threshold must be investigated as such		

		6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent		
		7	Complaints themes and trends must be monitored by the maternity governance team.		
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.		
		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.		
		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.		
7: MULTIDISCIPLANRY TRAINING					
7: MULTIDISCIPLINARY 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 training and emergency skills training	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.		
		2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.		
		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.		
		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.		
		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.		
		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.		
		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		
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 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	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.		
		2	Trusts must have in place specialist antenatal clinics dedicated to accommodate 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		
		3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.		
		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.		
		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).		
9: PRETERM BIRTH					
9: PRETERM BIRTH	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	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.		
		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.		
		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.		

		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.		
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		
		2	Midwifery-led units must complete yearly operational risk assessments.		
		3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan		
		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 to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust		
		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.		
		6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs		
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. 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.	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		
		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.		
		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		
		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.		
	Obstetric anaesthesia staffing guidance to include:	5	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.		
		6	• 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.		
		7	• The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.		
		8	• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		
12: POSTNATEL CARE					
12: POSTNATAL CARE	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times	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		
		2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum		
		3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary		
		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.		
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.		
		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.		
		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		
		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 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.		
		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.		
		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.		
		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.		
		5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.		
		6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during 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		
		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.		
		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.		
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 those with lived experience, to deliver services that are informed by what women and their families say they need from their care	**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.		
		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.		
		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		

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**04 May 2022**
Agenda Item	**SO080/22**	**FOI Exempt**	**NO**
Report Title	**CQC REGISTRATION ANNUAL DECLARATION**		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ✓ **To Receive**	

Purpose

This paper provides a summary of policies, processes and practices across the Trust to demonstrate how on-going compliance is maintained with the fundamental standards required by the CQC (Appendix 1), to provide assurance to the Strategic Overview Committee.

Executive Summary

The Trust is required to register with the CQC and has a legal duty to be compliant with the fundamental standards set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

The Trust's last 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.

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 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.

Appendix 1 provides an updated summary of compliance against each of the relevant standards.

Financial implications:

The CQC charges all providers an annual registration fee to cover its regulatory activities based on a % of the patient care income from the most recent annual accounts.

2019-20 fee = £111,605

2020-21 fee = £119,675

2021-22 fee = £133,920

2022-23 fee = £154,411

Recommendations

The Strategy and Operations Committee is asked to receive the update to the CQC progress, actions, engagement and well-led improvement journey.

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:**
Jo Simpson, Assistant Director of Quality	Lynne Barnes, Director of Nursing, Midwifery and Therapies

Appendix 1

Compliance with CQC Regulations and Fundamental Standards

Key	This paper was updated on 27th April 2022
	Full assurance in place in Southport & Ormskirk NHS Trust
	Process in place, further work required until full assurance can be given
	No assurance in place
	Position not yet assessed and, therefore, not known
	Not applicable

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
No FS maps to this regulation	5 - Fit and proper persons: directors	People with director-level responsibility for meeting the standards are fit to carry out this role.	**Well-led**	Audit Committee SOC	DoCS		Process in place for confirming all current Directors including Non-Executive Directors meet the required standard, which is applied to all new appointments and renewed annually. All records available for review by CQC if required.

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
No FS maps to this regulation	6 - Requirement where the service provider is a body other than a partnership	Provider is represented by an appropriate person nominated by the organisation who is responsible for the management of regulated activity.	**Well-led**	Executive Committee	DoN		Director of Nursing, Midwifery and Therapies is the Nominated Individual registered with the CQC and confirmed in the latest certificate received dated 06.01.2022.
No FSs map to this regulation	8 - General	Registered person must comply with regulations 9 to 19 in carrying on a regulated activity	**Well-led**	QSC	DoN		See information below for compliance

1	9 - Person-centred care	Providers must do everything reasonably practicable to put patients at the centre and to reflect personal preferences, taking account of people's capacity and ability to consent.	Safe, **Caring,** Responsive	QSC	DoN		• All patients are assessed on admission and have comprehensive treatment/care plans in place. Trust has examples of adjustments made to meet individual needs, including electronic alerts (on Care Flow), hospital passports (Learning Disabilities and Dementia), side-rooms – if applicable, additional staffing where needed, promotion of John's Campaign to support carers who wish to stay with patients/carer beds, hearing loops & communication aids and communication boxes on wards. • In outpatients, double, early and late appointments are used along with desensitising visits to clinics. Learning Disability Nurse in post to support development of individualised care plans and reasonable adjustments for planned admissions, outpatients and pre / post-surgery. For complex patients, best interest decision-making and journey planning involving multi-disciplinary teams are routine. • Mental Capacity Act included in mandatory training. • Up-to-date Consent Policy in place and available on the Trust's intranet, new e-learning package for consent agreed at Consent Committee in March 2022 and is awaiting roll out. • An Annual Consent audit is included on the audit forward plan, consent is also reviewed through Tendable audits. • Compliance with clinical standards measures is regularly audited and reported to each ward using the audit app, Tendable. This is also reported through the monthly ward dashboard. • SOCAAS Ward Accreditation assessments continue to be carried out and reported to Quality and Safety Committee. • Senor Nurse walkabouts are undertaken on both sites on a weekly basis. • The Trust received an overall rating of good for the caring domain in the last comprehensive CQC inspection in 2019. No 'Must Do' actions were identified at the focused inspection of Medical Core service in March 2021. CQC noted *Patients are treated with compassion and kindness and their privacy and dignity is respected and takes account of their individual needs.* Outstanding practice was also identified through a QI project in partnership with the local hospice to look at how fundamental care could be improved, based on the ethos of individualised patient centred care as experienced on the Oasis ward during wave one of Covid-19. The remit of the team was to support staff and develop skills in relation to the delivery of the fundamentals of care and help develop holistic patient centred care as experienced on the Oasis ward. The Oasis team was also supporting the review and launch of the Care Certificate. • Positive comments continue to be received via NHS website and Friends and Family Test and compliments feedback are shared with the relevant teams to continue to support high quality care.

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
2	10 - Dignity and respect	Have due regard to the Equality Act 2010 protected characteristic – staff demonstrating compassion and respect. Maintain privacy **at all times**, including when sleeping, toileting and conversing.	Safe, **Caring**, Responsive	QSC	DoN		• The Trust's values are SCOPE (Supportive, Caring, Open & Honest, Professional, Efficient) and these are reiterated to staff members at interview, on induction and during appraisals. • Privacy and dignity is assessed as part of the CQC inspection, external PLACE assessments (which were paused during the pandemic), SOCAAS Ward Accreditation, Clinical Standards Tendable audits, senior nursing walk arounds. • 2020 inpatient survey (reported 2021) results state 95% of patients reported that they were given enough privacy when being examined or treated, compared to the average score of 95%. • Any areas of concern highlighted through the complaints process are responded to and actions taken to address shortfalls. • Provision of Single Sex Accommodation (as per national guidance) in place, which requires any breaches to be reported via the Datix system. This is reported monthly to Board through the IPR, the only areas experiencing breaches are for step down patients in Critical Care due to estate issues.

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
3	11 - Need for consent	All people using the service or those acting lawfully on their behalf give consent. (Meeting this regulation may mean not meeting other regulations eg this might apply in regard to nutrition and person centred care. However, providers must not provide unsafe or inappropriate care just because someone has consented.)	**Safe**, Responsive	QSC	MD		• Up-to-date Consent Policy in place (approved April 2022) and patients are consented using standard Trust forms for all procedures. • Consent Committee in place with revised TORs – new Chair and Deputy identified • Annual consent audit undertaken as part of the clinical audit programme which is reported to the Consent Committee and CEC. Consent is also reviewed through Tendable audits. • Capacity assessments related to DNACPR are incorporated into the Treatment Escalation Plans (TEPs) and monitored through Consent Committee • Quality Improvement work stream is established and monitored through Quality Improvement Board and Consent Committee which provide assurance to the Quality and Safety Committee.

4	12 - Safe care and treatment	Assessing risks against health and safety standards, mitigating risks, staff providing care have relevant qualifications, competence, skills and experience, ensure premises and equipment used are safe for intended purpose. Ensure sufficient quantities of medicines/equipment to remain safe. Proper oversight of safe management of medicines. Infection prevention and control (IPC).	**Safe**	WSC; Workforce, Executive	DoHR, DoN, DoF		• H&S risk assessments in place and outlined in H&S Policy & supporting documents. • Workplace inspections reported to Health and Safety Committee which reports to Quality & Safety Committee and programme of environmental checks in place, with actions taken to address any issues identified. • H&S Teamwork with Quality Matrons to review areas highlighted for improvement in 2019 CQC Inspections (COSH Cupboards locked and hazardous substances locked away & placement of Oxygen cylinders) • All staff were risk assessed as part of the pandemic response, with appropriate redeployment put in place depending on the outcome of the risk assessment. • Working from Home risk assessments in place and reviewed • Staff reported positively on the availability of personal protective equipment during the pandemic, no reports of any shortages • Relevant checks against job description/person specification undertaken as part of recruitment process for all staff. Annual appraisals confirm staff have maintained knowledge and expertise to undertake roles and responsibilities. • Missed doses of medication are recorded, audits undertaken by the pharmacy team and reviewed on senior nurse walk around (this was included as a measure for Improving Medicines Safety Quality Priority in 2021/22 • Programme of medical device maintenance in place. Medical Devices Group reports into CEC via AAA • Compliance with infection prevention control (IPC) is regularly audited and assessed through SOCAAS, Clinical Standards and separate IPC audit • RCAs undertaken on any serious IPC incidents including C.Diff/MRSA bacteraemia cases to identify lessons learned. IPC panels in place. Two MRSA bacteraemia reported year to date in 2021-22 and C.Diff cases remain below trajectory set in 2021-22. • Mandatory skills compliance monitored at Workforce Committee and reported regularly to Quality and Safety Committee.
5	13 - Safeguarding service users from abuse	Zero tolerance approach to abuse and unlawful	**Safe**	QSC, Workforc	DoN, DoHR		• The Trust has a zero-tolerance approach to abuse, discrimination and unlawful restraint (policies also in place) The Trust has a Freedom to Speak Up - Raising Concerns Policy and also Disciplinary Policy and Procedure in place for any staff who fail to meet the Trust's SCOPE values and behavioural standards.

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
	and improper treatment	discrimination and restraint, including neglect, degrading treatment, unnecessary restraint, deprivation of liberty. All staff to be aware of local safeguarding policy and procedure and actions needed if suspicion of abuse.					• Each clinical area has a Safeguarding resource file with key information to ensure all areas for safeguarding are reported appropriately. • Safeguarding Ambassadors inn place to act as a point of contact for safeguarding for wards and clinical areas • Safeguarding level 1 is the minimum mandatory requirement for all staff, with level 2&3 targeted at those who require it, i.e. those working with children and young people and those in decision-making roles respectively. Compliance with training is reported to the Safeguarding Assurance Group and Quality & Safety Committee. Awareness of Deprivation of Liberty Safeguards (DoLS) is included in induction and mandatory training. All training thresholds met in March 2022. • The Trust provides training in conflict resolution. • Security is on site 24 / 7 at both Southport and Ormskirk sites

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
6	14 - Meeting nutritional and hydration needs	People who use services have adequate nutrition and hydration to maintain life and good health.	**Effective**	QSC	DoN		• Trust utilises the Malnutrition Universal Screening Tool (MUST) for adults to ensure compliance with NICE guidance, this is now included in the patient's admission documentation and risk assessments. • Patients identified as at risk of malnutrition have nutritional care plans in place, information is also monitored through fluid balance charts. • There is a red tray and red jug system in place for patients who require additional support with eating and drinking. • All general wards are required to operate protected mealtimes. • Patients are regularly assessed to note any changes in nutrition and hydration status. Fluid balance is reviewed at the end of each shift and MUST assessments completed within 24 hours of admission, then weekly. • Regular audits are conducted to maintain focus on high standards of hydration and nutrition throughout the Trust. A specific fluid balance audit has been developed on Tendable • In addition, Trust is exploring the future use of VitalPac for recording of fluid balance going forward. • Nutrition & Hydration was a Quality Priority for the Trust in 2021/22 and will be rolled over into 2022/23 with AKI incorporated, this will be monitored through Quality Improvement Board. Quality Matrons are leading a piece of QI work in relation to timely completion of MUST assessments, this includes reviewing weighing devices on wards and clinical areas. • The volunteer service prior to the pandemic provided dining companions to further support patients feeding during meal times. This is planned to be reinstated in 2022/23. • Recommendations in relation to nutrition and hydration were highlighted in the 2019 CQC Inspection and focused Medical Core Services inspection in 2021. All recommendations are addressed through the actions described above and monitoring continues through the Quality Priority and Nutrition Hydration & Mouth Care Group which provide assurance to the Quality and Safety Committee

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
7	15 - Premises and equipment	Premises and equipment are clean, secure, suitable, properly used/maintained, appropriately located and able to maintain standards of hygiene. Management of hazardous/clinical waste within current legislation. Security arrangements in place to ensure staff are safe.	**Safe**	QSC	DoCS		• Workplace inspections and COSHH risk assessments in place. • Waste Management Policy in place with regular awareness raising and training provided for staff. Recent investment to provide adequate storage for clinical and domestic waste within the hospital corridors, work has recently been completed to install dedicated external waste storage within hospital grounds • Security is on site 24 / 7 at both Southport and Ormskirk sites • Cleaning metric included in the Covid 19 Executive Dashboard • PLACE Inspections expected to resume in 2022/23 • Cleaning standards are monitored and displayed outside clinical areas • HEAT (multi-disciplinary Team) inspections have recommenced following the pandemic • IPC audits on equipment continue to be carried out with both direct feedback and support to wards and reported to IPC operational group which provides assurance to the Quality and Safety Committee

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
8	16 - Receiving and acting on complaints	All staff to know how to respond when receiving a complaint. Effective and accessible system for identifying, receiving, handling and responding to complaints, with full investigation and actions taken. Providers must monitor complaints over time looking for trends and areas of risk.	**Responsive**	QSC	DoN		• Staff aware of how to manage complaints at a local level, process in place for MP complaints • PALS Team in place including an enhanced presence in A&E department to deal with issues experienced in urgent care • Improvements to the management of complaints remain ongoing, with effective system in place via Datix for recording and monitoring each complaint. • Themes and actions taken identified and reported to Patient and Community Engagement Group, the Quality and Safety Committee and the Board, to support Trust-wide lessons learned, Patient Stories also agenda item at Board and SOC. • MIAA audit carried out in December 2021 provided moderate assurance on lessons learned from complaints being disseminated. • Scrutiny & Assurance Group is in place to monitor impact of actions and learning.

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
9	17 - Good governance	Robust assurance and auditing processes in place to drive improvement in quality and safety, health, safety and welfare of patients and staff. Effective communication system for users/staff/ regulatory bodies/ stakeholders so they know the results of reviews about the quality and safety of services and actions required.	**Well-led,** Responsive	Audit Committee / SOC	CEO / DoN		• Trust currently undertaking a Well Led Assessment to identify any areas needing improvement • Progress in delivering the Trust's objectives is included in the new QSC and Board Business Cycle. Progress against the Quality Account is reported bi-annually • The Board and its committees review key performance indicators via the integrated performance report (IPR) monthly, identifying areas where compliance could be improved to target actions appropriately. • External Audit review the annual governance statement. • Ward accreditation scheme in place (SOCAAS) that is aligned to CQC standards, which was relaunched in 2021-22 following temporary suspension due to the pandemic. • Senior Nursing quality walk arounds in place • Bimonthly CQC Engagement meetings in place held via Teams or on site. Regular contact between CQC RO and ADQ. • Policy in place for the Management of Visits to the Trust by External Regulatory Agencies

10	18 - Staffing	**Sufficient numbers** of suitably qualified, competent, skilled and experienced persons deployed to meet CQC requirements.	**Safe, Effective**	Workforce	DoHR		• Workforce priorities are referenced withing the Board Assurance Framework (BAF) (Strategic Objectives 4 & 5) with clear actions to mitigate. • 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 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. • Whilst significant national recruitment challenges remain within specific specialties and for specific roles, in particular, 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 the 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 regular recruitment events; this remains a challenge. Further retention initiatives include the development of a bespoke induction and preceptorship programme, recognising 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. • Medical vacancies are now at the lowest level the Trust has seen for at least 4 years, with the vacancy rate current at 5.8% bringing it in line with the national average.

Southport and Ormskirk Hospital NHS Trust

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
11	19 - Fit and proper persons employed	Staff to be of good character with appropriate qualifications, competence, skills and experience ie all staff are fit and proper – honest, trustworthy, reliable and respectful	**Well-led**	Workforce	DoHR		• Effective procedures in place for pre-employment and on-going revalidation of relevant staff. • The Trust has range of HR policies and procedures in place. Staff are aware of the requirement to raise any concerns about patient care and anything that may affect them personally in fulfilling their duties. • SCOPE values are assessed at interview and during appraisals • Continued development through working groups to support Just and Learning Culture principles.

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position

No FS maps to this regulation	20 - Duty of candour	Open and transparent with people who use services/people acting lawfully on their behalf. Promote culture of openness, transparency at all levels, with focus on safety to support organisational and personal learning. Actions taken to ensure bullying and harassment is tackled in relation to duty of candour.	**Safe**	QSC	DoNMG		• Electronic reporting system, Datix, includes mandatory field to confirm compliance with Duty of Candour
							• Compliance included in Patient Safety and Integrated Governance Report presented at QSC
							• There are a number of routes for raising concerns across the Trust including Freedom to Speak Up Guardian and ambassadors as well as through Health and Wellbeing.
							• Training is provided to staff within the following training programmes:
							  ○ Trust's induction.
							  ○ Mandatory training
							  ○ Risk / Governance training

Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
No FS maps to this regulation	20A - Requirement as to display of performance assessments	Notify via all websites and in each premise where services are provided the latest CQC rating, including principal premises. The information is to include the CQC's website address and where the rating is to be found and for each service/premise the rating for that service/premise.	**Responsive,** Well-led	Executive	DoCS		Ratings available on internet with links to the full reports via the CQC website. Ratings also on display at main receptions on both Southport & Ormskirk sites

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Workforce Committee
MEETING DATE:	26 April 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. An interventional approach is now being adopted by the Workforce Directorate to ensure compliance increases. Issues remain related to the quality of conversations and the electronic system being difficult to use and report PDRs. An electronic-PDR form/document is planned to be developed in collaboration with IT to support with ease of recording.

Sickness Absence
The Workforce Committee received a presentation on sickness absence. They were informed of specific figures per CBU, hotspot areas of sickness reasons and the actions to be taken to address sickness in certain staff groups. It was suggested that a totality approach is to be used for sickness, by triangulating Driving Culture Change, Just and Learning Culture and the Annual Staff Survey 2021 results. The proposed sickness absence targets for staff groups from the IPR were queried.

Freedom To Speak Up Q4
The number of concerns raised have decreased since 2021/2022, due to potentially the more appropriate co-ordination of concerns that are true Guardian issues. The Chair felt positively about inclusion of FTSU training included in the report.

ASSURE

Just and Learning Culture Thematic Presentation
The Workforce Committee received the Just and Learning Culture presentation which generated a large discussion involving links to the Driving Culture Change work and the Annual Staff Survey 2021 results. It allowed the members to reflect upon their own personal lived experiences and it set the tone of the meeting.

Workforce Committee Cycle of Business
The Workforce Committee approved the Cycle of Business.

Workforce Committee IPR
The members were supportive of the revision of metrics proposed.

CORP 19 – Policy for Recruitment and Management of Volunteers
The Workforce Committee approved the policy. Members celebrated and thought positively of the revision to allow 16-17 years olds to volunteer in the organisation.

New Risks identified at the meeting: None

Review of the Risk Register: Yes

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**04 May 2022**
Agenda Item	**SO082/22**	**FOI Exempt**	**NO**
Report Title	**2021 STAFF SURVEY RESULTS AND ACTION PLAN**		
Executive Lead	Jane Royds, Director of HR and OD		
Lead Officer	Sonya Clarkson, Deputy Director of HR and OD		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To provide a summary of the highlights from the recent Staff Survey and recommendations for next steps in response to the feedback from staff.

Executive Summary

Overall, the positive responses are consistent with the comparator throughout the survey and there are elements of the responses that we should be really proud of.

Responses have shown we have a great workforce who enjoy working with each other, but teams do not necessarily feel connected with each other across the Trust. In addition, staff seem to be happy with their role, working in the team, however, there is something about the work environment that is frustrating them.

It is very disappointing that only 54% of staff would recommend this Trust as a place to work and 54% would be happy with the standard of care provided by the Trust if their friend or relative needed it. Whilst our comparators have also seen a similar reduction in positive responses for these questions, our response rate is not acceptable to us.

Relationships and teams, staff health and wellbeing and safety at work were shown to be our strengths, and areas of improvement were staff voice (feeling valued), personal development, inclusive workplace, flexible working and support for line managers.

The results also flag a retention risk for the Trust, with 23 more staff responding that they are thinking about leaving this Trust and 263 will probably look for another job in the next 12 months. The impact of the recent VCOD situation, increased competition within the health care assistant talent pool, ongoing challenges recruiting to nursing and medical positions and changes to pensions from April 2022, builds a compelling case to retain the staff we have got by focusing on attracting a more diverse population to the workforce and supporting older staff to remain in work

Recommendations

The Strategy and Operations Committee is asked to receive the 2021 Staff Survey Annual Results and approve the Action Plan.

Previously Considered By:

☐ **Strategy and Operations Committee**	☐ **Executive Committee**
☐ **Finance, Performance & Investment Committee**	☐ **Quality & Safety Committee**

Southport and Ormskirk Hospital NHS Trust

☐ **Remuneration & Nominations Committee** ☐ **Charitable Funds Committee**	✓ **Workforce Committee** ☐ **Audit Committee**

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

Prepared By:	**Presented By:**
Sonya Clarkson, Deputy Director of HR and OD Tony Ellis, Head of Communications Tracy Gunn, Head of Education, Learning and OD	Jane Royds, Director of HR and OD

Southport and Ormskirk Hospital NHS Trust

Staff Survey highlights

1. Purpose

To provide a summary of the highlights from the recent 2021 Staff Survey and recommendations for next steps in response to the feedback from staff.

2. National context

The Operational Planning guidance 2022/23 has identified the following priority areas for 2022/23:

- Improve staff experience
- Support health and wellbeing of our staff
- Address health inequalities in recruitment and promotion
- New ways of working (virtual care and care closer to home)
- Training and recruitment efforts to grow workforce

The addition of new questions to the annual survey this year further strengthen the areas for national focus and serve as a baseline for the Trust.

Table 1 below gives a high-level view RAG rating of the Trust's position against these new areas of focus.

Table 1

Thematic area	**RAG rating**
Health, wellbeing and safety at work	
Relationships with own team	
Relationships with others across the Trust	
Relationships with manager	
Personal development	

3. Engagement and Morale

Overall, the positive responses are consistent with the comparator throughout the survey and there are elements of the responses that we should be really proud of.

Responses have shown we have a great workforce who enjoy working with each other, but teams do not necessarily feel connected with each other across the Trust. It is really positive that staff feel their roles make a difference to patients (particularly as the highest proportion of respondents are from Corporate and Estates & Facilities), providing a strong sense of shared purpose to build upon.

Staff seem to be happy with their role, working in the team, however, there is something about the work environment that is frustrating them. Staff responded better to what they do and the work they are doing as opposed to where they are doing it.

It is very disappointing that only 54% of staff would recommend this Trust as a place to work (Q21c) and 54% would be happy with the standard of care provided by the Trust if their friend or relative needed it (Q21d). Whilst our comparators have also seen a similar reduction in positive responses for these questions, our response rate is not acceptable to us. Deep analysis of the responses gives an idea of why staff may think/feel this and has highlighted strengths to build on and areas of improvement to work on to make this better.

The age profile of respondents aligns to the workforce age profile with 1/3 under 40 years old and majority of respondents are between 41-65 years old (higher than the comparator).

+23 more staff responded that they are thinking about leaving this Trust (Q22a) and 263 will probably look for another job in the next 12 months (Q22b). The impact of the recent VCOD situation, increased competition within the health care assistant talent pool, ongoing challenges recruiting to nursing and medical positions and changes to pensions from April 2022, builds a compelling case to retain the staff we have got by focusing on attracting a more diverse population to the workforce and supporting older staff to remain in work.

Staff responded less positively about looking forward to coming to work (Q2a) than being positive about their job (Q2b). Whilst both responses were better than the comparator, there was a reduction from the year before. Staff responded better to what they do and the work they are doing (purpose) than where they are doing it (sense of belonging). In later questions, the team staff work within plays a key part in how staff feel about their job, equally the high positive response that staff feel their role makes a difference to patients/service users (Q6a) indicates a strong motivation for what staff do (87%).

Q3a-i give indications of the demotivating elements of working at this Trust. The most significant drop in positive responses compared to the previous year relate to Q3i not enough staff to do my job properly (-10%) and Q3h adequate materials, supplies and equipment (-4%). Research suggests that where resources are lacking, staff are likely to experience feelings of frustration [*Ref: The Lippitt-Knoster Model for Managing Complex Change*].

Table 2 below highlights themes considered to be our strengths and areas for improvement based on the responses received.

Table 2

Our strengths	Areas for improvement
- Relationships and Teams - Staff health and wellbeing - Your safety at work	- Staff voice: Feeling valued - Your personal development - An inclusive workplace - Flexible working - Support for line managers

4. People Promise Elements

Promise element 1: We are compassionate and inclusive

The positive responses to questions pertaining to the line manager (Q9a-i) were all 3-4% lower than the comparator. The responses suggest line managers are not necessarily considered to be part of

the team, and there are staff that don't feel valued by their line manager, are not being asked for the opinion and are not sure how they are viewed by their manager.

It is important to put these responses into the context of the pandemic, challenges with staffing and other resources, and whether staff are showing enough empathy towards managers. The Trust is about to embark on further change over the next 18 months and line managers play a key role in taking staff along that journey. Two new questions have been included this year (Q9g and h) signalling the importance of the role in listening to staff and caring about their concerns.

The positive responses to Q15 remains unchanged (50%). 'Addressing health inequalities in recruitment and promotion' is a priority identified in the NHS Operational Planning guidance for 2022/23, so increased focus on this is required.

Staff responded -6% less positively than the comparator to the new question related to the Trust respecting individual differences (Q18) providing a disappointing baseline and giving further indication of why staff are feeling less valued by the organisation (Q4b). Staff with protected characteristics also shared their experience of discrimination at work (Q16). Whilst positive responses were high amongst most characteristics and only reduced slightly compared to last year, positive response were lowest amongst staff from ethnic background (66%) and had dropped the most (-4%) compared to the previous year. Positive responses related to disability, age and ethnic minority were all 4% lower than the comparator, providing specific areas for focus for the Trust.

Promise element 2: We are recognised and rewarded

Q4a-d give indications of the motivators that ensure staff feel valued. Staff have shared a strong sense of purpose in what they do, but there was a 4% reduction in staff feeling their good work was recognised (Q4a) and valued by the organisation (Q4b). A drop in positive responses to Q5c (-3%) suggest relationships are strained, this is unlikely to be amongst the immediate team (given the positive responses) and are likely to be in relation to line manager relationship (given the responses to these questions) and/or the lack of connectivity between teams across the Trust suggested in the responses.

All staff are paid in accordance with nationally agreed terms and conditions, positive responses lower than comparator would suggest local issues with the application of the national terms and conditions of service. Anecdotal evidence suggests dissatisfaction with the Agenda for Change outcomes, being lower than other Trusts. The positive responses being higher than comparator for Q4c puts this into perspective.

Promise element 3: We each have a voice that counts

There was a very positive response (93%) to staff feeling trusted in their jobs (Q3b). Linking this to other responses suggests that staff are trusted within their teams but find it hard to influence, change things outside their role or circle of influence.

The responses to Q3c, d, e, f suggest a need to encourage staff voice more, provide opportunities to make suggestions and drive improvements. Whilst these responses are better than the comparator, positive responses have reduced this year rather than improving.

Promise element 4: We are Safe and Healthy

Given the challenges over the last 2 years, the responses to questions related to health, wellbeing and safety at work (Q10-12) demonstrate how our staff have pulled together to deal with the pressures. Staff have also responded positively that the Trust has taken positive action on health and wellbeing (Q11a). In relation to work-related stress, responses to Q11c suggest staff have coped well during the last 2 years (with only a slight reduction from the previous year and 9% higher than comparators). There is also evidence that staff are coping well with the demands whilst in work, responding more positively than comparator to the burn out (Q12b) and frustration with work (Q12c) questions. Going forward, the Trust needs to engage with staff to understand the frustrations better.

Staff responded extremely positively that they are not experiencing violence from patients (87%), managers (99%) or colleagues (99%). Despite the suggestion that incidences of violence are very low, the inclination to report it has reduced (-1%) and is below the comparator (Q13d). This is also apparent in the response to Q14d (-3%) reporting harassment, bullying or abuse.

Positive responses have improved slightly in respect of staff experiencing harassment, bullying or abuse from other colleagues (Q14c), reinforcing the strength of team working and relationships. Conversely, the number of occasions of this behaviour from patients etc. (Q14a) seems to be increasing (although frequency decreasing), and there is a slight reduction for the same question related to managers (Q14b). There is some consolation that whilst managers are under pressure and lacking some insight/empathy (as alluded to in Q9), this is not manifesting itself as aggressive behaviours. However, the responses to these two questions potentially indicate the contributing factors to the frustration staff seem to be feeling.

There needs to be a continued focus on staff feeling comfortable to challenge or report matters of concern (as indicated in Q14d, Q17a, Q21e), influenced by instilling confidence about what action is being taken to address those concerns (Q17b shows no improvement since last year, Q21b -4% drop that Trust acts no concerns raised by patients and -4% below comparator for Q21f confident Trust will address own concern).

Promise element 5: We are always learning

Questions have been added around personal development this year (Q20a-e) highlighting the national steer to place emphasis on this. All positive responses were on average -5% lower than comparator and pose a risk to retaining staff if actions are not taken to improve this. Put into context, the pandemic has reduced the capacity to release staff for training and historically, the HEE continued professional development monies has not been well handled. In addition, there is no central development budget and the only realistic option for funded development is through the apprenticeship levy. However, only 43% of staff responded positively to the opportunities for them to develop in this Trust (Q20b), presenting the risk that they may look elsewhere to seek those opportunities.

Encouragingly though, slightly more staff reported positively about having had an appraisal in the last 12 months (Q19a) aligning to the improving compliance trajectory as part of the Trust's year 1 plan to improve PDR. The responses to the newly added questions (Q19 b-d and 20a-e) act as a baseline to the year 2 plan to improve quality of PDR conversations and their impact on staff feeling valued (Q19d) and helping address their frustrations.

Promise element 6: We work flexibly

Agile working is a key programme of work in the Trust's Our People Plan and work commenced on this in January 2021. Therefore, the responses in this year's survey offer a useful baseline to measure the cultural impact moving forward.

There has been a 2% reduction in positive responses for Q4d since last year but is 1% higher than comparators. This is a key area of national focus, as appears in the majority of Trust's action plans for addressing retention, supporting attendance and gender pay gap issues, so +1% is not enough of a competitive advantage in the current climate.

Reflecting on the responses relating to staffing (Q3i), it is possible the staffing levels during the last 12 months have affected the positive response rate and/or is inhibiting managers to be creative or think more flexibly at this present time.

Q6b-d are all new questions this year and provide a good baseline to start from with all responses either equal or above the comparator.

Promise element 7: We are a team

Q7a-f explore the relationship with team. The responses suggest staff enjoy working with colleagues in their team (81%) and there is mutual respect and understanding of each other's roles. The new questions that have been added this year related to team demonstrate the importance placed on team working in helping motivate staff to come to work. Q7e, f and g are all new and the positive responses are equal to the comparator, which is encouraging. Q8a -d are new questions and the responses (all around 3% below comparator) suggest these are aspects that could be strengthened further by increased connectivity of teams across all levels of the Trust, nurturing a culture of openness and trust so staff can share their ideas.

5. Action to address survey feedback

The communication of the results in promoting transparency. However, of equal, or more importance, is sharing with staff what the Trust is doing with the feedback and instilling confidence in addressing issues raised by staff. Where possible, we need to link the communication into what we are doing already.

Listening Plan

(i) Staff Voice

Open and honest communication with staff needs to be driven from the Board, with a commitment to open up ongoing dialogue with staff about whether the responses reflect how staff feel or what they think about working here.

The ongoing dialogue will require all leaders to be involved in listening to the voice of staff, helping to collate intelligence in a structured way and share routinely at the Valuing Our People Inclusion Group (VOPIG) to help review priorities and programmes of work.

In practice, this will require all those with leadership roles or engagement roles (i.e. Comms / Workforce / FTSU / Staff side / Risk & Governance teams/ Exec Buddies) to feel equipped and

prepared to reach out to staff, attending existing meetings such as staffing huddles, team meetings etc. This needs to be done in a structured way so we can collate feedback in a consistently, exploring:

- What makes you want to come to work?
- When you get here, how does the Trust help you to do your best and be your best?

(ii) Targeted engagement sessions

The staff survey has highlighted retention risks for the Trust, and we need to build a greater understanding of what can be done to reduce this risk. Further insights are required to identify the 'hot spots' to then enable targeted engagement with areas or staff groups or roles that indicate a need for improvement.

The survey responses have also shown the support from managers may be lacking and the important role they play in promoting the positive wellbeing of our staff. In order to support staff, we need to ensure our managers feel supported. Targeted engagement with line managers/leaders will also form a key aspect of this plan, exploring how they feel and what they need to support staff.

6. Corporate-led programmes of work

Table 3 below shows the current programmes of work within *Our People Plan* overseen by VOPIG and how the programmes need to evolve in response to the recent staff survey feedback and reflection on national priorities for next 12 months.

Table 3

Our People Plan programmes and key workstreams	Further enhancements required	Corporate leads	Key indicators (from Staff and Pulse Survey)
Staff wellbeing - Winter wellness - Individual restoration programme - Schwartz Rounds - Increase access to health and wellbeing support	Support and training for managers to fulfil their role in relation to staff wellbeing More Schwartz Rounds to increase empathy, insight and appreciation of others	Associate Director of Occupational Health and Wellbeing	Q10-12 Q11a
Just and Learning culture - Embed principles - Civility, respect and kindness campaign - Align policies	Campaign of zero tolerance Increase confidence of dealing with concerns	Senior HR Business Partner Head of Risk and Governance	Q13d, Q14a-c,

		Freedom to Speak Up Staff Side Lead	
Agile working - Formalising safe blended working - Alignment to digitisation	Support and training for managers to increase openness to exploring flexible working options Oversight of flexible working requests	Deputy Director of HR & OD	Q4d, 6b,c
Listening Plan - Annual staff survey - Quarterly pulse surveys - Tell us Tuesdays (Discharge ideas)	Staff voice – what makes you feel valued at work? Encourage staff networks and use lived experiences to shape decisions etc. Board involvement in listening plan	Head of Education, Training and OD	Q4a,b
Equality, Diversity and Inclusion - Cultural awareness campaign - Supporting staff networks	Root and branch review of recruitment and selection process Focussed engagement with staff from ethnic minorities and disability Roll out bystander training and training for managers on reasonable adjustments	Deputy Director of HR / OD EDI Lead Recruitment Manager	Q18, Q16

	Raise awareness of micro-aggressions		
Reward and Recognition - Pay progression - Appraisals	Improve quality of PDR conversations #SOProud Initiatives to increase appreciation and recognition of others	Senior HR Partner	Q2a Q5c Q4b
Transformational leadership - Career pathways for Ops / Nursing - Clarity on development offer	Leadership and management development offer Change management training and guidance to leaders/managers	Deputy Director of HR & OD / Ops / Nursing Head of Education, Training and OD	Q19a-d and Q20a-e Q9a-i
Clinical workforce plan - Workforce plan - Joint appointments	Trainee strategy Skills mix review to establish health care assistant needs - Introduction of new band 2 ward-based roles - Improve progress from Band 5 to 6 Registered Nursing - Increase number of Band 3 Health Care Assistant opportunities to aid progression	Deputy Director of Nursing / Medical Head of Education, Training and OD / Medical Education / Professional Practice / Resourcing	Q20a-e
***NEW* Retention**	Improved flexible retirement options Exit questionnaires or 'Stay' discussions	Head of Resourcing / Head of Nursing Workforce	Q21c & d Q22a, b

7. CBU Specific Actions

Each CBU leadership team will work with their HR Business Partner to:

- Identify focussed OD work required to address consistently flagged low scores across a range of themes/questions
- Engage innovatively with staff to share the feedback from the responses and more importantly, what action is being taken
- Produce local People Plan to be monitored through quarterly PIDA.

8. Recommendations

8.1 Note the content of this report and to approve and support the recommendations.

8.2 Actions to address the areas of concern will be incorporated into the 2022/23 Our People Plan Key Deliverables Plan, monitored by the Workforce Committee.

8.3 Board commitment to engage and be an active part of the Listening.

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**04 May 2022**
Agenda Item	**SO083/22**	**FOI Exempt**	**NO**
Report Title	**FREEDOM TO SPEAK UP QUARTER 4 REPORT**		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Linda Douglas, Freedom to Speak Up (FTSU) Guardian		
Action Required	✓ **To Approve** ✓ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

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

Executive Summary

This report identifies the number of concerns raised through the Freedom to Speak Up service (FTSU) during Quarter 4 of 2022 (01 January – 31 March*)*. Over the quarter, 11 concerns have been raised through FTSU. During this quarter, three concerns have had Human Resources input either directly via the Guardian or Manager.

Over the whole year – April 2021 to March 2022 there were 51 concerns raised, this is 32 less than the previous year. The Q4 Report for 2020 – 2021 recorded 83 concerns. To help with the overview, some statistics are included from the last twelve months.

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

During Quarter 4 the themes of concerns raised have included:

- System/Process
- Behaviour/Relationship (Attitude)
- Patient Safety
- Leadership

Recommendations

The Strategy and Operations Committee is asked to receive the Freedom to Speak Up Quarter 4 Report and note the update and action for the FTSU Office.

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**

Southport and Ormskirk Hospital NHS Trust

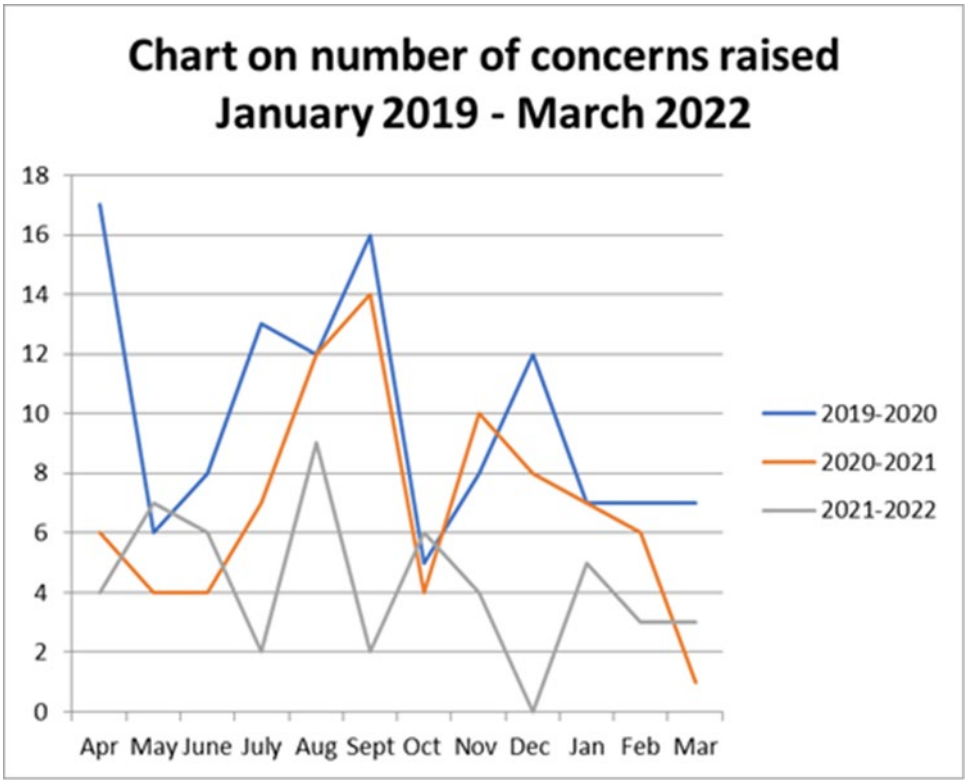
Strategic Objectives	
☐ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	
☐ **SO2** Deliver services that meet NHS constitutional and regulatory standards	
☐ **SO3** Efficiently and productively provide care within agreed financial limits	
✓ **SO4** Develop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

Southport and Ormskirk Hospital NHS Trust

Report on Submission to National Guardian's Office

Quarter 4	01 January – 31 March 2022
Date submitted to NGO:	**0**5 April 2022
Date National Data to be published:	To Be Confirmed
Number of Concerns Raised	**11** concerns (January 5 , February 3, March 3) 10 of these were directly raised with the Freedom to Speak Up Guardian (FTSUG) and one was directly raised with the FTSU Champions. When concerns are raised directly with FTSU champions, the FTSUG always gives support and advice, often meeting those who raise the concern, and sometimes being used in a consultative role.

Over the whole year – April 2021 to March 2022 there were 51 concerns raised, this is 32 less than the previous year. The Q4 Report for 2020 – 2021 recorded 83 concerns.



1.2 Themes of Concerns

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

- System/Process
- Behaviour/Relationship (Attitude)
- Patient Safety
- Leadership

In terms of proportion, the table below expresses concerns raised as a percentage:

(Please note the themes in the %table and the graph are the categories required by the National Guardian's Office for submission)

Primary Issues

Theme	% this Quarter
Behavioural / Relationship	45.45%
System / Process	27.27%
Cultural	0.00%
Bullying/Harassment	18.18%
Middle Management issue	0.00%
Not Known	0.00%
Staff Safety	9.09%

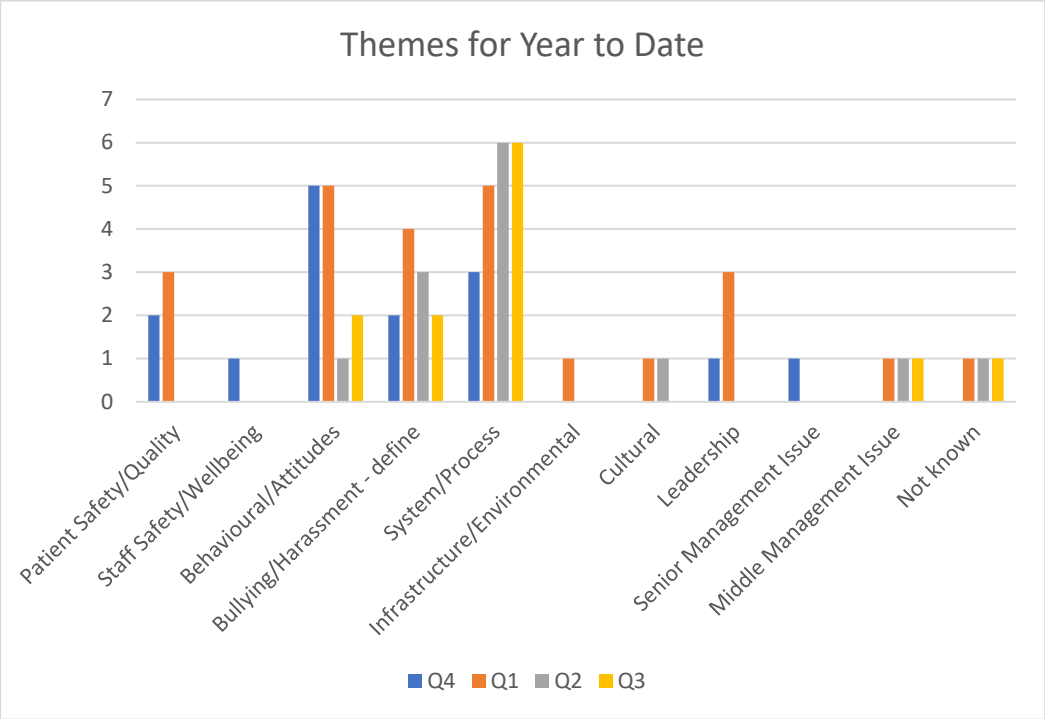
Secondary Issues

Theme	% this Quarter
Infrastructure/Environment	0.00%
Leadership	9.09%
Senior Management Issue	9.09%
Patient Safety/Quality	18.18%

Graph of Themes for Year to Date

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

(Please note quarter 4 is the most recent (01 January – 31 March).



1.3.2 Anonymous Concerns

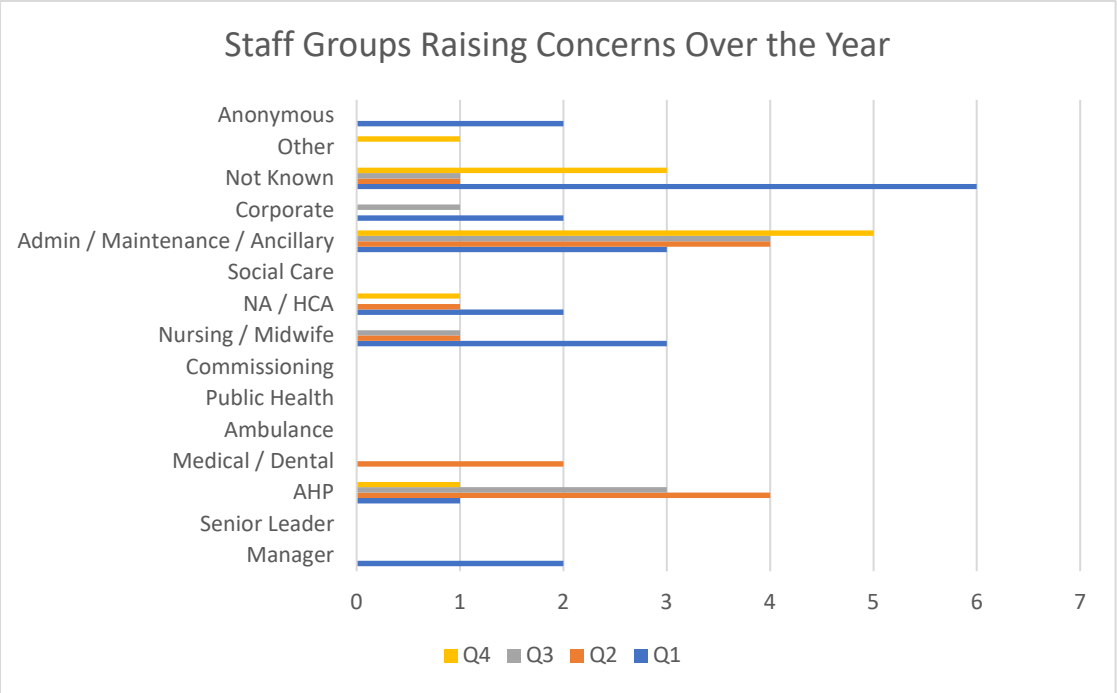
During Quarter 4, there were four anonymous concerns. This is where the person raising the concern cannot be contacted as there are no contact details, e.g. anonymous letter / phone call. There were also five concerns where the person does not want their name associated with the concern as they were worried about potential repercussions.

1.4 Staff Groups Raising Concerns

Concerns this quarter have been raised by a cross-section of staff, as shown below. These follow the definition of the National Guardian's Office.

Staff Group	% this Quarter
AHP	9.09%
Medical and Dental	00.00%
Nursing / Midwives	00.00%
HCA	9.09%
Admin	45.45%
Corporate	00.00%
Not known	27.27%
Other	9.09%
Anonymous	0.00%

1.4.1 Staff Groups Raising Concerns Over the Year



1.4.2 Situations where detriment was expressed because of speaking up

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

1.5 Feedback Post Raising Concerns

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

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

During this quarter feedback was received from 5 people who have raised concerns with the FTSU service.
All of the feedback received this quarter was positive.

- *Would speak up again*
- *Amazed how quickly the process started and a result straight away*
- *Feel very reassured for the support you and your team provide*
- *Perfect, thanks for listening.*

1.6 Changes as a Result of Speaking Up

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

Recent conversations have also highlighted FTSU as providing:

- *Some changes in leadership/management*
- *Concerns addressed*
- *Recruitment in place*

1.7 How Concerns are Managed

Concerns are managed on a concern-by-concern basis, in line with the trust's FTSU policy. The FTSUG has regular 1-1's with the FTSU executive lead and CEO.

1.8 Training and Development for Guardians

The FTSU guardian is part of the regional and national network of guardians and prior to the first wave of Covid-19 regularly attended quarterly regional events, and annual national events. Although these are not meeting face to face, there is a fortnightly "teams" regional support meeting or workshop, with input from the national office.

1.9 Update on Freedom to Speak Up, Raising Concerns Policy (Corp 69)

The updated policy has now had final approval by PRG and accessible on the intranet. The NGO is currently developing a revised policy template for organisations to map local policy.

1.10. Staff Survey

The recent staff survey Results indicate we are below average with regards to

Q21e I feel safe to speak up about anything that concerns me in this organisation.
Q21f If I spoke up about something that concerned me, I am confident my organisation would address my concerns.

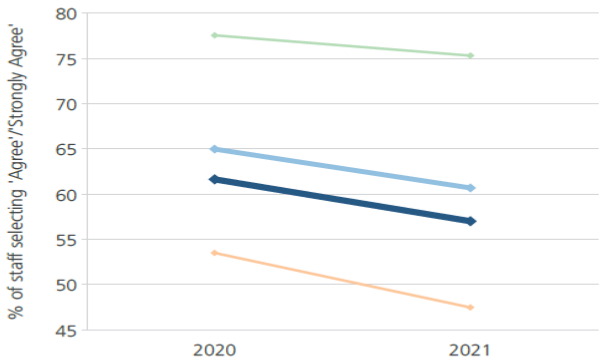
There is clearly some work to be actioned in encouraging our colleagues to speak up and raise concerns, utilising the various routes for reporting such as raising issues with managers and incident reporting etc.

However, the feedback from those who have spoken up via FTSUG as indicated in this report offers positive comments.

Survey Coordination Centre

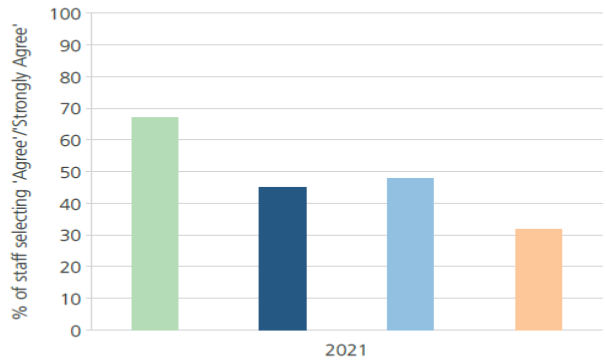
2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We each have a voice that counts** – Raising concerns

Q21e
I feel safe to speak up about anything that concerns me in this organisation



	2020	2021
Best	77.6%	75.3%
Your org	61.6%	57.0%
Average	65.0%	60.7%
Worst	53.5%	47.5%
Responses	1,396	1,325

Q21f
If I spoke up about something that concerned me I am confident my organisation would address my concern
No trend data are shown as this is a new question



	2021
Best	67.2%
Your org	44.8%
Average	47.9%
Worst	31.9%
Responses	1,323

46

2 Concerns Taken Directly to CQC

During Quarter 4, 3 concerns were referred directly to CQC.

However, the CQC are satisfied with the actions taken by the Trust.

3 Freedom to Speak Up Champions – new guidance from the NGO

The new guidance on FTSU Champions provided by the National Guardian's Office (NGO) in April 2021 was advised at the Southport and Ormskirk Trust Board meeting in Q2 2021. Champions are now being recruited. We have recently successfully recruited 5 new Champions in the last quarter with a current establishment of 20 champions .

We held our local Freedom to Speak Up Champion Network meeting during the months of February and April. Future meetings will take place bimonthly to ensure our local champions have access to peer support and shared learning from the Guardians.

4 The National Picture

The final module of the Freedom to Speak Up E-learning will be launched on 12 April. This module is designed for leaders at all levels to help foster a speaking up culture in their organisations.

You can access the e-learning via the E-learning for Health hub here https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/

The Freedom to Speak Up training - 'Speak Up, Listen Up, Follow Up' - is freely available for everyone who works in healthcare. Divided into three modules, it helps people understand the vital role we all play in a healthy speaking up culture which protects patients and service users and enhances worker experience.

The latest session - Follow Up – completes the package. Developed for senior leaders throughout healthcare - including executive and non-executive directors, lay members and governors – this module aims to promote a consistent and effective Freedom to Speak Up culture across the system which enables workers to speak up and be confident they will be listened to and action taken.

4.1 National Guardians Office (NGO) Freedom to Speak up Guardian Survey 2021/22 Senior leaders' essential role in Freedom to Speak Up (Appendix 1)

The NGO undertook this survey to gain insight into the implementation of the freedom to speak UP Guardian role and how this could be improved. Feedback from respondents helps us assess developments since the launch of freedom to Speak Up Guardian role and identify and prioritise improvements that the NGO may need to make to support the Freedom to Speak Up Guardian. This is the firth survey of its kind, 745 Guardians were invited to participate in the survey, which was open from 13 September to 31 October 2021. There were 333 responses- a response rate of 44.7%.

Recommendations

- Senior leaders should deepen their support for speaking up by taking action to demonstrate learning from speaking up, tackling detriment, and supporting further cooperation within organisations on all matters related to speaking up.
- To improve their ability to act as effective role-models for speaking up we encourage all senior leaders to complete the NGO / HEE 'speak up, listen up, follow up' training.
- Senior leaders should discuss the findings of this survey with their Freedom to Speak Up Guardian and assess with them the amount of ring-fenced time and the balance of time available for reactive and proactive support for speaking up
- There should be visible action on detriment for speaking up wherever this is reported.
- The frequency and status of training on speaking up matters should be reviewed so that guardians and leaders can satisfy themselves that workers and those who support them have the knowledge and skills they need to speak up, listen up, and follow up, well.
- Senior leaders should take the necessary steps to tackle the perception that speaking up is futile, including ensuring appropriate action is taken when individuals speak up and that they are offered timely and meaningful feedback.

5.1 Finally

I am pleased to share with you the agree Anti-Fraud Specialist (AFS) & Freedom to Speak Up Guardian (FSTUG) Liaison & Joint Working Protocol (Appendix 2)

This protocol is intended to clarify the relationship and provide guidance on areas of joint working and interaction between Southport and Ormskirk Hospital Trust Freedom to Speak Up Guardian (FTSUG) and the Southport and Ormskirk Hospital Trust's nominated Anti-Fraud Specialist (AFS) in the course of them undertaking their respective roles and responsibilities.

FREEDOM TO SPEAK UP GUARDIAN SURVEY 2021

Senior leaders' essential role in Freedom to Speak Up

March 2022

National Guardian

Freedom to Speak Up

Freedom to Speak Up Guardian Survey 2021

Senior leaders' essential role in Freedom to Speak Up

March 2022

National Guardian
Freedom to Speak Up

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Foreword

As the new National Guardian for the NHS, I appreciate how this survey of Freedom to Speak Up Guardians provides valuable insight into how the Guardian role is implemented. It helps me understand what further support and learning is needed to create a culture where speaking up is business as usual.

The experience of Freedom to Speak Up Guardians reflects the continued pressures of the pandemic and its effects on the healthcare sector. I am especially grateful to Freedom to Speak Up Guardians for taking part in the survey, mindful of their significant workloads as they seek to support their colleagues whilst the sector remains under strain.

The picture guardians paint of speaking up in a sector still experiencing the effects of the pandemic is a complex one. Positively, many guardians who responded thought that speaking up culture had improved in the healthcare sector (72.8%) and in the organisations they support (74.3%) in the last 12 months. Yet there has been a fall in the proportion of respondents who said their organisation had a positive culture of speaking up, a drop of five percentage points from 2020 (to 62.8%).

Senior leaders

Freedom to Speak Up Guardians do not work in isolation. Leaders set the tone for fostering a healthy speak up, listen up, follow up culture. In 2020, 80% of Freedom to Speak Up Guardians who responded to this survey said senior leaders supported workers to speak up. But in 2021, this fell to 71%. This nine-percentage point difference is a notable drop, which is cause for concern. Also of concern is the indication from 11.5% of respondents who felt that their senior leaders did not understand the Freedom to Speak Up Guardian role and 13.4% did not agree that senior leaders were effective role models for speaking up.

Senior leaders must understand how important fostering a positive speaking up culture is for the success of their organisation, how it protects their workers, their patients and service users. I urge all leaders to use the results of this survey to prompt a conversation with their Freedom to Speak Up Guardian. The benefits speaking up brings can only be realised if leaders listen up and follow up. Guardians can be a significant source of support for leaders, as an important additional route for speaking up, but they cannot do their job for them; however, they can support them

with the themes of what workers are speaking up about - whether those are patient safety concerns, ideas for improvement, or issues affecting their work or wellbeing.

The NGO, in collaboration with HEE, is launching the third and final module in the Freedom to Speak Up e-learning training package. This will provide an opportunity for leaders to pause and reflect on their influence in shaping the speaking up culture in their organisation; I urge you to undertake this training. The revised universal freedom to speak up policy and implementation tools that NHSEI will shortly be publishing will provide an additional opportunity to reset and refresh efforts to improve speaking up culture.

Working proactively

It is only with the full support of their leaders that Freedom to Speak Up Guardians can fully deliver the two key elements of their role. One part is reactive – listening to workers, thanking them and supporting them so that their voices can be heard, and actions are taken. The other part is the proactive element – supporting their organisation to learn from the opportunities that speaking up brings and tackling barriers to speaking up wherever they are.

For the first time in this survey, we asked guardians about the proportion of time they spent on these two aspects of their role. The highest proportion of respondents were those who spent three-quarters of their time on the reactive elements of the role and one quarter on the proactive aspects. A third of respondents said they had a 50:50 split but 10.3% of respondents indicated that they only work reactively.

This is just one example of the inconsistencies across the system in how the Freedom to Speak Up Guardian role is implemented and this matters: speaking up will not become business as usual if guardians are spending all their time acting as an additional channel rather than working in their organisations to overcome the barriers that result in workers feeling that they must come to a guardian in the first place.

Barriers to speaking up

According to the perception of guardians responding to the survey, the fear of retaliation for speaking up was the greatest barrier to speaking up. In addition, nearly a quarter of respondents said the concern that nothing will be done about the matter raised had a very strong impact as a barrier to workers speaking up. These findings are not new but continue to illustrate the importance of creating an environment where workers do not feel fearful of speaking up and where everyone can see how speaking up is used to make a difference. I ask all leaders to consider what actions their organisations are taking to reduce the fear of futility of speaking up.

Detriment

Guardians tell us that workers continue to say that they feel they experience detriment for speaking up. This is reflected in the information they provide the National Guardian Office in their quarterly data returns. Whilst this survey tells us

that 72% of respondents agreed that detriment was taken seriously, it also shows that nearly one in ten (9.5%) believed that the response to detriment were ineffective.

It is not enough for there to be a statement of zero tolerance on detriment in a speaking up policy. I want to see senior leaders take note of these findings and take more actions to reduce the level of detriment that is being experienced.

Assurance and oversight

Boards, trustees, governors and those with an oversight role have a duty to assure themselves that the behaviours and the culture in the organisation are operating as they should. So, it is disappointing that there was an 11-percentage point decrease in respondents who said they had sufficient access to the board or equivalent, down from 94.0% in 2020 to 83.1% in 2021.

The insights that Freedom to Speak Up Guardians bring us are so important in helping understand the behaviours and culture that workers experience in practice. These insights can highlight challenges and act as an early warning system of where failings might occur. Recent, high-profile, cases have highlighted the consequences of not embracing speaking up in this spirit; this influences the whole sector and, as a result, the truth can be silenced. I ask all senior leaders to prevent this. The starting point is to listen with compassion and embrace speaking up as a means of learning and improving. It is an opportunity when workers speak up to us and something that must be encouraged, supported and acted upon as it is vital for patient safety and worker wellbeing.

Dr Jayne Chidgey-Clark
National Guardian for the NHS

March 2022

Acknowledgements

We want to thank Freedom to Speak Up Guardians for participating in the survey, particularly given the additional pressures on the healthcare system. We also want to thank Picker Institute Europe for their expertise and support in running the survey.

National Guardian's Office

The National Guardian's Office works to make speaking up business as usual in England's healthcare sector.

The office leads, trains and supports Freedom to Speak Up Guardians and provides learning and challenge on speaking up matters to the healthcare system.

Since the establishment of the NHS National Guardian's Office in 2016 following the recommendation of Sir Robert Francis' Freedom to Speak Up Review, the network of Freedom to Speak Up Guardians has grown to over 800. Freedom to Speak Up Guardians support workers in a range of organisations in primary and secondary care, the independent sector and national bodies.

Freedom to Speak Up Guardians

Freedom to Speak Up (FTSU) Guardians support workers to speak up and work within their organisation to tackle barriers to speaking up.

NHS trusts and providers of NHS care subject to the NHS standard contract must appoint a Freedom to Speak Up Guardian and follow the National Guardian's Office's (NGO) guidance on speaking up.[1] Increasingly, other organisations are also introducing the Freedom to Speak Up Guardian role.

Freedom to Speak Up Guardian Survey: 2021/22

We undertook this survey to gain insight into the implementation of the Freedom to Speak Up Guardian role and how this could be improved. Feedback from respondents helps us assess developments since the launch of the Freedom to Speak Up Guardian role and identify and prioritise improvements that we may need to make to support the Freedom to Speak Up network.

This is the fifth survey of its kind. Please see here for reports from our previous surveys.

We invited 745 Freedom to Speak Up Guardians to participate in the survey, which was open from 13 September to 31 October 2021. In total, there were 333 responses - a response rate of 44.7%.

Table 1 (below) shows the number of those invited to participate in the survey by organisation type and the percentage of those groups that completed the survey.[2]

[1] Though some primary care and independent healthcare providers subject to the NHS standard contract have appointed Freedom to Speak Up Guardians, many have not. This needs to continue to change so that all workers have access to this essential, additional route to speak up.
[2] The breakdown by organisation type excludes respondents from organisations with fewer than five respondents in order protect anonymity

Organisation Type	Invites sent	Surveys completed
NHS Trust/Foundation Trust	374	212
Independent Provider of Healthcare Services	150	41
National Bodies	64	21
Hospice	51	24
Clinical Commissioning Groups	37	10
Other (inc. primary care)	61	-
Total	**737**	**325**

Table 1: *Respondents by organisation type*

There were some changes to the questions in the 2021/22 compared to previous years. Please see here for the Freedom to Speak Up Guardian Survey 2021 Question List.

All questions in the survey were voluntary, and so the number of responses to each question varies. Results are shown as a percentage of the total number of responses to each question.

The survey included questions regarding the following areas:

- Health and wellbeing
- Freedom to Speak Up Guardian networks
- National Guardian's Office

We will be publishing the results in bespoke reports in the first half of 2022/23.

Key Findings

Speaking up culture

- Almost three quarters of respondents (74.3%) thought that the speaking up culture in the organisation(s) they support had improved over the last year. A similar portion (72.8%) thought the same about the healthcare sector.

- Sixty-three per cent (62.8%) of respondents said their organisation had a positive culture of speaking up, down five percentage points compared to 2020.

- Seven out of ten (70.8%) respondents said that senior leaders supported workers to speak up. This is a 10-percentage point decrease compared to last year (80.2%, 2020).

- Respondents perceived that fear of retaliation/suffering as a result of speaking up and concerns that nothing will be done were key barriers to speaking up in the organisation(s) they supported, with 69.0% of respondents saying that fear of retaliation/suffering due to speaking up had an impact on speaking up and 58.4% saying the same for the concern that nothing will be done in response to speaking up.

- Three quarters (75.3%) of respondents said action was being taken to tackle barriers to speak up. However, one in ten (11.3%) respondents said action had not been taken.

- Nearly 80% (28.4%) of respondents thought that action taken to tackle barriers to speaking up was somewhat or very effective.

- Seventy-two per cent (72.1%) of respondents agreed or strongly agreed that detriment was taken seriously in the organisation(s) they support but nearly one in ten (9.5%) thought that action taken was ineffective.

Appointment and carrying out the role

- Most respondents (77.7%) said they were appointed to the Freedom to Speak Up Guardian role through fair and open competition. A greater portion of respondents supporting NHS Trusts or National Bodies said that they were appointed through fair and open competition compared to other organisations.

- Three-fifths of respondents (60.4%) had been in the role for 18 months or longer

- Respondents represented a wide range of occupational groups. Twenty-seven per cent (27.3%) of respondents were registered nurses and midwives.

- The most represented pay bands among respondents were Agenda for Change (AfC) band 7 (22.1%) and AfC band 8a (20.6%).

- Most respondents (72.1%) to the survey were confident that they were meeting the needs of workers in the organisation(s) they support as Freedom to Speak Up Guardian.

- Overall, respondents spent a greater proportion of their time on the reactive aspects of their Freedom to Speak Up Guardian role. Forty-five per cent (45.2%) of respondents spent most of their time on the reactive elements of the role, compared to 24.7% that spent most of their time on the proactive aspects of the role.

- Two-thirds (67.0%) of respondents that spent an equal amount of their time on the proactive and reactive aspects of the role thought that the allocation felt right to them. Most respondents that spent a greater portion of their time on the reactive aspects of the role thought that the allocation was not right.

- A greater proportion of respondents were reporting to their boards (or equivalent) in person, up 3.8 percentage points from last year to 81.3%.

- Seventy-two per cent (71.7%) of respondents felt valued by managers in the organisation(s) they support, up 3.3 percentage points (68.4%, 2020).

- Most respondents felt supported by their chief executive (85.7%) and senior leaders (77.9%).

- Ninety-three per cent (93.2%) of respondents said they felt safe speaking up to senior leaders. Four per cent (3.9%) did not feel safe speaking up to senior leaders.

- Almost three-quarters (74.1%) of respondents agreed with the statement: ‘I feel confident that my suggestions and challenges to senior leaders will be acted upon.’ However, one in ten (10.2%) disagreed or strongly disagreed.

- There was a 5.8 percentage point decrease in respondents who said they had direct access to the non-executive director (or equivalent) with speaking up as part of their portfolio, down from 87.7% in 2020 to 81.9% in 2021.

- There was an 11-percentage point drop in respondents who said they had sufficient access to the board (or equivalent), from 94.0% in 2020 to 83.1% in 2021.

- Less than half of the respondents (48.7%) said that they had sufficient time to carry out their Freedom to Speak Up responsibilities. Almost a third of respondents (32.6%) said it was insufficient.

- Twenty-nine per cent (28.6%) of respondents said they had insufficient budget for expenses associated with the role.

Ring-fenced time

- Two-thirds (65.6) of respondents had ring-fenced time to carry out their role, a 4.7 percentage point decrease compared to the previous year (70.3%, 2020).

- A greater proportion of respondents with ring-fenced time said that they had sufficient time to carry out their Freedom to Speak Up responsibilities. Twenty-seven per cent (27.2%) of respondents with ring-fenced time strongly agree that they had sufficient time compared to 5.5% of respondents with no ring-fenced time.

Training for workers

- Four out of five (79.5%) respondents said speaking up training was available for workers at the organisation(s) they supported; 67.1% said training was available on listening up.

- Most respondents said that this training was not mandatory.

- Around two-thirds (64.4% - 67.8%) thought speaking up and listening up training was effective.

Demographics

- Four out of five (79.7%) respondents were female.

- Fifteen per cent of respondents (15.2%) were from an ethnic minority background, up from 9.1% in 2020.

- Most respondents (52.9%) were in the 51-65 age band.

- Eighty-seven per cent (86.6%) of respondents identified as heterosexual. Four per cent (3.8%) were gay or lesbian and 2.1% were bi-sexual.

- Over a quarter (25.9%) of respondents said they had a long-term health condition (physical or mental) lasting or expected to last for 12 months or more. This was an 8.6 percentage point increase compared to 2020.

Recommendations

- Senior leaders should deepen their support for speaking up by taking action to demonstrate learning from speaking up, tackling detriment, and supporting further cooperation within organisations on all matters related to speaking up.

- To improve their ability to act as effective role-models for speaking up we encourage all senior leaders to complete the NGO / HEE ‘speak up, listen up, follow up’ training.

- Senior leaders should discuss the findings of this survey with their Freedom to Speak Up Guardian and assess with them the amount of ring-fenced time and the balance of time available for reactive and proactive support for speaking up

- There should be visible action on detriment for speaking up wherever this is reported.

- The frequency and status of training on speaking up matters should be reviewed so that guardians and leaders can satisfy themselves that workers and those who support them have the knowledge and skills they need to speak up, listen up, and follow up, well.

- Senior leaders should take the necessary steps to tackle the perception that speaking up is futile, including ensuring appropriate action is taken when individuals speak up and that they are offered timely and meaningful feedback.

Changes in speaking up culture

We asked guardians about their perceptions of how the speaking up culture in the healthcare sector had changed over the past year. Seventy-three per cent (72.9%) of respondents said it had improved considerably or slightly.

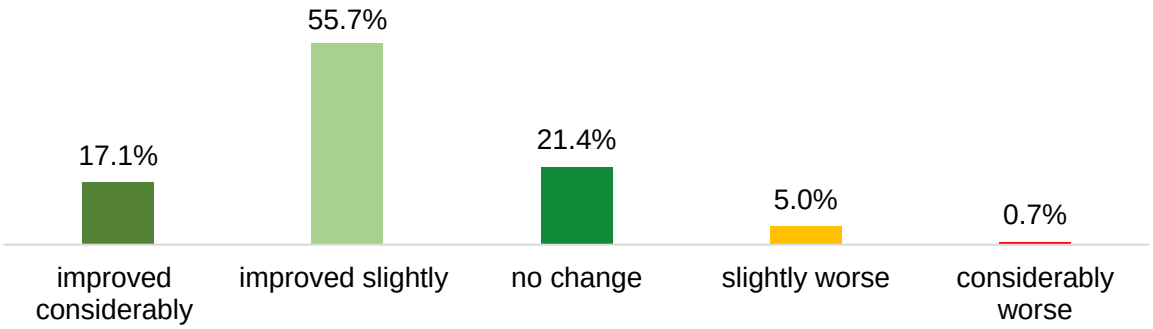

Figure 1. *Which of these statements best describes how Freedom to Speak Up culture has changed in the last 12 months in: The healthcare sector*

In previous surveys, we sought perceptions of the speaking up culture specifically in the NHS rather than the healthcare sector. In 2020, 80% of respondents said the speak-up culture in the NHS had improved considerably or slightly.

Three quarters (75.0%) of respondents supporting NHS trusts thought the speak-up culture in the healthcare sector had improved (considerably or slightly) in the last 12 months. This compares with 80.6% of respondents supporting independent healthcare providers and 50.0% of respondents supporting hospices.

Organisations supported by Freedom to Speak Up Guardians

We asked respondents to share their views on how the speaking up culture in the organisation(s) they support had changed over the preceding 12 months.

Almost three-quarters of respondents (74.3%) said the speaking up culture in the organisation(s) they support had improved: 23.6% said it had considerably improved and 50.7% that it had slightly improved.

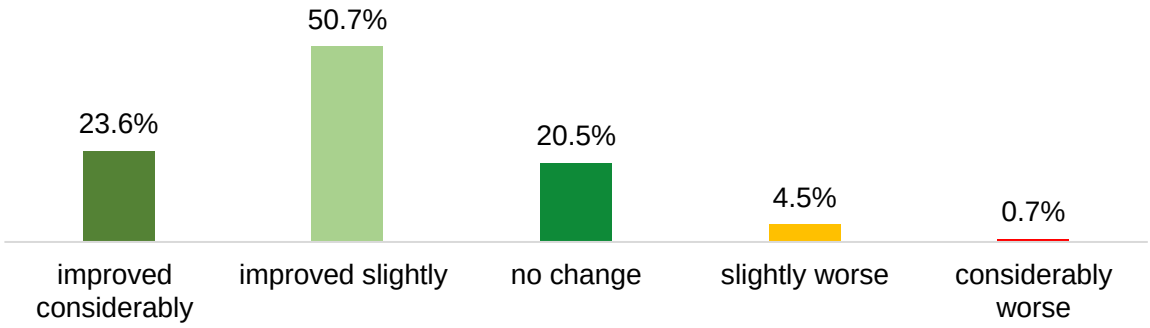

Figure 2. *Which of these statements best describes how Freedom to Speak Up culture has changed in the last 12 months in: The organisation(s) you support*

A minority of respondents (5.2%) said that the speaking up culture in the organisation(s) they support had deteriorated.

In previous surveys, we asked guardians about how Freedom to Speak Up culture in their organisation had changed in the last 12 months. In 2020, eighty-four per cent (84%) of respondents said that it had improved slightly or considerably.[3]

In 2021, we found that the responses varied depending on the type of organisation(s) supported by the respondents: seventy-eight per cent (78.1%) of respondents from independent healthcare providers said the culture had improved, 73.8% for respondents supporting NHS trusts said the same, as did 65.2% for those supporting hospices.

[3] National Guardian's Office, *Freedom to Speak Up Guardian Survey 2020: Guardian insights on support for and barriers to speaking up*, page 41.

As in previous surveys, we sought guardians' views on statements about the speaking up culture in their organisation(s) (figure 3, below).

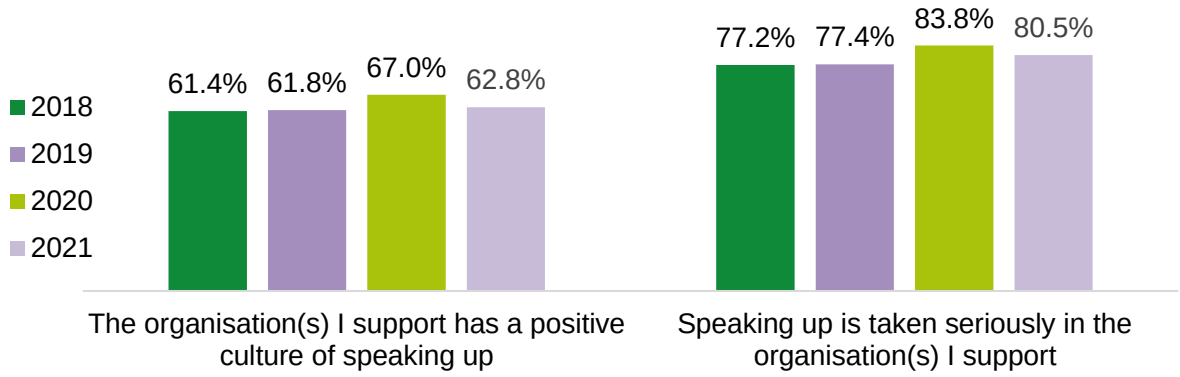

Figure 3. *Agree or strongly agree*

Sixty-three per cent (62.8%) of respondents agreed or strongly agreed with the statement that the organisation(s) they support has a positive speaking up culture. In 2020, 67.0% of respondents agreed or strongly agreed with this statement.

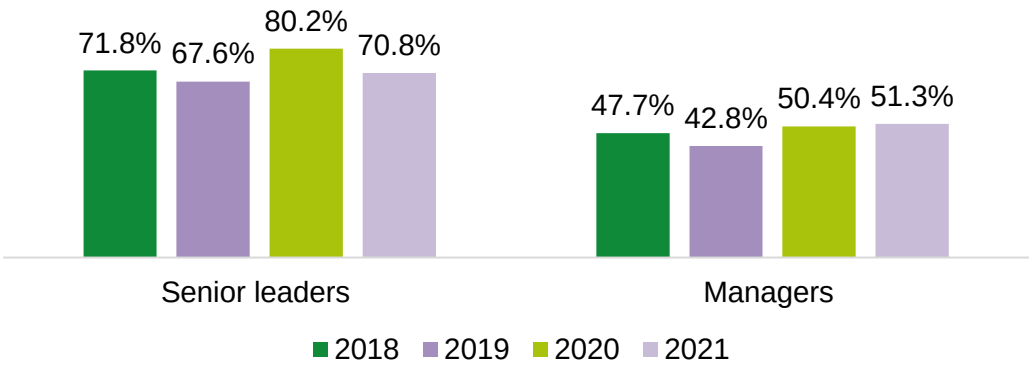

Figure 4 *'… support workers to speak up' (agree or strongly agree)*

Seven out of ten respondents (70.8%) said that senior leaders support workers to speak up. This was a 9.4 percentage point decrease compared the previous survey results.

The proportion of respondents agreeing or strongly agreeing with the statement that managers support workers to speak up continued to increase, up from 42.8% in 2019 to 51.3% in 2021.

For the first time, we asked respondents to rate - on a scale from 'excellent' to 'very poor' - their perceptions of eight aspects of freedom to speak up in the organisation(s) they support. The aspects included confidence in the Freedom to Speak Up Guardian role among certain staff groups (please see figure 5, below).

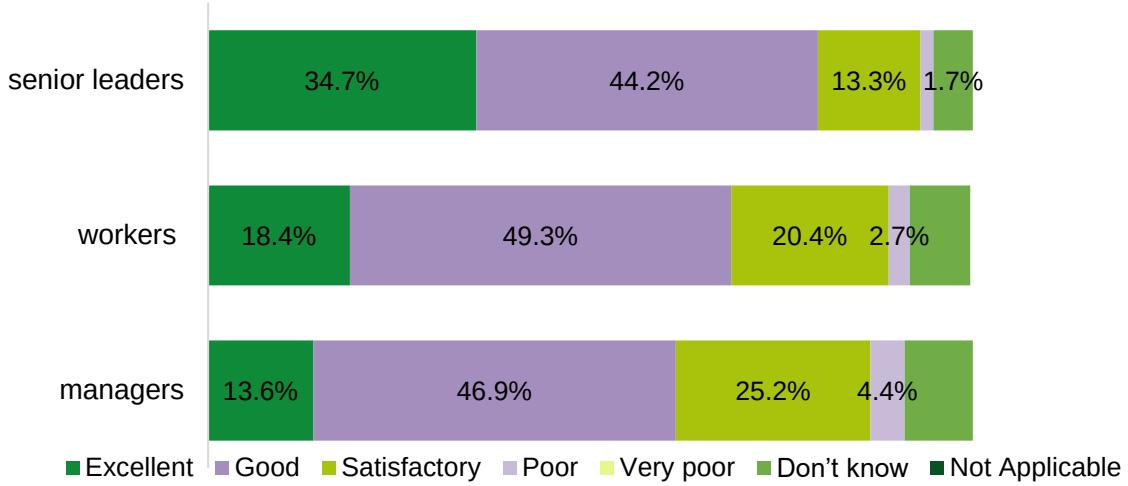

Figure 5. How would you rate each aspect at the organisation(s) you support? 'Confidence in the FTSU Guardian role among... '

In every case, most respondents gave a 'good' or 'excellent' rating regarding these staff groups' confidence in the Freedom to Speak Up Guardian role.

Almost eight out of 10 (78.9%) respondents rated senior leaders' confidence in the role as 'good' or 'excellent', meaning that it was the aspect of freedom to speak up that attracted the greatest portion of 'good' or 'excellent' ratings.

The engagement of board members (or equivalent) in FTSU matters was also rated relatively highly, with over two-thirds of respondents (68.4%) rating it 'good' or 'excellent'

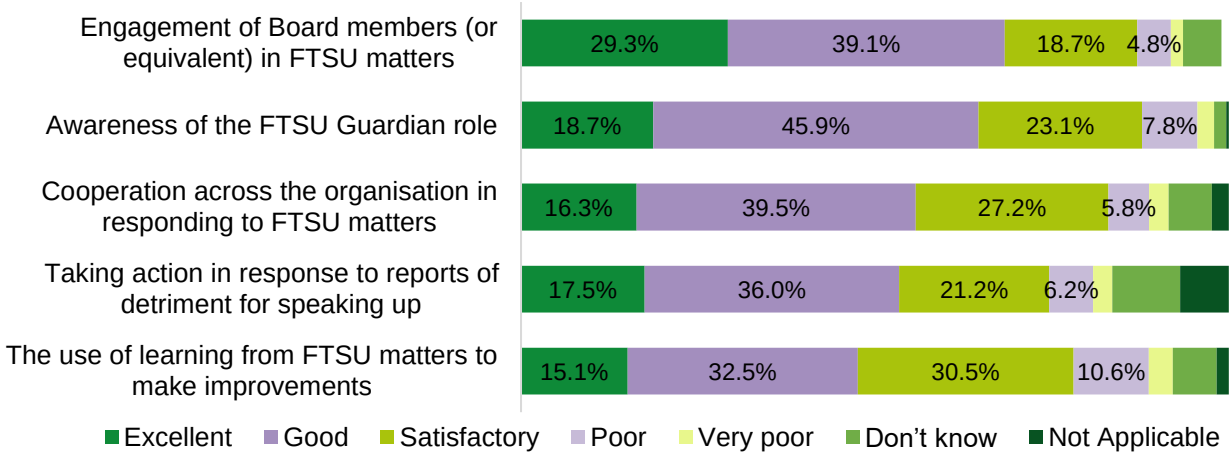

Figure 6. *How would you rate each aspect at the organisation(s) you support?*

In contrast to the above findings, forty-eight per cent (47.6%) of respondents rated the use of learning from FTSU matters in the organisation(s) they support as 'good' or 'excellent'. This aspect also attracted the highest portion of 'poor' and 'very poor' ratings (14.0%) (see figure 7, below).

Awareness of the FTSU Guardian role was among the aspects of freedom to speak up that attracted the highest proportion of 'good' and 'excellent' ratings, but one in ten (10.2%) of respondents gave it a 'poor' or 'very poor' rating.

Figure 7. *How would you rate each aspect at the organisation(s) you support? 'Poor' or 'very poor' ratings*

Barriers to speaking up

On a scale from 'no impact' to 'very strong impact', we asked guardians to share their perceptions of the degree to which certain factors act as barriers to speaking up.

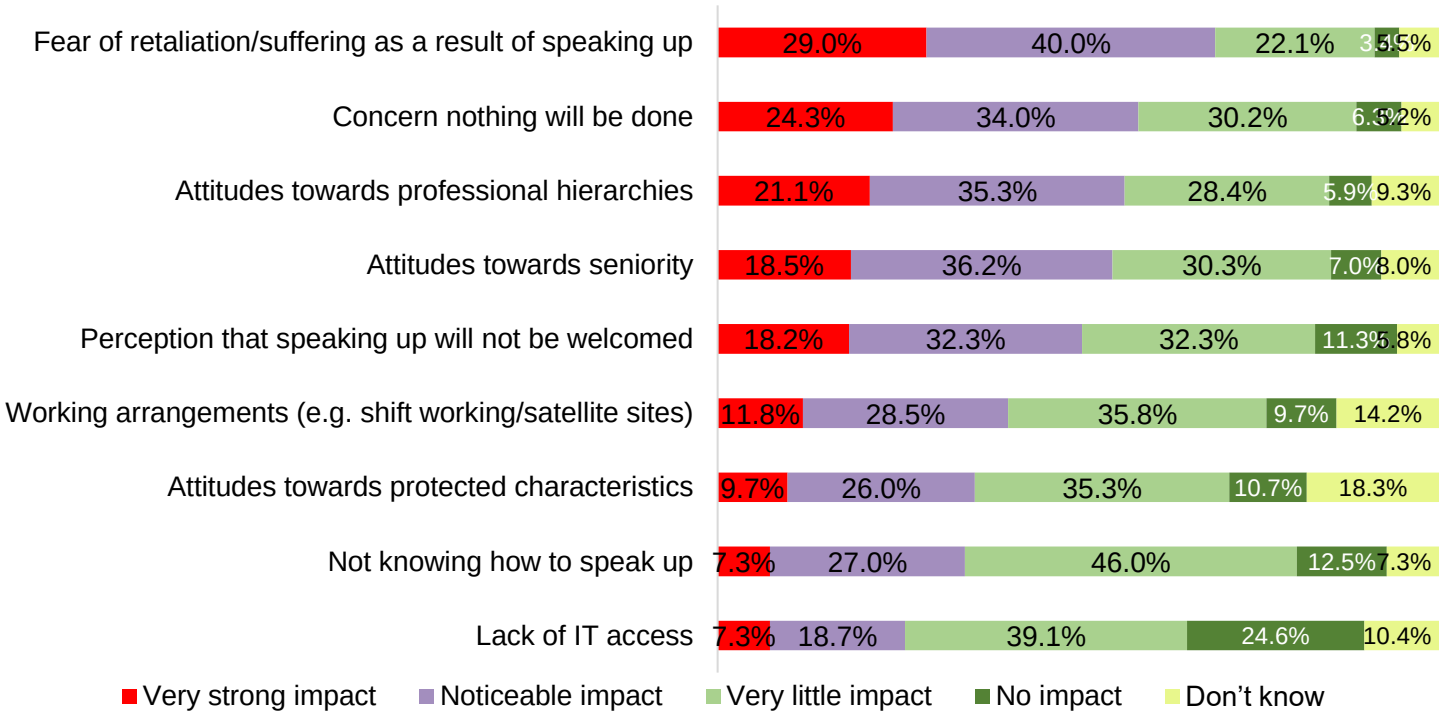

Figure 8 *To what degree do the following act as barriers to speaking up for workers in your organisation*

Thirty per cent (29.0%) of respondents said that fear of retaliation/suffering due to speaking up had a very strong impact on speaking up. A further 40.0% said that it had a noticeable impact.

Almost a quarter of respondents (24.3%) thought that the concern that nothing will be done in response to speaking up had a 'very strong impact' on speaking up. Thirty-four per cent (34.0%) said it had a noticeable impact.

The following were also each identified by around a fifth of respondents as having a 'very strong impact' as a barrier to speaking up:

- Attitudes towards:
  - Professional hierarchies (21.1%)
  - Seniority (18.5)
- Perception that speaking up will not be welcomed (18.2%)

Most respondents thought that a lack of IT access (63.7%) or not knowing how to speak up (58.5%) had very little or no impact on speaking up.

These results echo other findings. For instance, research we commissioned (*Difference Matters*, 2021) found that the two most significant barriers to people raising concerns were fear of repercussions from managers/other leaders and a belief nothing will change as a result:

- I didn't believe anything would change
- I was worried about repercussions from my line manager/other leaders

The Institute of Business Ethics (IBE) found that fear and futility remained barriers to speaking up. The IBE's *Ethics at Work: 2021 international survey of employees* found a decrease in willingness to speak up in the UK since 2018, and the most common reasons for this were concern about jeopardising jobs and not believing corrective action would be taken.

Acting against barriers to speaking up

We asked guardians if and what action had been taken to tackle barriers to speaking up, as well as their thoughts on its effectiveness.

Figure 9. *How effective are the actions?*

Three quarters (75.3%) of respondents said action had been taken to tackle barriers. Eleven per cent (11.3%) of respondents who said that actions had been taken to tackle barriers to speaking up felt they were very effective. Sixty-seven per cent (67.1%) said they were somewhat effective, and just over one in ten thought they were neither effective nor ineffective. Fewer than one per cent said actions were somewhat or very ineffective.

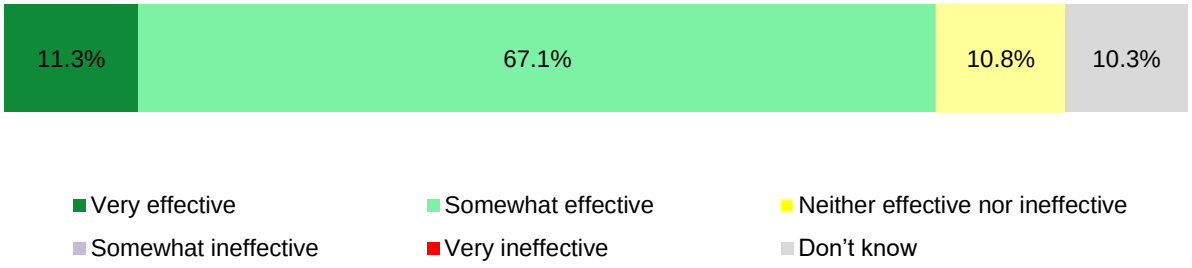

Figure 10. *How effective are the actions?*

Guardians described the actions taken to tackle barriers to speaking up. A key theme arising from these responses was the continuation of efforts to improve awareness of Freedom to Speak Up, including reaching out to groups who perhaps were not speaking up as often.

"Where there …[is] evidence of barriers, managers have meetings and help promote the need for speaking up with more listening exercises and awareness"

"Visiting hard to reach groups of staff with little IT access"

"Discussions with HR who can seem negative about the FTSU service"

"Lots of positive involvement from CEO/Chief People Office."

"More board to ward rounds across different shift patterns, FTSUG has been included in these events."

Detriment

Workers should be able to share improvement suggestions or voice concerns without fearing or experiencing detriment.

Detriment refers to disadvantageous or demeaning treatment as a result of speaking up, such as being ostracised, given unfavourable shifts, being overlooked for promotion, and being moved from a team. Such treatment can be deliberate or the result of a failure to act (i.e. an omission).

Workers who experience detriment - or witness or hear about it happening to others - may hesitate to speak up themselves. Therefore, it is particularly important that effective action to tackle detriment is taken.

Seventy-two per cent (72.1%) of guardians agreed or strongly agreed when presented with the statement: 'Detriment is taken seriously in the organisation(s) I support'. However, over one in ten (10.1%) disagreed with it.

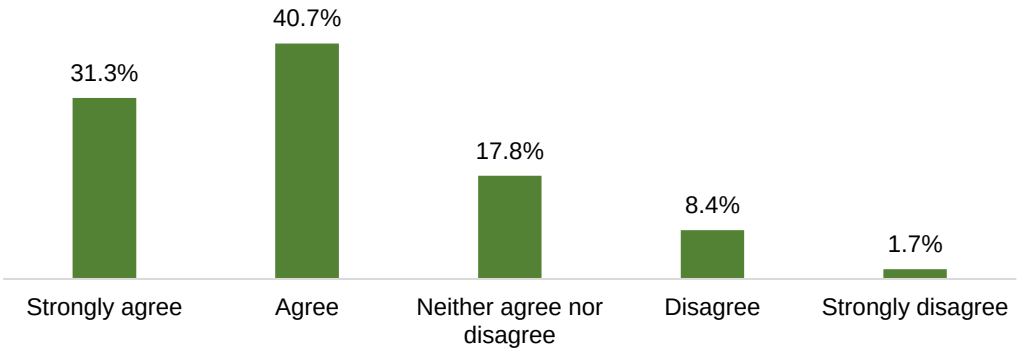

Figure 11. *Detriment is taken seriously in the organisation(s) I support*

When asked about the effectiveness of responses to detriment, only 58.1% of respondents described this as somewhat effective or very effective. Nearly a third of respondents (32.4%) considered actions as neither effective nor ineffective and 9.5% of respondents considered them to be somewhat or very ineffective.

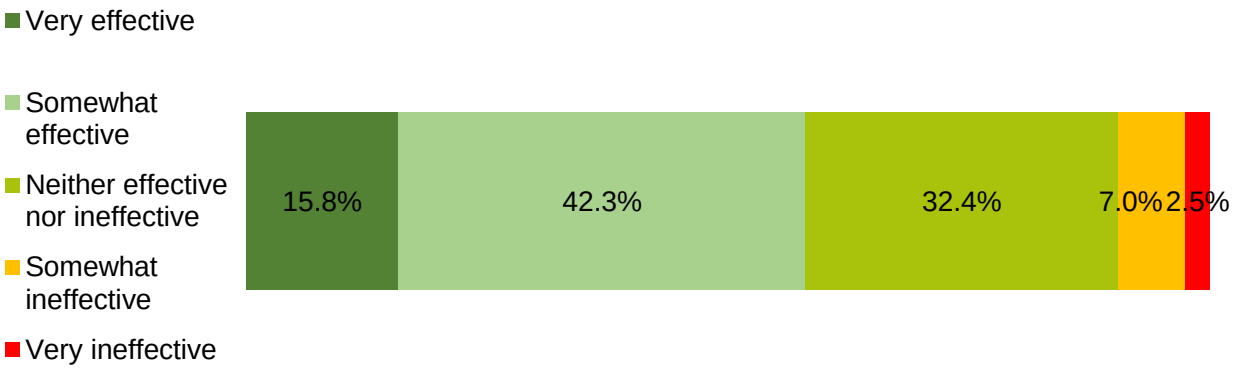

Figure 12. *How effective is the response to detriment in the organisation(s) you support?*

We invited respondents to share information about the action taken to tackle detriment. The responses included the explicit communication detriment was unacceptable and respect for the confidentiality of those speaking up:

"...staff and managers... reminded about possible repercussions of detrimental treatment towards staff who speak up and staff are reminded that detrimental treatment will not be tolerated and that they will [be] protected... if necessary through the use of HR policies"

"Chief Exec talks about detriment and that this is taken seriously... and consideration undertaken if it has happened."

"Confidentiality is maintained"

However, some respondents indicated that more could be done to tackle detriment:

"I'm not sure anything is [done], other than us having a policy against it"

"in reality, very little [is done]"

“Not enough [is done]. The problem lies in professional hierarchies and behaviours - not so much a 'management' issue as one of interpersonal relationships, tribes and cliques."

“Nothing [is done]. I've raised it numerous times."

Training for workers

Workers need to know how to speak up and respond well to others speaking up. This includes thanking people for speaking up, taking timely and appropriate action in response to the matter raised, and providing and seeking timely and meaningful feedback from those who have spoken up.

The NGO’s guidance on Freedom to Speak Up training states that such training should be treated on a par with mandatory training. It also states that training should be repeated as often as appropriate to ensure that senior leaders have assurance that all workers have the knowledge they need to speak up and respond well. Nearly four in five of respondents (79.5%) said that that speaking up training is available, and over a third (37.2%) said that it is mandatory.

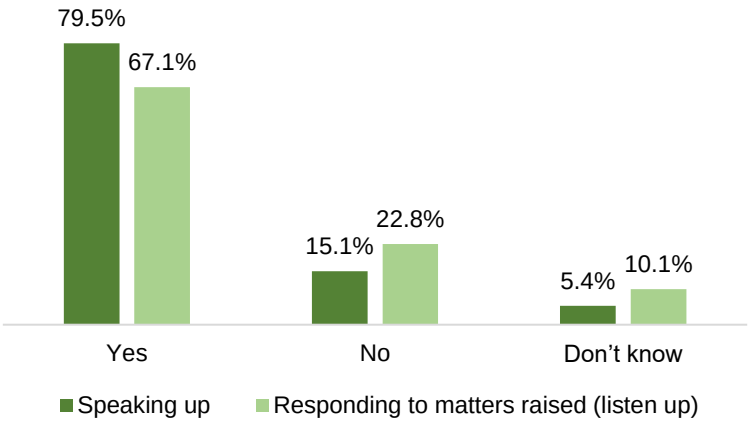

Figure 13. *Is training available for workers?*

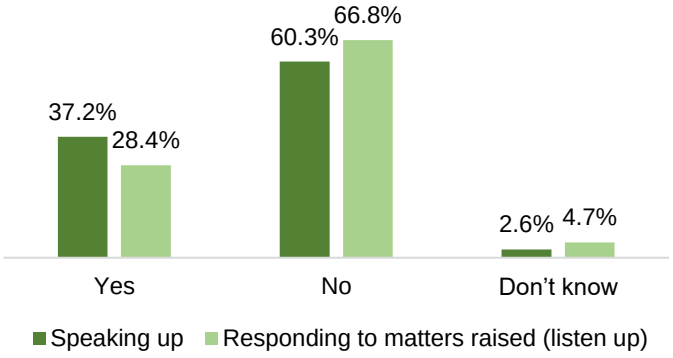

Figure 14. *Is training mandatory?*

Over 40% of respondents indicated that training was undertaken only once, with over 20% of respondents indicating that training was annual, and around a further 30% indicating that training was repeated but less frequently than annually.

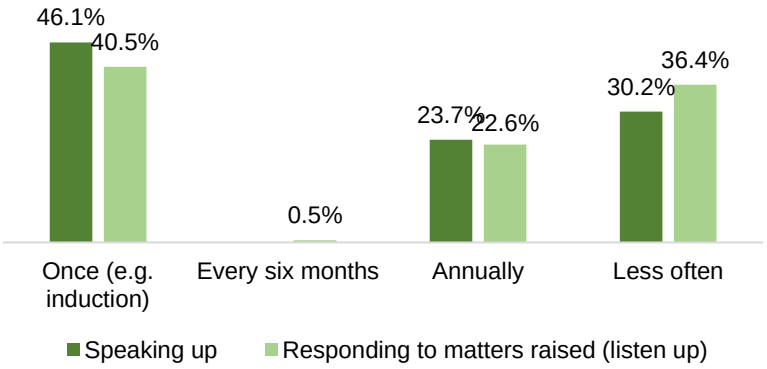

Figure 15. *How often is training expected to be undertaken?*

Over half of respondents indicated that the training available was somewhat effective with just over a further 12% indicating that it is very effective.

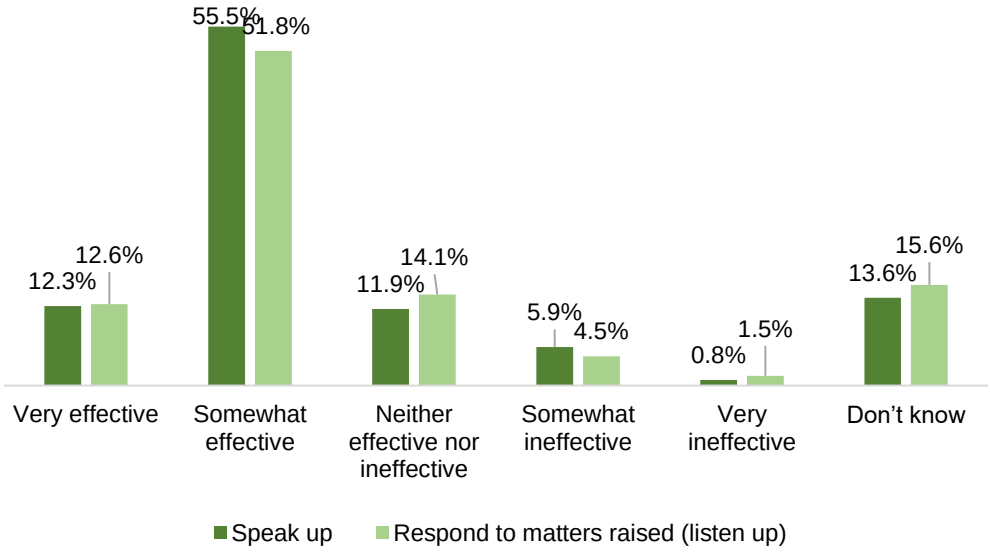

Figure 16. *How effective do you think it is in enabling workers to …*

Appointment and carrying out the guardian role

Appointment

Appointments to roles should be made based on fair and open competition, and the Freedom to Speak Up Guardian role is no exception. This allows for the appointment of the best candidates and makes it more likely that workers will have confidence in their Freedom to Speak Up Guardian, including their operational independence, impartiality and objectivity.

We asked guardians how they were appointed to the Freedom to Speak Up Guardian role.

Over two-thirds (77.7%) of respondents reported that they were appointed through fair and open competition.

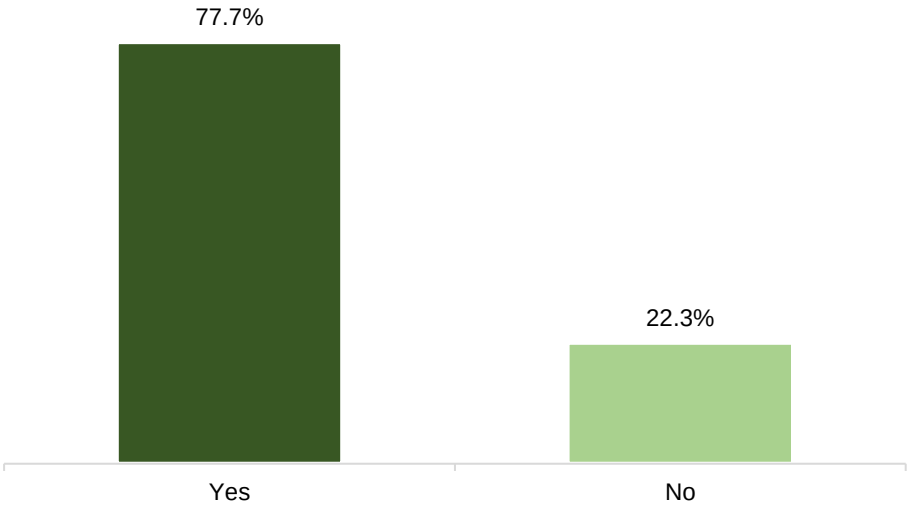

Figure 17. *Were you appointed through fair and open competition?*

A like-for-like comparison to previous surveys is not possible but in last year's survey 41% of respondents said they were appointed through open competition and a further 22% were approached, volunteered, elected or nominated with an interview.

We found that the results varied depending on the type of organisation(s) supported by the respondents. For example, a greater proportion of respondents supporting national bodies (95.0%) and NHS trusts (88.3%) were appointed through fair and open competition compared to other organisations. The proportion of respondents

appointed through fair and open competition fell to 43.5% for guardians supporting hospices.

We invited respondents who had not been appointed through fair and open competition to expand on their response. Most of the comments we received indicated that the respondents were individually approached and asked to take on the role. In some cases, this was because their pre-existing role was thought to be closely aligned with the Freedom to Speak Up Guardian role.

"[I was] Advised I had to take the role"

"I was asked by the… board to take on the role"

"I was approached by the… CEO and asked if I would take on the additional role"

"[I was] requested to take the role by Senior Management"

Length of service

Sixty per cent (60.4%) of respondents had been in the Freedom to Speak Up Guardian role for 18 months or longer, which is in line with the preceding survey results.

Thirty-two per cent (31.5%) had been in the role longer than three years.

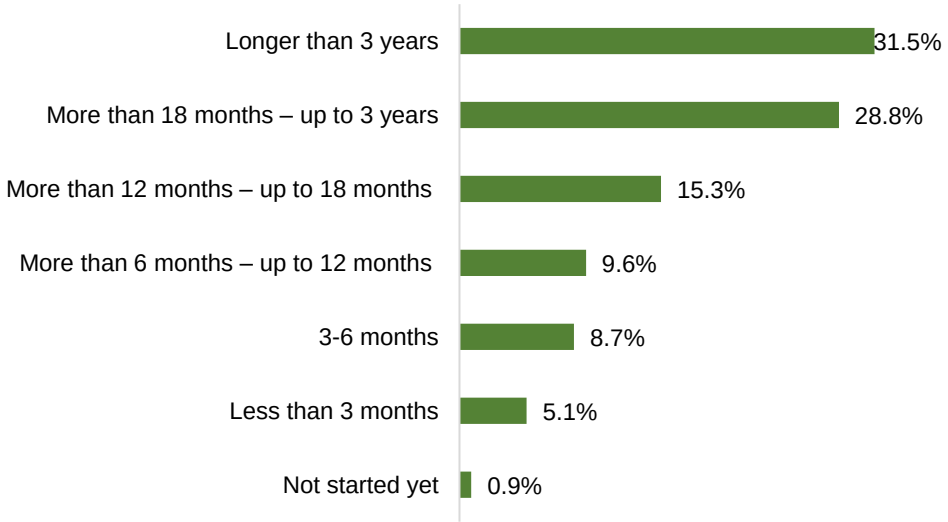

Figure 18. *Length of time in the role*

Who is in the role?

Respondents came from various occupational groups, including nurses and midwives, general management and allied health professionals.

Nurses and midwives remained the most common occupation group among respondents. Twenty-seven per cent (27.3%) of respondents were registered nurses and midwives, a 4.8 percentage point increase from 2020.

Fifteen per cent (15.0%) of respondents were from the wider organisational team, including administrative/clerical staff and corporate services (such as human resources, finance and information technology). In comparison, 22.0% of respondents in the preceding survey assigned themselves to this category. Twenty per cent (20.0%) of respondents defined themselves as 'Other', including trustees, lay members, volunteers and directors.

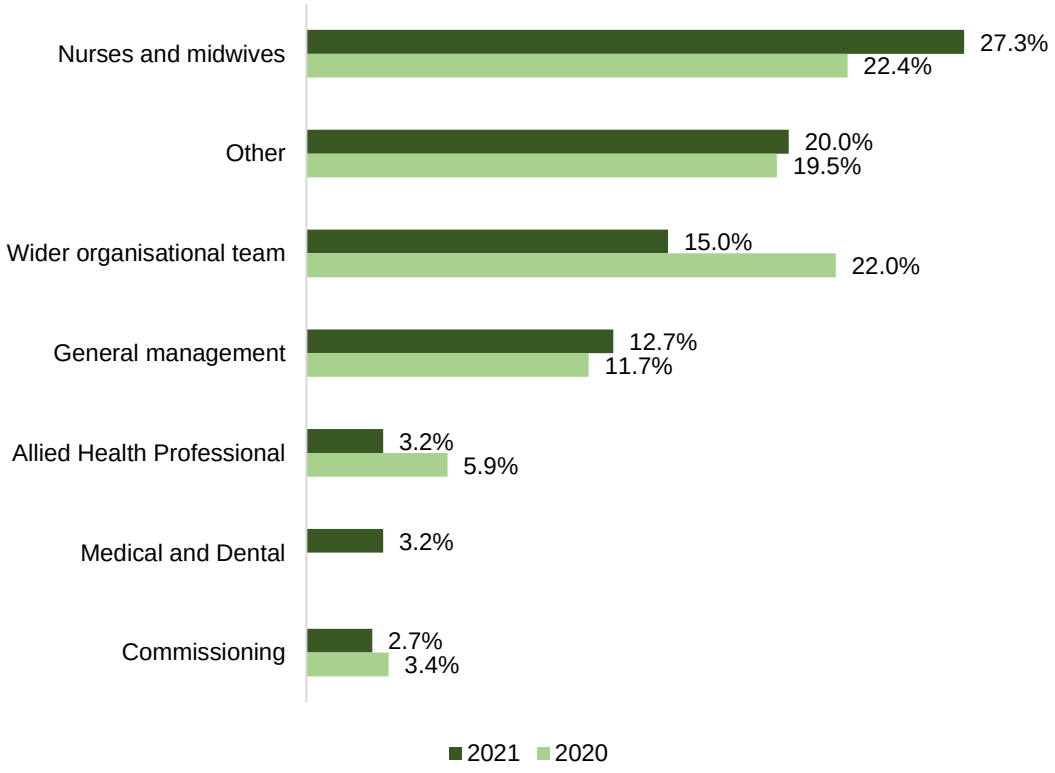

Figure 19. *Occupational group*

Respondents reported belonging to other occupational groups, but these have not been included in figure 19 (above) due to low numbers.

In addition to their guardian role, nearly 70 per cent (69.2%) of respondents had another role. The percentage of respondents with another role had declined since 2019, when it was 78.8%.

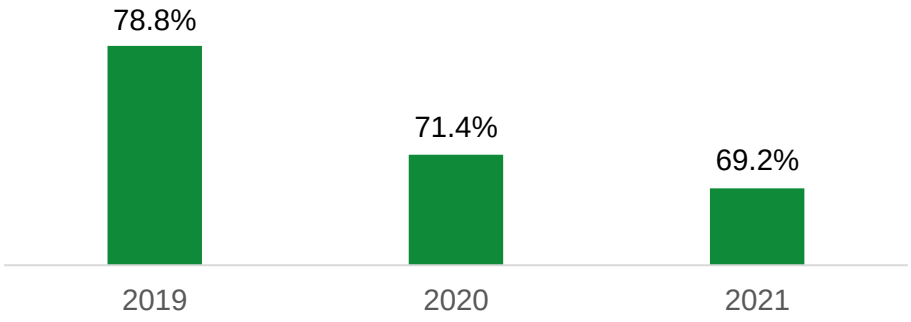

Figure 20. *Do you have another role? ('Yes')*

Banding/grading

We asked respondents about their pay banding/grade.

Twenty-two per cent (22.1%) of respondents reported that they were in AfC Band 7, making this the most common banding/grading among respondents. This was followed by over a fifth (20.6%) as AfC Band 8A. AfC Bands 7 and 8A were also the two most common bands in the previous survey (see figure 21, below).

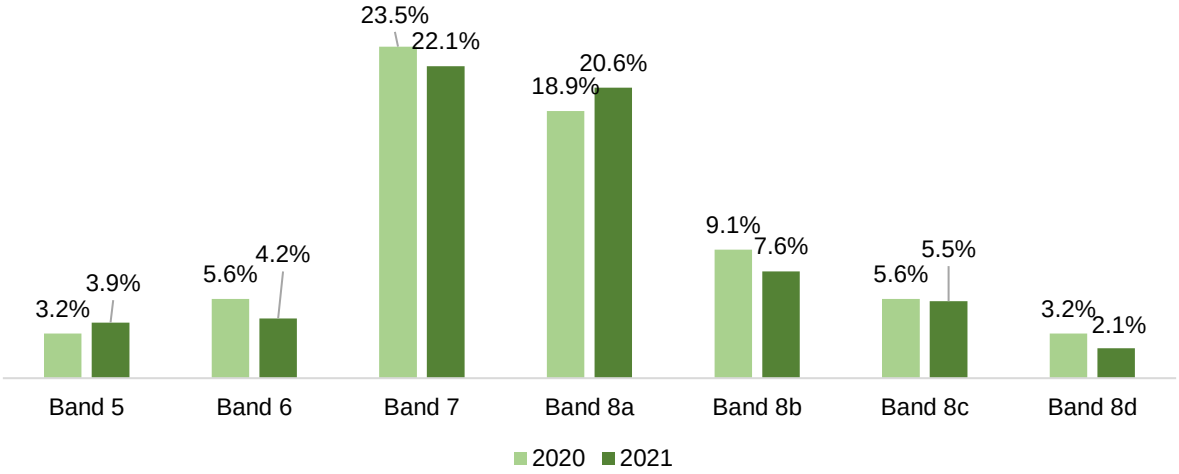

Figure 21. *AfC Banding*

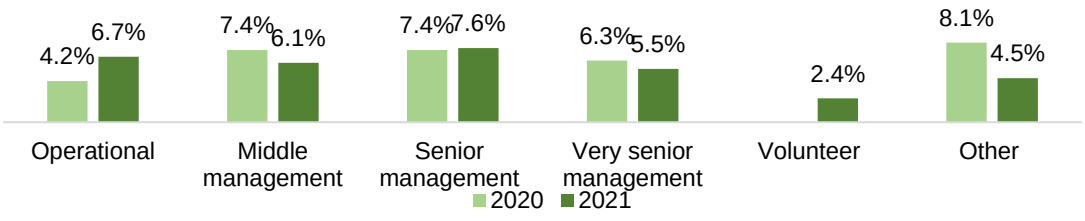

Figure 22*. Non-AfC*

Reactive and proactive working

We asked guardians about how they split their time between the 'reactive' and ‘proactive’ aspects of their Freedom to Speak Up Guardian role.

Thirty per cent (30.1%) of respondents reported that their time was split 50:50 between working reactively (such as supporting workers who speak up to them) and working proactively (such as working within their organisation to tackle barriers to speaking up). Forty-five per cent (45.2%) of respondents spent most of their time working reactively with 24.7% of respondents spending more time working proactively.

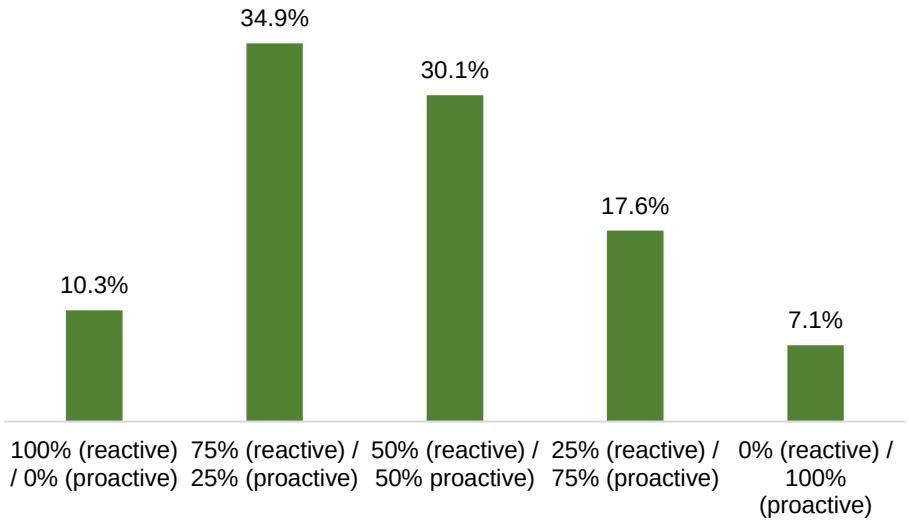

Figure 23. *Reactive/Proactive time split*

We found variations in the responses to this question depending on the type of organisation(s) supported by respondents. For example, a greater proportion of respondents that supported NHS trusts spent a greater proportionate of their time on the reactive aspects of the role compared to those supporting independent healthcare providers.

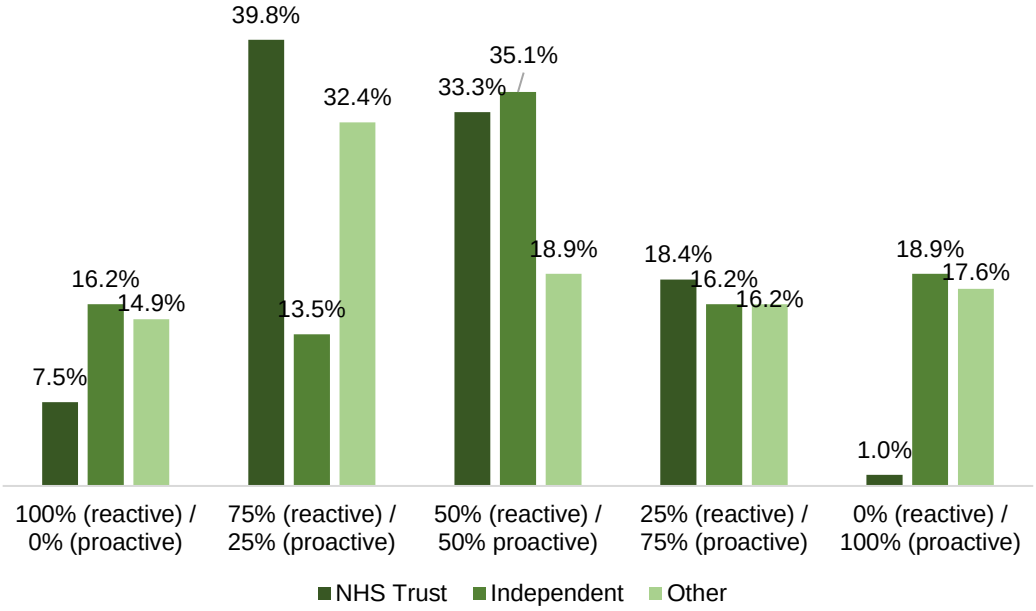

Figure 24. *Reactive/Proactive time split by organisation type*

We asked respondents whether the proportion of time they spent on the reactive and proactive aspects of the role felt right.

Nearly 43% of respondents (42.9%) said their time split felt right. Forty-one per cent (41.0%) said that it wasn't right. Sixteen per cent (16.0%) did not know.

Over two-thirds (67.0%) of respondents who spent an equal amount of their time on the proactive and reactive aspects of the role thought that the allocation felt right to them. However, respondents that spent a greater portion of their time on the reactive aspects of the role were mostly of the view that the allocation did not feel right.

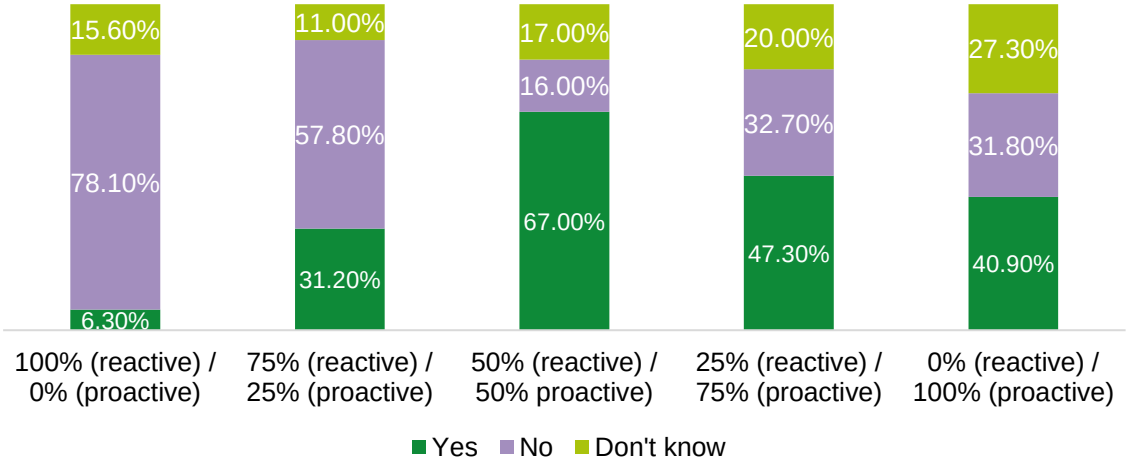

Figure 25. *Reactive/Proactive time – does this proportion feel right?*

Access to chief executives, non-executive directors, and reporting to the board

Freedom to Speak Up Guardians should have the support of, and access to, chief executives (or equivalent) and board (or equivalent) in the organisations they support.

The expectation that Freedom to Speak Up Guardians have such access, and present their reports in person, is included in the Guidance for Boards on Freedom to Speak Up issued by NHS England and Improvement and supported by the National Guardian's Office.

Over nine in ten (93.0%) respondents had direct access to their chief executives (or equivalent), which was similar to the results in the previous year (93.7%, 2020).

Also, an increasing percentage of respondents were presenting Freedom to Speak Up reports to their boards (or equivalent) in person:

- 81.3% (2021)
- 77.5% (2020)
- 66.1% (2019)

However, compared to the previous survey results, there was a 5.8 percentage point decrease in respondents who had direct access to the non-executive director (or equivalent) with speaking up as part of their portfolio, down from 87.7% in 2020 to 81.9% in 2021.

Access to resources for the role

Freedom to Speak Up Guardians should have sufficient access to the resources they need to carry out the role effectively.

Most respondents said that they had sufficient access to the following resources:

- Technology and IT support, 76.4% strongly agree or agree
- Accessibility across the organisation (, maternity wards, secure areas), 72.4% strongly agree or agree
- room access for private meetings/conversations, 63.2% strongly agree or agree

Less than half of the respondents said that they had sufficient access to other resources identified in the survey:

- Time to carry out the Freedom to Speak Up responsibilities, 48.7% strongly agree or agree
- Budget for expenses (e.g., travel to network meetings, promotional materials), 44.1% strongly agree or agree

'I have sufficient time to carry out my Freedom to Speak Up responsibilities' was the statement that attracted the most disagreement among respondents. Just under a third of respondents disagreed with it, strongly or otherwise.

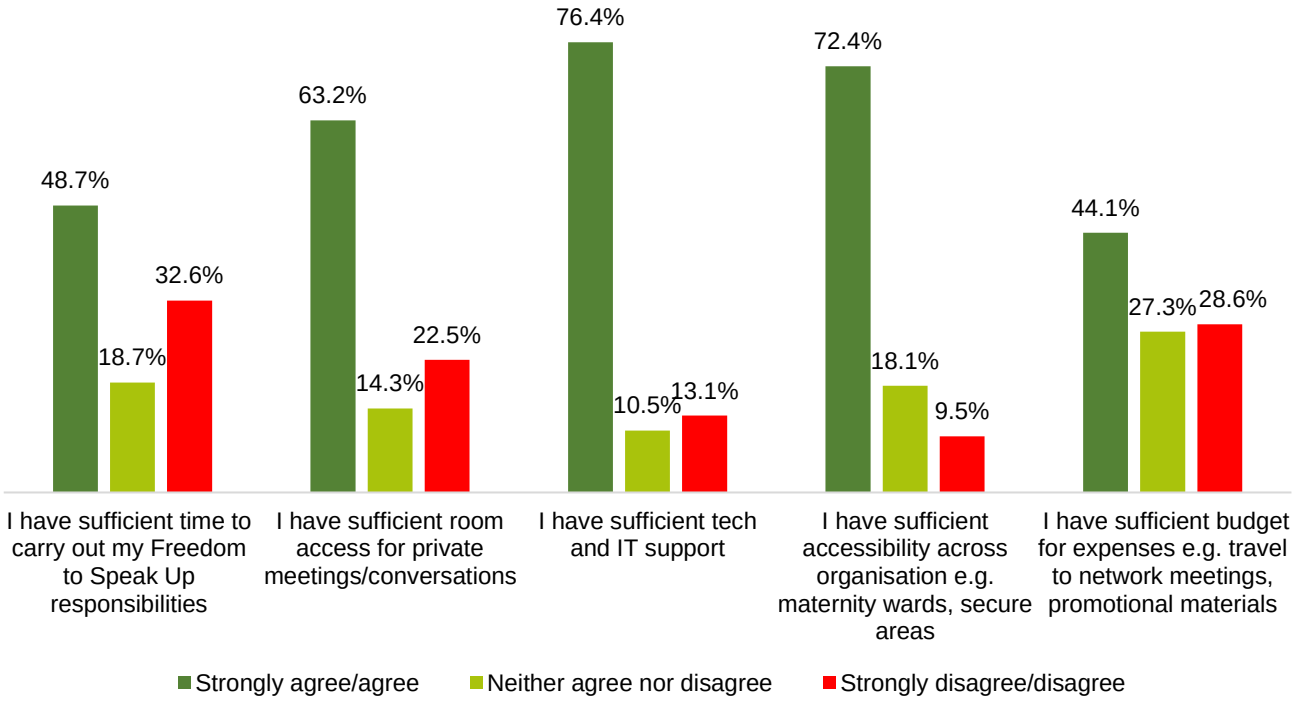

Figure 26. *Access to resources for the role*

Value and support for Freedom to Speak Up Guardians

Freedom to Speak Up Guardians were asked whether they felt valued by those in the organisations they support.

There was a 3.3 percentage point increase from 2020 to 2021 for respondents agreeing or strongly agreeing that they felt valued by managers, the highest result in three years. However, managers remain the group that attracted the lowest proportion of agree/strongly agree responses.

There was a small percentage point decrease in respondents feeling valued by senior leaders and individuals they support (1.7 and 2.4 percentage points respectively). The result for workers remained very similar to 2019 and 2020.

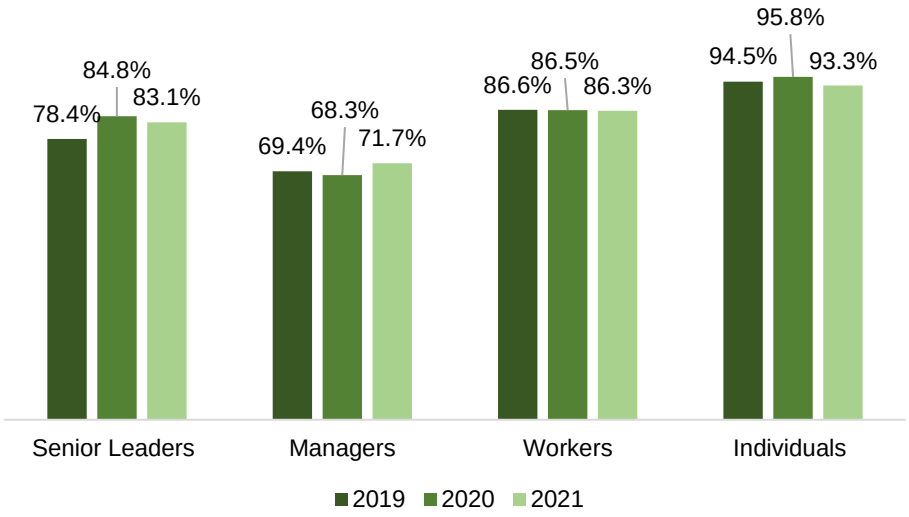

Figure 27. *I feel valued by… % answering strongly agree/agree*

Most respondents (72.1%) to the survey were confident that they were meeting the needs of workers in the organisation(s) they support. However, 8.3% did not think this was the case for them.

Respondents also felt supported by the senior people in their organisation, with 85.7% of respondents agreeing or strongly agreeing that their Chief Executive (or equivalent) supports them and 77.9% agreeing or strongly agreeing that senior leaders support them. In contrast, however, there was an 11-percentage point decrease in respondents who said they had sufficient access to the board (down from 94.0% in 2020 to 83.1% in 2021).

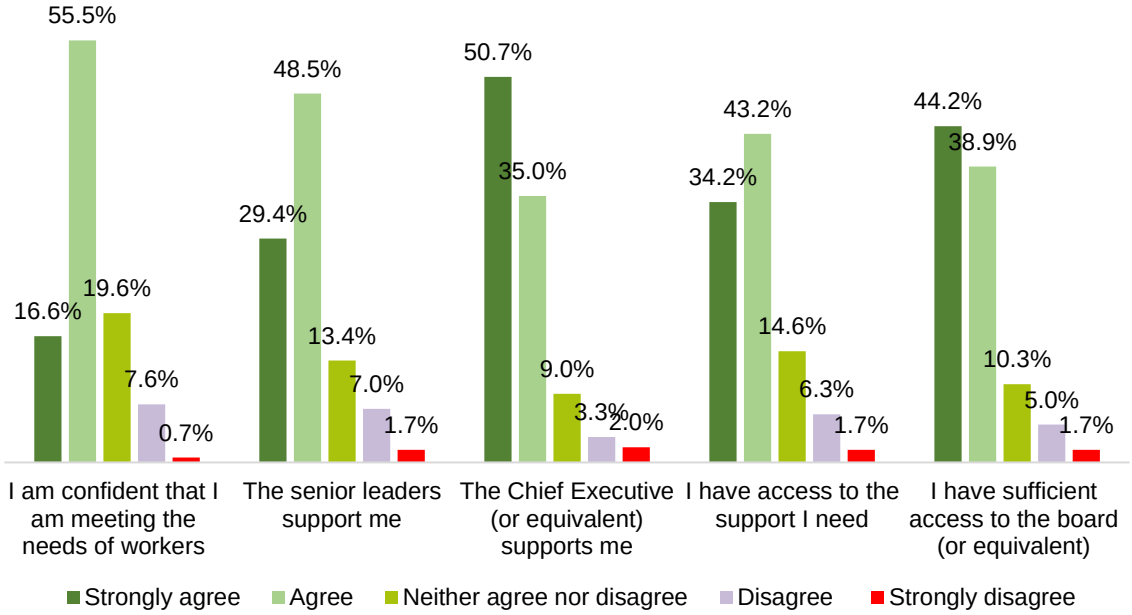

Figure 28. *Confidence, support and access*

Job requirements and promoting outcomes

There is a universal job description for the role of Freedom to Speak Up Guardian which contains key requirements for anyone undertaking the role.

We asked guardians about their ability to meet elements of the job description, as show in figure 29 (below).

For each element, most respondents agreed or strongly agreed that they felt able to meet the job description requirements.

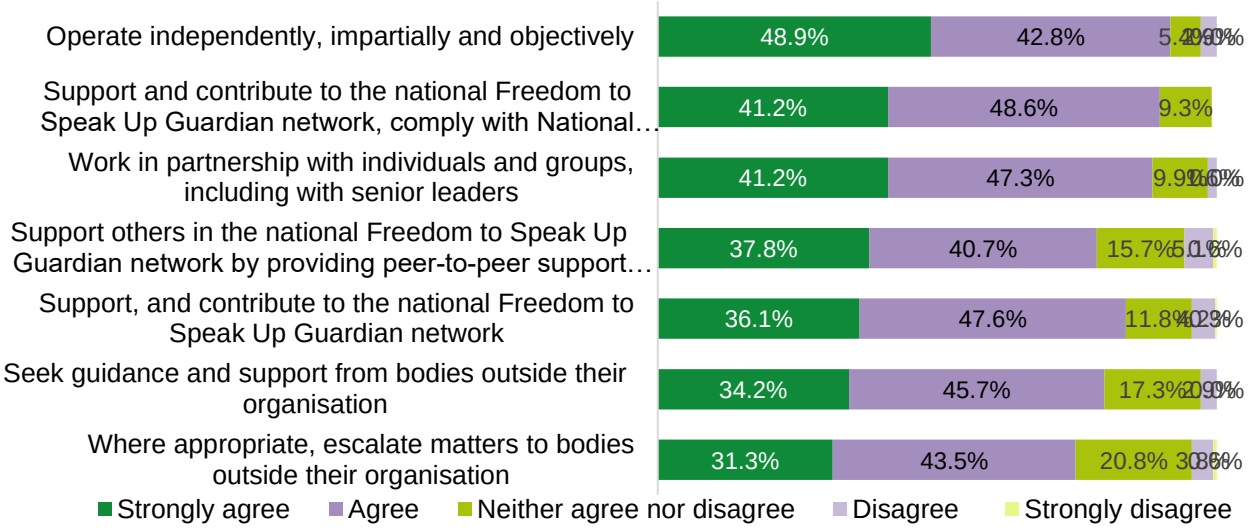

Figure 29. *Ability to meet requirements of role*

The job requirements for a Freedom to Speak Up Guardian includes intended outcomes for the role. We asked guardians about the extent to which they have taken action to promote these outcomes in the past 12 months (see figure 30, below).

The outcome that attracted the highest proportion of agreement was for supporting individual who speak up, with three-quarters (74.1%) of respondents reporting that they had fully taken action in this area. The outcome with the lowest proportion of respondents saying they had fully taken action was making sure Freedom to Speak Up is consistent throughout the health and care system, and ever improving.

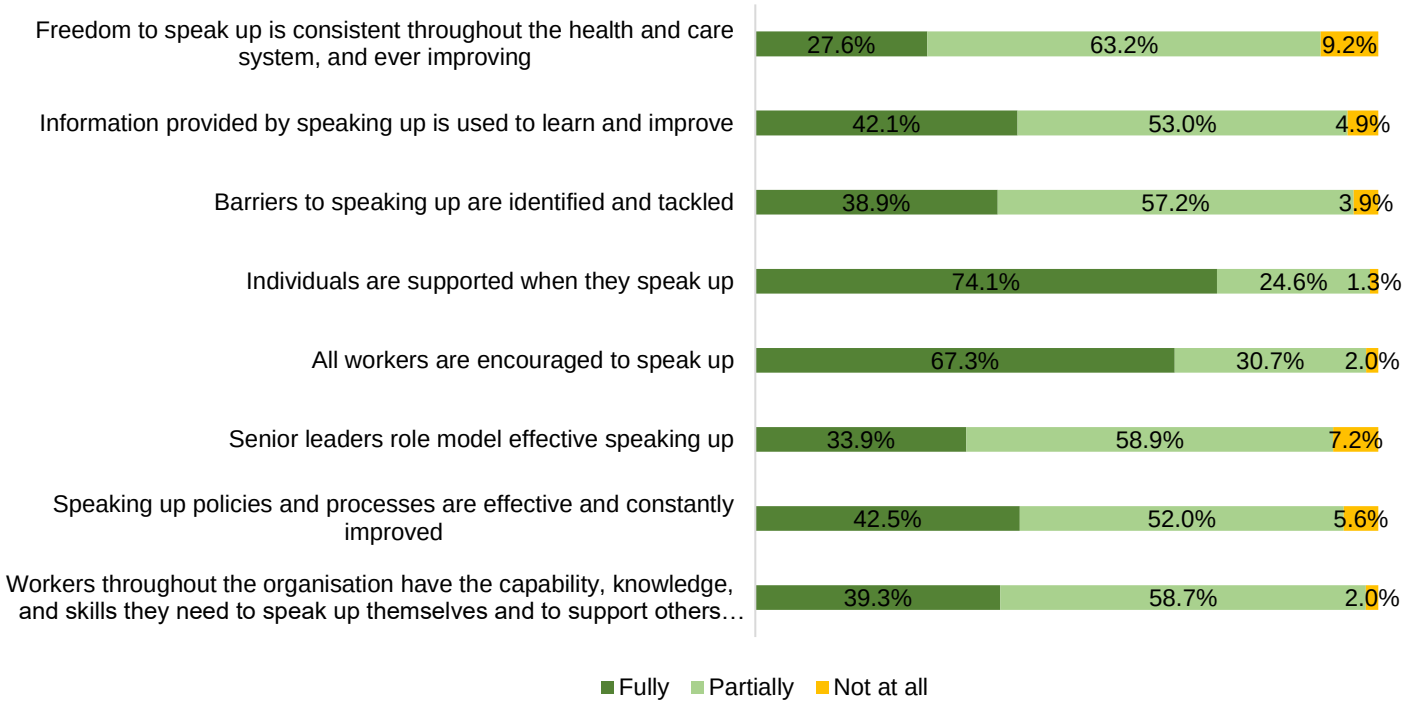

Figure 30. *To what extent have you taken action to promote the following outcomes in the last 12 months*

We asked guardians what would enable them to meet the expectations of the job description more fully. Six suggestions were offered plus an 'other' category. The most common suggestion chosen was 'more ring-fenced time' (selected by 55.3% of respondents), followed by access to more resource (45%) and more support from senior leaders (42.3%).

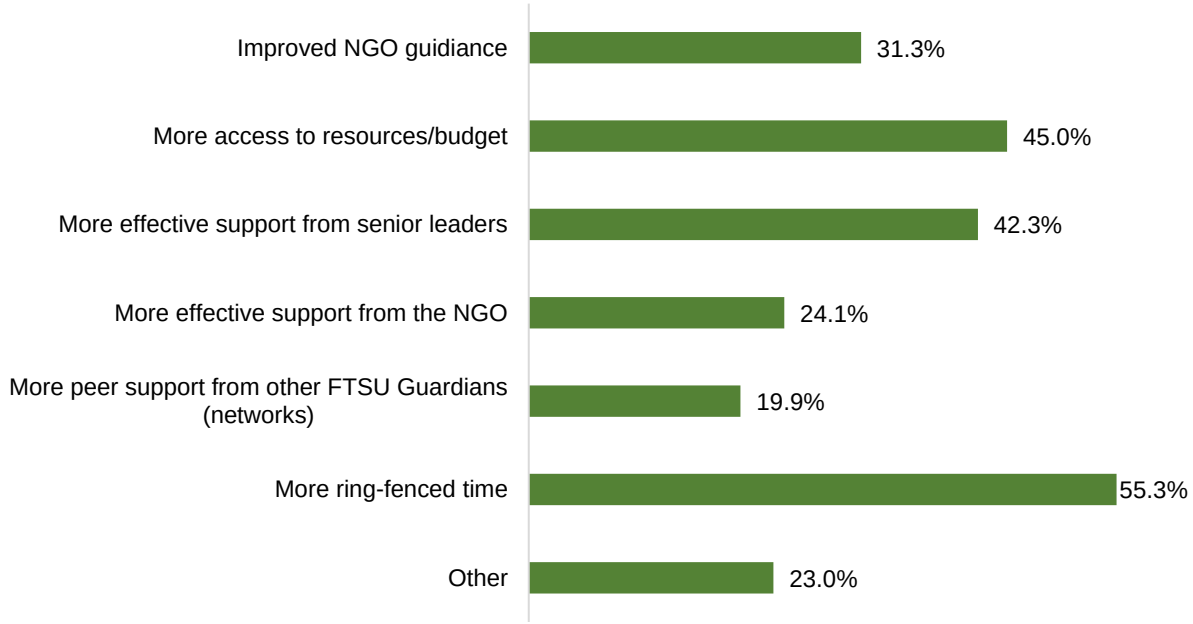

Figure 31. *What would enable you to meet those expectations more fully?*

Senior Leaders

Freedom to Speak Up Guardians should feel able to make suggestions and challenge senior leaders – and be assured that these will be actioned. This year's survey had a detailed focus on senior leaders as the support and actions of senior leaders are key to promoting a positive speaking up culture.

Over nine out of ten respondents (93.2%) agreed or strongly agreed that they felt safe speaking up to senior leaders (see figure 32, below).

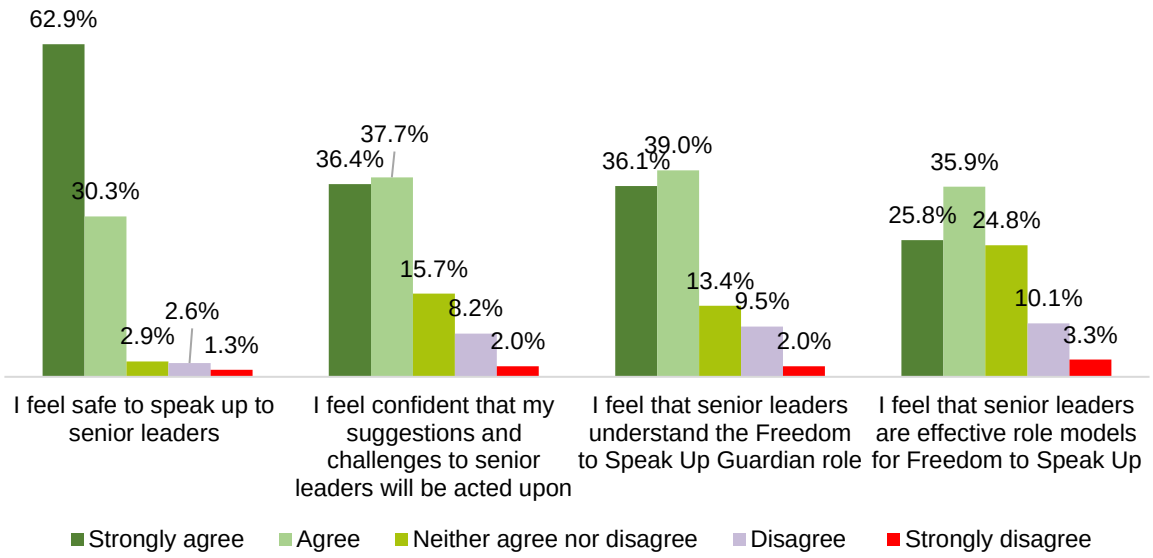

Figure 32. *Senior Leaders*

Most respondents felt that senior leaders understood the Freedom to Speak Up Guardian role (75.1%). However, 11.5% did not agree that senior leaders in the organisation(s) they support understood the role.

Almost three quarters of respondents (74.1%) also agreed or strongly agreed with the statement: '*I feel confident that my suggestions and challenges to senor leaders will be acted upon'*, though one in 10 (10.2%) disagreed or strongly disagreed this statement.

A smaller majority of respondents (61.7%) agreed or strongly agreed with the statement: *'I feel confident that senior leaders are effective role models for Freedom to Speak Up'.* Thirteen per cent (13.4%) of respondents disagreed or strongly disagreed with the statement.

Ring-fenced time and its impact

The National Guardian's Office recommends ring-fenced time should be allocated to those in a speaking up role. This is an aspect of speaking up that is included in the CQC's well-led inspection guidance, and guidance issued to trust boards includes an assessment of the amount of ring-fenced time Freedom to Speak Up Guardians have.

Following last year's survey, we reiterated our recommendation that leaders should provide Freedom to Speak Up Guardians with ring-fenced time for the role, taking account of the time needed to carry out the role and meet the needs of workers in their organisation. We added that leaders should be able to demonstrate the rationale for their decisions about how much time is allocated to the role.

In this section of the report, we look closer at the impact of ring-fenced time on guardians responding to the survey.

This year there was a 4.7 percentage point decrease in respondents who had ring-fenced time to carry out their role, down from 70.3% in 2020 to 65.6% in 2021.

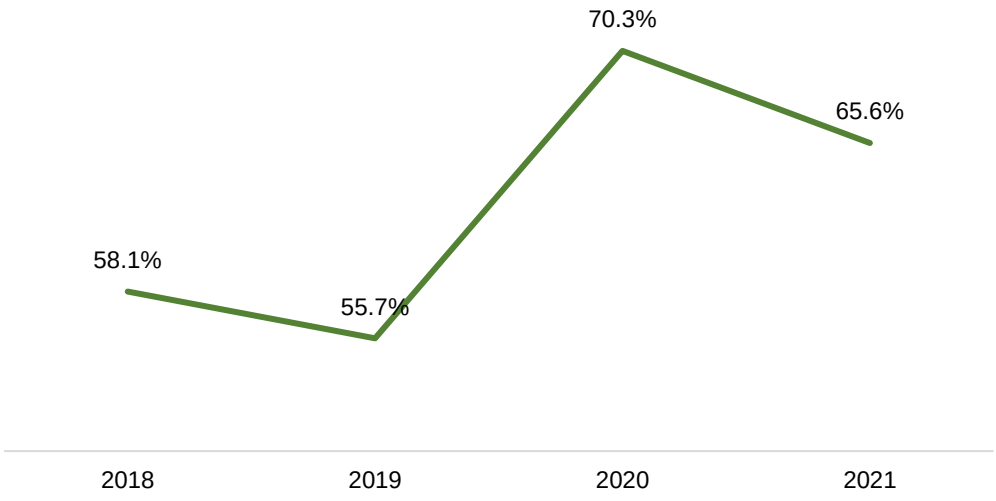

Figure 33. *Ring-fenced time*

Seventy-eight per cent (78.2%) of respondents from NHS Trusts had some ring-fenced time to carry out the role (at least half a day per week). In comparison, 20.8% of respondents supporting hospices said that they have ring-fenced time. This might be expected to some extent due to the Freedom to Speak Up Guardian role being

more embedded in NHS Trusts. We have observed a general trend that more ring-fenced time is allocated to the role as it becomes more established.

We also observed that 61.1 per cent of those with ring-fenced time had been in the role for at least 18 months.

The amount of ring-fenced time respondents continues to vary, as shown in Figure 34 below.

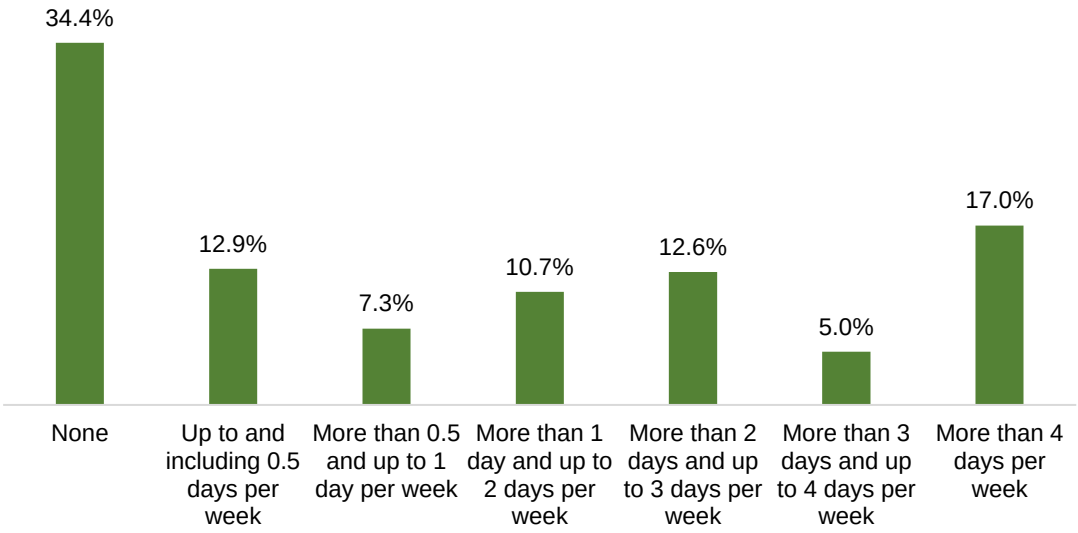

Figure 34. *Ring-fenced time 2021*

Most respondents (83.5%) said the amount of ring-fenced time they have had not changed over the past 12 months. Thirteen per cent (12.7%) said it had increased and 3.8% said it decreased.

Sufficient time to carry out the role

Respondents who had ring-fenced time to carry out their role (at least half a day per week) were more likely to strongly agree (27.2%) with the statement 'I have sufficient time to carry out my Freedom to Speak Up responsibilities' compared to respondents with no ring-fenced time (5.5%). Nineteen per cent (19.3%) of respondents with no ring-fenced time strongly disagreed with the statement compared to 8.7 per cent of those with ring-fenced time.

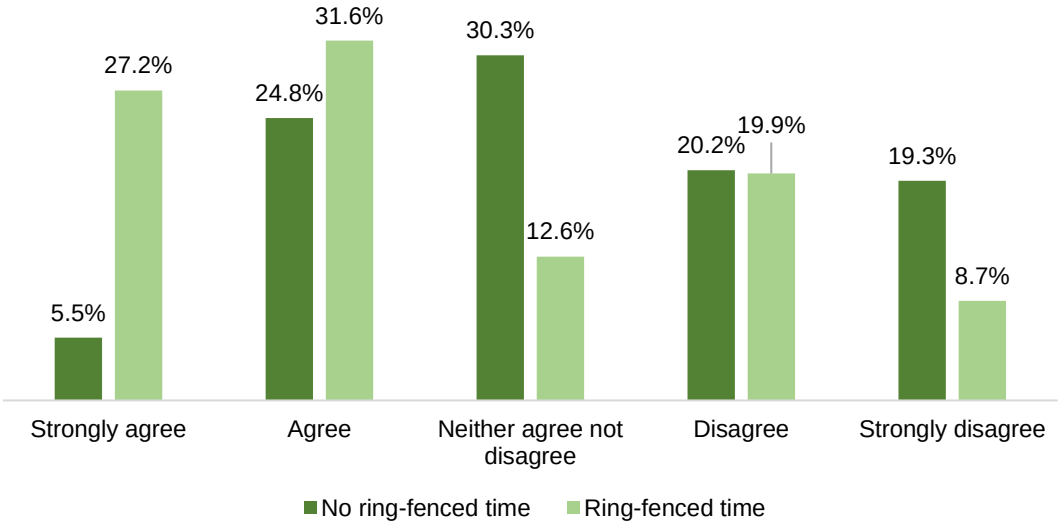

Figure 35. *I have sufficient time to carry out my Freedom to Speak Up responsibilities*

Respondents were also asked how far they agree with the statement 'I have sufficient accessibility across the organisation e.g. maternity wards, secure areas. Less than a quarter of respondents with no ring-fenced time (23.1%) strongly agreed with this statement compared to 37.9% of respondents with ring-fenced time.

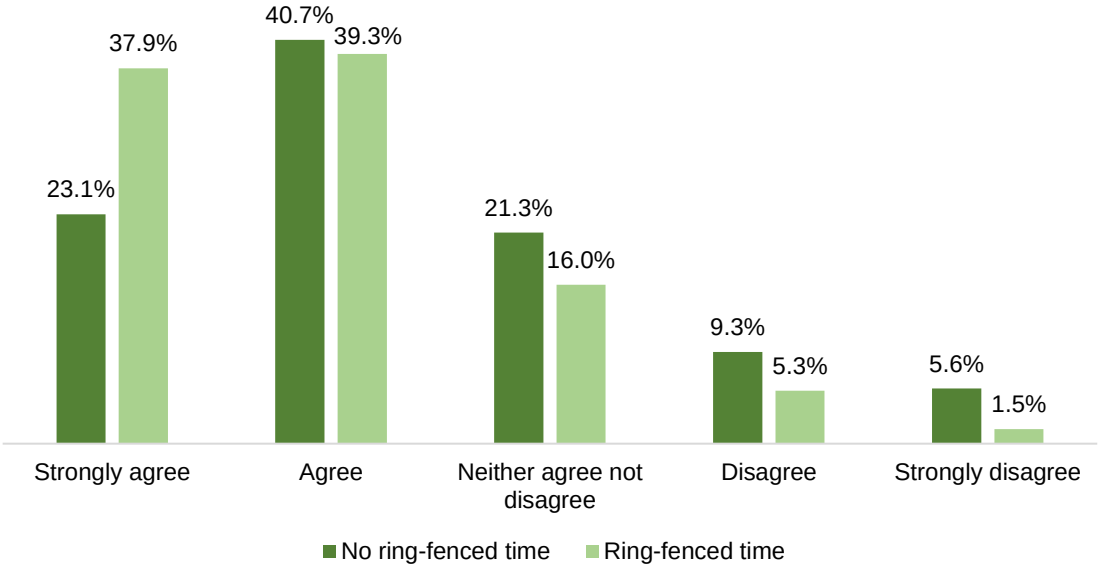

Figure 36. *I have sufficient accessibility across the organisation*

Ability to meet the requirements of the role and promote outcomes

We asked guardians about whether or not they agreed with the statement '*I am able to meet the job description requirement to support others in the national Freedom to Speak Up Guardian network by providing peer-to-peer support and sharing learning'*. Twice the proportion of respondents with ring-fenced time strongly agreed (45.9%) with this statement compared to those with no ring-fenced time (22.6%).

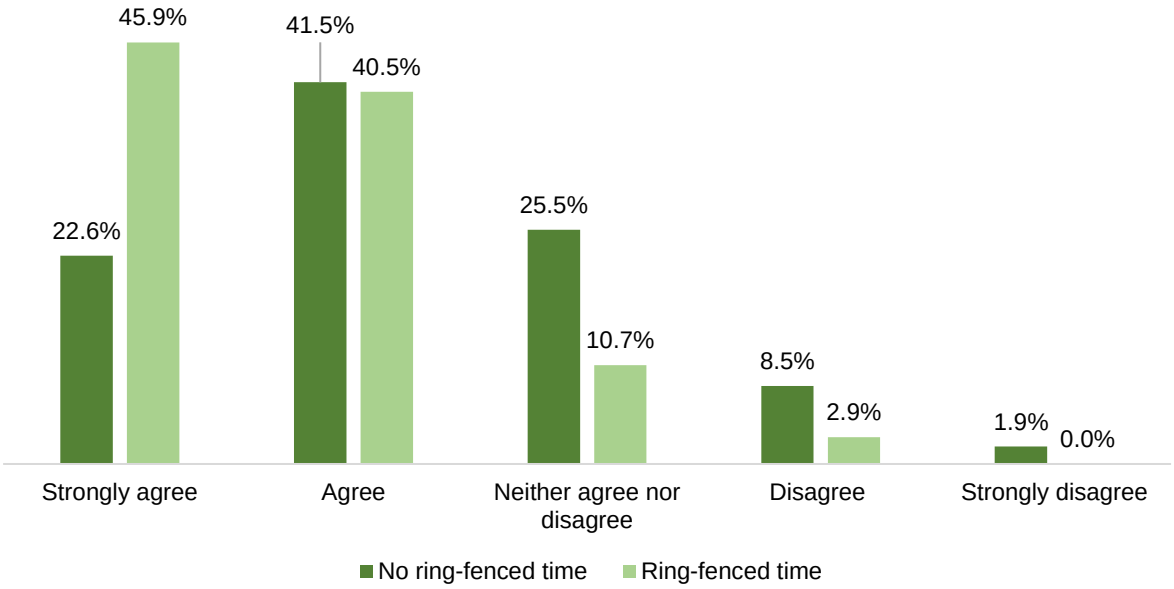

Figure 37. *Support others in the national Freedom to Speak Up Guardian network by providing peer-to-peer support and sharing learning*

A similar pattern emerged for the job requirement to support and contribute to the national Freedom to Speak Up Guardian network, 43.4% of respondents with ring-fenced time answered strongly agree to this statement compared to 22.4% of respondents with no ring-fenced time.

Seventy-six per cent of respondents with ring-fenced time said they felt confident that they were meeting the needs of workers (agree or strongly agree to the statement), this was 11 percentage points higher than respondents with no ring-fenced time (65.0%).

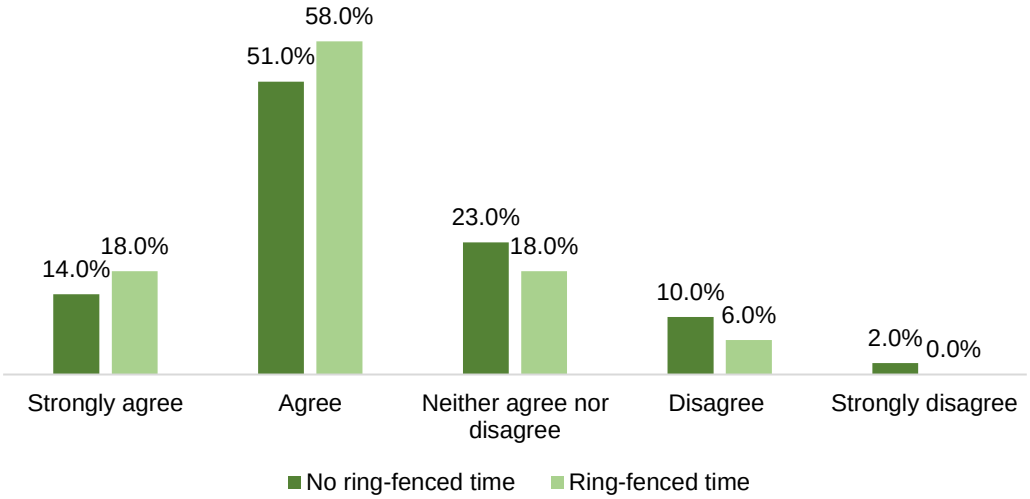

Figure 38. *Confidence in meeting the needs of workers*

We also asked respondents to what extent they had taken action to promote certain outcomes in the last 12 months. A higher proportion of respondents with ring-fenced answered that they were fully able to promote outcomes for seven of the eight outcomes compared to respondents with no ring-fenced time.

Reactive and proactive working

A fifth of respondents (20.8%) with no ring-fenced time said they spent 100% of their time in the guardian role on reactive elements of the role. This compares to 4.9% of those with ring-fenced time.

A greater proportion of respondents with ring-fenced time, 34.6%, said they split their time 50:50 compared to 21.7% of respondents with no ring-fenced time.

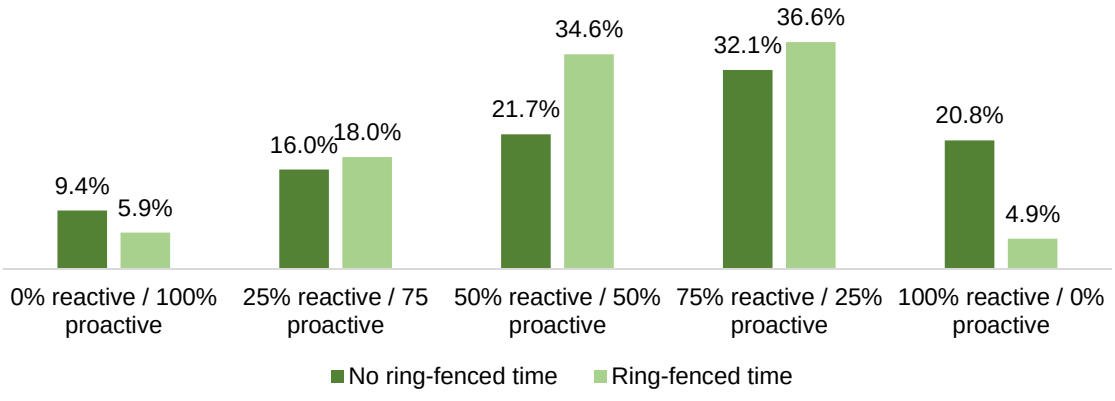

Figure 39. *Reactive and proactive working*

Respondents were asked if they thought their time split felt right to them. Thirty-seven per cent (36.8%) of those with no ring-fenced time said this proportion felt right compared to 46.3% of respondents with ring fenced time.

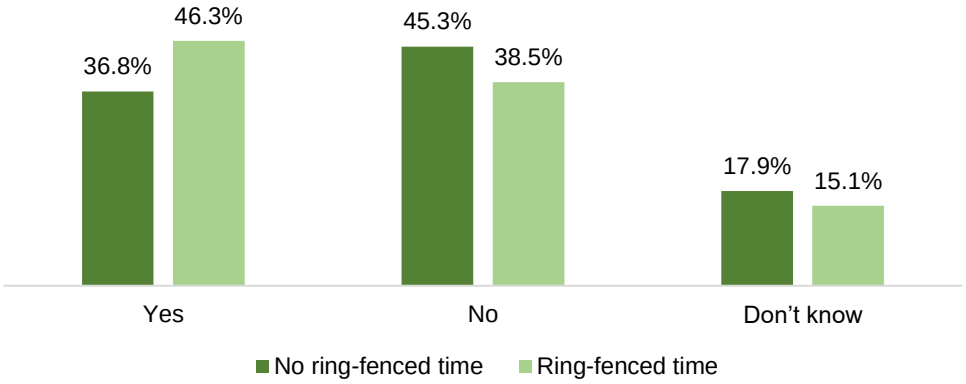

Figure 40. Does the proportion feel right?

Value and support for Freedom to Speak Up Guardians

We asked guardians about how supported they felt by senior leaders, workers, managers and individuals they support.

Respondents with ring-fenced time were more likely to agree or strongly agree that they felt valued by these groups than respondents with no ring-fenced time. There was a ten-percentage point difference in those who felt valued by senior leaders: 76.7% of respondents with no ring-fenced time compared to 86.8% of respondents with some ring-fenced time.

Demographics of Freedom to Speak Up Guardians

We ask respondents to share demographic information to inform us of the make-up of the Freedom to Speak Up Guardian network.

Gender

Eighty per cent (79.7%) of respondents were female.

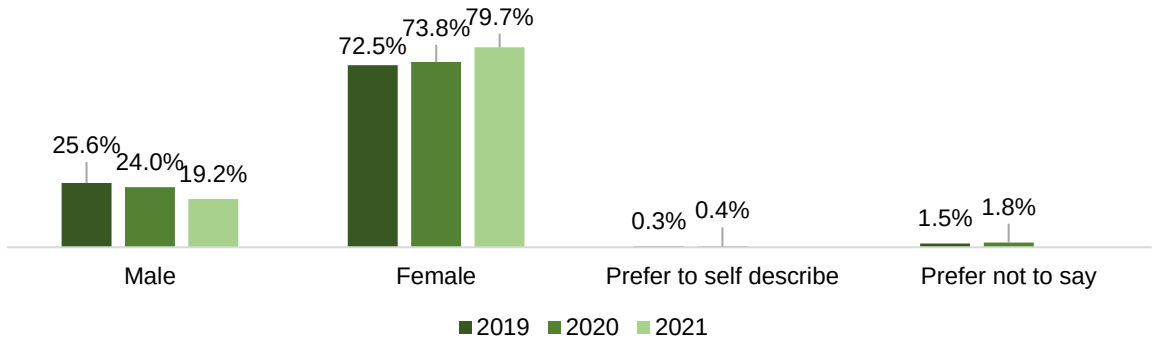

Figure 41. *Gender of respondents*

The numbers of respondents answering prefer to self-describe and prefer not to say were omitted in 2021 due to low numbers.

Age

Over half of respondents (52.9%) were aged 51 to 65 years old.

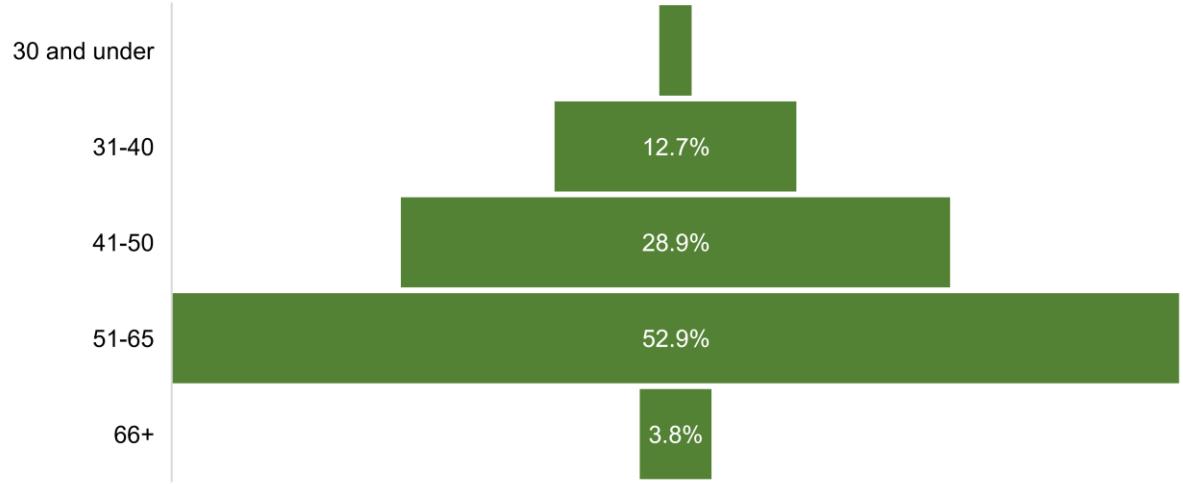

Figure 42. *Age of respondents*

Ethnic background

In 2021, 84.8% of respondents to the survey were white and 15.2% were from minority ethnic groups. This shows a six-percentage point increase in minority ethnic respondents from 2020.

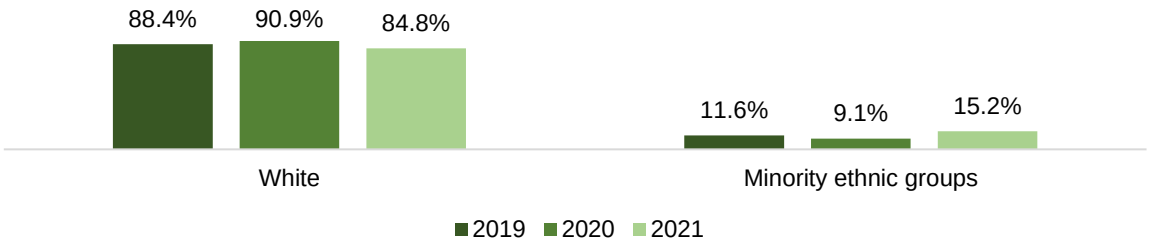

Figure 43. *Ethnicity of respondents*

The percentage of white respondents remains higher than the NHS workforce (77.9%), however it is lower than the percentage of working age population (2011 census) at 85.6%[4].

Sexual orientation

There were 86.6% of responding Freedom to Speak Up Guardians who identified as heterosexual, 3.8 percent were gay or lesbian and 2.1% were bi-sexual. A further 6.6 % preferred not to say. There were too few responses in the other category to be included in Figure 43.

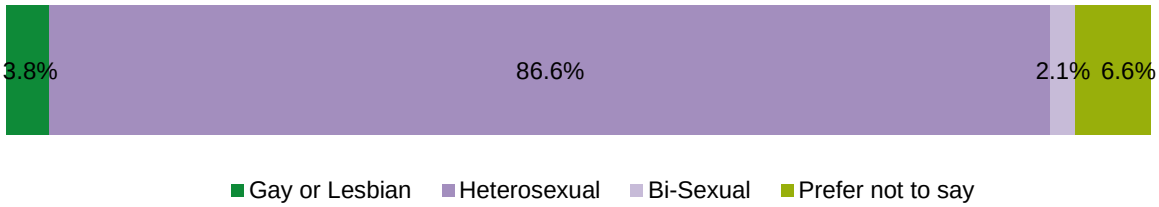

Figure 44. *Sexual orientation of respondents*

Long term conditions

A quarter (25.9%) of respondents said they had a long-term health condition (physical or mental) lasting or expected to last for 12 months or more, up 8.6 percentage points (17%, 2020).

Of those with a long-term condition:

- 53.3% said their organisation had made adequate adjustments for them
- 10.7% said adjustments had not been made (4.3%, 2020)
- 36.0% said they did not require adjustments

[4] https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest#by-ethnicity

Caring responsibilities

Two-fifths (40.2%) of respondents said they look after, or give any help or support to family members, friends, neighbours or others because of either: long term physical or mental ill health / disability, or problems related to old age (35.8%, 2020).

Anti-Fraud Specialist (AFS) & Freedom to Speak Up Guardian (FTSUG)

Liaison & Joint Working Protocol March 2022

Southport and Ormskirk Hospital Trust

MIAA ASSURANCE

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1. Introduction

2. General Principles

3. Roles & Responsibilities (in respect of this protocol)

4. Routine Liaison & Interaction

5. Information Sharing

6. Confidentiality

Appendix A: Relevant Legislation, Regulations, Policies & Procedures

1. Introduction

1.1 This protocol is intended to clarify the relationship and provide guidance on areas of joint working and interaction between Southport and Ormskirk Hospital Trust Freedom to Speak Up Guardian (FTSUG) and the Southport and Ormskirk Hospital Trust's nominated Anti-Fraud Specialist (AFS) in the course of them undertaking their respective roles and responsibilities.

1.2 Appendix A lists the relevant legislation, directions, guidance, policies and procedures which have been considered in the construction of this protocol and should be referred to by all interested parties as appropriate.

1.3 The information and guidance contained in this protocol should also be considered for inclusion, or referred to, in any other internal guidance, policies or procedures which the Southport and Ormskirk Hospital Trust may issue relating to the work of the AFS and the FTSUG.

1.4 For the purposes of this protocol, reference to a 'Speaking Up' policy equates to any such organisational policy or procedure which covers the terms 'raising concerns', 'speaking out' etc.

1.5 It is acknowledged that FTSUGs are often supported by 'Speak-Up Champions' or similar. For the purposes of this protocol, the primary relationship is between the AFS and the Guardian, unless a nominated deputy is identified by either party to cover a temporary period of absence (i.e. annual leave or sickness absence). It is anticipated that the FTSUG should make all relevant support staff aware of this protocol.

2. General Principles

2.1 Staff, patient and public welfare, safety or safeguarding matters, where there is an immediate or imminent risk or concern, will take precedence over any investigation requirements in virtually all instances.

2.2 Fraud, bribery and corruption investigations undertaken by the AFS, whether arising from NHS employees speaking up about concerns or not, must be conducted in accordance with relevant UK legislation relating to the conduct of criminal investigations (e.g. PACE, CPIA etc.) and NHS Counter Fraud Authority (NHSCFA) requirements.

2.3 Internal investigations (e.g. disciplinary, grievance, bullying and harassment investigations) must be carried out in accordance with relevant internal policies and procedures, as well as any applicable ACAS Codes of Practice (i.e. on Disciplinary and Grievance Procedures) and UK employment law.

2.4 Parallel investigations (i.e. criminal and non-criminal, internal or external) may be conducted appropriately and simultaneously to ensure that respective objectives are met through distinct, independent, timely and transparent processes. In such circumstances, investigators should maintain a general dialogue to identify where information / evidence may legitimately be shared and to ensure that the respective investigations do not clash.

2.5 Where a person raising a concern requests anonymity, this must be respected and maintained at all times. However, there are potential circumstances where this may need to be over-ridden; for example, where there is an imminent danger to "life and limb", or where there may be a safeguarding of children or vulnerable adults concern. Additionally, evidence which establishes that a concern raised was malicious or vexatious in nature would normally also remove this protection. Similarly, a judicial ruling could compel the disclosure of a person raising a concern's identity. A person raising a concern may also, at a later date, provide a formal witness statement to the AFS; it is important that they are made aware by the AFS that this would usually remove their anonymity should the matter progress to prosecution.

There may also be circumstances whereby the nature of an investigation makes it obvious to some whom a person raising a concern may be.

2.6 Information and evidence relating to concerns raised, or to the identity of persons raising concerns, or to the conduct and progression of investigations should be shared between the AFS and the FTSUG (or other internal investigators) only where and when it is lawful and appropriate to do so.

3. Roles & Responsibilities (in respect of this protocol)

3.1 The AFS shall:

3.1.1 Lead on all Southport and Ormskirk Hospital Trust cases and referrals involving alleged or suspected fraud, bribery or corruption, including those which originate via the FTSUG's office. The AFS will comply with all usual legal and NHSCFA investigation requirements in that regard, as well as with the organisation's Anti-Fraud, Bribery and Corruption Policy.

3.1.2 Advise the FTSUG in a timely manner of any alleged or suspected fraud, bribery or corruption referral originating from a Southport and Ormskirk Hospital Trust employee, where the AFS identifies that the concern raised also falls within the Southport and Ormskirk Hospital Trust's 'Speaking Up' policy, or equivalent.

- The AFS must be alert to identifying referrers raising fraud, bribery or corruption concerns who fall within the parameters of the organisation's 'Speaking Up' policy. The AFS should familiarise themselves with the policy.
- The AFS will advise the referrer to speak to the FTSUG directly, if they so wish.
- The AFS will not provide the FTSUG directly with any details of the referrer / employee, unless the consent of that individual to do so is provided in writing (i.e. by email).
- The notification of the alleged fraud, bribery or corruption to the FTSUG only needs to be in general terms.

3.1.3 Keep the FTSUG informed (in general terms), in accordance with a mutually agreed timescale, of the progress of all such fraud, bribery or corruption referrals which have been logged as 'Speaking Up' concerns, in order to ensure that the FTSUG can comply with the wider requirements of the 'Speaking Up' policy.

3.1.4 Share information relevant to the fraud, bribery or corruption concern which has been raised and investigated by the AFS with the FTSUG and/or other parallel investigators, but only where it is permissible and appropriate to do so.

3.1.5 Provide the FTSUG with a summary of the findings and outcomes, as may be necessary or appropriate, at the completion of any enquiry or investigation and after approval to do so has been received from the Director of Finance.

3.1.6 Be a source of advice to the FTSUG regarding any raising concerns procedural matter, including interviewing a person raising a concern, or receiving and recording potential information / evidence provided by a person raising a concern etc.

3.1.7 Be a source of advice to the FTSUG on any other potential criminality which may need to be considered arising from any concern which has been raised.

3.1.8 Be a source of advice to the FTSUG and other internal investigators conducting any enquiries under the 'Speaking Up' policy, including in respect of non-fraud, bribery or corruption concerns, where appropriate to do so and where no conflict arises.

3.2 The Freedom to Speak Up Guardian (FTSUG) shall:

3.2.1 In line with 3.1.2, the FTSUG will inform the AFS in a timely manner where a concern has been raised which indicates that fraud, bribery or corruption is, or might be, suspected.

- If in doubt, the concern should be discussed with the AFS in confidence, without identifying the person raising the concern if anonymity has been requested. [The FTSUG should familiarise themselves with the Anti-Fraud, Bribery and Corruption Policy which provides definitions and examples of both offences.]
- The FTSUG should encourage the referrer to raise the fraud, bribery or corruption concern directly with the AFS, if at all possible.
- The AFS and FTSUG will liaise closely regarding the conduct of any subsequent enquiries (i.e. the FTSUG potentially facilitating the AFS meeting with the person raising the concern at some point, if the person raising the concern is willing).

3.2.2 Share information / evidence relevant to the concern which has been raised and investigated by the AFS and/or other investigators, but only where it is permissible and appropriate to do so.

3.2.3 Ensure the AFS is promptly informed where a parallel internal (or other external) investigation is also initiated alongside the AFS' fraud, bribery or corruption investigation.

3.2.4 Keep the AFS promptly updated as to any further / new developments relating to the fraud, bribery or corruption concern raised which might subsequently arise.

3.2.5 Consult with the AFS, if necessary, regarding any non-fraud, bribery or corruption concern raised, but which indicates other potential criminality, in order to identify the most appropriate way forward.

3.2.6 Consult with the AFS, if necessary, regarding the conduct of any non-fraud, bribery or corruption internal investigation(s) which may be required as a result of any concern raised. (In this capacity, the AFS acts as a source of expert advice on investigatory methodology.)

3.2.7 Provide advice and guidance to the AFS on any fraud, bribery or corruption matter referred to the AFS by an NHS employee (an 'employee' as defined by the organisation's 'Speaking Up' policy) where there may also be a raising concerns consideration.

3.2.8 It is not the role of the FTSUG to investigate, but rather facilitate referral to a relevant investigation resource where necessary.

4. Routine Liaison & Interaction

4.1 The FTSUG is considered to be a Key Stakeholder Contact of the AFS. The AFS will liaise routinely with the FTSUG during the course of the year, in accordance with the AFS' annual work plan commitments and budget, to discuss opportunities for joint initiatives, to consider ways to raise awareness of their respective roles to staff jointly, to 'learn lessons' from investigations conducted, and to periodically update the protocol as may be necessary. Otherwise, this protocol primarily covers instances related to actual concerns and referrals raised on an as/when basis.

5. Information Sharing

5.1. In general, it is not problematic for the FTSUG or internal investigators to share general information obtained when addressing a raised concern with the AFS to help further a criminal investigation. However, the AFS should endeavour, as far as possible, to obtain information they need through a separate investigation, particularly where this information is provided by an individual (i.e. a possible witness). Likewise, the AFS should not run into problems by sharing information or material with the FTSUG or internal investigators which belongs to the Southport and Ormskirk Hospital Trust, or which is freely available (e.g. organisational policies on the website, or public domain information).

5.2. However, disclosure of certain material, particularly where it is confidential and/or originates from a third party, can be problematic. Therefore, there should be no routine or blanket sharing of information.

5.3. The separate **AFS-HR Protocol** provides more detailed information on data sharing in respect of parallel criminal and disciplinary investigations, with specific regard to AFS information obtained from witness statements, interviews under caution, DPA 2018 exemption requests and with regard to the AFS' role in providing information which might be used for disciplinary investigations / hearings.

6. Confidentiality

6.1 All parties to this protocol acknowledge the need for complete discretion and confidentiality when being made aware of and discussing sensitive matters relating to concerns raised, to the identity of persons raising concerns and witnesses, and to the conduct of criminal and non-criminal investigations. Any inappropriate disclosures of confidential information will be treated as a serious disciplinary matter.

Appendix A

Relevant Legislation, Regulations, Policies & Procedures

- NHS Standard Contract – Service Condition 24
- NHS Counter Fraud Authority Standards for Fraud, Bribery and Corruption
- NHS Counter Fraud Authority Anti-Fraud Manual
- Applying Appropriate Sanctions Consistently (NHS Counter Fraud Authority Policy)
- NHS Counter Fraud Authority: Parallel Criminal & Disciplinary Investigations (Policy Statement & Guidance)
- Police and Criminal Evidence Act (1984) (PACE)
- Criminal Procedure and Investigations Act (1996) (CPIA)
- Public Interest Disclosure Act (1998)
- UK General Data Protection Regulations
- S&O Hospital Trust's Anti-Fraud, Corruption and Bribery Policy
- S&O Hospital Trust's Disciplinary Policy
- S&O Hospital Trust's Raising Concerns / Speaking Up Policy
- S&O Hospital Trust's AFS-HR Liaison & Joint Working Protocol
- ACAS Codes of Practice – Disciplinary and Grievance Procedures
- Information Commissioners Office (ICO) Guidance
- National Guardian's Officer (NGO) Guidance

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**04 May 2022**
Agenda Item	**SO084/22**	**FOI Exempt**	**NO**
Report Title	**GUARDIAN OF SAFE WORKING QUARTER 1 REPORT (01 OCTOBER TO 31 DECEMBER 2021)**		
Executive Lead	Dr Kate Clark, Medical Director		
Lead Officer	Dr Kate Clark, Medical Director		
Action Required	✓ **To Approve** ☐ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

To update on issues related to Guardian of Safe Working.

Executive Summary

Key Messages of this Report & Recommendations:

- Trainees are much more engaged with the exception report process. When supervisor meetings have not taken place, trainees were claiming additional pay, this should default to TOIL.
- Theme persists of trainees continuing often to stay late in medical wards rather than elsewhere.
- Concerns noted relating to phlebotomy provision on acute wards.
- Issues with one non-compliant rota with max one in three weekend frequency – only Trust in region with this issue. There were two rotas previously. Remaining issue relates to Paediatric ED.
- Monies still available from the HEE Facilities funding.

Recommendations

The Strategy and Operations Committee is asked to approve the Guardian of Safe Working Quarter 1 Report.

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	**Presented By:**
Andrea Padgeon, Head of Resourcing	Dr Kate Clark, Medical Director

THE GUARDIAN OF SAFE WORKING

Southport and Ormskirk Hospital NHS Trust

QUARTERLY TRUST REPORT

01 October 2021 – 31 December 2021

INTRODUCTION

As we currently are in the processes of appointing a Guardian of Safe Working, this report has been prepared on behalf of the Medical Director collating information with regard to safe working for trainee doctors. This information is produced from Hours, Pattern and Service Support Exception Reports generated by trainees Education Exception Reports are monitored by Director of Medical Education who will report on these to Board.

1. EXCEPTION REPORT OVERVIEW (31st December 2021)

COVID and its ramifications continue to affect day to day hospital work and so affect trainees.

Trainees are much more engaged with the Exception Report system overall. They tend to see it as individually transactional though, in that If they stay late they are compensated rather than a tool to collectively improve things. They don't tend to see missed Educational Opportunities or Service Support issues as having direct results of their submission of an exception report. It is also notable that whilst overall engagement is good this tends to relate only to the Foundation Doctors, and those from ST1 upwards tend not to report exceptions. This is borne out by the submissions during with current reporting period, as all exceptions were raised by foundation doctors.

Trainee and supervisor meetings continue to be a black spot with meetings often held well after the 7-day requirement (if at all). Many historical exceptions are closed with payment. This issue was recently discussed at the Medical Staff Committee.

Trainees reported that consultants can appear to actively discourage ERs. This has been highlighted to clinical leads to ensure the understanding that this should be a supportive process and identify potential resource implications.

Trainees reported that some Consultants continue to expect them to be up to speed immediately in new role (balance between being new and performing at expected level for a new trainee).

Some Consultant Supervisors unwilling to sanction Reports from posts in other specialties as no direct knowledge. These requests should be forwarded to the parent specialty to support the reporting process.

There were no immediate patient safety issues raised via exception reports during this period.

Reference period of report	01/10/21-31/12/21
Total number of exception reports received	22
Number relating to immediate patient safety issues	0
Number relating to hours of working	19
Number relating to pattern of work	0
Number relating to educational opportunities	3

Number relating to service support available to the doctor	0

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	6
Total number of overtime payments	4
Total number of work schedule reviews	0
Total number of reports resulting in no action	0
Total number of organisation changes	0
Compensation	0
Unresolved	12
Total number of resolutions	**10**
Total resolved exceptions	**12**

1.1. MEDICINE

Workload across the organisation remains high. Most exception reports are about additional hours. It is however noted that only 6 exceptions were raised during the reporting period

1.2. SURGERY

16 Exception Reports this quarter generally for additional hours due to excessive workload

2. PAYMENT AND FINES

There have been no GoSW fines levied in either of the last three quarters.

There was one potential episode picked up by a trainee that should have flagged and was resolved before the day of the issue. It remains unclear why this was not picked up by the Allocate software.

3. ROTA COMPLIANCE AND IN-HOUSE LOCUM ARRANGEMENTS

All Trust Rota's are 2016 compliant.

There were no Work schedule reviews during this period.

One rota continues not to be compliant with the maximum 1:3 weekends which should have been in place by August 2020. This has been highlighted to the Trust Board as well as the fact that we are the only Trust in the region in this situation.

The clinical director is developing a statement of case, this relates to paediatric ED which is currently temporarily closed between midnight – 8am as a result of medical staffing issues. This has been exacerbated with the removal of 3 ST PEM trainees being replaced with 3 HST. A plan needs to be in place by August 2022 when these changes occur.

The BMA remain very concerned about this issue and could progress with formal actions.

DOCTORS NOT ON THE NEW CONTRACT

All trainees are on the 2016 contract.

No concerns about safe working from non-trainee doctors have been escalated to the GoSW.

4. VACANCIES (as of 1st January 2022)

SOHT continue to actively recruit and therefore vacancy rates are changing frequently – there are currently 29 vacancies spread across the specialties. The overall number of vacancies is reducing due to proactive support from HR, this is helping to reduce episodes of excessive workload.

5. TRAINEE CONCERNS

a) Attendance at the TDF continues to be fluctuant.

b) As a result, actions allocated to trainees are difficult to track and confirm completion.

c) The trainees are mostly not presenting with significant concerns. Most Exception reports are about staying late for 30 mins - 2hrs. This does not necessarily provide assurance that there are no active issues.

d) The relevant Rota's now have Self Development Time included. This is mostly in blocks of 4 or more hours which is popular and said to work well. Medicine trainees have an hour before and after teaching. This means that they inevitably miss a proportion of them. Some trainees have found this fragmented and not very useful. It is not clear if the required Personalised work schedules are in progress rather than all medicine trainees routinely working the generic work schedules.

e) Trainees report delayed responses to annual leave requests and cancellation of expected leave at very short notice. We expect 6 weeks' notice and late notice means that a further 6 weeks' notice makes taking any leave very difficult. Late approval means that trainees often miss offers / cheaper prices etc. The new leave policy is set to prescribe a maximum 7 days to decision on approval / rejection of leave.

6. FACILITIES

Facilities funding of over £60 000 has been made available for the Trust's Trainee doctors to improve rest and related facilities. It has been used to upgrade the mess in ODGH (indirectly funded) and to improve the Senior Trainee room at SDGH.

There remains an outstanding proposal to change the kitchen/bar/toilets area in the CEC to a bigger sleep area with non-gendered bathrooms.

Estate's capacity to do this remains an issue.

Executive support is requested to confirm timescales for this to be completed.

7. ADDITIONAL GOSW CONCERNS

In terms of management priorities

1) At present we have no Guardian of Safe Working in post, however the post has been widely advertised.

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Finance, Performance, and Investment Committee
MEETING DATE:	25 April 2022
LEAD:	Jeff Kozer

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The financial plan for 2022/23 was presented with an overall deficit of £20.5m. The changes from the draft plan consist of £6.2m increase in allocation relating to top up and covid, £1.1m release of annual leave accrual, and £0.2m related to the removal of the cost of loans required in 2022/23. The Committee noted the need for more formal confirmation of the ICS support to move cash around the system to reduce the requirement for loans in 2022/23. The context of the organisation's plan is that Integrated Care System (ICS) is still planning a significant deficit for 2022/23, which may well impact on the system's ability to attract both revenue and capital resources. As a result of the current ICS position there may well be a need for further amendments prior to final submission and potentially beyond that date. The Committee discussed the areas for further improvement being considered by the system. The capital plan figure included in the final plan totals £34.6m, which was in line with the ICS guidance to the Trust at draft plan stage. Of this the £5.5m internally generated resource plus the £3.2m for fire safety works are confirmed. The £22.8m balance of backlog maintenance built into the plan is subject to an ICS process to agree the allocation of funds held centrally.
- Work is ongoing to finalise the plan for the network replacement programme. In the meantime the Trust is in the process of replacing its VPN and its cross-site core network switches to support improvements in the current performance.
- Whilst a recent reduction in covid+ patients, still accounts for 12% of current bed base being managed over 2 three G&A wards. Impacting upon operational delivery both from an urgent and emergency care perspective and an elective recovery perspective.
- A&E performance in March 2022 was significantly below the national standard but compared positively to peers and first out of all acute adult Trusts across C&M . The Trust has seen some improvement with 12 hour duration breaches but has delivered care in escalation areas in ED.
- Deterioration across all cancer metrics in February 2022. Upper & lower GI, head and neck and gynaecology continue to be the most challenged in terms of performance. Endoscopy improvements will support upper and lower GI and discussions are taking place with other Trusts re mutual aid to support gynaecology.

ADVISE

- The Committee approved the Private Patient and Overseas Visitors policies.
- Work is ongoing to see how the network replacement programme can be completed as soon as possible. In the meantime the Trust is investigating whether a third party is able to offer support, and some generic network on call support from STHK.
- Discussions continue with LUHFT regarding the feasibility of expediting the implementation of the North Mersey Stroke pathway for S&O patients from September 2022 and SLAs relating to fragile services. The first Partnership Group is being planned for May 2022.

ASSURE

- The Cheshire & Merseyside Fire & Rescue Service granted a 12 month extension to the fire enforcement notice after acknowledging the significant progress that had been made.
- The Lancashire Fire & Rescue Service were very positive about the proactive learning from the Southport work undertaken, and the commitment to rectify issues with the fire alarm and compartmentation. A further visit will be undertaken in June to review the estates work undertaken to resolve the storage issues.
- At month 12 the Trust is reporting a surplus of £81k and a yearend forecast of breakeven. The cash balance at yearend is forecast to be £18.5m.
- The Trust was £1k underspent against the £13.689m capital programme 2021/22.
- The Trust achieved 90% against its Better Practice Payment Code.
- Elective activity for March 2022 was significantly above the 89% ERF target at 94.9% however this didn't attract ERF funding due to case mix of activity.
- Significant improvement in endoscopy with the trust delivering 118% for scopes in March 22, now delivering 12 points per list and commended by C&M ICB.
- Sefton as a place has been selected as one of three pilot sites nationally for the Optometry First model, with funding and national resource available to support the implementation. Workshops are in place to facilitate the process, which will allow the place to utilise all available ophthalmology resource across the system to improve current waiting times and clinical outcomes.

New Risks identified at the meeting: None

Review of the Risk Register: No action taken

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY & OPERATIONS (S&O) COMMITTEE**	**Date**	**04 May 2022**
Agenda Item	**SO085/22**	**FOI Exempt**	**NO**
Report Title	**2022/23 FINANCIAL PLAN**		
Executive Lead	John McLuckie, Director of Finance		
Lead Officer	Andy Large, Deputy Director of Finance		
Action Required	✓ **To Approve** ☐ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

To bring to the attention of the Committee the Trust 2022/23 Financial Plan submission

Executive Summary

The 2022/23 Financial Plan sets out:

- £20.5m Deficit;
- CIP 3.5% (£7.8m);
- £5.5m Capital Investment; plus
- £10.2m capital investment in high risk backlog maintenance, of which £3.2m is confirmed and is for Fire Safety

Updates since Draft Plan:

- £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

Recommendations

The Committee are asked to note:

- Finance, Performance & Investment Committee support for the 2022/23 Plan – 25 April
- CEO Approval of 2022/23 Plan - 28 April
- Submission of 2022/23 Plan to NHSE/I – 28 April
- Change to backlog capital from £26m to £3.2m for fire and safety and a further £7m pending a formal ICS allocation process
- Trust to write to CEO of ICS regarding the funding of the outstanding backlog resources required
- ICS expected to continue to seek further improvement from Providers post national submission

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**

Southport and Ormskirk Hospital NHS Trust

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:**
Andy Large, Deputy Director of Finance	John McLuckie, Director of Finance

Southport and Ormskirk Hospital NHS Trust

1. Executive Summary

1.1 The purpose of this paper is to provide an update on the financial plan for the 2022/23 financial year.

1.2 The Trust's financial plan for 2022/23 gives a deficit of £20.5m. Of this, £9.1m relates to income shortfalls, and £19.2m relates to pressures - partly offset by assumed CIP of £7.8m (3.5%).

1.3 The Trust's Internal Capital Resource Limit (CRL) totals £5.5m (IFRS16 capital expenditure is excluded from the CRL)

1.4 Following FP&I support for the proposed plan on 25th April the ICS asked the Trust to remove the £26m backlog figure and instead to include £3.2m confirmed funding for Fire Safety, and a further £7m for backlog pending a formal ICS allocation process.

1.5 The Trust CEO is writing to the ICS CEO on this matter to seek clarity on how the balance of the backlog resource required will be funded.

1.6 The Trust's 2022/23 Financial plan was submitted to NHSEI following FP&I support on 25th April, and CEO approval on 28th April.

2. Income & Expenditure Plan

2.1 The following table shows the movements from Draft Plan to Final Plan:

2022/23 PLAN £m	Draft	Movement	Final
2021/22 Surplus/(Deficit)	**0.0**	**0.0**	**0.0**
Income			
Tariff Uplift	3.7	0.0	3.7
Covid Funding	(10.3)	(0.9)	(11.2)
System Allocations	(15.6)	7.1	(8.5)
22/23 ERF	5.3	0.0	5.3
Out of Area Activity	1.6	0.0	1.6
HEE Adjustment	(0.2)	0.0	(0.2)
Car Park Income to 19/20	0.4	0.0	0.4
TOTAL INCOME PRESSURES	**(15.2)**	**6.2**	**(9.1)**
NATIONAL PRESSURES			
Inflation	(7.2)	0.0	(7.2)
Energy Costs	(1.6)	0.0	(1.6)
PDC	(0.5)	0.0	(0.5)
SYSTEM PRESSURES			
Activity to 104%	(2.7)	0.0	(2.7)
LOCAL PRESSURES			
Contingency	(1.2)	0.0	(1.2)
Statutory / Quality Investments	(2.1)	0.0	(2.1)
Service Changes	(0.5)	0.0	(0.5)
OTHER			
Non-Recurrent CIP	(3.8)	0.0	(3.8)
NR Balance Sheet Mitigations	(1.0)	0.0	(1.0)
Annual Leave Accrual movement	0.0	1.1	1.1
Remove Interest on Borrowing	0.0	0.2	0.2
CIP			
National (2%)	4.5	0.0	4.5
Local pressures (0.9%)	2.0	0.0	2.0
Covid (0.6%)	1.3	0.0	1.3
TOTAL EXPENDITURE PRESSURES	**(12.8)**	**1.3**	**(11.5)**
Surplus / (Deficit)	**(28.0)**	**7.5**	**(20.5)**

2.2 Updates since Draft Plan are as follows:

- £6.2 net improvement to system allocations
- £1.1m assumed release of annual leave accrual
- £0.2m interest associated with revenue funding removed

2.3 The 2022/23 plan shown above includes an assumed Trust CIP target of 3.5% (£7.8m).

2.4 The ICS is expected to continue to seek further improvement from Providers following national submission, having proposed some areas for further discussion:

- Annual Leave Accrual
- ERF income
- Balance Sheet
- Provision against assumed winter income during 22/23
- Provision against assumed other income during 22/23
- Increased level of CIP

2.5 The Trust's revenue support requirement of c£9m included in Plan from H2 is acknowledged, and to be funded within the ICS for 2022/23 (as per ICS instruction to remove £0.2m interest on borrowing referenced above).

3. Capital

3.1 The Trust's initial Capital Resource Limit (CRL) of £5.5m is broken down as follows:

2022/23 CAPITAL	£m
Medical Equipment	1.0
IM&T	1.0
Estates & Facilities	2.8
EPMA	0.4
Contingency	0.3
Total Capital	**5.5**

3.2 IFRS16 capital expenditure is excluded from the CRL.

3.3 Following FP&I support for the proposed plan on 25th April the ICS asked the Trust to remove the £26m backlog figure and instead to include £3.2m confirmed funding for Fire Safety, and a further £7m for backlog pending a formal ICS allocation process.

3.4 The Trust CEO is writing to the ICS CEO on this matter to seek clarity on how the balance of the backlog resource required will be funded.

4. Risks

4.1 Key risks to delivery of the draft financial plan for 2022/23 are as follows:

Risk	Description	Mitigation
Shortfall in funding allocation	Deficit due to removal of non-recurrent funding plus unfunded cost pressures e.g. energy inflation	ICS to review block allocations and incentive payments for final plan
CQUIN (£2m) & Best Practice Tariffs	Income dependant on delivery of targets	Delivery reviewed at Exec Committee and Quality Committee
ERF income (£5.3m)	Income dependant on delivery of target within system and locally	To be reviewed at FP&I Committee
CIP	CIP target of 3.5% (£7.8m)	22/23 schemes to be progressed through Use of Resources and CBU Efficiency Meetings and reported to FP&I
Cash	Deficit will require external cash support	Ongoing monitoring of cash position
Capital	Capital allocations still to be finalised with ICS, noting funding for Critical Backlog Maintenance is included in plans	Monitor of capital spend and project progress against planned timescales. Additional bids for backlog/strategic schemes.
Hospital Discharge Programme	To cease from 22/23 - impact to funding and deliverability of operational targets	Continued escalation ward
Potential cost pressures due to Covid-19	Reduced Covid-19 funding allocation may be insufficient	Continue to engage with HCP/ICS for appropriate funding allocation based on costs
Agreement of contracts with commissioners	Impact of transition from CCGs to ICSs in July 2022	Engagement with commissioning as soon as possible and throughout transition
Breakeven duty	Draft plan deficit will cause the Trust to fail the breakeven duty in 22/23	Trusts have 3 years to recover breakeven duty cumulative position

5. Recommendation

The Committee are asked to note:

- Finance, Performance & Investment Committee support for the 2022/23 Plan – 25th April
- CEO Approval of 2022/23 Plan - 28th April
- Submission of 2022/23 Plan to NHSE/I – 28th April
- Change to backlog capital from £26m to £3.2m for fire and safety and a further £7m pending a formal ICS allocation process
- Trust to write to CEO of ICS regarding the funding of the outstanding backlog resources required.
- ICS expected to continue to seek further improvement from Providers post national submission

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Executive Committee
MEETINGS HELD:	April 2022
LEAD:	Anne-Marie Stretch

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Liberty Protection Safeguarding – The Deprivation of Liberty Safeguards (DoLS) will be replaced with a scheme called Liberty Protection Safeguarding (LPS). This change has been delayed due to the pandemic. The Code of Practice 16-week public consultation period has commenced. Under the new arrangement, the responsibility to undertake and authorise the LPS process will transfer from the Local Authority to the Trust, making the organisation a 'Responsible Body'. The amount of work anticipated under the new scheme will be extensive and will have an impact on the Safeguarding Team. Some aspects of service change and funding remain unclear. The Assistant Director of Safeguarding will provide the EC with further updates as necessary.
- Ockenden Report - As part of Ockenden 2, there are now 15 Immediate and Essential Actions (IEAs) that organisations are required to report against, with 92 specific points under each IEA. EC acknowledged this take a significant amount of work and funding to complete. It was agreed to add Ockenden 2 compliance to the Quality Priorities for 2022/23 (remove Continuity of Carer). The Strategy and Operations Committee (SOC) will be provided with an update in May.
- Maternity Incident – The Director of Nursing and the Medical Director provided an update at EC on 19.04.22. Internal and external incident response and governance processes are being followed and staff are being supported.

ADVISE

- The Executive Team Meeting (ETM) changed its name to the Executive Committee (EC) in April 2022, following agreement and approval of the ToR by SOC on 06.04.22.
- Learning Disability (LD) and Autism Practitioner Business Case – The Quality Schedule for 2022/23 states that all commissioned providers are required to achieve the Learning Disability Improvement Standards by 2023/24. An LD and Autism Practitioner would work alongside safeguarding colleagues, supporting patients and staff in both paediatrics and adult services, to review complex cases and offer training and support for colleagues within the Trust. EC recognised the benefits of having an LD and Autism Nurse Practitioner would improve both patient and carer experience and increase staff knowledge and awareness. The business case was approved subject to further discussion about hours and funding.
- Trust 'Vision' – Following consultation with various staff groups about the Vision, *'Delivering great care, for every patient, every time',* was recommended by EC for approval by SOC.
- Covid National Inquiry – Dr Clark presented a draft summary of the ToR and highlighted some of the things relevant to the health and care sector that the Trust should be aware of, including decision making, evidence of planning and preparedness, staffing levels, following IPC processes, workforce testing and approach to palliative care. The draft ToR are out for public consultation. Health organisations will be invited to comment. EC with be provided with further updates as and when received.
- Monthly Medical Leadership AAA Report received.

- Mersey Internal Audit Agency (MIAA) – Mobile computing Review 2021/22 Audit received.
- IPR Presentation - EC received a proposal on the Trust's reporting relating to performance against key national and local priorities for 2022/23. The Trust is in the process of reviewing key metrics and individual meetings have taken place with each Executive Director to ensure the Trust is reporting against the relevant metrics and targets
- Occupational Health Software Business Case – The purpose was to seek funding to upgrade the occupational health system to COHORT 10, to ensure the system is supported and to enable staff medical records to be scanned into the system. The business case was approved, subject to funding being agreed.
- Medical Day Unit (Temporary Service Change) – The MDU was temporarily relocated from Southport to Ormskirk during the pandemic. A formal review was undertaken in October 2021, and the new Directorate Manager and Associate Director of Operations for Medicine & Emergency Care completed a follow-up review in February 2022. It was agreed that given the ongoing challenges of the pandemic that the MDU should remain at Ormskirk, with regular review of the situation.
- MIAA SOHT Draft Internal Audit Plan 2022/23 – The Executives had met with MIAA to agree the internal audit plan for 2022/23 and this was presented to EC.
- 7-Day Services Update - On 08 February 2022 updated guidance relating to the 7-days service clinical standards were published. This was discussed within the Medical Leadership Team - it was noted that for a small organisation we are able to provide access to many of the services identified. It is recommended that further work is required to align previous action plan to current position referencing collaboration with STHK and GIRFT principles. A further report will come back to EC.
- ECIST – Final report received. The ADO for Medicine & Emergency Care has been tasked with producing an action plan that addresses the recommendations. The EC will receive an update on the action plan in May.
- Car Parking – Payroll have been instructed to defer car parking charges until May for S&O staff, allowing time for a review of the car parking scheme.
- IPC – Recent changes to guidance on how testing and cases are managed will be discussed by the Clinical Risk Group and necessary actions taken. The advice says masks must continue to be worn in non-clinical areas.

ASSURE

- Endoscopy – LN noted that the improvement work against the activity trajectory and improvement targets is going really well and is ongoing. EC will receive a monthly update for assurance.
- Contract Clinical Quality Review Meeting (CCQRM) – The draft agenda items are reviewed each month before being shared with the CCG.
- Mortuary – Action Plan discussed at the Health & Safety(H&S) Committee. Completed actions include CCTV at the entrance of the mortuary. Outstanding access control actions will be completed imminently. It was highlighted there is a requirement to have a security officer as part of the H&S Team and this post will have a role in monitoring access to the mortuary and auditing the CCTV. This role is currently going through the Agenda for Change process.

New Risk identified at the meeting	None

Review of the Risk Register