AGENDA
STRATEGY AND OPERATIONS (S&O) COMMITTEE

To be held at 0930 on Wednesday 06 April 2022

V = Verbal D = Document P = Presentation

Ref Nº·	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0930***
SO043/22 (P)	**Patient Story** *Purpose: To **receive** the patient story*	*No*	*L Barnes*	15 mins
SO044/22 (V)	**Chair's welcome and note of apologies** *Purpose: To **record** apologies for absence and confirm the meeting is quorate.*	*No*	*Chair*	
SO045/22 (D)	**Declaration of interests** *Purpose: To **record** any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
SO046/22 (D)	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 02 March 2022.*	No	*Chair*	10 mins
SO047/22 (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**
SO048/22 (D)	**Approval of the 2022/23 Trust Objectives** *Purpose: To **approve** the 2022/23 Trust Objectives*	*No*	*AM Stretch*	15 mins
SO049/22 (D)	**Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework*	*No*	*N Bunce*	10 mins
SO051/22 (D)	**Terms of Reference** a) Assurance Committees b) To establish an Executive Management Committee *Purpose: To **receive** and **approve** the Terms of Reference*	*No*	*N Bunce*	10 Mins

SO052/22 (D)	**Charitable Funds Committee AAA Highlight Report** *Purpose: To* ***note*** *the Charitable Funds Committee AAA Highlight Report*	*No*	*J McLuckie*	5 mins
INTEGRATED PERFORMANCE REPORT				**1045**
SO053/22 (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				**1105**
SO054/22 (D)	**Quality and Safety Committee AAA Highlight Report** *Purpose: To* ***receive*** *the Quality and Safety AAA Highlight report*	*No*	*G Brown*	5 Mins
SO055/22 (D)	**CQC Progress Update** *Purpose: To* ***receive*** *an update on the CQC Progress, Actions, Engagement and Well Led Improvement Journey*	*No*	*L Barnes*	10 mins
WORKFORCE				**1120**
SO056/22 (D)	**Workforce Reports** a) Committee AAA Highlight Report b) People Plan Update (including 2021 Staff Survey results and action plan) *Purpose: To* ***receive*** *the Workforce reports*	*No*	*L Knight* *J Royds*	20 Mins
SO057/22 (D)	**Freedom to Speak Up Annual Self-Assessment 2022** *Purpose: To* ***approve*** *the Freedom to Speak Up Annual Self-Assessment 2022*	*No*	*L Barnes*	5 mins
FINANCE, OPERATIONS AND INVESTMENT				**1145**
SO058/22 (D)	**Finance, Performance and Investment Reports** a) Committee AAA Highlight Report b) Draft Financial Plan 2022/23 *Purpose: To* ***receive*** *the FP&I AAA report for information and assurance and to* ***approve*** *the 2022/23 Budget*	*No*	*J Kozer* *J McLuckie*	20 mins

CORPORATE				1205
SO059/22 (D)	**Executive Management Team AAA Highlight Report** *Purpose: To **receive** the Executive Management Team AAA Highlight Report*	*No*	*AM Stretch*	5 Mins
CONCLUDING BUSINESS				**1210**
SO060/22 (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*
SO061/22 (V)	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*		*Chair*	*5 mins*
	Date and time of next meeting: 0900 Wednesday 04 May 2022			***1230 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.

***Draft* Minutes of the Strategy and Operations Committee**
Held on Microsoft Teams
Wednesday 02 March 2022
(Subject to the approval of the Strategy and Operations Committee on 06 April 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
Nicola Bunce	NB	Director of Corporate Services, StHK
Kate Clark	KC	Medical Director
Ian Clayton	ICl	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
Jane Royds	JR	Director of HR and OD
Nina Russell	NR	Director of Transformation *(Part 2 only)*
Christine Walters	CW	Director of Informatics, StHK *(Part 2 only)*

In Attendance

Name	Initials	Title
Geoffrey Appleton	GA,	Board Advisor, StHK
Helen Day	HD	Paediatric Diabetes Specialist Nurse *(Item SO0024/22)*
Linda Douglas	LD	Freedom to Speak Up Guardian *(Item SO032/22 only)*
Michelle Kitson	MK	Matron, Patient Experience *(Item SO0024/22)*
Stephen Mellars	SM	Interim Director of Nursing *(Item SO024/22 only)*
Alan Sharples	AS	Board Advisor, StHK
Juanita Wallace	JW	Assistant to ADCG (minute taker)

Apologies

Name	Initials	Title
Tony Ellis	TE	Communications and Marketing Manager *(Part 1 only)*
Paul Growney	PG	Non-Executive Director, StHK
Nikhil Khashu	NK	Director of Finance and Information, StHK
Rowan-Pritchard-Jones	RPJ	Medical Director, StHK
Sue Redfern	SR	Director of Nursing, Midwifery and Governance, StHK
Rani Thind	RT	Non-Executive Director, StHK

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
SO024/22	**Patient Story**	
	SM introduced the patient story video which was provided by a mother	

whose daughter had been diagnosed as a Type 1 Diabetic and was participating in the Paediatric Diabetes Closed Loop trial. She discussed her experience of caring for her daughter as a newly diagnosed diabetic child, as well as her experience of care and support during Covid-19. The impact of only one parent being able to attend appointments and provide support during admissions during the pandemic was highlighted.

In response to AM's query around the time scales for the results of the clinical trial, HD advised that prior to the National Institute for Health and Care Excellence (NICE) guidelines changing the biggest issue was in obtaining the continuous glucose monitor as there were a number of criteria that needed to be met in order for a patient to be eligible for the equipment. Additionally, the different Clinical Commission Groups (CCG) had various criteria that a patient needed to meet to be eligible for the equipment. Following the changes to the NICE guidelines the continuous glucose monitors should be made available to all Type 1 Diabetics and it was the responsibility of the Diabetic team to be trained on the use of the equipment and to roll this out to the patients. It was noted that there were other makes of equipment available, but these were not compatible with the App which had been the real benefit in this trial.

LB's asked if there was anything that the team felt could have been done differently to involve the father in appointments and admissions. HD advised that the diabetic team did try to include both parents in the education sessions, however during Covid-19 it was only possible to allow one parent at the child's bedside. Additionally, the patient had been diagnosed at the start of Covid-19 and that lessons had been learnt and changes had been made to improve the involvement of both parents since then. There were certain instances, e.g. blood clinics, where the inclusion of both parents was more difficult due to the size of the clinic rooms and the number of staff involved in the procedure. During Covid-19 three of the four clinic appointments were held virtually to enable both parents to attend and going forward there would be more face to face appointments with both parents. It was noted that there would still be an option of virtual appointments if this was better suited to family circumstances.

GB asked if the number of children being diagnosed annually with Type 1 Diabetes had increased during the pandemic. HD advised that whilst research was ongoing there was not currently strong evidence of a definitive link between Covid-19 and the trigger for Type 1 Diabetes in children.

HD advised that the Trust was one of only five Paediatric Diabetes Teams that had been selected nationally to participate in the trial. The Team had worked hard to recruit the 42 patients that were taking part in the trial. The results after the first three months were very positive and it was hoped that

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those participating would be able to continue using the equipment when the trial ended and that it would also be offered to other young patients. GB commented that she has received positive feedback from the local community and that she was pleased that the Trust was involved in this research project.

RESOLVED

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

SO025/22 Chair's Welcome and Note of Apologies

RF welcomed all to the meeting and in particular Linda Douglas, the newly appointed Freedom to Speak Up Guardian who was attending her first Strategy and Operations Committee meeting.

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

SO026/22 Declaration of interests

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

SO027/22 Minutes of the previous meetings

The Committee reviewed the minutes of the previous meeting held on 02 February and approved them as a correct and accurate record of proceedings subject to the following amendments:

- *KC's initials to be amended from KB to KC.*
- *SO006/22 – to be amended to 'The Committee had received the External Audit Strategy Memorandum from Mazars and approved the Losses and Special Payments policy. Additionally the Committee had recommended to the Board that the revised Anti-Fraud and Corruption Policy be approved.'*
- *SO009/22 – to be amended to read ' the recently appointed Falls Coordinator would be reviewing'*
- *SO010/22 to be amended to read 'S&O Clinical Assessment and Accreditation Scheme (SOCAAS) - one ward, of those assessed to date, failed to meet the required standard. The issues were mainly related to documentation/recording issues and not training.'*
- *SO010/22 – to be amended to read 'GB commented that the presentation by Medicine and Emergency Care to the Quality and Safety Committee showcased the excellent quality improvement work being undertaken by the Trust and the enthusiasm and commitment of staff to improve services for patients. LB reported that the Frailty Team were working with patients to focus on "What matters to you" so that care could be personalised.'*

RESOLVED:

The Strategy and Operations Committee **approved** the minutes from the meeting held 02 February 2022

SO028/22 **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 Board **approved** the action log

STRATEGIC AND GOVERNANCE

SO029/22 **Strategy and Operations Committee Annual Workplan 2022/23**

NB presented the Strategy and Operations (S&O) Committee Annual Workplan 2022/23 which identified the reports that would regularly be presented for consideration during the year. The annual workplan had been updated to reflect the changes discussed and agreed by the Committee since its formation and changes to regulatory and statutory requirements and included a comprehensive description of the regular business to be transacted by the Committee.

It was noted that the workplan still needed to be aligned with the work plans of the assurance committees and decisions were needed regarding whether an item was for the S&O Committee approval or noting. The meeting was asked to approve the workplan whilst recognising that it was a work in progress.

LK noted that the Workforce Committee had been meeting monthly, but the work plan indicated bi-monthly AAA reports. NB confirmed that the frequency of the Workforce Committee meetings would be reviewed as part of the Terms of Reference (ToR) review.

RESOLVED:
The Strategy and Operations Committee **approved** the Strategy and Operations Committee Annual Workplan 2022/23

INTEGRATED PERFORMANCE REPORT

SO030/22 The Committee noted the Integrated Performance Report (IPR) Summary which provided an update on the Trust's performance against key national and local priorities during January 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:

- There had been one case of methicillin-resistant Staphylococcus aureus (MRSA) recorded in January and the completed root cause analysis (RCA) had identified areas of learning but no lapses in care. Targeted training around antibiotic prescribing and MRSA had been provided in the relevant areas.
- 28 cases of hospital-acquired Covid-19 infections were recorded in January 2022 and this was in line with other organisations in the region. It was noted that most of these cases were related to nursing home contacts or contacts of patients who had tested negative on admission but tested positive on day three. These cases were being reviewed for learning opportunities that focused on the environment and IPC practice.
- The mortality screening had shown an improvement and a review of fractured neck of femur cases has been undertaken to understand the reasons for delays to theatre.
- There had been five falls with harm reported in January 2022 and the Falls Coordinator would be working closely with the relevant wards.
- There had been an increase in category three Hospital Acquired Pressure Ulcers and the tissue viability team were working with the Emergency Department (ED) to ensure the quicker diagnosis of pressure ulcers.
- One stillbirth, due to a concealed pregnancy, had been reported in January. It was noted that the NHSE had issued new guidance in February 2022 relating to the reporting of Caesarean Section percentages and that this metric would change as a result of the guidance.

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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 23 Covid-19 patients in the hospital of which only one was being treated specifically for Covid-19. There were no Covid-19 positive patients being cared for in the Critical Care Unit. The fourth wave had peaked on 07 January 2022 with 79 Covid-19 positive patients. The Trust was in line with other trusts in the area with about 8% of beds being allocated to Covid-19 patients and these patients were being cared for on one ward. The impact of staff sickness absence (13%) at the peak of the fourth wave had impacted significantly on operational performance.
- Whilst Urgent and Emergency Care (UEC) performance remained significantly challenged against the 4hour standard, the Trust had

compared positively to peers both regionally and nationally. The 12hour position remained an area of concern and the Trust was an outlier nationally.

- There was a direct correlation between the lack of discharges and the 12hour performance. The number of ready for discharge (RFD) patients had increased to 75 patients each day (40% of accessible bed stock) compared to an average of 35 patients in June 2021.
- The review of all 12hour breaches had demonstrated good standards of care, timely reviews and commencement of plans, and no instances of harm had occurred.
- The following key actions had been taken:
    - Ensuring the Clinical Decision Unit was used appropriately to support flow and ensure timely treatment of patients.
    - An Implementation Group was established to deliver the Same Day Emergency Care (SDEC) Frailty pathway
    - A Lead Nurse had been appointed to develop ambulatory pathways.
    - Executive lead meetings with System Partners has continued to take place to increase discharges of medically optimised patients, which was having a major impact on patient flow and patients being admitted from ED to a ward
- There had been a decrease in Elective restoration activity (86.3% of the baseline against a target of 89%) and the position in outpatients was similar with non-urgent clinics being stood down to release resources to support UEC pressures.
- There had also been a deterioration in the 52 week wait as the Trust recorded being above the 52+ weeks 2021/22 trajectory for the first time this year.
- Despite an improvement in Cancer in October and November 2021, there had been a deterioration in December 2021 with five out of eight tumour sites achieving the 14 day target. The Cancer Improvement Plan was signed off by the Quality and Safety Committee. The delivery of endoscopy services remained a challenge to the delivery of cancer standards and the Endoscopy Improvement Group would be reviewing the action plans and support has been sought from the Endoscopy network. The possibility of a five point mutual aid plan was also being discussed with St Helens and Knowsley Teaching Hospitals NHS Trust (StHK).
- Radiology capacity was also a contributing factor to the delivery of cancer services and there were currently seven substantive staff members in post against an establishment of 10 and recruitment was ongoing.

GB asked if there was sufficient support from system partners for the safe discharge of medically optimised patients from the RFD lists. LN advised that the Trust was a member of the North Mersey Capacity and Flow

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Group which looked for collective ways to drive discharges, regular meetings were held with system partners and this was discussed at the bi-weekly System Gold meetings. There had also recently been a reduction in the number of care homes that were closed due to Covid-19 outbreaks. AM commented that this was an issue nationally and there was a possibility of more rigid trajectories being introduced. AMS commented that several patients had required complex packages of care that were not readily available due to various factors, but the system partners were engaged and supportive.

The Trust had submitted a bid for funding to support the Southport Hospital site becoming a Diagnostic Centre for the region.

GA asked about the challenges for the cancer pathways and capacity and LN advised that once the work on the new Endoscopy suite at Ormskirk Hospital had been completed, this would alleviate some of the issues and there should be an improvement in diagnostic capacity. Furthermore, the Endoscopy Improvement Group had set realistic but challenging trajectories for 2022/23.

In response to JK's comment about a paper on Service Level Agreements (SLAs) being presented at the Finance Performance and Investment Committee (FP&I), AM confirmed that this had been raised with the Cheshire and Merseyside Integrated Care System (ICS) and the regulators.

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 forecasting financial breakeven from month 10 following the confirmation of £4.7m System Top Up Funding for 2021/22.
- Expenditure in respect of Bank and Agency staff had increased but this was due to the operational pressures experienced in January and February 2022.

JMcL provided assurance that all Capital schemes with funding of £13.5m would be completed before 31 March 2022.

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

Performance Report

d) Workforce Performance Report

JR presented the Workforce Performance report and advised that:

- There had been an increase in Sickness Absence in January 2022 due to Covid-19 and advised that the Trust was not an outlier regionally.
- There had been a 1% reduction in the nursing vacancy rate due to the recruitment of international nurses and the 'Grow Your Own Campaign'
- Five of the 22 medical posts under offer had been filled in the preceding week and two locums had also been offered substantive posts.
- It was anticipated that there would be several Band 6 nursing vacancies and the Health Care Assistants (HCA) vacancies remained an issue.

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

QUALITY AND SAFETY

SO031/22 **Quality and Safety Report**

a) Quality and Safety Committee AAA Highlight Report

GB presented the AAA Highlight report and alerted to the Committee that the Maternity Reports, which included the Ockenden One Year On (OOYO) and Perinatal Mortality Review (PMR) Reports had been noted with an action that further details of themes and learning from the PMR's as well as timescales for OOYO outstanding actions were completed.

GB advised the Committee of the following:

- whilst there had been an improvement in the Core Mandatory Training, Essential Skills training still required additional work and, with the emphasis on elective recovery, it was important that this training was up to date.
- The Learning from Deaths report had shown a triangulation of data within the IPR and other reports being presented. The team was commended on the progress that has been made on the screening of deaths.

The presentation by the Dementia and Delirium Team showed great insight as well as ownership of the issues and the Team was congratulated on the positive work that has been undertaken.

ICI commented that, as the CQC Well Led Action plan was no longer

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presented at this Committee, he required assurance, as the Chair of the Audit Committee, around the 2019 actions and the progress being made. LB advised that a paper detailing the status of all the CQC actions would be presented at a future Quality and Safety Committee and GB advised that a Well Led domain self-assessment was being completed.

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

b) Bi-Annual Safe Staffing Report

LB presented the report which provided the Committee with a comprehensive update on staffing for nursing and midwifery and Allied Health Professionals (AHP). The update focused predominantly on the inpatient bed base areas and included an overview of the current staffing position as well as the measures taken to ensure staffing levels are safe and sustainable.

LB highlighted the following:

- There had been a focus on Band 5 recruitment and the vacancy rate had reduced from 20% in June 2021 to 8% in December 2021.
- There needed to be more focus on the Care Hours Per Patient Day (CHPPD)
- The International Nurses Recruitment programme had been successful and 145 international nurses had been recruited between June 2020 and December 2021. It was noted that the Trust would be submitting an application for the NHS Pastoral Care Quality Award.
- The Health Care Assistants (HCA) workforce was fit for purpose and a recruitment programme to reduce vacancies would be launched.
- The Trust has continued to use the apprenticeship route to develop existing staff, with staff being enrolled on both the Physiotherapy Degree and the Therapy Assistant Practitioner apprenticeships. It was noted that there was currently no availability of apprenticeship courses for other therapies professions such as Dietetics or Speech and Language Therapy (S<).

In response to JK's query around interactions with local schools, LB confirmed that the Trust did have excellent links with local schools and colleges to attract young people into healthcare and that the Freedom to Speak Up Guardian and the Health and Well Being Leads had recently presented a master class at Edge Hill University.

GB thanked LB for a comprehensive report and asked for further detail on the issues around recruitment and retention of AHPs. LB advised that there were national shortages in some of the professions. Also during the

pandemic the roles of these staff had become more operational and involved in discharges to maintain patient flow. The structure and skill mix was being reviewed to try and make the roles attractive and offer career development.

GB commented on the importance of creating apprenticeships for S< and Dietetics due to the national shortages. JR advised that the Trust was looking at improving the number of apprenticeships and was working with local universities. KC commented that a paper, which had been produced towards the end of 2021, had highlighted the shortage of training places nationally for S< and discussions were ongoing with the University of Central Lancashire (UCLAN) on how to improve this. AMS commented that, when the apprenticeship levy had started, the full range of healthcare apprenticeships had not been developed and new apprenticeships could take up to 10 months for approval.

RESOLVED:
The Strategy and Operations Committee **received** the Bi-Annual Safe Staffing Report

c) Learning from Deaths Report

KC presented the Learning from Deaths presentation which provided an overview of the Trust's performance against key national and local mortality indicators and highlighted the following themes:

- Communication - KC referenced the serious incident review of a paediatric death which had highlighted poor communication between organisations that had led to the uncertainty over who was providing follow-up and ongoing care and for what condition. This had led to a lack of timely intervention for infection which subsequently led to death. Following this review, the Trust had assessed its policies to ensure that a robust access framework was in place. It was noted that the lessons learnt from the case had an impact locally and across the system.
- Patient Flow – this has been recognised as an area of improvement and learning actions to improve care have been identified.
- Clinical Care – the timely administration of antibiotics and the reporting of blood cultures were identified as a theme and further focus on the impact and lessons learnt would be required.
- End of Life Care – there has been an improvement in staff recognition of patients requiring end of life care as well as the involvement of the patient and relatives in the planning of this care.

VD asked if there was a process in place to review and rescind Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. KC advised that each plan was reviewed on a case to case basis and, if the plan was

related to an acute illness that would resolve, the clinician would assess how long the order should be in place for. Furthermore, the quality of documentation was monitored on an ongoing basis. A bespoke piece of work around communication with relatives had resulted in an improvement in communication.

LB advised that proposals for the re-introduction of visiting was being presented at the Clinical Reference Group.

RESOLVED:
The Strategy and Operations Committee **received** the Learning from Deaths Report

d) Maternity Report

LB presented the Maternity Report which provided the Committee with an overview and update on:
1. Ockenden Review of Maternity – One Year On (Letter from NHSE/I)
2. Perinatal Mortality Review Tool (quarter 3)
3. Quarterly Update on Maternity

LB highlighted the following:
- Progress had been made on the implementation of the seven Immediate and Essential Actions (EIAs) outlined in the first Ockenden Report and the Trust had submitted its compliance report.
- Additional work was required around managing the complex pregnancy pathway and this would be led by the Local Maternity System (LMS).
- Dr Rani Thind had been appointed as the Maternity Safety Champion.
- The Cheshire and Mersey (C&M) Local Maternity System had agreed on a standardised regional reporting template and this had been utilised for this reporting period but would require additional information going forward.

VD asked about the results of the Birthrate plus review and if there was still a shortage of midwives. LB advised the Birthrate plus review had indicated that there was now sufficient staff for the predicted births. In relation to the new guidance on monitoring caesarean section rates, the new metrics had not yet been published that caesarean rates would be monitored differently going forward and that she was waiting on the details. She also advised that the Birmingham Symptom-specific Obstetric Triage System (BSOTS) were taken into account for staffing. NB commented that, as far as she understood, the revised Birthrate plus tool did take into account the BSOTS requirements and it was agreed the LB would clarify this.

RESOLVED:
The Strategy and Operations Committee **received** the Maternity Report

WORKFORCE

SO032/22 Workforce Reports

a) Workforce Committee AAA Highlight Report

LK presented the AAA Highlight report and advised the following:

- There were no issues that were escalated to the Committee as alerts.
- PDR rates had reduced in month and this had been expected due to operational pressures and sickness absence caused by the Omicron wave. Trajectories for improvement had been agreed with the Clinical Business Units (CBUs) to see improvement by April.
- The sickness rates in January had increased as expected due to the Omicron wave. Overall sickness in January reached 9.2% against a target of 5%. Nursing absence reached 11.7%, Medics 4.8% and Health Care Assistant sickness absence peaked at 13.9% in month

The Season's Greetings Campaign had been a success and well received by staff and any reflections and learning will be taken forward.

The Committee had received the findings of a National Report into the People Profession and its part in shaping the future of the NHS in 2030.

Assurance was received that progress was being made against the Undergraduate Medical Education Plan ahead of the planned visit by Liverpool University in the Spring.

The following posts were currently under offer in the recruitment cycle:

- 22 Medics
- 17 Band 6 Nursing posts
- 31 AHPs
- 31 Health Care Assistant posts

The compliance for Core Mandatory Training had increased this month from 88.7% to 89.2% against a target of 85%.

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

b) Freedom to Speak Up Report (Quarter 3)

LD presented the Freedom to Speak Up Report for Q3 2021/22 which provided assurance regarding staff members' ability to raise any concerns and that there were appropriate systems and processes in place for staff to do this safely and confidentially, knowing that appropriate action would be taken. It was noted that 10 concerns had been raised during the period and covered the following themes:

- System / Process
- Bullying / Harassment / Leadership

- Behaviour / Relationship

It was noted that three concerns had Human Resources input either directly via the Guardian or the Manager. The importance of soft intelligence was highlighted at LD's one to one meetings with LB, Executive Champion, and AMS.

There were currently between 10 and 12 active Freedom to Speak Up Guardians in the Trust and the local network group, which was being revived, would offer peer support. LD has received 15 to 20 applications for new champions and will be conducting interviews shortly.

LD advised that she would be collaborating with Mersey Internal Audit Agency (MIAA) to develop a protocol to review the set of parameters to work safely within. AS commented that he was in favour of LD's collaboration with MIAA as, from his previous experience, he had found the team helpful, and they had provided advice and independent investigations when required. In response to his concern that five out of 10 staff members wished to remain anonymous when raising concerns LD advised that, when she had discussed this with the individuals, some staff members wished to remain anonymous as they had family members working within the Trust who they did not wish to be aware of the issues reported. She would be discussing other ways to report concerns with the North West Group. Joint communications with LD and MIAA were planned for the Freedom to Speak Up month in October.

RF commented that he had found it interesting that 50% of the concerns raised had related to systems and processes and were easy to resolve. VD asked how improvements made as a result of the FTSU concerns were fed back to staff and LD advised that this would form part of the FTSU communication plan going forward.

GB thanked LD for a comprehensive report and commented on the fact that there had been no concerns raised about patient safety. Additionally, there was a year on year reduction in the number of concerns being raised. GB noted that there had been three concerns raised by the AHP staff and asked if these were all related to the same issue. LD advised that these were being used to inform the work taking place around leadership and strategy across the Trust, which had attracted some external funding.

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RESOLVED:
The Strategy and Operations Committee **received** the Freedom to Speak Up Report (Quarter 3) and **noted** the activity during the quarter.

FINANCE, OPERATIONS AND INVESTMENT

SO033/22 **Finance, Performance and Investment Committee AAA Highlight Report**

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

- The Omicron variant had been responsible for an increase in Covid-19 admissions which had impacted significantly upon operational delivery both from an urgent and emergency care perspective as well as an elective recovery perspective.
- Both the 62 day and 14 day cancer standards were not achieved in December 2021. Whilst there were a number of challenged pathways, upper and lower gastroenterology as well as Head and Neck continued to be the most challenged in terms of performance.
- Elective activity for January 2022 was below the 89% Elective Recovery (ERF) target.

JMcL advised that work on the electric cabling at the Southport site was ongoing and provided assurance that this would be completed before the end of March 2022.

JK advised that NHSE training regarding the IPR and Statistical Process Control (SPC) charts had been arranged for June 2022 and that this would be helpful for new members. AS commented that he had met with the subject matter expert on SPC and had found this informative and thanked LN for arranging this.

RESOLVED:

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

CORPORATE GOVERNANCE

SO0034/22 **Executive Management Committee Report**

AMS presented the AAA Highlight report that detailed the activity and reports considered by the EMC during February and advised that there were no issues escalated to the Committee as alerts. She advised that the following Agenda Items had been considered:

- ETM had signed off 2022/23 Draft Activity Plans. It was noted that the CBUs would be presenting their draft Activity Plans at the next Hospital Management Board meeting.
- As part of the Quality Improvement Plan 2022/23 Staff Listening events had taken place during February to engage with staff about what areas of improvement they felt should be included in the plan.
- The Executive Team regularly reviewed the Cancer Improvement Plan, trajectories and actions that had been developed at tumour specific level and presented to the Q&S Committee in February 2022.
- The Trust was waiting on the formal feedback following the NHSI National Estates Team visit

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AMS advised that NB had now joined the Trust part time to undertake the Company Secretary role during the substantive post holders secondment.

GB commented on the Robotic Process Automation and advised that this was also used by STHK's payroll team.

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

CONCLUDING BUSINESS

SO035/22 Questions from Members of the Public

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

SO036/222 Any Other Business

AM advised that following the discussion around the reinstatement of financial undertakings she had prepared a draft letter of response to NHSE stating that the Trust would not be able to provide an absolute guarantee on the 2022/23 financial targets as allocations had not yet been communicated. She was, however, confident in the organisation and the plans that were being developed.

In response to RF's comment on the variable sound issues that had been experienced during the meeting, JMcL advised that the IT Team was currently reviewing all recently implemented changes to understand what has created the current issue so that it can be resolved.

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 1146.

The next meeting would be held on **Wednesday 06 April 2022 at 09.00**

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Strategy and Operations Committee Attendance 2021/22												
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							✓	✓	A		✓	A
Val Davies							✓	✓	✓		✓	✓
Paul Growney							A	A	A		A	A
Nikhil Khashu							✓	✓	✓		✓	A
Lisa Knight							A	A	✓		✓	✓
Jeff Kozer							A	✓	✓		✓	✓
Rowan Pritchard Jones							✓	✓	✓		✓	A
Sue Redfern							✓	✓	A		✓	A
Alan Sharples									✓		✓	✓
Anne-Marie Stretch							✓	✓	✓		✓	✓
Rani Thind								✓	✓		✓	A
Christine Walters							✓	✓	✓		✓	✓
S&O Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Lynne Barnes											✓	✓
Kate Clark							✓	✓	✓		✓	✓
Sharon Katema							A	✓	✓		✓	
Bridget Lees							✓	✓	✓			
John McLuckie							✓	✓	✓		✓	✓
Lesley Neary							✓	✓	✓		✓	✓
Jane Royds							✓	✓	A		✓	✓
Nina Russell							✓	✓	✓		✓	✓
✓ = In attendance A = Apologies												

Strategy and Operations Committee (Part 1)

Matters Arising Action Log

Action Log updated 31 March 2022

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
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
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
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	**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	Green
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	Included on Agenda

COMPLETED ACTIONS

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

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
SCO035/21	03/11/2021	**Learning from Deaths Report**	Dr Clark to provide a progress update which will include communication with the deteriorating patients following an update from the Resuscitation group in March 2022.	K Clark	03/11/2021	Mar-22	**November Update:** Action progressing and not due **January Update:** Action progressing with next quarterly report scheduled for presentation in March 2022 **February Update:** Item included on Agenda, Action completed	Blue
SO044/21	01/12/2021	**Integrated Performance Report (IPR)** a) Quality and Safety Performance Report	In response to IC's query around the Care Quality Commission's (CQC) action plan and where it sat within the governance structure, BL advised that the updated action plan including the actions from the 2019 and 2021 inspections would be presented at the Quality and Safety Committee. IC suggested that actions concerning the Well-Led domain should be reported to this committee to ensure the governance across the organisation met requirements	L Barnes	01/12/2021	Mar-22	**December Update:** Actions around the Well-Led domain to be reported at S&O Committee to ensure governance across the organisation meets requirements **January Update:** Action progressing and not due **February Update:** This was discussed at the Executive Away Day held on 15 February and a plan for self-assessment and action plan to be completed in Quarter 1 and presented at Quality and Safety Committee and Strategy and Operations Committee as part of the regular CQC Updates. Action completed	Blue

Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 April 2022
Agenda Item	SO048/22	FOI Exempt	NO
Report Title	2022/23 TRUST OBJECTIVES		
Executive Lead	Anne-Marie Stretch, Managing Director		
Lead Officer	Nicola Bunce, Director of Corporate Services		
Action Required	✓ To Approve ☐ To Assure	☐ To Note ✓ To Receive	

Purpose

To approve the proposed 2022/23 Trust Objectives

Executive Summary

1. The Executive have developed proposals for Trust objectives for 2022-23 in support of delivering the 6 strategic goals of the organisation (Appendix1).
2. These objectives incorporate the quality improvement priorities agreed as part of the Quality Account
3. The approved Trust objectives will be launched at a "Start of the Year Conference" with a simplified version being distributed to every ward and department so that staff will be aware of the Trust priorities for the coming year and can develop their own service and personal objectives in support these.
4. Each objective is aligned to a committee for regular oversight and assurance whilst the Executive Committee will performance manage delivery.
5. A formal mid-year review of progress will be brought to the Strategy and Operations Committee in October.

Recommendations

The Strategy and Operations Committee is asked to approve the 2022/23 Trust Objectives.

Previously Considered By:

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

Strategic Objectives

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

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

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

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

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

✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable

services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Nicola Bunce, Director of Corporate Services	Anne-Marie Stretch, Managing Director

Appendix 1

Southport and Ormskirk Hospital NHST - Trust Objectives 2022/23

Objective	Lead Director	Outcomes Measures	Governance Route	Comment
1. Strategic Objective 1 - Improve clinical outcomes and patient safety to ensure we deliver high quality services				
1.1 Reduce number of falls and hospital acquired pressure ulcers	DoN	• Reduce all falls by at least 10% and falls resulting in harm by at least 20% compared to 2021/22 • Reduce number hospital acquired pressure ulcers with lapses in care by 10% compared to 2021/22 • Ensure all patient harm incidents are reported and investigated	Quality and Safety Committee	Quality Account priority
1.2 Improve the early detection of deteriorating patients.	DoN/MD	• Achieve compliance with AQUA Acquired Kidney Injury (AKI) standard for US within 24hrs and urinalysis. • Reduce Hospital Acquired AKI compared to the 2021/22 baseline • Implement and report hydration and nutrition performance metrics • Undertake NEWS2 observations at the correct intervals 95% of the time • Audit compliance with the sepsis bundle and reduce incidents related to late detection • Achieve CQUIN standard for unexpected admissions to critical care	Quality and Safety Committee	Quality Account priority
1.3 Improve the quality of end of life care.	DoN/MD	• Improve DNACPR documentation with additional training, awareness raising and regular audits • Improve documentation pertaining to communication of diagnosis and end of life planning (documentation audit) • Recognition of patients approaching end of life with application of advanced management and treatment plans with clear levels of escalation (NACEL audit) • Improve feedback from patients and relatives evaluated via PALs/Complaints/patient survey results	Quality and Safety Committee	
1.4 Continue roll out and development of the S&O hospitals Clinical Assessment & Accreditation Scheme (SOCAAS) to demonstrate a cycle of continuous quality improvement	DoN/MD	• Complete SOCAAS evaluation for every ward • Results of SOCAAS and delivery of the improvement plans to be reported as part of the CBU performance metrics	Quality and Safety Committee	

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Objective	Lead Director	Outcomes Measures	Governance Route	Comment
1.5 Improve Patient Experience and reduce complaints	DoN/MD	• Learning from complaints and focussing on improving communication between staff, patients and their relatives • Reporting and learning from incidents with SMART actions • Increase in FFT response rates in areas that aren't meeting the expected number • Increase in FFT scores for patients having a positive experience • Reduction in patient complaints • Increase in complaint case resolution.	Quality and Safety Committee	
1.6 Implement the recommendations of the Ockenden report into the safety of maternity services	DoN	• Delivery of the recommendations of the second Ockenden Report • Double the % of women booked onto a continuity pathway to at least 25% • Achievement of the CNST maternity safety bundle for 2022/23	Quality and Safety Committee	Quality Account Priority
1.7 Improve Same Day Emergency Care Services to avoid unnecessary hospital admission	COO	• Increase 0 and 1 day LOS • Reduce conversion to admissions 1+ day LOS • Reduced number of patient ward moves • Implement direct to specialty pathways	Finance, Performance and Investment Committee	
1.8 Improve frailty services to avoid unnecessary admissions for 65+ patients	COO	• Increase 0 and 1 day LOS for age 65+ patients • Reduce average LOS for age 65+ patients	Finance, Performance and Investment Committee	
2. Strategic Objective 2 – Deliver services that meet NHS constitutional and regulatory standards				
2.1 Elective Restoration - to deliver against elective levels in line with 2022/23 operating plan	COO	• Deliver 104% 2019/2020 elective activity levels • Deliver 120% 2019/20 diagnostic activity levels • Improve theatre utilisation to pre COVID levels • Improve cancer performance to meet national standards • Improve endoscopy productivity and performance • Reduce long waiters in line with the elective recovery plan targets	Finance, Performance and Investment Committee	
2.2 Improve the effectiveness of discharge Processes	COO/DoN/ MD	• Release the maximum number of beds. As a minimum this should be half the current delayed discharges • Ensure sufficient and appropriate information is provided to all	Finance, Performance and Investment	Quality Account priority

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Objective	Lead Director	Outcomes Measures	Governance Route	Comment
		patients on discharge • Improve Inpatient Survey satisfaction rates for receiving discharge information • Achievement of 30% target for patients discharged before noon during the week and 85% of the weekday average discharges to be achieved before noon at the weekends consistently across all wards.at weekends • Introduce criteria led discharge	Committee	
2.3 Delivery of the agreed Trust financial targets: outturn, cash balances and revised capital resource limits	DoF	• Achieve the approved financial plan for 2022/23 agreed under the new NHS financial regime • Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income • Deliver the approved capital programme	Finance, Performance and Investment Committee	

2.4 UEC Delivery – to deliver against UEC levels in line with 2022/23 operating plan	COO	• Improve 4 hour performance (vs TBC).
		• Reduce 12 hour waits in ED (total).
		• Minimise ambulance handover delays
		  o Eliminate > 60 mins
		  o 95% h/o < 30 mins
		• 65% h/o < 15 mins.
			Finance, Performance and Investment Committee	

2.5 Transformation of diagnostics services by becoming a Community Diagnostic Hub (CDC) to maximise capacity, throughput and patient experience	COO	• Deliver 120% 2019/20 diagnostic activity levels • Reduce waiting times in line with national standard	Finance, Performance and Investment Committee	
3. Strategic Objective 3 – Efficiently and productively provide care within agreed financial limits				
3.1 Reduction in the level of backlog maintenance across the Trust estate	DOF	• Development of a 3 year backlog maintenance strategy • Reduction in backlog maintenance figures reported via ERIC submission 2022/23 by targeted capital investment • Completion of all fire safety actions to achieve a fire safety certificate for both sites • Wherever possible invest to improve the environment for patients and staff	Finance, Performance and Investment Committee	
3.2 Improve the quality and resilience of Trust IT systems	DOF	• Reduce the number of system outages as a result of poor network resilience	Finance, Performance	

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Objective	Lead Director	Outcomes Measures	Governance Route	Comment
		• Reduce the cyber security risk across the network by replacing all network hardware with supported systems • • Improve the reliance and resilience of the network and therefore reduce the number of system outages	and Investment Committee tee	
3.3 Further develop the use of electronic patient information to replace paper based medical records e.g. observation charts, nursing assessments and care plans, AHP assessments and inpatient clinical narrative	DoF	• Reduce the amount of paper in nursing documentation produced as part of the paper based medical record by 25% • Reduce time spent by clinicians using paper-based processes by providing them access to a full and salient electronic documentation trail of a patient's care from wherever they need to access • Improve e-observations (NEWS2) to facilitate early identification of deterioration leading to earlier intervention • Enabling speciality reviews of patient pathways resulting in the reduction in variation in patient care	Finance, Performance and Investment Committee	
3.4 Maximise the productivity and effectiveness of clinical services using benchmarking and comparative data to reduce unwarranted variation	COO/DoT	• Named productivity programmes for 22/23 and action plan monitoring • Continued participation in national GIRFT programme, including reviews and delivery of the resulting action plans	Finance, Performance and Investment Committee	
3.5 Implement robotic process automation within CBU's and corporate functions to automate manual tasks and release workforce	DoF	• Reduction in delays with referrals due to having a 24-hour service that can process referrals across all specialties • Reduction of spend on Agency and Bank staff as a % of these roles will be automated • Better use of data across the departments, to include an increase in real time reporting in order to improve decision making • Increased capacity to manage the backlog of referrals in a time efficient manner due to robot workers available 24/7 • Improvements in quality of data integrity and reduce errors • Improve DNA rates- Increased accuracy of patient demographics has a positive impact on DNA's and clinic utilisation which results in more patients being seen • Improved patient safety as a result of reduced administrative processing errors and reducing the likelihood of these resulting	Finance, Performance and Investment Committee	

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Objective	Lead Director	Outcomes Measures	Governance Route	Comment
		in delays in the care process • Increased efficiency of administrative processes, releasing time for more value-added activities		
4. Strategic Objective 4 – Develop a flexible responsive workforce of the right size and with the right skills who feel valued and motivated				
4.1 Safe Staffing	DoN/HRD	• Real time staffing – Staffing against minimum compliance • Continue international recruitment of nurses up to 160 WTE • Reduce the number of HCA vacancies to below 20 WTE Real time staffing – Staffing against minimum compliance • Continue international recruitment of nurses • Reduce the number of HCA vacancies	Workforce Committee	
5. Strategic Objective 5 - Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of Trust Values				
5.1 Launch and embed the Trust's values known as SCOPE (Supportive Caring Open and Honest Professional Efficient)	HRD	• Formal launch of the Trust SCOPE values • Specific focus on values and behaviours at Induction / Warm Welcome • Evidence of regular, consistent reference to SCOPE values in Trust meetings and staff engagement in sharing stories of living the values • Increase in staff engagement score (Annual staff survey) at least in line with NHS average (6.8 in 2021) • Positive impact on staff survey questions 'Recommend as place to work' and 'Standard of care at this organisation' • Launch of Listening Plan including Exec Back to Floor building OD network and widening participation in Valuing Our People through Inclusion Group work streams • Assurance staff are having at least annual career conversation with line manager (evidenced by >85% PDR compliance) • Roots and branch review of recruitment and selection process with a view to introducing values based recruitment	Workforce Committee	

5.2 Embed just and learning (JLC) principles into people practices	HRD	• Mandated training for line managers
		  ○ All Board/SOC members received JLC training by Dec 22
		  ○ >30% completion of training for line managers in Year 1
			Workforce Committee	

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Objective	Lead Director	Outcomes Measures	Governance Route	Comment

		• Awareness of civility and respect behaviours across all employees
		    ○ Civility and respect workshops delivered to >300 staff members in Year 1
		    ○ Learning at workshops converted into behavioural objectives set in 2022/23 PDRs (evidenced by audit)
		• Increase in number of employee relations cases resolved informally and maintain level of formal cases <10 per month Reduction in concerns raised by staff about their treatment at work		

5.3 Promote a supportive and inclusive environment	HRD	• Redesigned core leadership and development programme incorporating compassionate leadership • Hold 6 weekly Schwartz Rounds • 40 staff to have completed an individual restoration programme and returned to work • Improvements on staff survey themes linked to compassionate leadership / team / safe and healthy • Promotion of flexible working practices (target of >200 staff with formal blended working arrangements in place) • Revised Health and Wellbeing strategy agreed by Workforce Committee by October 2022	Workforce Committee	
6. Strategic Objective 6 - Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire				
6.1 Work with local health care organisations, Place and Cheshire & Merseyside ICB to explore opportunities for collaboration to ensure future-proof services for the local population	DoT	• Implementation of North Mersey Stroke Pathways • Continue to build on the key relationship with Liverpool University Hospital Trusts for current hub & spoke models in Head & Neck and Vascular • Demonstration of on-going clinical collaboration with STHK • Influence the ICB collaboration areas for focus to achieve maximum impact on fragile clinical pathways at S&O • Development of business cases/cases for change relating to service development and sustainability • Clear alignment to Place/Commissioning and ICB priorities	Strategy and Operations Committee	

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Objective	Lead Director	Outcomes Measures	Governance Route	Comment
6.2 Continue to address service fragility to ensure we maintain oversight of the risks and opportunities going forward	DoT	• Continued update of service assessment and monitoring of identified key drivers of fragility and work with partners to develop long term plans to meet the health needs of the population • Reduce the number of services assessed as being ‘fragile’. • Reduction in number of services requiring medium-term transformation input to support sustainability and returned to BAU governance processes	Strategy and Operations Committee	
6.3 Work with partners across the local health system to implement Place Based Partnership Boards to improve the health of the local population	DoT	• Be a member of each PBPB in each Place • Continue to be an equal partner in the Shaping Care Together Programme to develop a long term plan for the future clinical and financial sustainability of services	Strategy and Operations Committee	
6.4 Continue to work with STHK to deliver the objectives of the Agreement for Long Term Collaboration	All	• Deliver the agreed milestones to improve services for patients	Strategy and Operations Committee	

ENDS

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Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 April 2022
Agenda Item	SO049/22	FOI Exempt	NO
Report Title	BOARD ASSURANCE FRAMEWORK (BAF)		
Executive Lead	Nicola Bunce, Director of Corporate Services		
Lead Officer	Nicola Bunce, Director of Corporate Services		
Action Required	☐ To Approve ✓ To Assure	☐ To Note ✓ To Receive	

Purpose

The Board Assurance Framework (BAF) provides assurance that the principal risks to achieving the Trust's Strategic Objectives are identified, regularly reviewed, and systematically managed.

Executive Summary

The Board Assurance Framework (BAF) provides a structure and process which enables the Board/Strategy and Operations Committee to review its principal objectives, the extent to which the Trust has appropriate and robust controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls. The BAF continues to be reviewed regularly by the executive director leads, and the BAF risks are aligned to the Assurance Committees. The Executive Committee will also monitor that the actions are progressing and any new gaps in control are identified.

Since the last update on the Board Assurance Framework (BAF):

- All risks have been reviewed by the Executive Director lead.
- The Director of Corporate Services has undertaken a critical friend review on a number of the key risks
- A new risk reflecting the specific IM&T and cyber security threat to the Trust has been added to the BAF
- A number of other changes are recommended to the committee;
  - The addition of a new strategic risk relating to the condition of the estates and backlog maintenance issues faced by the Trust
  - An increase in the BAF score (likelihood and consequence) in relation to the financial risks facing the Trust, reflecting the challenging of delivering the 2022/23 financial plans

Recommendations

The Strategy and Operations Committee is asked to **receive** the Board Assurance Framework and **approve** the recommended changes.

Previously Considered By:

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

Strategic Objectives

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

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

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

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

✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	**Presented By:**
Nicola Bunce, Director of Corporate Services	Nicola Bunce, Director of Corporate Services

BOARD ASSURANCE OVERVIEW (UPDATED 28 March 2022)

Strategic Objective	Principal Risk	Risk Appetite	Inherent Risk	Current Risk Score	Target Risk Score	Lead Committee	Executive Lead	Direction of travel
SO1: Improve clinical outcomes and patient safety to ensure we deliver high quality services	**Risk ID 1**: If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety	**CAUTIOUS**	**20**	**15**	**8**	Quality and Safety Committee	DoN/MD	
SO2: Deliver services that meet NHS constitutional and regulatory standards	**Risk ID 2:** If the Trust cannot achieve its key performance targets it may lead of loss of services	**OPEN**	**16**	**16**	**8**	Finance, Performance and Investment Committee	Dep CEO/COO	
SO3: Efficiently and productively provide care within agreed financial limits	**Risk ID 3:** If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.	**OPEN**	**20**	**12**	**12**	Finance, Performance & Investment Committee	DoF	
SO4: Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	**Risk ID 4:** If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience	**OPEN**	**12**	**12**	**8**	Workforce Committee	Dir of HR & OD	
SO5: Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	**Risk ID 5:**If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted	**OPEN**	**12**	**12**	**8**	Workforce Committee	Dir of HR & OD	
SO6: Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	**Risk ID 6:** There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services	**Hungry**	**20**	**15**	**10**	Strategy and Operations Committee	DOT	

BOARD ASSURANCE OVERVIEW (UPDATED 28 March 2022)

SO7: The Trust has the IT systems and security infrastructure to support the delivery of high quality services	Major and sustained failure of essential IT systems	**Moderate**	**20**	**16**	**8**	Finance, Performance and Investment Committee	DoF	New

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

Strategic Objective 1: Improve clinical outcomes and patient safety to ensure we deliver high quality services									**Assurance Committee:** Quality & Safety Committee **Executive Lead:** Director of Nursing / Medical Director
RISK ID	**1**	**Risk Description**	**If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety**						
Inherent Risk			**Risk as at 07/01/2022**			**Target Risk position**			
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	
4	5	**20**	3	5	**15**	2	4	**8**	

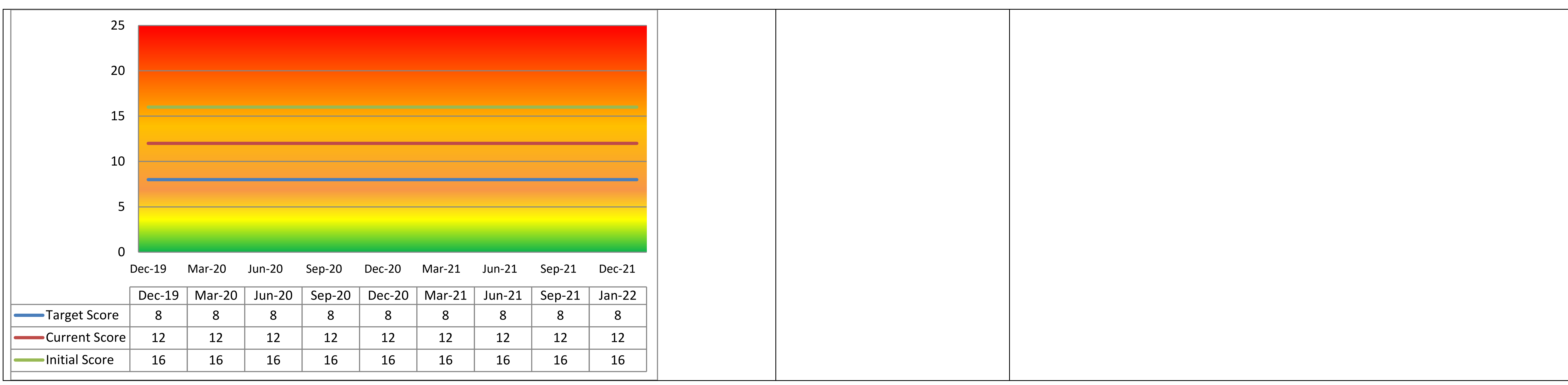
Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety **CAUSE** Immature governance and risk management processes; poor understanding of minimum standards; shortage of appropriately trained clinical staff in certain specialties and professions; lack of robust processes and management systems to provide evidence and assurance to regulatory agencies. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; inability to demonstrate that risks are managed in a timely way; learning and improvements are delayed; poor clinical outcomes; difficulty in recruiting to clinical vacancies; high use of agency and locum staff leading to increased costs; reduced patient experience feedback; enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.	1. Trust Governance Structures. 2. Trust policies and procedures. 3. Quality priorities programme encompassing five priority areas: • • Falls • Pressure Ulcers • AKI: hydration & nutrition • Communication with families • Continuity of carer 4. Risk Management Strategy and escalation framework. 5. Quality impact assessments (QIAs) for all service changes that are considered. 6. Single accountability framework for reviewing CBU areas for development/strengths. 7. Application of clinical pathways and guidelines. 8. Programmes in place for clinical standards and professional practice. 9. Work plans for medical staff. 10. Clinical revalidation. 11. Ward/departments staffing position is controlled through: • 3 x daily at staffing huddle; • 7 day staffing matron in place for oversight and management; • Weekly staffing review and sign off; • Roster sign off meeting. 12. Training programme (mandatory and non-mandatory). 13. CQC action plan to address areas of underperformance highlighted on inspection. 14. Supervision and education of clinical staff across all professions. 15. Application of Patient Safety and other safety alerts. 16. Patient Safety Specialists appointed. 17. Cycles of business for governance meetings 18. Use of temporary staffing arrangements to maintain Unify Fill-rates of above 90%. ~~19. Appointment of patient safety specialist~~ 20. Medical examiners roles and fully established programme to review all	1. Non-standardised Trust approach to quality improvement. 2. Clinical workforce strategy not fully developed. 3. Nursing, midwife, AHP and support staff recruitment and retention programme needs further development.	**LEVEL 1** (Operational Management) 1. Alert, Advise, Assure reports from Groups. • Harm free care panel • Serious Incident Review Group • Health and Safety Group • Risk and Compliance Group 2. Performance, Improvement, Delivery and Assurance (PIDA) with suite of measures. 3. Patient feedback (FFT/Patient Surveys) 4. Clinical audit reports 5. Mortality and SJR Process. 6. Review of documentation and quality indicators through use of perfect ward. 7. Health and Safety Inspection Programme 8. IPC Assurance Framework 9. Health and safety/fire risk assessment/audit programme. 10. Medical Examiners office/officers now set up and in practice. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Q&S Committee (monthly): ○ Mortality metrics ○ Never events ○ Incident data ○ Serious Incidents ○ CQUINS ○ Performance data ○ Complaints and compliments 2. HSMR/SHMI. 3. Quality Strategy metrics 4. Mandatory training 5. Monthly Safe Staffing Report 6. Nurse establishment reviews 7. SONASS ward accreditation programme 8. VitalPac deterioration measures 9. Freedom to speak up guardian 10. IPC BAF 11. Winter Staffing Assurance Framework Assessment **LEVEL 3** (Independent/Semi-Independent) 1. GMC / NMC Reports 2. Royal College Reports / Visits. 3. CQC inspection visits	1. CQC 'Must and should do' actions not addressed in full. 2. Gaps in evidencing that lessons are consistently learnt and changes in practice embedded following incidents, complaints, claims, inquests, and audit.	~~1.~~ Clinical workforce strategy to be completed – ~~**by end of Jan-21.**~~ **April 22 Update: Action overdue** 2. Complete CQC Must and Should Do actions – ~~**Jan 2022 update** – 20 actions remain Green (not yet complete), all have timescales and trajectories to complete. A paper to ETM will be completed to propose moving the Trust into 'business as usual, programme of work.~~ **April 22 update: Paper presented to the Quality and Safety Committee** 3. Enhance the sharing of lessons across the organisation and test that actions/changes are complete/ embedded into practice. ~~**Jan 2022 update:** The Trust recently undertook a lessons learnt audit by MIAA which gave the Trust MODERATE ASSURANCE. Actions from the audit are being reviewed and updated for sign off but can be given as an assurance once signed of by Executives.~~ **April 22 Update: MIAA audit report to be presented at Audit Committee with target completion dates** 4. Complete review of Risk Management Policies and Assistant Director of Integrated Governance now developing a framework with associated training to bridge the gap on Risk Management Training in the Trust and a clear process. **Due March 2022** ~~5.~~ Risk Management training launched September 2021 and being regularly reviewed and rolled out to staff across the Trust. **On-going**

		deaths 21. Full roll-out/reporting of Tendable ~~Perfect Ward~~ app measures 22. Nursing, midwife, AHP and support staff recruitment and retention programme in place. 23. Regular risk management training taking place across the Trust and available to book onto for all Trust staff. Patient safety managers also holding risk management training within the CBU's and specialities. 24. Quality Improvement Plan goes through bi-monthly to QSC and is presented to the SOC ~~board.~~ 25. Incident reporting and investigation process 26. Ockenden 1 Action plan 27. Reporting of nosocomial infections and outbreaks		4. CQC Insight Report, Outlier Alerts and engagement meetings 5. Healthwatch 6. Peer Reviews and accreditation. 7. Getting it right first time (GIRFT) programme. 8. NHSI/E oversight meetings 9. Quarterly and Annual Guardian of Safe Working Report. 10. CCG monthly quality and performance meetings 11. Internal/External Audit 12. Quality Account 13. Risk management deep dives and self-checks by the Integrated Governance team 14. Quality Improvement Plan goes through bi-monthly to QSC and is presented to the board.		
	The Q&S Committee reviews key quality requirements, expectations and performance requesting remedial action plans where required using a systematic and robust methodology of review and challenge					

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

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

RISK TRACKING	Linked Risks: 6	Comments
Risk Rating: Initial 4 x 4 = 16 Current 3 x 4 = 12 Target 2 x 4 =8 **(Likelihood x Consequence)**	a) 1862 – Safe Staffing b) 1622 – Shortage of middle grades in obs & gynae c) 2122 – Medicines Management d) 2056 – Missing Patient appointments e) 2226 – Inadequate staffing within Anaesthetics f) 2074 – Consultant Medical Vacancies g) 2218 – CQC compliance	**Update – April 2022** • The strategic risk and associated linked risks have been reviewed and this remains a **high risk**.



	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21	Jun-21	Sep-21	Jan-22
Target Score	8	8	8	8	8	8	8	8	8
Current Score	12	12	12	12	12	12	12	12	12
Initial Score	16	16	16	16	16	16	16	16	16

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

Strategic Objective 2: Deliver services that meet NHS constitutional and regulatory standards	**Assurance Committee:** Finance, Performance and Investment Committee **Executive Lead:** Chief Operating Officer

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

Inherent Risk			Risk as at 28/03/2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	4	4	16	2	4	8

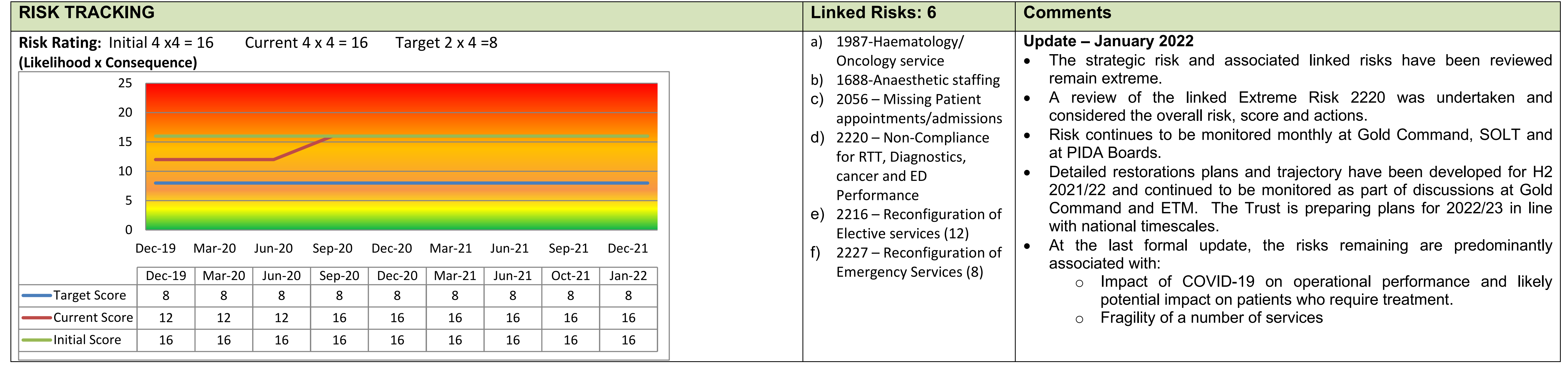
Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust cannot achieve its key performance targets it could lead to failure in delivering safe, high quality patient care and experience and failure to deliver contracts. **CAUSE** • COVID-19 causing delays in elective and diagnostic recovery, cancer pathways and patient discharge. • Continued rise in UEC demand and challenges with patient discharge due to insufficient/inconsistent alternative provisions across the system. • Reduction in the supply of suitably skilled and experienced staff across a number of services. • Ineffective use of resources to support improvements in productivity and improve clinical outcomes. • Failure in operational leadership **CONSEQUENCE** • Failure to deliver safe, high quality patient care • Reduced patient experience • Poor clinical outcomes • Over-reliance on	COVID-19 and Recovery • Bronze, silver, gold command structure for oversight and decision making. • Frequency of gold/silver/bronze meetings revised based upon trigger alerts linked to COVID-19 admissions. • Part of C&M hospital cell group monitoring COVID-19 recovery and supporting mutual aid discussions. • Single accountability framework for reviewing CBU areas for development/strengths. • RTT restoration plan being monitored on a weekly basis and reported to gold weekly and ETM monthly. • Non RTT trackers in place with planned programme of work • Directorate Manager role that is solely responsible for access - providing greater strengthen in governance and compliance. • Access policy for validation of all patients on waiting lists. • Clinical prioritisation of all patients. UEC and Discharges • ED RCA process for breaches • Agreed in-hospital winter plan 2020/21. • Agreed out of hospital (system) winter plan 2020/21. • System wide capacity and flow meeting held twice weekly to review system discharge delivery. • 4 x daily bed capacity meetings to support daily planning. • Additional funding to support UEC winter plans. Workforce • Shaping care together programme. • Comprehensive trust service assessment completed to establish levels of fragility and core drivers	1. Expected outcomes and opportunities of partnership with STHK are still being explored. 2. STHK are not the only key stakeholder for clinical services 3. Shaping Care Together programme is yet to define preferred option 4. Clinical workforce strategy not fully developed. 5. The workforce of the Trust does not have the mature level of expertise to ensure QI methodology can be applied. 6. Lack of systematic capacity and demand. 7. Sefton Brough is still developing plans for ICP from June 2022	**LEVEL 1** (Operational Management) 1. Performance, Improvement, Delivery and Assurance (PIDA) Boards – CBU assurance 2. Number of improvement boards in place reporting in via PIDA ○ Theatre Utilisation Board ○ Urgent and Emergency Care Improvement Board ○ Endoscopy Improvement Board ○ Cancer Improvement Board 3. Review of CBU Risk Registers at Risk and Compliance Group. 4. CBU review at Clinical Effectiveness Committee. 5. CBU Governance Meetings in place. 6. Local IPRs in place to monitor performance which are presented at Performance, Improvement, Delivery and Assurance (PIDA). **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 7. CEO's reports to Board 8. Integrated Performance Report (IPR) to SOC, FP&I, Q&S and Workforce Committee (monthly) to monitor any impacts on patients as a result of the risk including: ○ Mortality ○ Incident data ○ CQUINS ○ Operational performance data ○ Complaints and compliments ○ Financial position 9. Monthly reports on Covid-19, elective restoration, UEC performance to FP&I. 10. Monthly reports on cancer improvement to QSC 11. Quarterly Joint Performance Meeting (NHSE, STHK and S&O) . **LEVEL 3** (Independent/Semi-Independent) 12. NHSI Single Oversight framework and monitoring arrangements 13. CCG monthly quality and performance meetings.	1. Constitutional standards are not being met 2. H2/ERF plans for 2021/22 are not being met 3. Challenging operational plans for 2022/23. 4. COVID-19 impacting on elective recovery and discharge of patients	1. Clinical workforce strategy to be completed **March 22 Update: To be finalised in Q1 2022/23 In line with Operational plan submissions, fragile services development plans and STHK partnership working** 2. COVID-19 and recovery plans in place. **March 22 Update: Ongoing. RTT restoration plan being monitored and reported on a weekly basis and via the IPR.** ~~3. Develop sustainable plan to address validation issues in relation to the non-RTT tracker.~~ ~~**Jan 22 Update: Completed. Plan developed and non RTT trackers in place to support the non RTT validation. Open pathways reduced from 205,425 to 154,574 with 84,509 pathways closed.**~~ 4. Develop cancer improvement plan to address performance across all cancer metrics by Dec 21. **March 22 Update: Ongoing. Cancer improvement plan and trajectories in place and impact monitored via monthly activity report at FP&I.** 5. Develop endoscopy Improvement Plan **March 22 Update: Endoscopy improvement plan developed and new endoscopy unit now operational allowing single sex lists and increased productivity.** **6.** Develop plans for 2022/23 in line with national guidance **March 22 Update: Draft activity and recovery plans for 2022/23 submitted and will be finalised in April in line with the national timetable.** 7. Discharge planning: Additional focus in place across system to increase pathway 0 & 1 discharges. Regional ask is to achieve a 30% improvement on these patient pathways by Feb 22

Consequences	Controls		Assurances		Update
temporary workforce due to current and projected workforce gaps leading to increasing costs and potential impact upon quality of patient care and experience. • Failure in delivery of national performance targets/plans which could lead to intervention by regulator(s)/ and/or commissioner(s) • Reputational damage and loss of public confidence. • Financial penalties and loss of services. • Loss of market share. • Reliance on other acute providers to support the delivery of clinical services • Loss of ERF funds.	Use of Resources • Use of Resources Programme established to support well led approach for clinical and corporate services. • Quality impact assessments (QIAs) for all service changes that are considered. • Use of Quality Improvement (QI) Methodology to ensure any service improvement becomes sustained and embedded. Operational leadership • Weekly Senior Operational Leadership (SOLT) Meetings • Monthly Senior Operational group (SOG) meetings with development plan in place • Essential skills and mandatory skills training programme		14. NHS benchmarking data including Model Hospital Dashboard and Dr Foster reporting 15. Getting it right first time (GIRFT) programme. 16. Cancer alliance oversee delivery and performance regarding cancer metrics. 17. NHS England / NHS Improvement 18. CQC 19. Internal Audit 20. External Audit.		compared with 13th Dec 21 baseline.. **March 22 Update: Daily RFD meetings with system partners in place. Remains challenging when care homes closed to admissions due to increased incidence of COVID.**

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

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

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



RISK TRACKING | **Linked Risks: 6** | **Comments**

Risk Rating: Initial 4 x4 = 16 Current 4 x 4 = 16 Target 2 x 4 =8
(Likelihood x Consequence)

	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21	Jun-21	Oct-21	Jan-22
Target Score	8	8	8	8	8	8	8	8	8
Current Score	12	12	12	16	16	16	16	16	16
Initial Score	16	16	16	16	16	16	16	16	16

Linked Risks: 6

a) 1987-Haematology/ Oncology service
b) 1688-Anaesthetic staffing
c) 2056 – Missing Patient appointments/admissions
d) 2220 – Non-Compliance for RTT, Diagnostics, cancer and ED Performance
e) 2216 – Reconfiguration of Elective services (12)
f) 2227 – Reconfiguration of Emergency Services (8)

Comments

Update – January 2022

- The strategic risk and associated linked risks have been reviewed remain extreme.
- A review of the linked Extreme Risk 2220 was undertaken and considered the overall risk, score and actions.
- Risk continues to be monitored monthly at Gold Command, SOLT and at PIDA Boards.
- Detailed restorations plans and trajectory have been developed for H2 2021/22 and continued to be monitored as part of discussions at Gold Command and ETM. The Trust is preparing plans for 2022/23 in line with national timescales.
- At the last formal update, the risks remaining are predominantly associated with:
  - Impact of COVID-19 on operational performance and likely potential impact on patients who require treatment.
  - Fragility of a number of services

Risk Description: If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.

Strategic Objective 3: Efficiently and productively provide care within agreed financial limits	**Assurance Committee:** Finance, Performance and Investment Committee **Executive Lead:** Director of Finance

RISK ID	**3**	**Risk Description**	**If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources the sustainability of services will be in question.**

Inherent Risk			**Risk as at 14/01/2022**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
4	4	**16**	3	4	**12**	3	4	**12**

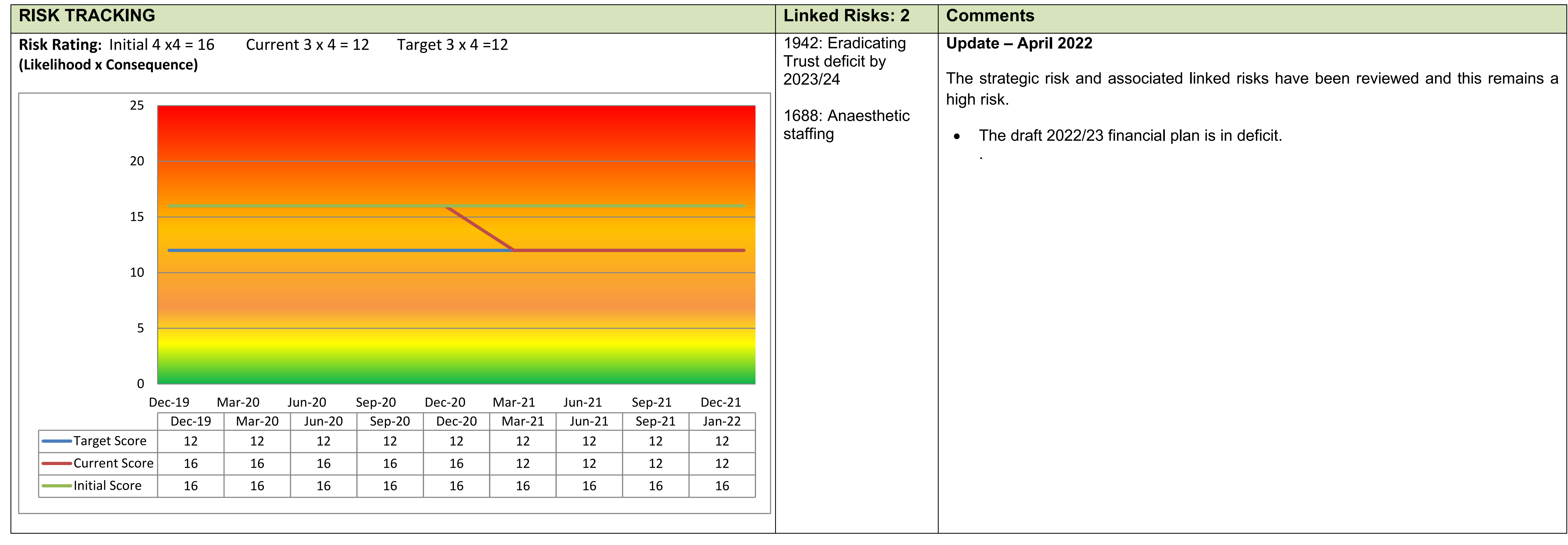
Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If the Trust cannot meet its financial regulatory standards and operate within agreed financial resources, the sustainability of services will be in question. **CAUSE** Reductions in services or the level of service provision in some areas; potential loss in market share; ability to deliver the levels of CIP in excess of the national efficiency requirement; reliance on agency costs and premium payments to support fragile services; insufficient liquid cash to meet expenditure obligations on a monthly basis; impact of restricted access to capital resources. **CONSEQUENCE** Changes in income & activity; Shortfall in support funding (PSF/FRF or equivalent); regulatory intervention; lack of financial stability; missed opportunities to invest in services and new technologies; failure to service the Trust's capital requirements and maintain the estate.	1. Financial Systems and processes. 2. Scheme of Reservation and delegation 3. Standing financial instructions 4. Budget holder training. 5. Short term financial plan for the Trust. 6. Cheshire and Mersey ICS ~~Health Care Partnership (HCP)~~ 5 year plan 7. Capital Investment Group 8. Strategy Task and Finish Group 9. Shaping care together programme 10. Health Trust Europe (HTE) Procurement Framework 11. Cheshire and Mersey Framework 12. National Agency Team Support 13. People Activity Group (PAG) 14. 2021/22 Cost improvement (CIP) programme delivery, and development of 2022/23 plans. 15. Strategy, Transformation and PMO resources 16. ~~Smart sheet software from PMO~~. 17. e-Rostering 18. ~~Financial Management Framework~~ 19. Use of Resources Action Plan in place. 20. Implementation of strategy for the roll out of patient level costing to inform clinical understanding of cost drivers 21. Introduction of Clinical Business Unit FP&I meetings as part of the performance management framework	1. Due to COVID-19, Trust income has been determined by ICS system allocations, with a new financial regime being introduced to support elective recovery for 2022/23. 2. Currently no financial recovery plan that delivers break-even/ services the underlying deficit. 3. Lack of medium & long term financial model, taking into account current position and savings from any reconfiguration 4. E-rostering system not fully utilised across the Trust. 5. Premium Rate Pay Control Panel across the CBUs, as well as centralising the management of rostering in process of being established	**LEVEL 1** (Operational Management) 1. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 2. Use of Resources Programme Board 3. Reports to the Corporate and CBU Efficiency Programme Group (EPG) meetings 4. Monthly CIP review meetings 5. Monthly cash flow forecast **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 6. Integrated Performance Report (IPR) 7. Monthly financial position reports/CIP Reports to HMB, FP&I Committee and Board 8. Activity and performance reports 9. Updated financial reporting format which includes more issues, risk and action focused **LEVEL 3** (Independent/Semi-Independent) 10. NHS England/Improvement 11. CQC 12. CCG 13. Internal Audit reports 14. External Audit reports 15. Model Hospital 16. Costing returns 17. National Agency Team reports 18. Internal Audit Review of the CIP Programme report	1. Inability to monitor trajectory against financial recovery plan until developed. 2. Robust tracking of CIP programme. 3. High level forecasting is a manual driven process.	1. Develop scenario-based approach to business plan/budget setting for 2022/23 taking account of the COVID-19 trajectory and emerging financial arrangements for 2021/22 **April Update**: 2022/23 draft financial and activity plan submitted. 2. ~~Develop financial framework to underpin Shaping Care Together programme, setting out affordability and potential financial improvement/recovery – by end of March 2021.~~ ~~.**January 2022:** Update provided to S&O Board and will be considered as part of the wider collaboration agreement with StHK.~~ 3. Establish process for identifying, implementing and monitoring delivery of efficiency/productivity (CIP) ~~**January 22 Update**: Action progressing and expected to be completed March 2022.~~ **April Update: 2022/23 CIP plans being developed as part of the financial plans** 4. Report progress against the Use of Resources action plan **– report to FP&I Committee by end of March 2021.** ~~**January 2022 Update** – Action progressing and expected to be completed by March 2022~~. **April Update: Action overdue** 5. E-rostering to be fully rolled out in all areas Rostering management to be centralised Jan 2022 which will ensure consistent best practice is in place. ~~**January 2022 Update**: Revised target date March 2022.~~ **April Update: Action Overdue** 6. Trust is moving to establish a Premium Rate Pay Control Panel across the CBUs, as well as centralising the management of rostering **April Update: Target completion date needed** 7. Analysis of activity in relation to PBR to understand the drivers of changes and potential solutions **April Update; Block contracts continue for 2022/23** 8. NHS Shared Business Services developing a new forecasting and budgeting tool See 1 above. January Update: Finance teams across the C&M are working with SBS and are looking

					to develop own tools internally. **April Update: Target completion date needed**

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

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

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



RISK TRACKING	Linked Risks: 2	Comments
Risk Rating: Initial 4 x4 = 16 Current 3 x 4 = 12 Target 3 x 4 =12 **(Likelihood x Consequence)**	1942: Eradicating Trust deficit by 2023/24 1688: Anaesthetic staffing	**Update – April 2022** The strategic risk and associated linked risks have been reviewed and this remains a high risk. • The draft 2022/23 financial plan is in deficit. .

	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21	Jun-21	Sep-21	Jan-22
Target Score	12	12	12	12	12	12	12	12	12
Current Score	16	16	16	16	16	12	12	12	12
Initial Score	16	16	16	16	16	16	16	16	16

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

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

Inherent Risk			**Risk as at 28/03/2022**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	4	**12**	3	4	**12**	2	4	**8**

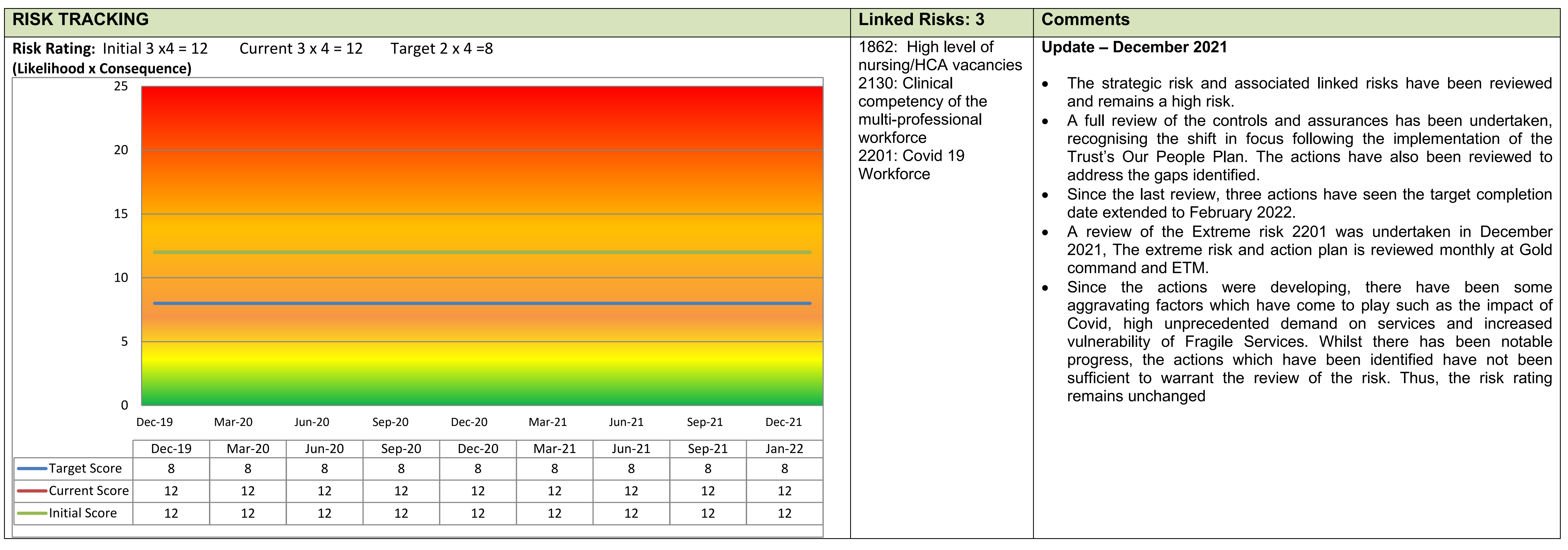
Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience **CAUSE** Shortage of appropriately trained clinical staff in certain specialties and professions; Trust's geographic location; Trust's close proximity to other teaching hospitals with clearer USPs from a learning/ career development perspective; reputational damage over last 3 – 5 years has impacted on external perceptions of the Trust; Trust approach to recruitment and retention is underdeveloped across all areas. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; high vacancy and attrition rates; over-reliance on temporary workforce leading to increasing prevalence of fragile services; higher costs associated with temporary staffing; enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of	1. Our People Plan (Workforce and OD Strategy) aligned to NHS People Plan 2. Our Resourcing Plan (Strategy supported by clinical workforce plan). 3. Inclusive recruitment and selection processes in place 4. Overseas Recruitment Campaign for Nurses 5. Effective management of the junior doctor rotation programme and early indications of any shortages from the Lead Employer. 6. Job plans for medical staff. 7. Warm Welcome staff induction in place 8. Quality PDR process and career development discussion 9. Flexible working options in place including team rostering 10. Ward/departments non-medical staffing position is controlled through: 11. 3 x daily at staffing huddle; 12. 7 day staffing matron in place for oversight and management; 13. Weekly staffing review and sign off; 14. Roster sign off meeting. 15. People Activity Group (PAG) with oversight of business cases for additional staffing 16. Leadership development programmes & 360 feedback available to all staff 17. Apprenticeship programmes available to all staff from Level 2-7 qualifications 18. Effective approach to supporting attendance to reduce sickness absence levels.	1. Low number of applicants from BAME backgrounds successful at interview 2. In need of earlier identification of junior doctor rota gaps and proactive block booking to address. 3. Alignment of job planning rounds to business planning cycle 4. Poor PDR compliance rate 5. E-rostering system not fully utilised across the Trust and limited options for flexible working 6. Policy has too many stages/trigger points reducing effectiveness and limited manager informal interaction with staff in early stages of absence management 7. No easy ability for staff to move without full application process 8. Failure to meet essential skills training targets 9. Education Governance structure requires revision	**LEVEL 1** (Operational Management) 1. Workforce Committee 2. Workforce Improvement Group (WIG) oversees work against the four operational priorities: ○ Agile working ○ Workforce systems ○ Clinical workforce plan ○ Change management 3. Quality and Safety Committee 4. Clinical Effectiveness Committee 5. Finance, Performance and Investment Committee. 6. Risk and Compliance Group. 7. Clinical Effectiveness committee; 8. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 9. CBU Governance Meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): 2. PDR completion; 3. Sickness rates. 4. Absence Data 5. Turnover Data 6. Vacancy Rate 7. Time to Hire monitoring and reporting. 8. Apprenticeship Levy/Programmes 9. Staff Survey & Quarterly Staff FFT/Survey 10. GMC Medical Staff survey – annual 11. Nursing temporary staffing fill rate/ NHSP contract performance **LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement	1. Sickness absence above target 2. Low compliance rates for PDR completion 3. High nursing vacancy rates 4. A number of medical vacancies have been vacant for a long time	1. Clinical workforce plan to be developed. A work stream has been established as part of Workforce Improvement group (led by the Deputy Medical Director) to develop a framework for workforce planning and link to Fragile Services and Shaping Care Together. Implementation of establishment control is required before a robust workforce plan can be developed, the implementation of establishment control is progressing at pace and the majority of the preparation work is now complete. Aiming for this to be in place by the **end of December 2021**. **April 22 Update:** overdue action. Work has commenced to develop a Nursing Workforce Plan / Pilot areas identified to trial STAR workforce planning methodology with medical workforce to support development of a clinical workforce plan. 2. Engagement planned with recent staff appointments (6-12mths) to review Recruitment and Selection process to identify improvements & develop further inclusive approaches Ongoing – expected completion date December 2021. **April 22 Update:** Work has now commenced, and project initiation document being developed for May 2022. 3. Work with international colleagues as a bespoke group to support & develop career pathways to aid performance & retention. **Commence January 2022** **April 22 Update:** Ongoing 4. Alignment of business planning to Job Planning Round 2021. **2021 Round still in progress, but closing on 30th November and 2022 round will open on 14th December** **April 22 Update:** Ongoing 5. E-rostering system now being rolled out to remaining departments (**target completion date September 2021, delayed by Covid and availability of required staff but revised completion dates 30th January 2022 due to COVID pressures, which means staff are unavailable for training**;

	services.	19. Updated Resourcing Plan required and no clinical workforce plan in place 20. Lead Employer progression 21. Internal transfer principles to be explored 22. Core mandatory & essential skills training programmes in place 23. Clinical Education Review undertaken		2. CQC 3. CCG 4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		**April 22 Update:** 87% roll out – outstanding departments are Radiology and Estates & Facilities. Revised target completion date end of August 2022 6.Work is now ongoing to look at current rostering practice across each area and guidance and support is being offered to improve as phase 2 of the benefits realisation. 4 departments identified as pilots for team/self-rostering is now underway **paused due to current pressures on the chosen ward areas. Restart in Feb 2022.** – **evaluation timescale yet to be agreed**; agile working group developing principles for hybrid working and review of flexible working policy to be piloted with CMO staff in **July 2021.** ~~**Ongoing and expected for completion in March 2022**~~ **April 22 Update: Completed** 6. Review of supporting attendance policy to commence and support being access from NHS England/Improvement to address areas identified as outliers compared to Trust's with lower absences. Further meeting to take place with NHSE/I **w/c 12th July 2021**. Been reviewed and targeted date for completion of review December 2021. **Jan 22 Update**: Action ongoing expected completion revised to Feb 22. 7. Each CBU has developed an improvement trajectory showing planned reduction in sickness absence over next 3 months and progress to be monitored through monthly PIDA **from April 2021. Expected to continue throughout the winter period.** 8. Two joint Clinical Academic posts with Edge Hill University currently being advertised to increase attractiveness to medical posts at the Trust – **aim to appoint by September 2021. April 22 Update:** Successful appointment made to one of the posts. 9. Internal transfer principles to be explored. There is no easy ability for staff to move without a full application process. T&F group established mid-October 2021 to assess need for transfer SOP with potential qualifying criteria to be determined. Completion by mid-December 2021 **April 22 Update:** Paused due to Winter pressures. VOPIG Reward and Recognition group to pick this up again from April 2022. 10. Essential Skills Risk under review and action plan to be implemented to achieve Trust target. **April 22 Update: Completed** Clinical Education Risk & Governance structure & processes under review by Executive Team **April 22 Update:** Ongoing

The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

AMBITION: To be the employer of choice in Merseyside and Lancashire

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



RISK TRACKING

Risk Rating: Initial 3 x4 = 12 Current 3 x 4 = 12 Target 2 x 4 =8
(Likelihood x Consequence)

	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21	Jun-21	Sep-21	Jan-22
Target Score	8	8	8	8	8	8	8	8	8
Current Score	12	12	12	12	12	12	12	12	12
Initial Score	12	12	12	12	12	12	12	12	12

Linked Risks: 3

1862: High level of nursing/HCA vacancies
2130: Clinical competency of the multi-professional workforce
2201: Covid 19 Workforce

Comments

Update – December 2021

- The strategic risk and associated linked risks have been reviewed and remains a high risk.
- A full review of the controls and assurances has been undertaken, recognising the shift in focus following the implementation of the Trust's Our People Plan. The actions have also been reviewed to address the gaps identified.
- Since the last review, three actions have seen the target completion date extended to February 2022.
- A review of the Extreme risk 2201 was undertaken in December 2021, The extreme risk and action plan is reviewed monthly at Gold command and ETM.
- Since the actions were developing, there have been some aggravating factors which have come to play such as the impact of Covid, high unprecedented demand on services and increased vulnerability of Fragile Services. Whilst there has been notable progress, the actions which have been identified have not been sufficient to warrant the review of the risk. Thus, the risk rating remains unchanged

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

Strategic Objective 5: Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	**Assurance Committee:** Workforce Committee **Executive Lead:** Director of HR and OD

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

Inherent Risk			**Risk as at 13/01/2022**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	4	**12**	3	4	**12**	2	4	**8**

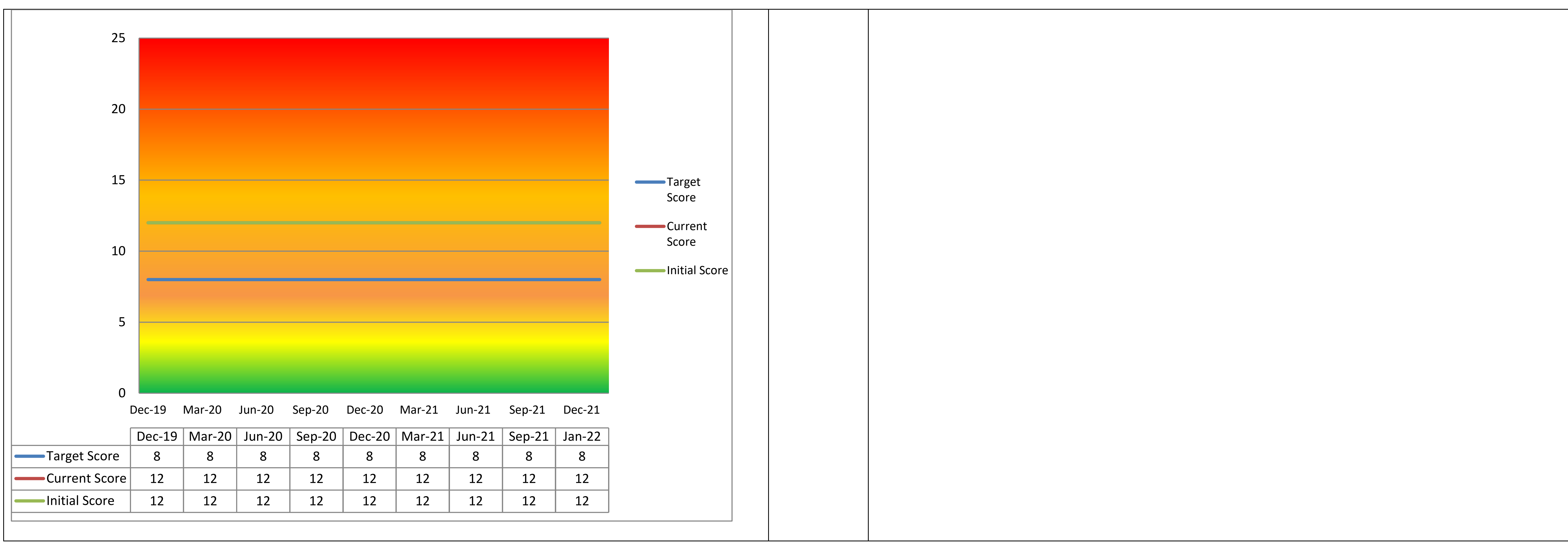
Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If the Trust does not have leadership at all levels patient and staff satisfaction will be impacted **CAUSES** Inappropriate behaviours; leaders not always supported or developed; no clear definition of what talent management looks like at the Trust; board approved leadership and staff engagement strategies not owned across the organisation; equality and diversity not fully recognised and responded to; ineffective team working; less than optimal management practice in some areas; lack of clarity for staff on direction of travel for the organisation. **CONSEQUENCE** Negative impact on quality of patient care, experience and service provision; poor retention of staff; inability to recruit the right people; staff are not developed to be patient-centred leaders; high levels of sickness; low staff morale; potential of poor outcomes of regulatory assessments; intervention by regulator(s)/ commissioner(s); reputational damage; loss of public confidence.	1. Our People Plan (Workforce and OD Strategy) aligned to NHS People Plan 2. Trust Values & Behaviours Framework 3. Trust values and behaviours embedded in the employee life cycle 4. Our Equality, Diversity and Inclusion Plan in place to deliver Trust's mission and objectives 5. Equality, diversity and inclusion networks in place 6. Just and learning principles embedded at the Trust, particularly in processes for raising/investigating concerns and lessons learned 7. Freedom to speak up guardian 8. Joint negotiating committee (JNC) 9. Staff Stories presented to Workforce Committee 10. Team development support available to promote positive relationships 11. Access to NHS Leadership Academy Programmes & 360 feedback, and internal leadership and management development programmes available 12. Mandatory and role specific training programme in place 13. Quality PDR discussions to promote positive behaviours 14. Talent management framework 15. Apprenticeship programmes leadership & management offer Levels 3-7 16. Board role modelling and visibility through: a. Back to the floor sessions; b. 15 steps walkabouts in wards/departments 17. Board Development sessions planned throughout the year 18. Work stream established as part of Valuing Our People Inclusion Group focussed on embedding the Trust's Values and Behaviours. 19. Staff communication and engagement plan 20. Embedding Values and Behaviours in Induction and PDR processes.	1. Awareness of Trust Values and Behaviour framework 2. Limited alignment of values to key stages in employee life cycle 3. Up to date EDI mission and objectives required 4. Low participation in staff networks 5. Limited awareness of Just and Learning Culture and alignment to processes for looking into incidents/lessons learned 6. Team development interventions are currently expensive and resource intensive 7. No talent management/succession planning frameworks in place 8. Low visibility of leadership team reported in recent Staff Survey 9. Pause of Board Development sessions due to COVID-19. 10. Schwartz round facilitators	**LEVEL 1** (Operational Management) 1. Workforce Committee 2. Workforce Improvement Group (OPIG) oversees work against the two agreed priorities: • Appraisals • Values & Behaviours Framework 3. Quality and Safety Committee 4. Clinical Effectiveness Committee 5. Finance, Performance, and Investment Committee. 6. Risk and Compliance Group. 7. Clinical Effectiveness committee. 8. Remunerations and Nominations Committee. 9. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 10. CBU Governance Meetings. ~~11. Valuing our people report~~ **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): ○ Mandatory training. ○ PDR completion. ○ Sickness rates. 2. Turnover. 3. Vacancies. 4. Performance Reports (monthly) 5. NHS staff Survey 6. Quarterly Staff Friends and family Test/Survey 7. GMC Medical Staff survey – annual **LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement 2. CQC	1. Staff Survey Engagement score has improved in year and but remains below national average in some areas. 2. Low compliance rates for PDR completion and need to ensure it meets the Trust's and individual's needs. 3. Need to understand and address poor engagement with equality, diversity, and inclusion networks. 4. High number of employee relations cases and concerns raised through Freedom to Speak Up linked to negative interactions and relationship issues	1. EDI Board development programme agreed to promote and embed inclusive leadership practices at a senior level. Starting with an externally facilitated session with Board **on 7th July 2021**, to help shape Trust's EDI Mission and Objectives. **Update - Currently under review.** Awaiting launch of national talent management/succession planning framework to apply at the Trust. **April 22 Update:** Work to commence April 2022 as part of WIG Transformational Leadership workstream (Operations Career Development Framework) and with conversations with ETM led by newly appointed Learning and OD Manager. The Trust is adopting the Leadership Academy system leadership competency framework and will undertake a self-assessment with leaders through a programme of work overseeing by the workforce Improvement group. **Targeted completion date: End of Q4 (2021/22)** **April 22 Update:** This has been superseded by funding received nationally to support development of system leaders across the Sefton Place. To commence May 2022 2. Back to Floor sessions reinstated for Board members; 11 Wellbeing Guardians assigned to hotspot ward areas; Ward Buddy initiative to be launched in July 2021 assigning Wards to Directors and Deputies; increased presence of Executive Team at Ormskirk (permanent office base identified). **April 22 Update:** Due to visiting restrictions in Wards only recently being relaxed and the current escalated pressures, the Back to Floor sessions remain paused and awaiting revised UKHSA IPC guidance for healthcare settings 3. Work programmes identified by the Valuing Our People Inclusion group from feedback from staff survey to improve staff engagement score. Quarterly Staff Survey to be launched on 1st July and support regularly monitoring of impact of the VOPIG

	21. Refreshed and introduced groups within the structure to support delivery of Our People Plan • Valuing Our People Inclusion Group • Just and Learning Culture Group 22. At our Best leadership programme 23. Medical Leadership programme 24. PDR Improvement Plan monitored though PIDA and the valuing our people inclusion.		3. CCG 4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		programme of work. **April 22 Update**: 2021 staff survey results to be published 30th March 2022 and the *Our People Plan* action plan will be revised and presented to the May Workforce Committee and SOC. 4. Revised proposals for strengthening engagement presented to the Executive Committee for review in March 2022. 5. Increased engagement with the regional mediation service to assist in the informal resolution of relationship issues. Progress to be reviewed at VOPIG in **December 2021.** **April 22 Update: Ongoing**
The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

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

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

RISK TRACKING	Linked Risks: 0	Comments
Risk Rating: Initial 3 x4 = 12 Current 3 x 4 = 12 Target 2 x 4 =8 **(Likelihood x Consequence)**		**Update – April 2022** • The BAF risks remains high • Progress on actions has been limited due to the COVID escalation status and operational pressures leading to the suspension of BAU activities



	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21	Jun-21	Sep-21	Jan-22
Target Score	8	8	8	8	8	8	8	8	8
Current Score	12	12	12	12	12	12	12	12	12
Initial Score	12	12	12	12	12	12	12	12	12

Risk Description: There is a risk due to the system not having an agreed acute services strategy leading to non-alignment of partner organisations plans resulting in the inability to develop and deliver sustainable services

Strategic Objective 6: Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

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

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

Inherent Risk			Risk as at 28/03/2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	5	20	3	5	15	2	5	10

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust, as a small DGH, fails to exploit all potential opportunities to engage and collaborate with strategic partners; delivery of an acute services strategy will fail to provide sustainable services to our population. **CAUSE** • Insufficient and inconsistent primary, community and intermediate care provision across Southport, Formby and West Lancashire • Lack of system-wide workforce planning to address reduction in supply of suitably skilled and experienced staff. • Emerging Cheshire & Mersey Health & Care Partnership (CMHCP) wide acute provider partnership approach • Complex health economy • Lack of clarity about additional investment to address sustainability challenges • Lack of public and staff engagement to ensure effective co-production of potential solutions to clinical and financial sustainability challenges. **CONSEQUENCE** • Clinical unsustainability due to current and projected workforce gaps. • Failure to deliver safe, high quality patient care and experience in the most appropriate environment • Financial unsustainability due	1. Whole system engagement to address the required whole system change 2. SCT Programme Plan including key milestones to enable public consultation 3. Robust system governance structure in place to support the Shaping Care Together (SCT) programme • Programme Board • Operational delivery groups • Clinical Leaders Group 4. Strategic partnership (ALTC) established with StHK 5. Comprehensive trust service assessment completed to establish levels of fragility and core drivers 6. Member of Sefton Integrated Care Partnership (ICP) 7. Member of the Cheshire & Merseyside Acute Provider Collaborative. 8. Patient and Public Engagement strategy for SCT programme 9. Comprehensive due diligence completed, and documentation library created. 10. Quality and equality impact assessments completed and reviewed in advance of any changes to Trust service provision. 11. System Equality Impact Assessment process established. 12. Cheshire and Merseyside Integrated Care System	1. Clear alignment between Shaping Care Together programme, System Management Board & Sefton ICP 2. Sefton Brough is still developing plans for ICP from June 2022 3. Lack of established Patient & Public Reference Group 4. Expected outcomes and opportunities of partnership with StHK are still being explored 5. StHK are not the only key stakeholder for clinical services 6. Shaping Care Together programme is yet to define preferred option 7. Clinical workforce strategy not fully developed. 8. Risks relating to current estates and infrastructure continues to be defined 9. CCGs are still defining their commissioning and transformation priorities for 22/23 10. Cheshire and Merseyside Acute provider collaborative have not yet identified key clinical pathways for system collaboration.	**LEVEL 1** (Operational Management) 1. Performance, Improvement, Delivery and Assurance (PIDA) Boards, with suite of measures. 2. Ongoing review and management of 'fragile services'. 3. Collaboration Senior Team Meetings (StHK & S&O Trust) reviewing immediate priorities and opportunities 4. Shaping Care Together (SCT) programme plan – monitored for delivery at Programme Board and Trust Board. 5. Patient and public engagement strategy monitored at Programme Board. 6. Equality Impact Assessment outcomes monitored at SCT programme board. 7. Haematology Assurance Group – partnership meeting to monitor improvement delivery 8. Ophthalmology Improvement Group – partnership meeting to develop and monitor system improvement plan 9. North Mersey Stroke Board – partnership board to develop and implement case for change, engagement & operational plans **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. CEO's reports to Board 2. Integrated Performance Report (IPR) to Board and Q&S Committee (monthly) to monitor any impacts on patients as a result of the risk including: ○ Mortality ○ Incident data ○ CQUINS ○ Operational performance data ○ Complaints and compliments 3. Monthly reports to SCT Programme Board, SF&WL Joint Committee and NHSEI/CMHCP Oversight Group 4. Sustainability and collaboration update to Strategy and Operations Committee 5. Quarterly Joint Performance Meeting (NHSE, StHK and S&O)	Development of good working relationships with the new Primary Care Networks Understanding of the performance monitoring systems that will be established under the new NHS Bill that comes into effect on 1 July 2022	1. SCT Programme to develop Models of Care and define preferred option. **March 22 Update:** Models of Care developed, and initial options assesses against hurdle criteria. Programme plan has been extended to allow StHK collaboration to be considered and included in work programme. Estimated date for commencement of Stage II assurance as July 2022. 2. Establish Finance and Capital Assurance Group with alignment to the System Management Board **March 22 Update** FCA group established with work near completion on the drivers of deficit. Key risk to progress around the imminent retirement of 3 senior financial leads across the CCG and Trust – DoFs have met and agreed mitigation approach to be concluded by July 2022 3. Continue to develop collaboration opportunities with StHK a. Paediatric Dietetic model developed by April 2022 b. Establish Therapies Assurance group by February 2022 – March update - meetings in place c. Endoscopy – develop 5 point plan by January 2022 March update – plan in place and monitored via Endoscopy Improvement Group 4. Continue North Mersey Stroke Programme with implementation date of September 2022 5. Continue to support Sefton ICP task and finish group with Bill due to come into effect on 1st July 2022 6. Develop a North Mersey Ophthalmology Steering group supported by local CCGs – March 2022. March Update – first meeting due to take place on 20/04/22

to increased costs • Poor estate utilisation due to inability to fully reconfigure services • Failure to provide acute core services to our population • Potential impact on neighbouring organisations if core acute services can no longer be delivered by the Trust • Reliance on other acute providers to support the delivery of clinical services • Reputational damage	governance structure		**LEVEL 3** (Independent/Semi-Independent) 1. Southport, Formby & West Lancashire Joint Committee 2. Participation in the C&M ICS leadership and programme boards 3. Active member of Sefton Integrated Care Partnership (ICP) 4. Active Member of the Cheshire & Merseyside Acute Provider Collaborative & supporting transformation/improvement work stream. 5. Collaborative working with CCGs to develop commissioning and transformation priorities for 22/23 6. Northern Clinical Senate and Yorkshire and Humber Clinical Senate Report recommendations 7. NHS England / NHS Improvement 8. CQC 9. Internal Audit 10. External Audit.		

The Hospital Management Board can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge

AMBITION: To provide sustainable services for the patients we serve

Category	AVERSE	CAUTIOUS	MODERATE	OPEN	HUNGRY
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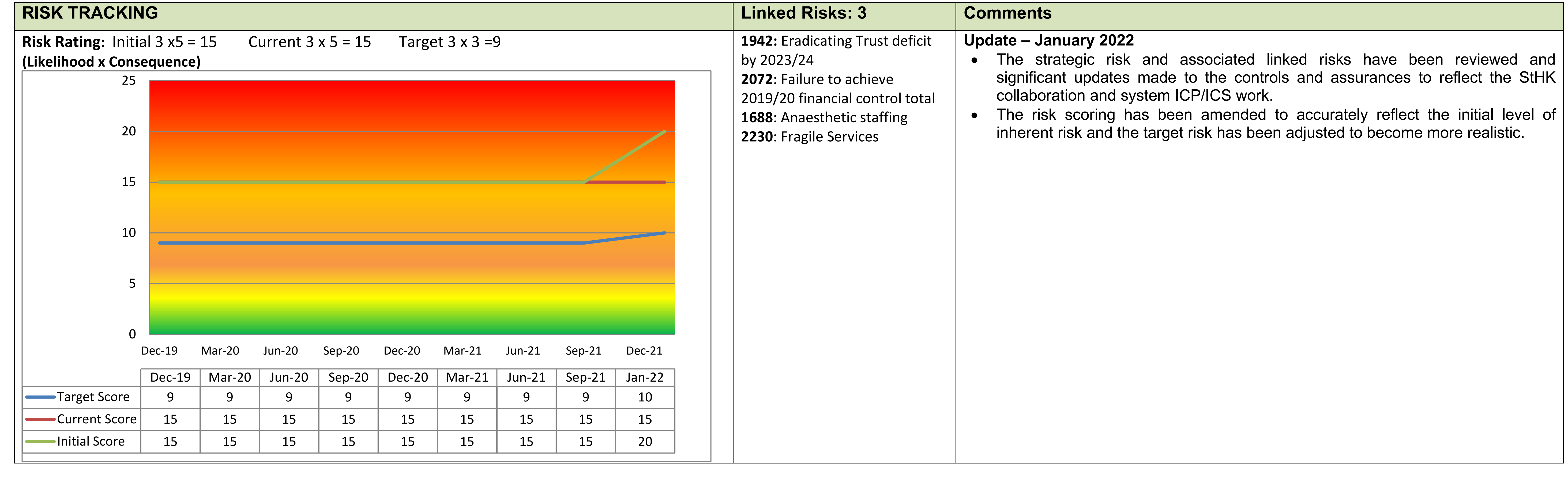


RISK TRACKING	Linked Risks: 3	Comments
Risk Rating: Initial 3 x5 = 15 Current 3 x 5 = 15 Target 3 x 3 =9 **(Likelihood x Consequence)**	**1942:** Eradicating Trust deficit by 2023/24 **2072**: Failure to achieve 2019/20 financial control total **1688**: Anaesthetic staffing **2230**: Fragile Services	**Update – January 2022** • The strategic risk and associated linked risks have been reviewed and significant updates made to the controls and assurances to reflect the StHK collaboration and system ICP/ICS work. • The risk scoring has been amended to accurately reflect the initial level of inherent risk and the target risk has been adjusted to become more realistic.

	Dec-19	Mar-20	Jun-20	Sep-20	Dec-20	Mar-21	Jun-21	Sep-21	Jan-22
Target Score	9	9	9	9	9	9	9	9	10
Current Score	15	15	15	15	15	15	15	15	15
Initial Score	15	15	15	15	15	15	15	15	20

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

Strategic Objective 7: Major and sustained failure of essential IT systems

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

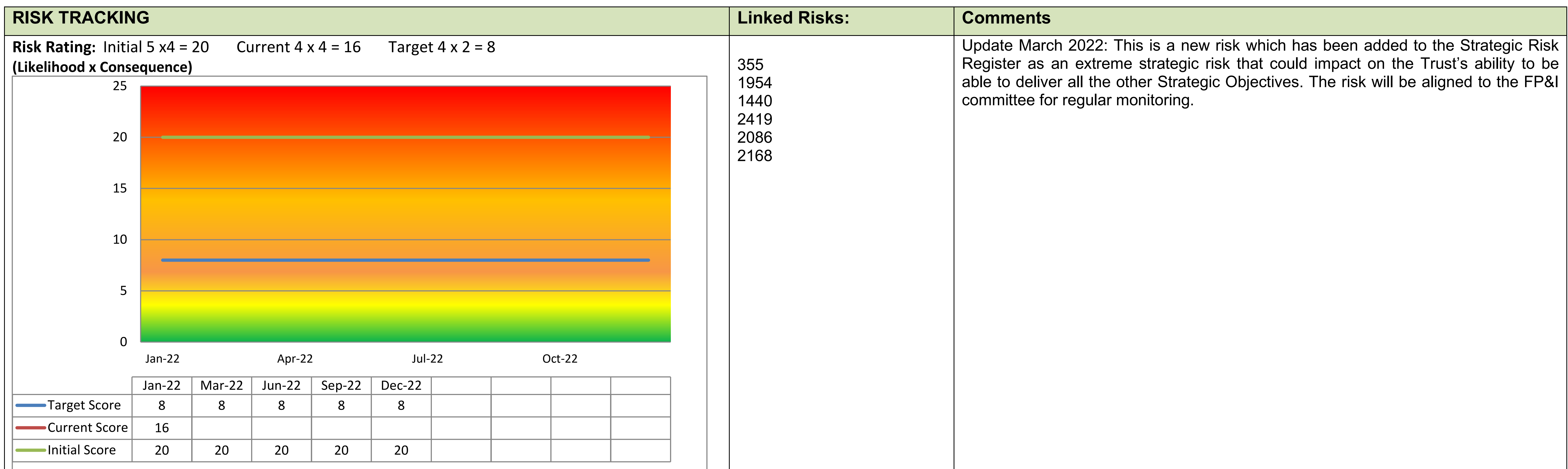
RISK ID	2411	Risk Description	There is a risk of major and sustained failure of essential IT systems

Inherent Risk			Risk as at 28/03/2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	4	4	16	4	2	8

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK There is a risk of a major and sustained failure of essential IT infrastructure **CAUSE** • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Inadequate investment in systems and infrastructure **CONSEQUENCE** • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	1. IM& T Committee Oversight & IT Management Governance 2. Procurement Frameworks 3. Trust Digital Strategy 4. Performance framework and KPI's 5. Cyber Security Response Plan 6. Benchmarking 7. Workforce Development 8. Risk Register 9. Major Incident Reviews 10. Disaster Recovery Policy 11. Disaster Recovery Plan and restore procedures 12. Backup System in place and operational 13. Engagement with C&M Cyber Security Group 14. Cyber Associates Network Membership 15. Business Continuity Plans 16. Care Cert Response Process 17. Project Management framework 18. Change Advisory Board 19. Digital Design Authority 20. Information asset owner / administrator register	1. Minimal Cyber Security Personnel 2. Technical Development of Trust Staff	**LEVEL 1** (Operational Management) 1. IM&T Committee 2. Digital design Authority 3. IT On Call 4. Risk and Compliance Group 5. Information Governance Steering Group 6. Executive Management Committee 7. Information Asset Owner Framework 8. Benefits Realisation Framework monitoring 9. Cyber Security Action Plan **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Board and Committee Reports 2. Quarterly Digital Strategy Reviews **LEVEL 3** (Independent/Semi-Independent) 1. Internal Audit reports 2. Annual Penetration Test and Report 3. Data Security Protection Toolkit Submission 4. Microsoft Unified Support Contract 5. Microsoft Server 2008 Extended Support 6. 24/7 Support Contracts in place for core systems such as EPR, Kainos, VMWare, Dell, etc.	1. Migration from end-of-life operating system ongoing and due to complete in March 2022 2. Cyber Essential Certification / Accreditation	1. Monthly Patching Strategy in place (Monthly ongoing) 2. Anti-Virus in place and actively monitoring (Ongoing) 3. All servers and PC's linked to Microsoft ATP\Defender (In Place\ Ongoing) 4. Regular Cyber Security Comms (Ongoing) 5. Regular NHS Digital Simulated Phishing Attacks (Quarterly) 6. Implementation of Intrusion Prevention System (IPS) that detects cyber-attacks within the network. (Q2 22/23) 7. Patch My PC deployment for 3rd party app patching (Q4 21/22) 8. Network Remediation Rollout underway (Ongoing with completion in Q3 22/23) 9. Cisco Identity Services Engine Implementation (Q2 22/23) 10. Geo-blocking in place for Russia and China internet traffic. Monitoring firewalls for further (Done) 11. Microsoft Unified Support Contract (In Place) 12. Backup System now functional with backup schedule in place (Ongoing) 13. Annual Penetration Test (Q1 22/23) 14. Care Cert Response Process (In Place\ Ongoing) 15. Role Based Access Control in place across domain and all clinical systems (Ongoing) 16. Failover technology in place across Trust VMWare estate 17. Server Network Segregation (In Place) 18. PC Network Segregation (to be complete Q3 22/23) 19. Imprivata Single Sign On Rollout (Q4 21/22)

AMBITION: To provide sustainable

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



RISK TRACKING	Linked Risks:	Comments
Risk Rating: Initial 5 x4 = 20 Current 4 x 4 = 16 Target 4 x 2 = 8 **(Likelihood x Consequence)**	355 1954 1440 2419 2086 2168	Update March 2022: This is a new risk which has been added to the Strategic Risk Register as an extreme strategic risk that could impact on the Trust's ability to be able to deliver all the other Strategic Objectives. The risk will be aligned to the FP&I committee for regular monitoring.

	Jan-22	Mar-22	Jun-22	Sep-22	Dec-22				
Target Score	8	8	8	8	8				
Current Score	16								
Initial Score	20	20	20	20	20				

<table>
<tr><td>Title of Meeting</td><td>STRATEGY AND OPERATIONS COMMITTEE</td><td>Date</td><td>06 April 2022</td></tr>
<tr><td>Agenda Item</td><td>SO0051/22</td><td>FOI Exempt</td><td>NO</td></tr>
<tr><td>Report Title</td><td colspan="3">ASSURANCE COMMITTEES DRAFT TERMS OF REFERENCE</td></tr>
<tr><td>Executive Lead</td><td colspan="3">Nicola Bunce, Director of Corporate Services</td></tr>
<tr><td>Lead Officer</td><td colspan="3">Nicola Bunce, Director of Corporate Services</td></tr>
<tr><td>Action Required</td><td>✓ To Approve
☐ To Assure</td><td colspan="2">☐ To Note
✓ To Receive</td></tr>
<tr><td colspan="4">Purpose</td></tr>
<tr><td colspan="4">To present the draft Terms of Reference (ToR) for the Assurance Committees for approval.</td></tr>
<tr><td colspan="4">Executive Summary</td></tr>
<tr><td colspan="4">The ToRs been reviewed by the committee chairs and lead Director(s) and the changes have been agreed at the March Committee meetings. The proposed changes reflect the terms of the Agreement for Long Term Collaboration with St Helens and Knowsley Hospitals NHS Trust and have removed duplication between committees. The governance diagram has also been updated.</td></tr>
<tr><td colspan="4">Recommendations</td></tr>
<tr><td colspan="4">The Strategy and Operations Committee is asked to approve the Terms of Reference for the Assurance Committees.</td></tr>
<tr><td colspan="4">Previously Considered By:</td></tr>
<tr><td colspan="2">✓ Finance, Performance & Investment Committee
☐ Remuneration & Nominations Committee
☐ Charitable Funds Committee</td><td colspan="2">✓ Quality & Safety Committee
✓ Workforce Committee
☐ Audit Committee</td></tr>
<tr><td colspan="4">Strategic Objectives</td></tr>
<tr><td colspan="4">✓ SO1 Improve clinical outcomes and patient safety to ensure we deliver high quality services</td></tr>
<tr><td colspan="4">✓ SO2 Deliver services that meet NHS constitutional and regulatory standards</td></tr>
<tr><td colspan="4">✓ SO3 Efficiently and productively provide care within agreed financial limits</td></tr>
<tr><td colspan="4">✓ SO4 Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated</td></tr>
<tr><td colspan="4">✓ SO5 Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values</td></tr>
<tr><td colspan="4">✓ SO6 Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire</td></tr>
<tr><td colspan="2">Prepared By:</td><td colspan="2">Presented By:</td></tr>
<tr><td colspan="2">Nicola Bunce, Director of Corporate Services</td><td colspan="2">Nicola Bunce, Director of Corporate Services</td></tr>
</table>

Finance, Performance and Investment Committee

Terms of Reference Document Control Sheet

MEETING	Finance, Performance and Investment Committee
ESTABLISHED BY /REPORTING TO:	Strategy and Operations Committee
Reviewer:	Nicola Bunce, Director of Corporate Services
REVIEW:	February 2022
ASSOCIATED DOCUMENTS:	Scheme of Reservation and Delegation Standing Financial Instructions Standing Orders IM&T Strategy Board Assurance Framework
RELATED FORUMS /COMMITTEES/ GROUPS	Trust Board Strategy and Operations Committee Executive Committee **Sub Committees** • Business Development and Investment Group • IM&T Group • Use of Resources Group • Capital Investment Group • Estates and Facilities Governance Group

Document Control	
Document Name	Finance Performance & Investment Committee ToR – March22
File Name	\\datamart1\Shared Files\Company Secretarial\16. TERMS OF REFERENCE (COMMITTEES)\3. 2022 Statutory and Assurance Committees\ Finance Performance and Investment Committee ToR – March 22
Version/Revision Number	**V6.1**

Finance, Performance and Investment Committee
Terms of Reference

1. Authority

1.1 The Board hereby resolves to establish a Committee of the Trust to be known as the Finance, Performance and Investment Committee, hereafter referred to within this to within this document as the Committee.

1.2 In line with the terms of the Agreement for Long Term Collaboration with St Helen's and Knowsley (StHK) NHS Trust, the Board has delegated all executive and assurance functions to the Strategy and Operations Committee except those which are reserved for the Board as set out in the Scheme of Reservation and Delegation (SoRD). The accountability and responsibility structure is set out in **Diagram 1.**

1.3 The Committee has no executive powers, other than those limited to these Terms of Reference.

1.4 The Committee has the delegated authority to monitor and scrutinise:

a) Financial performance – includes monthly performance and CIP
b) Patient flow- includes activity levels, AED and waiting time performance
c) Capital Programme, including IT
d) Annual review of the Performance Framework
e) Investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any requests made by the Committee.

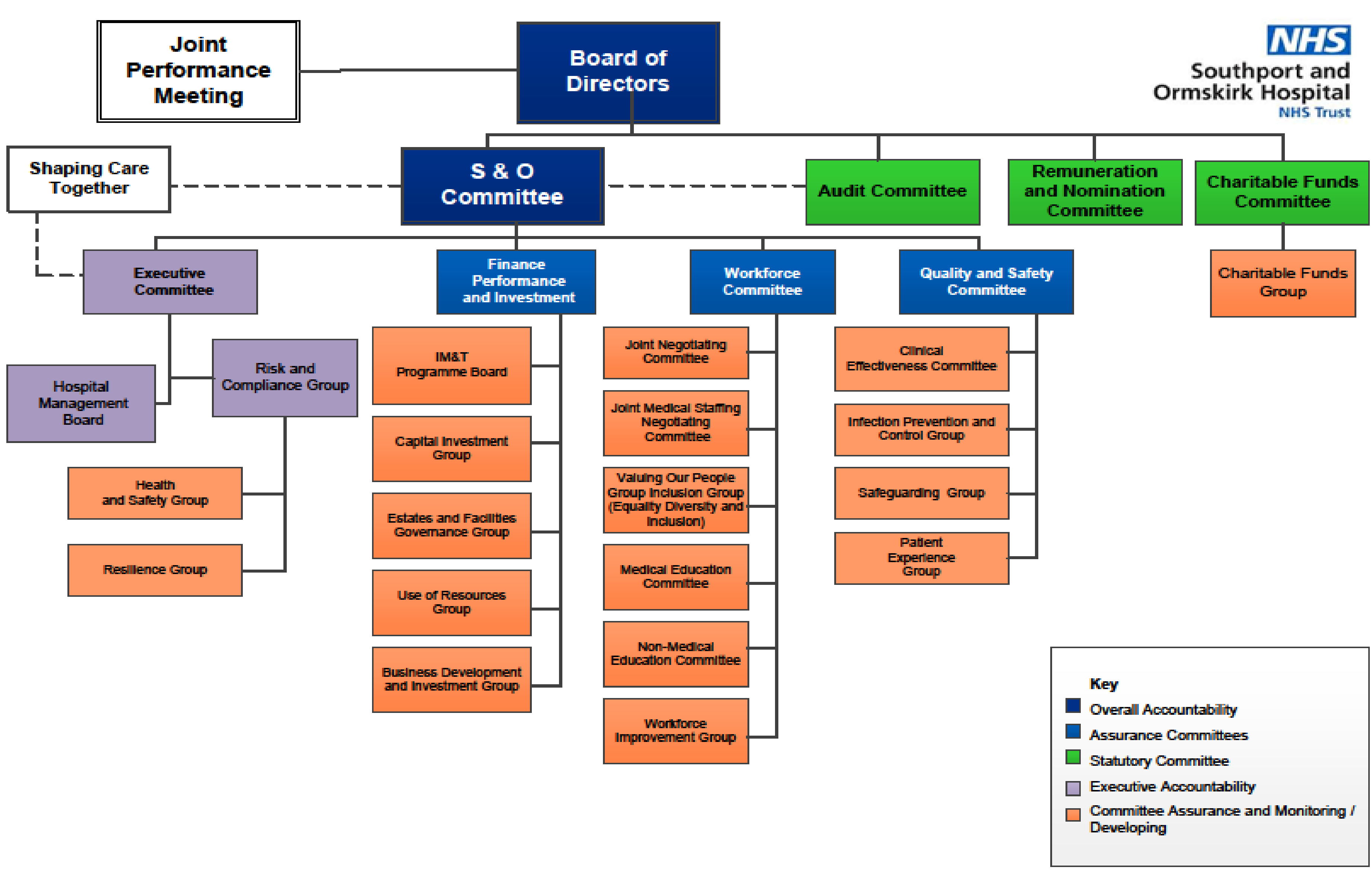
1.5 Any changes to these Terms of Reference must be approved by the Strategy and Operations Committee.

2. Purpose

2.1 The Committee is established to provide the Strategy and Operations Committee with assurance regarding the Trust's financial and operational performance against national key financial and operational performance indicators and local improvement objectives and to review and scrutinise business cases for new investment (capital and revenue) where these are above the delegated authority of the Executive, and make recommendations to the Strategy and Operations Committee.

2.2 The Committee will provide assurance on the delivery of the IM&T and Estates & Facilities Management Strategies.

Diagram 1. The relationship between the Finance, Performance & Investment Committee, the Board and other Trust committees 2022-23



3. Principal Duties

The duties of the Committee are as follows:

3.1 Financial planning and monitoring

a) Review the Trust's financial plans (both revenue and capital) and scrutinise key underpinning assumptions. Make recommendations to the Strategy and Operations Committee in respect of the annual financial plans (both revenue and capital)

b) Monitor monthly and year to date financial information including:
   - Performance against revenue budget at both Trust and Business Unit level.
   - Run rate performance to date and forecast.
   - Performance against the Cost Improvement Programme (CIP).
   - Cash, liquidity and working capital.
   - Performance against capital budget.
   - Any significant variations against plan and the remedial actions proposed.
   - Compliance with contractual issues impacting on the Trust finances e.g. CQUIN performance targets and contract penalty issues.

c) Monitor the effectiveness of corrective actions proposed by the Executive.

d) Review the Trust's Service Line Reporting (SLR) performance and consider implications for future service viability.

3.2 Cost Improvement Programme

a) Monitor the delivery of the agreed annual CIP Programme to deliver the agreed financial plan. This will include assurance that all proposed schemes have been assessed for the impact on quality.

b) Where CIP schemes are at risk of delivery the Committee will seek assurance from Executive Director lead that a plan is in place and being implemented to bring the schemes back on track.

c) Each CBU will be invited on a quarterly basis to report on progress in delivery of the CIP schemes for the Unit

3.3 Contract monitoring

a) To receive assurance that annual contract negotiations with the ICB or local Place leads are being undertaken to deliver the Trust's agreed contracting strategy.

b) Monitor compliance with the contract terms and any contract penalties for non-compliance

3.4 Investment

a) Consider the recommendations of the Executive Management Team (EMT) when considering business cases for both capital and revenue investments which are out with approved budgets.

b) Scrutinise all business cases for proposed investment that require Strategy and Operations Committee or Trust Board approval, ensuring that outcomes and benefits are clearly defined, are measurable and support delivery of the Trust's key objectives.

c) Receive post implementation reviews to ensure benefits realisation from approved business cases.

3.5 Performance

a) Monitor delivery of activity plans and NHS constitutional access standards, paying particular attention to areas of deterioration and the potential financial impact of actions taken to address issues.

b) Review the productivity and value for money of services using national benchmarking information such as GIRFT, Model Hospital, ERIC.

3.6 IM&T

a) Receive annual reports on the progress in delivering the Trusts approved IM&T strategy

b) Review the IM&T strategy and make recommendations to the Strategy and Operations committee

c) Receive twice annually, reports relating to the Trust's Compliance with the Freedom of Information Act 2000, GDPR and Data Protection Act 2018.

d) To receive and review the Trust's annual submission of the Information Governance Toolkit

3.7 Procurement

Monitor procurement arrangements to ensure compliance with regulations and maximise value for money.

Monitor benchmarking information to compare the efficiency of the Trust's procurement of goods and services.

3.8 Risk

Consider any relevant strategic or operational risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the Committee, and report any areas of significant concern or newly identified risks to the Strategy and Operations Committee.

4. Business Conduct

4.1 Chair

The Chair of the Committee will be a Non-Executive Director.

In the absence of the Chair, one of the other Non-Executive Directors, agreed in advance of the meeting, will chair that particular meeting.

4.2 Membership

The members of the Committee shall be appointed by the Board in accordance with the *Standing Orders* and shall consist of the following members:

- Three (3) independent Non-Executive Directors
- Managing Director
- Director of Finance
- Chief Operating Officer
- Medical Director
- Director of Transformation
- Director of HR and OD
- Director of Nursing, Midwifery and Therapies

4.3 A member of the Corporate Governance Team will attend meetings of the Committee.

4.4 The following persons shall be expected to normally be in attendance at meeting:

- Deputy Director of Finance

4.5 The Associate Directors of Operations from all CBUs will be invited to attend on a quarterly basis to discuss matters relating to CIP and Performance.

4.6 Only members of the Committee have the right to attend Committee meetings. Other officers of the Trust may be invited to attend all or part of any meeting as and when appropriate and necessary.

4.7 All members are required to attend at least 70% of meetings held. Each member is required to nominate a deputy to attend in their absence.

4.8 An officer formally acting up for a member will count towards a quorum.

5. Quorum

5.1 In order for the decisions of the Committee to be valid the meeting must be quorate. A quorum will be no less than three Members including two Non-Executive Directors and one Executive Director who will normally be either the Director of Finance or the Chief Operating Officer.

5.2 In the event there are insufficient regular NED members, a rotating NED will count toward the Quorum.

6. Frequency of meetings

6.1 The Committee will meet no less than ten times a year, usually once a calendar month with the exception of August and December.

6.2 The Chair of the Committee may arrange extraordinary meetings at his/her discretion or at the request of Committee members.

7. Organisation and Reporting Structure

7.1 The Chair of the Committee shall produce an Alert, Advise, Assurance (AAA) highlight report to draw the attention Strategy and Operations Committee to any issues that require escalation

7.2 The Committee will produce an annual work plan for the Strategy and Operations Committee to approve at the beginning of each financial year, mapping out how the Committee will fulfil its delegated duties.

7.3 The following sub-groups of the Committee will report via the formal submission of a AAAs report:

- IM&T Programme Board
- Capital Investment Group
- Estates and Facilities Governance Group
- Business Development and Investment Group
- Use of Resources Group

8. Conduct of Meetings

8.1 The PA to the Director of Finance shall provide administrative support to the meeting and duties with include:

- Formally recording the minutes of the Committee
- Collation and distribution of papers
- Keeping a record of matters arising and issues to be carried forward

8.2 The agenda for the meeting shall be drawn up by the PA to the Director of Finance and the Chair of the Committee in consultation with the Director of Finance and the Chief Operating Officer. The agenda and papers for the meeting shall be distributed no less than four days in advance of the meeting

8.3 Minutes of the meeting and the record of matters arising will be circulated promptly to all members as soon as reasonably practicable.

8.4 Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of their paper and the key issues. Committee members may question the presenter.

8.5 Meetings are not open to members of the public

9. Review of Terms of Reference

The Terms of Reference shall be reviewed annually or in light of changes in practice or legislation.

10. Review of Performance and Effectiveness

The Committee shall undertake a review of its performance and effectiveness at least once annually.

Approved by FP&I Committee	**March 2022**
Ratified by Strategy and Operations Committee**:**	**April 2022**
Date for next review:	**February 2023**

Version Control Document			
Version Ref	Amendment	Committee Review &	Ratified by

		approval	Board
V2.0	1.1 Added authority and responsibility diagram 1.2 Added more information on the purpose of the committee 1.3 Deleted *"by exception"* and added "*twice annually*" 1.4 Added that *the CEO is ex officio a member of the committee* and not a standing member Added: *An officer acting up for a member will count towards a quorum and will be allowed to vote* as though he or she is a member 1.5 Added that the Committee should review its performance and effectiveness twice annually-mid and year end 1.6 Added that the Committee will oversee the implementation of the IM&T and Estates Strategies 1.7 Added meeting attendance information 1.8 Added information regarding the agenda and distribution of papers	**2017**	**2017**
V3.0	2.1 Related Committees/Forums, added Remuneration and Nominations Committee, Charitable Funds Committee and Workforce Committee	**2018**	**2018**
V3.1	Added new governance structure showing reporting arrangements	**2019**	**2019**
V3.2	1.Changed name to read Finance & Investment 1.2 (b) Removed Patient flow- includes activity levels, AED and waiting time performance AND (d) Annual review of the Performance Framework 3.5 Removed Performance Section 3.6 Removed Information Governance Section 3.7 Removed Data Quality Section 4.3 Edited membership of Executives attending to read: Director of Finance and Deputy CEO/Director of Strategy and remove Chief Operating Officer 4.4 Edited Quorum to reflect change of membership	**April 2019**	**April 2019**
V3.3	• Added 'Risk' to Audit Committee name in narrative and governance structure • Added time limited Strategy Committee to Governance Structure 4.3 Updated membership to exclude NED with recent financial experience and removed Chair of Audit being a member 4.4 Added that rotating NED will count towards a Quorum if needed. 4.5 Removed Deputy CEO and reinstated COO 3.5 Reinstated Performance Section 3.6 Reinstated Information Governance Section 3.7 Reinstated Data Quality Section		**June 2019**
V.4	• Removed Risk from Audit & Risk Committee • Added Risk and Compliance Group • Added Hospital Management Board • Added Performance to Committee name throughout • 3.6 - replaced DPA 1998 with GDPR and DPA 2018 • 4.2 - added The members of the Committee shall be appointed by the Board in accordance with the *Standing Orders* • *7.2 added the subgroups to the list* • *8.2 added Committee Secretary*	**August 2020** *(approval deferred)*	**-**
V.4.1	• 3.1(a) amended to make recommendations to the Board on	**September**	**October**

	proposed revenue and capital budgets. • 3.3 (b) amended to 'On behalf of the Board the Committee should oversee the Trust's contract strategy, negotiation of contracts and monitoring of contractual performance • *4.1 removed “but not the Chair of the Audit Committee”* • *4.3 removed 'All Board members may attend any Committee meeting'* • *5.2 amended rotated NED to alternative NED will be asked to fulfil the quorum requirement* • S.7.4 Removed Transformation Committee, AIAG and PLICS Steering Group • Renamed Finance. Procurement and Information Governance Group as Finance, IM&T and Procurement Group.	**2020**	**2020**
V.5	• S2.3 – Added updated governance structure showing reporting arrangements • S3.9 – Removed ‘Risk’ from Audit Committee name	**June 2021**	
V.6	• Revised to reflect new arrangements under the ALTC and remove duplication with other committees.	**December 2021**	

Quality and Safety Committee

Terms of Reference

MEETING	Quality and Safety Committee
ESTABLISHED BY /REPORTING TO:	Strategy and Operations Committee
Reviewer:	Nicola Bunce, Director of Corporate Services
REVIEW:	March 2022
ASSOCIATED DOCUMENTS:	Standing Orders Scheme of Reservation and Delegation Quality Improvement Strategy Board Assurance Framework
RELATED COMMITTEES /GROUPS	Trust Board Strategy and Operations Committee Executive Committee **Sub Committees** • Safeguarding Group • Patient Experience Group • Infection Prevention and Control Group • Clinical Effectiveness Group

Document Control	
Document Name	Quality and Safety Committee – ToR March22
File Name	**\\datamart1\Shared Files\Company Secretarial\16. TERMS OF REFERENCE (COMMITTEES)\3. 2022 Statutory and Assurance Committees\Quality and Safety Committee ToR – March 22**
Version/Revision Number	**V6.1**

Quality and Safety Committee
Terms of Reference

1. Authority

1.1 The Board hereby resolves to establish a Committee of the Trust to be known as the Quality & Safety Committee, hereafter referred to within this document as the Committee.

1.2 In line with the terms of the Agreement for Long Term Collaboration with St Helen's and Knowsley (StHK) NHS Trust, the Board has delegated all executive and assurance functions to the Strategy and Operations Committee except those which are reserved for the Board as set out in the Scheme of Reservation and Delegation (SoRD). The accountability and responsibility structure is set out in **Diagram 1.**

1.3 The Committee has no executive powers, other than those limited to these Terms of Reference

1.4 The Committee has the delegated authority to:

a) Seek any information it requires and/or call any employee of the Trust to a meeting of the Committee in order to perform its duties as set out below.
b) Obtain, within the limits set out in the Trust's Scheme of Delegation, outside professional advice on any matter within its terms of reference.

1.5 Any changes to these Terms of Reference must be approved by the Strategy and Operations Committee.

2. Purpose

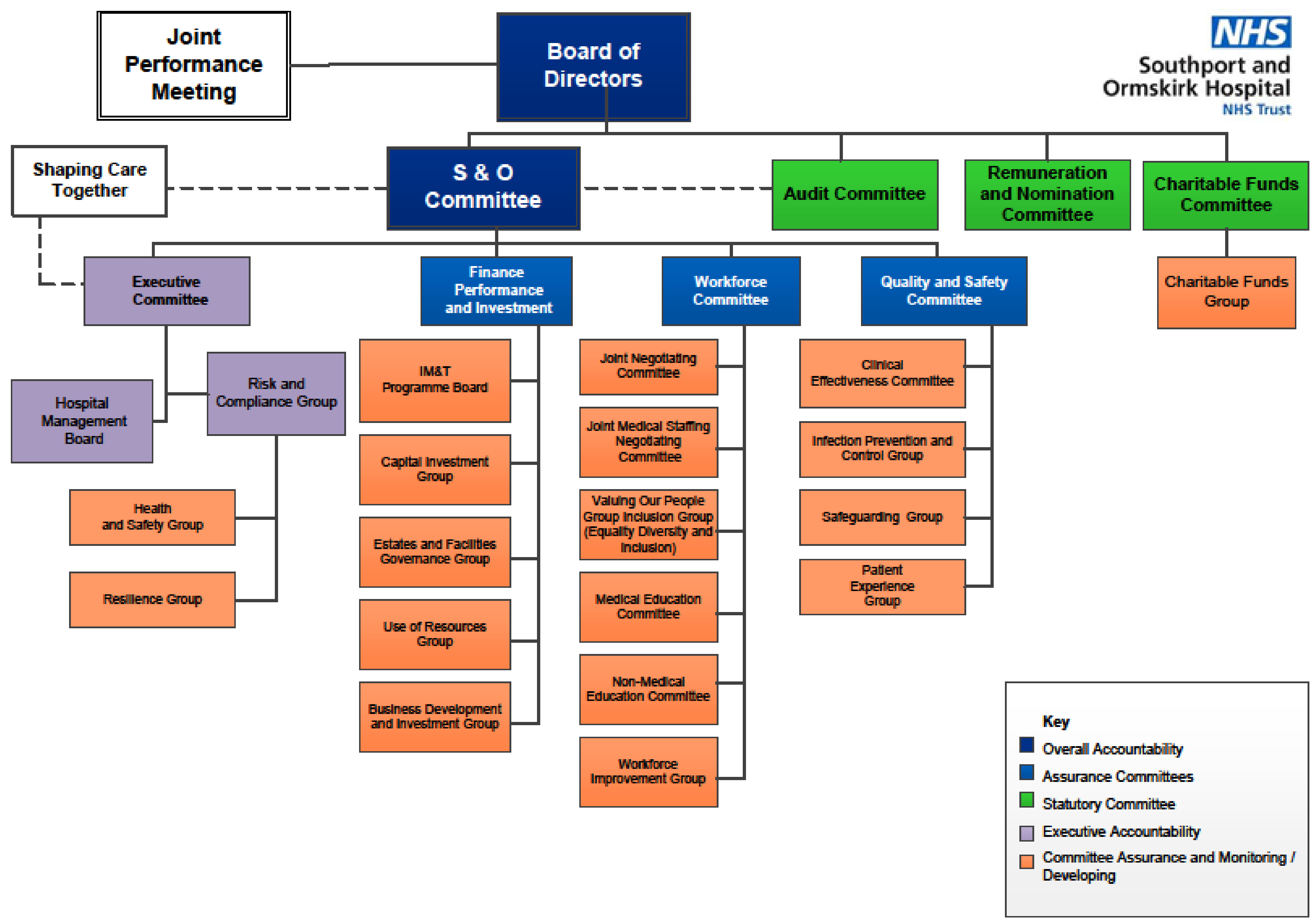
2.1 The Committee is established to provide the Strategy and Operations Committee with assurance regarding the effectiveness of all aspects of the clinical governance arrangements of the Trust, with a particular focus on safety, quality, patient experience, , safeguarding, performance in respect of quality and safety metrics, mortality and morbidity.

2.2 The Committee will triangulate patient safety, complaints management and incident management, quality and risk issues with operational, financial and workforce performance to identify areas of concern or deteriorating performance.

2.3 In particular, the Committee will review the adequacy and effectiveness of the underlying assurance processes that support achievement of the corporate objectives and the management of principal risks, including:

- Clinical Audit Programme
- Policies and Procedures
- Freedom to Speak up arrangements
- Maternity Safety and CNST assurance

Diagram 1. The relationship between the Quality & Safety Committee, the Board and other Trust committees (2022-23)



3. Principal Duties

3.1 The duties of the Committee can be categorised as follows:

a) Seeking assurance in respect of the effectiveness of the Trust’s Clinical Governance arrangements.

b) Monitoring the implementation of the Trust's Clinical Quality and Safety Improvement Strategy.

c) To review mortality and morbidity data and seek assurance on the effectiveness of the clinical care provided by the Trust.

d) Triangulate mortality and morbidity with patient safety, quality and risk issues with workforce performance and seek assurance that the Executive are addressing areas of concern or deteriorating performance as required.

e) Reviewing clinical outcomes and the impact of clinical service changes.

f) Receive reports that demonstrate the Trust learns lessons from past performance/incidents.

g) Make recommendations concerning the annual programme of internal audit work to the extent that it applies to matters within these terms of reference.

h) Monitor the effectiveness of the organisational arrangements for measuring and acting on feedback from patients and service users to improve quality of care.

i) Monitor that the Trust has robust arrangements in place to safeguard patients.

j) Receive and scrutinise draft annual reports e.g. Safeguarding, Infection Prevention Control and the Quality Account.

3.2 **Clinical Effectiveness**

a) Reviewing key quality performance indicators in order to monitor and evaluate clinical quality and performance within the Trust.

b) Receiving assurance that appropriate action is taken in response to adverse clinical incidents, complaints and litigation and ensuring learning is embedded across the Trust.

c) Reviewing trends in complaints, serious incidents, claims and litigation and receive assurance that examples of good practice are disseminated across the Trust.

d) Receiving assurance of compliance with the regulatory standards and guidelines e.g. CQC, NICE ensuring sufficient evidence of compliance is available to the Strategy and Operations Committee.

e) Ensuring that the Trust by gathering, analysing and using information effectively takes action to improve patient safety and creates a climate of continuous learning and improvement.

f) Promoting within the Trust a culture of open and honest reporting and monitoring compliance against the CQC's Duty of candour requirement.

4. Constitution

4.1 **Chair**

The chair of the committee will be a Non-Executive Director.

In the absence of the chair one of the other Non-Executive Directors, agreed in advance of the meeting, will chair that particular meeting.

4.2 **Membership**

The members of the Committee shall be appointed by the Strategy and Operations Committee in accordance with the *Standing Orders* and shall consist of the following members:

- Three (3) independent Non-Executive Directors, at least one of whom should have a clinical background
- Managing Director
- Director of Nursing, Midwifery & Therapies
- Medical Director
- Director of Finance
- Chief Operating Officer
- Director of HR and OD
- Director of Transformation

4.3 A member of the Corporate Governance team will attend meetings of the Committee.

4.4 Only members of the Committee have the right to attend Committee meetings. Other officers of the Trust may be invited to attend all or part of any meeting as and when appropriate and necessary.

4.5 All members are required to attend at least 70% of meetings held. Each member is required to nominate a deputy to attend in their absence.

4.6 An officer formally acting up for a member will count towards a quorum.

5. Quorum

5.1 A quorum will be no less than three Members including tat least one Non-Executive Director and one Executive Director who will usually be either the Director of Nursing & Midwifery or the Medical Director.

5.2 In the event there are insufficient regular NED members, a rotating NED who is present will count towards the Quorum.

6. Frequency of meetings

6.1 The Committee will meet no less than ten times a year, usually once a calendar month except in August and December.

6.2 The Chair of the Committee may arrange extraordinary meetings at his/her discretion or at the request of Committee members.

7. Organisation and Reporting Structure

7.1 The minutes of Committee meetings shall be formally recorded and submitted to the Strategy and Operations Committee.

7.2 The Chair of the Committee shall produce an Alert, Advise and Assurance (AAAs) highlight report to draw the attention of the Strategy and Operations Committee to any issues that require escalation.

The Committee will report to the Strategy and Operations Committee at least annually on its work

7.3 The Committee will produce an annual work-plan/business cycle for the Strategy and Operations Committee to approve at the beginning of each financial year, mapping out how the Committee will fulfil its delegated duties.

7.4 The following sub-groups of the Committee will report via the formal submission of a AAAs report:

- Safeguarding Group
- Patient Experience Group
- Infection Prevention and Control Group
- Clinical Effectiveness Group

8. Conduct of Meetings

8.1 The PA to the Medical Director (in their absence the PA to the Director of Nursing & Midwifery) shall provide administrative support to the meeting and duties will include:

- Formally recording the minutes of the Committee.
- Collation and distribution of papers.
- Keeping a record of matters arising and issues to be carried forward.

8.2 The agenda and papers for the meeting shall be distributed no less than four days in advance of the meeting.

8.3 The agenda for the meeting shall be drawn up by the Medical Director and Director of Nursing and Midwifery and agreed with the Chair.

8.4 Minutes of the meeting and the record of matters arising will be circulated promptly to all members as soon as reasonably practicable.

8.5 Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of their paper and the key issues. Committee members may question the presenter.

8.6 Meetings are not open to members of the public

9. Reviewing Terms of Reference

The Terms of Reference shall be reviewed annually or in light of changes in practice or legislation.

10. Review of Performance and effectiveness Review

The Committee shall also undertake a review of its performance and effectiveness at least once annually.

Approved by Quality & Safety Committee **March 2022**

Ratified by Strategy and Operations Committee: **April 2022**

Date for next review: **February2023**

Version Control Document			
Version Ref	**Amendment**	**Committee Review & Approval**	**Ratified by Board**
V2	1.1 Added authority and responsibility diagram 1.2 Purpose: Added four bullet points on purpose: 1.3 Replace *practical* with *practicable* *1.4 Replace Assistant Company Secretary taking minutes at committee* with *PA to Medical Director* 1.5 Added that the Committee should undertake a review of its performance and effectiveness at mid and year-end Added the Safeguarding and Freedom to Speak Up/Raising Concerns Policies	**Q&S Cttee 2017**	**2017**
V3.0	3.1 Front Page: Added the Mortality Operational Group and Charitable Funds Committee. Removed Mortality Assurance and Clinical Improvement Committee. Added Mortality Operational Group to Sub Committees. 3.2 Added Mortality Operational Group 3.4 Added Mortality Operational Group and its Principal Duties.	**2018**	**2018**

	3.5 Membership updated		
V3.1	Added new governance structure showing reporting arrangements	**2019**	**2019**
V3.2	Removed the following from the membership: • Chief Operating Officer • Director of HR & OD • Director of Strategy		**April 2019**
V3.3	• Edited 'Extreme' to 'Corporate' Risk Register • Added 'Risk' to Audit Committee name in narrative and governance structure • Added time limited Strategy Committee to Governance Structure 4.3 Updated membership to include a NED with recent financial experience 4.4 Added that a rotating NED will count towards a Quorum if needed		**June 2019**
V.4	• Added Risk and Compliance Group • Removed 'Risk' from Audit & Risk Committee name	**August 2020**	**Sept 2020**
V.4.1	• Updated Governance Structure following approval at Board in December.	**December 2020**	
V5	• S2.3 added updated Governance Structure showing reporting structure • S3.3k - Removed 'Risk' to Committee name in narrative • S4.1 Amended name of Committee from Workforce Committee to Quality and Safety	**June 2021**	
V6.1	• Aligned with the ALTC with STHK • H&S Group and Resilience Group to report via Risk and Compliance to the Executive Committee • Removed duplication	**March 2022**	

Workforce Committee

Terms of Reference Document Control Sheet

MEETING	Workforce Committee
ESTABLISHED BY /REPORTING TO:	Strategy and Operations Committee
REVIEWER:	Nicola Bunce, Director of Corporate Services
REVIEW:	March 2022
ASSOCIATED DOCUMENTS:	Standing Orders Standard Financial Instructions Scheme of Reservation and Delegation Board Assurance Framework
RELATED COMMITTEES /GROUPS	Trust Board Strategy and Operations Committee Executive Committee **Sub Groups** • Joint Negotiating Committee • Joint Medical Staffing Negotiating Committee • Valuing our People Inclusion Group *(now includes Equality & Diversity)* • Medical Education Committee • Non-Medical Clinical Education Group • Workforce Improvement Group

Document Control	
Document Name:	Workforce Committee ToR – March 2022
File Name:	\\datamart1\Shared Files\Company Secretarial\16. TERMS OF REFERENCE (COMMITTEES)\3. 2022 Statutory and Assurance Committees\Workforce Committee ToR-March22
Version/Revision Number:	V8.1

Workforce Committee
Terms of Reference

1. Authority

1.1 The Board hereby resolves to establish a Committee of the Trust to be known as the Workforce Committee, hereafter referred to within this to within this document as the Committee.

1.2 In line with the terms of the Agreement for Long Term Collaboration with St Helen's and Knowsley Hospitals (StHK) NHS Trust, the Board has delegated all executive and assurance functions to the Strategy and Operations Committee except those which are reserved for the Board as set out in the Scheme of Reservation and Delegation (SoRD). The accountability and responsibility structure is set out in **Diagram 1.**

1.3 The Committee has no executive powers, other than those limited to these Terms of Reference.

1.4 The Workforce Committee is authorised to obtain such information as is necessary and expedient to the fulfilment of its functions.

1.5 All members of staff are directed to co-operate with any request made by the Committee.

1.6 Any changes to these Terms of Reference must be approved by the Strategy and Operations Committee.

2. Purpose

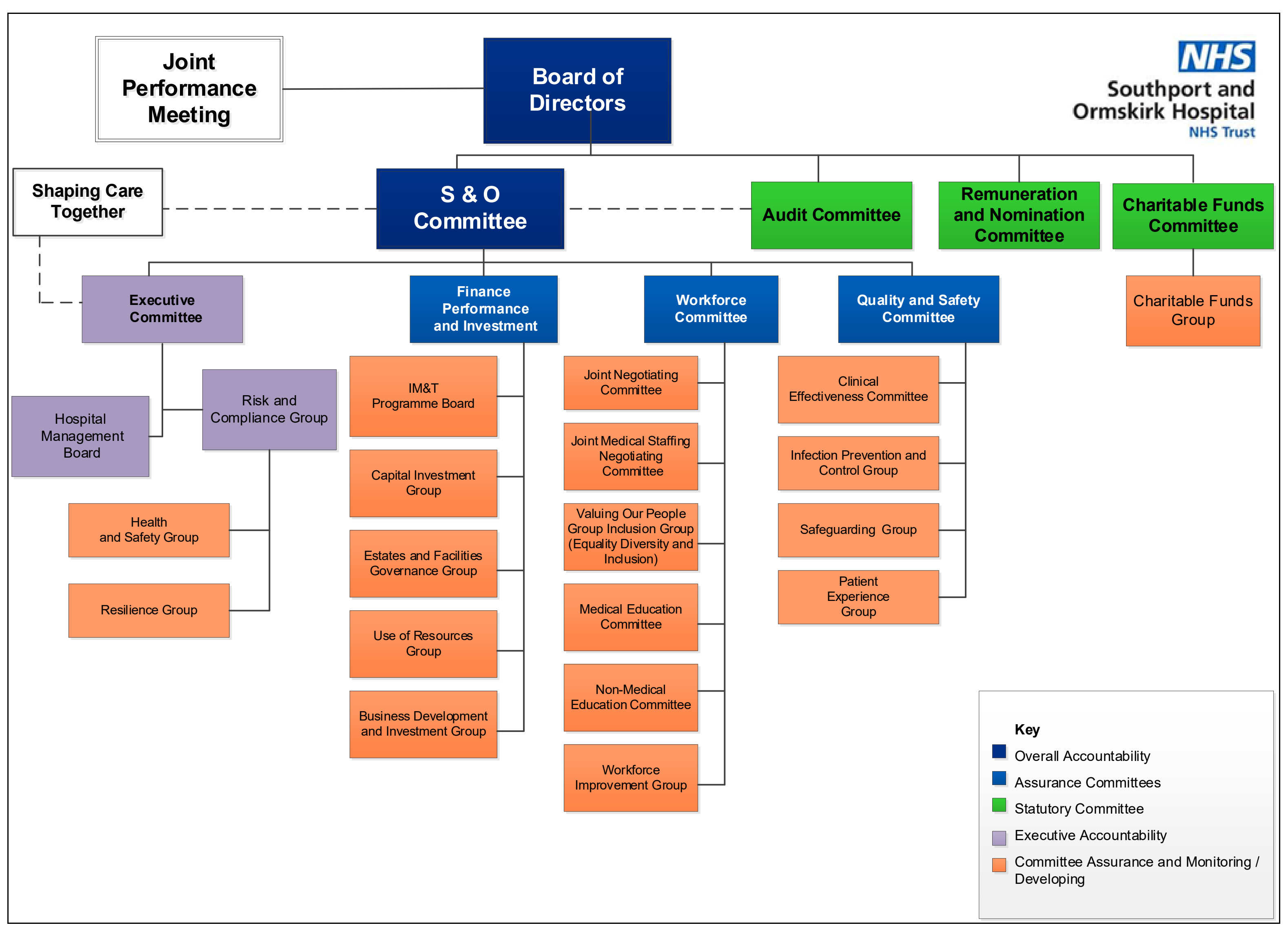
The Committee is established to:

2.1 Monitor Trust compliance with relevant legislation and externally set standards and receive and scrutinise assurance in relation to the delivery of the Trust's Workforce and Organisation Development Strategy, on behalf of the Strategy and Operations Committee.

2.2 Provide assurance to the Strategy and Operations Committee that the Trust's cultural identity, values and behaviours are aligned to the delivery of corporate objectives and compliance with legislation.

2.3 Provide assurance to the Strategy and Operations Committee that the Trust has a workforce with the capacity and capability to deliver the Trust's objectives particularly by monitoring the effectiveness of leadership and development plans, workforce planning and organisation development initiatives.

Diagram 1: The relationship between the Workforce Committee, the Board and other Trust committees 2022-23



3. Principal Duties

3.1 In order to achieve its purpose and obtain the necessary assurance, the Workforce Committee will:

- Monitor the delivery of the Trust's Workforce and Organisation Development Strategy.
- Monitor workforce performance data, quality indicators, and action plans to deliver improved performance covering key aspects of the Trust-wide workforce matters.
- Monitor and evaluate compliance with public sector equality duty and delivery of equality objectives to improve the experience of staff with protected characteristics via the annual WDES and WRES reports.
- Monitor the effectiveness of staff engagement processes.
- Receive assurance reports relating to compliance with external standards, Safe, Effective, Quality Occupational Health Service (SEQOHS), NHS Employers Guidance and CQC standards, and monitoring the delivery of Executive action plans in relation to any areas of non-compliance.
- Review and approving policies aligned to the Workforce Committee that have been reviewed by the Policy Review Group
- Ensure any areas of risk relating to HR practices and activities are highlighted and escalated to the Strategy and Operations Committee via the AAA reports.

3.2 **Other functions of the Workforce Committee**

- Review any other issues regarding workforce as requested by the Strategy and Operations Committee

4. Business Conduct

4.1 **Chair**

The Chair of the committee will be a Non-Executive Director. In the absence of the chair one of the other Non-Executive Directors, agreed in advance of the meeting, will chair that particular meeting.

4.2 **Membership**

The members of the Committee shall be appointed by the Board in accordance with the *Standing Orders* and shall consist of the following members:

- Two (2) independent Non-Executive Directors
- Managing Director
- Director of Finance
- Chief Operating Officer

- Director of Transformation
- Director of HR and OD
- Director of Nursing, Midwifery and Therapies
- Medical Director

4.3 The Director of Corporate Services or member of the Corporate Governance team will attend meetings of the Committee. The Deputy Director of HR and OD shall be expected to normally be in attendance at all meetings.

4.4 Other officers from the HR&OD function or other departments may be invited to the Committee to present specific reports

4.5 Only members of the Committee have the right to attend Committee meetings. Other officers of the Trust may be invited to attend all or part of any meeting as and when appropriate and necessary.

4.6 All members are required to attend at least 70% of meetings held. Deputies for Executive members should only attend if there are relevant agenda items and will not count towards the quorum of a meeting.

4.7 An officer formally acting up for a member will count towards a quorum.

5. Quorum

5.1 In order for the decisions of the Committee to be valid the meeting must be quorate. A quorum will be no less than four members including two Non-Executive Directors and two Executive Directors.

5.2 In the event there are insufficient regular NED members, a rotating NED will count toward the Quorum.

6. Frequency of Meetings

6.1 The Workforce Committee will meet a minimum of 10 times a year with the exception of August and December. The frequency of meetings will be reviewed annually.

7. Organisation and Reporting Structure

7.1 The Chair of the Committee shall produce an Alert, Advise, Assurance (AAA) highlight report to draw the attention Strategy and Operations Committee to any issues that need to be escalated.

7.2 The Committee will produce an annual workplan for the Strategy and Operations Committee to approve at the beginning of each financial year, mapping out how the Committee will fulfil its delegated duties.

7.3 The following sub-groups of the Committee will report via the formal submission of a AAAs report:

- Joint Negotiating Committee
- Joint Medical Staffing Negotiating Committee
- Valuing our People Inclusion Group (now includes Equality & Diversity)
- Medical Education Committee
- Non-Medical Clinical Education Group

- Workforce Improvement Group

8. Conduct of Meetings

8.1 The Personal Assistant to the Director of HR & OD shall provide administrative support to the meeting and duties will include:
- Formally recording the minutes of the Committee
- Collation and distribution of papers in good time
- Keep a record of matters arising and issues to be carried forward

8.2 The agenda and supporting papers will be distributed no less than four days in advance of the meeting. Papers must be received by the committee secretary in line with the published deadlines unless, in exceptional circumstances, explicit agreement has been reached with the Committee's Chair (or nominated Deputy).

8.3 The Director of HR & OD is responsible for setting the agenda, production and distribution of the minutes.

8.4 Meetings are not open to members of the public

9. Reviewing Terms of Reference

9.1 The Terms of Reference of the Committee (including membership) shall be reviewed annually or in light of changes in practice or legislation and approved by the Strategy and Operations Committee**.**

10. Review of Performance and Effectiveness

10.1 The Workforce Committee shall undertake a review of its performance and effectiveness annually.

Approved by: Workforce Committee

Submitted to: Strategy and Operations Committee for Ratification on [060422

Date of approval: **March 2022** **Date for review:** February 2023

Version Control Document			
Version Ref	**Amendment**	**Committee review and approval**	**Ratified by Board**
V5.0	Added accountability and responsibility diagram 1.2 Differentiated between membership and those in attendance Membership edited	Workforce Cttee 2017	**2017**

	1.3 Added a quorum 1.4 Added review of Terms of Reference and the Committee's performance and effectiveness Related Forums/Committees/Groups: removed Mortality Assurance and Clinical Improvement Committee. 1.5 Added 'and Safety' to Quality Committee; added Remuneration & Nomination Committee and Charitable Funds Committee.		
V6.0	**RELATED FORUMS/COMMITTEES/GROUPS** Removed: • Organisation Development • Education & Development Assurance Group Added: • Medical Education Committee (MEC) • Non-Medical Education Clinical Committee (NMCEC) Diagram 1 revised to reflect above changes **Other functions of the Workforce Committee** Removed: • Education & Development Assurance Group Added: • Medical Education Committee (MEC) • Non-Medical Education Clinical Committee (NMCEC) **Membership** Replaced Assistant Director of Organisational Development with Head of Education & Training **Groups reporting to Workforce Committee** Removed: • Education & Development Assurance Group Added: • Medical Education Committee (MEC) • Non-Medical Education Clinical Committee (NMCEC	Workforce Cttee 2018	**2018**
V6.1	Added new governance structure showing reporting arrangements	Workforce Cttee 2019	**2019**
V6.2	4.Removed Director of Nursing, Midwifery & Therapies Added Chief Operating Officer as substantive member from membership 4. Update title of Associate Director of HR to Director of HR & OD	Workforce Cttee 2019	2019
V6.3	• Added 'Risk' to Audit Committee name in narrative and governance structure • Added time limited Strategy Committee to Governance Structure • Added Deputy CEO to membership • Removed from Section 8 Health & Wellbeing Assurance, Medical Education Committee Added under Section 8 :	June 2019	**July 2019**

	• Valuing our People • HR Governance Assurance • Non-Medical Clinical Education Group • Nursing & Midwifery Recruitment and Retention Operational Group • Nursing & Midwifery Group		
V7.0	Amended to: Used new, revised template. Under 'Sub-Committees' Remove: • HR Contract with St Helens & Knowsley NHS Trust • Human Resources Add: • Workforce Improvement Group • Medical Workforce Taskforce Under section 3.2: Add: • Agency compliance • Rostering levels of attainment. • agenda for change job evaluation Remove: CQUIN Add 3.3: Volunteer / Community Strategy Amend 3.5: The Workforce Committee is able to approve policies for final approval and ratification from the Policy Development Group. Policies reporting to the Committee should be monitored on an annual basis. Amended under section 4: • Non-Medical Clinical Education Group • Joint Medical Staff Negotiating Committee Section 5: Amended: • Staff Side Lead • Head of Education, Training and Organisational Development • Associate Director of Health and Wellbeing • 4.2 - Replace Associate Director of Nursing – Workforce with Director of Nursing, Midwifery and Therapies / Deputy Director of Nursing, Midwifery and Therapies. • 4.5 - Add Associate Director of Nursing Workforce. • Remove Assistant Director of HR Governance and Quality from 4.2 and replace with Deputy Director of Human Resources & Organisational Development. Assistant Director of HR Governance and Quality to 4.5 Under section 4.5: Add: • Volunteer Manager • Head of Resourcing • Associate Directors of Operations (on rotation) Remove: • Estates and Facilities Management Representative	July 2020	September 2020

	• Removed under section 8.7: • Education and Training Assurance Group • Health & Safety • HR Policy Development Sub Group		

V8.0	• S2.3 added updated Governance Structure showing reporting structure
	• S4.2 Deputy Chief Executive amended to ???
	• 7.1 amended for 'four'
	• 7.7 updated to include the following Committees/ Group
	  ○ Medical Education Committee
	  ○ Equality and Diversity Group
		June 2021	

V8.1	• Updates to reflect the ALTC with STHK and streamlining to remove duplication and overlap with other committees	March 2022	

Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 April 2022
Agenda Item	SO051/22	FOI Exempt	NO
Report Title	EXECUTIVE COMMITTEE DRAFT TERMS OF REFERENCE		
Executive Lead	Nicola Bunce, Director of Corporate Services		
Lead Officer	Nicola Bunce, Director of Corporate Services		
Action Required	✓ To Approve ☐ To Assure	☐ To Note ✓ To Receive	

Purpose
To present the Terms of Reference (ToR) for the proposed Executive Committee for approval..
Executive Summary
The Committee is asked to review the draft ToR to formally establish an Executive Committee as a sub-committee of the Strategy and Operations Committee. The Executive Committee will be the final arbiter on all operational issues within the Trust. The draft ToR outlines the principal duties of the proposed Committee as well as membership of the Committee.
Recommendations
The Strategy and Operations Committee is asked to approve the Executive Committee draft Terms of Reference.

Previously Considered By:	
☐ Finance, Performance & Investment Committee ☐ Remuneration & Nominations Committee ☐ Charitable Funds 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:
Nicola Bunce, Director of Corporate Services	Nicola Bunce, Director of Corporate Services

Executive Committee

Terms of Reference Document Control Sheet

MEETING	Executive Committee
ESTABLISHED BY /REPORTING TO:	Strategy and Operations Committee
REVIEWER:	Nicola Bunce, Director of Corporate Services
REVIEW:	March 2022
ASSOCIATED DOCUMENTS:	Standing Orders Standard Financial Instructions Scheme of Reservation and Delegation
RELATED COMMITTEES /GROUPS	Trust Board Strategy and Operations Committee **Sub Groups** • Risk and Compliance Group • Hospital Management Board • Any command and control structures established in response to a major incident (as required)

Document Control	
Document Name:	Executive Committee ToR – March 2022
File Name:	\\datamart1\Shared Files\Company Secretarial\16. TERMS OF REFERENCE (COMMITTEES)\3. 2022 Statutory and Assurance Committees\Executive Committee ToR-March22
Version/Revision Number:	V1

Executive Committee
Terms of Reference

1. Authority

1.1 In line with the terms of the Agreement for Long Term Collaboration with St Helen's and Knowsley Hospitals (StHK) NHS Trust, the Board has delegated all executive and assurance functions to the Strategy and Operations Committee except those which are reserved for the Board as set out in the Scheme of Reservation and Delegation (SoRD). The accountability and responsibility structure is set out in **Diagram 1.**

1.2 The Strategy and Operations Committee hereby resolves to establish a Committee of the Trust to be known as the Executive Committee, hereafter referred to within this to within this document as the Committee.

1.3 The Committee can exercise the full executive powers as described in the Accountable Officer Memorandum and delegated from the Chief Executive to the Executive Directors of the Trust as set out in the SoRD. Except those powers that are reserved to either the Strategy and Operations Committee or the Board.

1.4 Any changes to these Terms of Reference must be approved by the Strategy and Operations Committee.

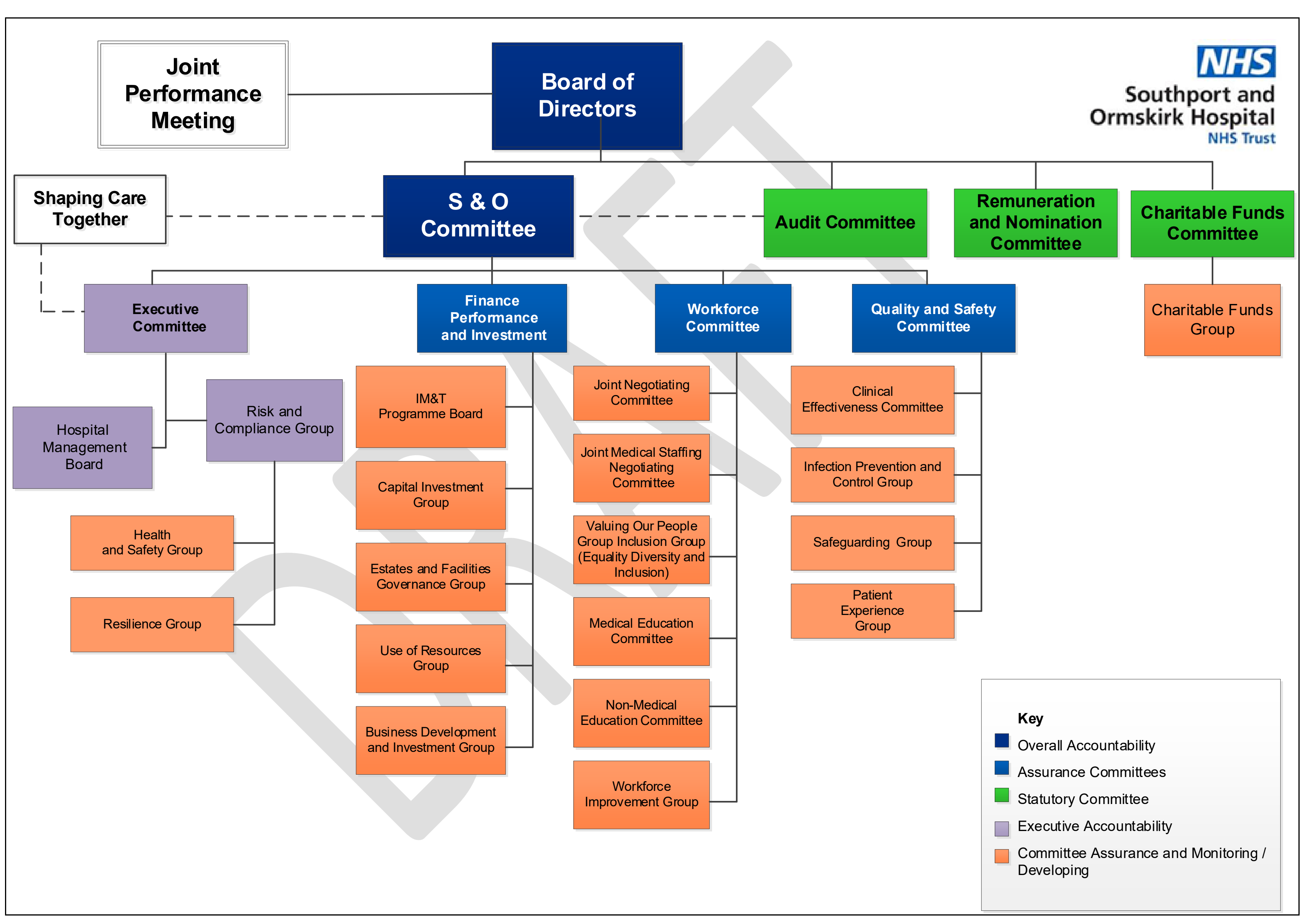
2. Purpose

2.1 This committee will be the final arbiter on all operational issues at the Trust.

2.2 Oversee the effective operational and strategic management including the achievement of statutory duties, clinical standards and targets, the delivery of high quality patient care and the delivery of the Service Strategy.

2.3 The prime role of meetings is to consider the operational issues within the Trust along with the coordination of work programmes required to deliver the annual and strategic objectives of the organisation.

Diagram 1: The relationship between the Workforce Committee, the Board and other Trust committees



DRAFT

3. Principal Duties

- The monitoring of Trust performance against all standards and targets including the development of any remedial actions

- To review and approve all regulatory compliance submissions prior to Board ratification

- To ensure that all risks identified are discussed and escalated in line with the Risk Management Policy

- Issues with reputational and relationship management significance

- Significant Tender documents submitted by the Trust

- The operational effectiveness of policies and procedures

- All risk related disclosure statements, prior to approval by the Board of Directors

- To review key reports prior to submission to the Board of Directors to ensure their accuracy and quality

- To ensure that equality and diversity issues are continually considered and addressed

- To review and approve business cases for the appointment of consultants and key Trust staff, or the creation of such posts

- To review and approve business cases for new service developments, material expansion or reduction of existing services including capital developments (within the approved budgets or delegated authority of the Chief Executive), arising within the year.

- To review and recommend business cases for new service developments and capital investment to the Strategy and Operations Committee, where they exceed the delegated limits of the Chief Executive.

- To monitor the delivery and benefits realisation of approved business cases and service developments.

- Receiving and considering the Chair's report from the Risk and Assurance Group and other governance groups that report into the Executive Committee

- Governance matters including preparation and arrangements for regulatory review

- Brief the Trust's senior managers on the business and decisions made at the Executive Committee

DRAFT

4. Business Conduct

4.1 **Chair**

The Chair of the committee will be a Chief Executive or Managing Director (in the CEO's absence). In the absence of the chair one of the other Executive Directors, agreed in advance of the meeting, will chair that particular meeting.

4.2 **Membership**

The members of the Committee will be the executive management of the Trust;

- Chief Executive
- Managing Director
- Director of Finance
- Chief Operating Officer
- Director of Transformation
- Director of HR and OD
- Director of Nursing, Midwifery and Therapies
- Medical Director
- Director of Corporate Services

4.3 Only members of the Committee have the right to attend Committee meetings. Other officers of the Trust may be invited to attend all or part of any meeting as and when appropriate and necessary.

4.4 All members are required to attend at least 70% of meetings held. Deputies for Executive members should only attend if there are relevant agenda items and will not count towards the quorum of a meeting.

4.5 An officer formally acting up for a member will count towards a quorum.

5. Quorum

5.1 A quorum will be 50% attendance. Where a decision is to be taken with financial consequences, the delegated authority for expenditure as contained in the Trust's Standing Financial Instructions must be adhered to.

6. Frequency of Meetings

6.1 Meetings will usually be scheduled weekly.

7. Organisation and Reporting Structure

7.1 The Chair of the Committee shall produce an Alert, Advise, Assurance (AAA) highlight report to draw the attention Strategy and Operations Committee to any issues that need to be escalated.

7.2 The following sub-groups of the Committee will report via the formal submission of a AAAs report:

- Risk and Assurance Group
- Hospital Management Board

DRAFT

- Any command and control structures established in response to a major incident (as required) e.g. COVID-19 Gold Command

8. Conduct of Meetings

8.1 The Personal Assistant to the Chief Executive and Managing Director shall provide administrative support to the meeting and duties will include:

- Formally recording the minutes of the Committee
- Collation and distribution of papers in good time
- Keep a record of matters arising and issues to be carried forward

8.2 The agenda and supporting papers will be distributed in advance of the meeting.

8.3 The Chief Executive/Managing Director is responsible for setting the agenda but any Executive Director can put urgent items on the agenda.

8.4 Meetings are not open to members of the public

9. Reviewing Terms of Reference

9.1 The Terms of Reference of the Committee shall be reviewed annually or in light of changes in practice or legislation and approved by the Strategy and Operations Committee**.**

10. Review of Performance and Effectiveness

10.1 The Committee shall undertake a review of its performance and effectiveness annually.

Approved by: Executive Committee

Submitted to: Strategy and Operations Committee for Ratification on 6/4/2022

Date of approval: TBA **Date for review:** TBA

Version Control Document			
Version Ref	**Amendment**	**Committee review and approval**	**Ratified by Board or SOC**
V1	Establishment of the Executive as a committee of the Strategy and Operations Committee	April 2022	

DRAFT

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Charitable Funds Committee
MEETING DATE:	22 March 2022
LEAD:	Neil Masom, Chair John McLuckie, Executive Lead

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The Charity Manager advised that the delivery of the strategy was being impacted by the now 11 month delay in installing the Harlequin fundraising database; a five-month delay on job matching a charity fundraising assistant; and three-month delay on updates to the charity website

ADVISE

- The Committee approved an additional £15k towards the wellbeing garden at Southport hospital bringing the total to £64k.
- The Committee agreed that the Charity Manager should apply for development from NHS Charities Together which will support the first-year costs of the fundraising assistant
- The Charity Manager advised the hospital lottery was scheduled to launch before the next committee meeting
- Expenditure Strategy to be developed and circulated to Charitable Funds Committee members.

ASSURE

- The Committee was told a Charitable Funds Group had met for first time under the leadership of Lesley Neary with the aim of developing ideas and suggestions for projects for the charity to fund.

New Risks identified at the meeting:
None

Review of the Risk Register:

Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 April 2022
Agenda Item	SO053/22	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 Executive summary highlights key changes in Trust performance and outlines specific actions linked to the Trust's improvement plan and key programmes of work*)*.

Recommendations

The Strategy and Operations Committee is asked to receive the Integrated Performance Report detailing Trust performance in February 2022.

Previously Considered By:

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

Strategic Objectives

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

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

Trust Board - Integrated Performance Report

Performance Summary

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

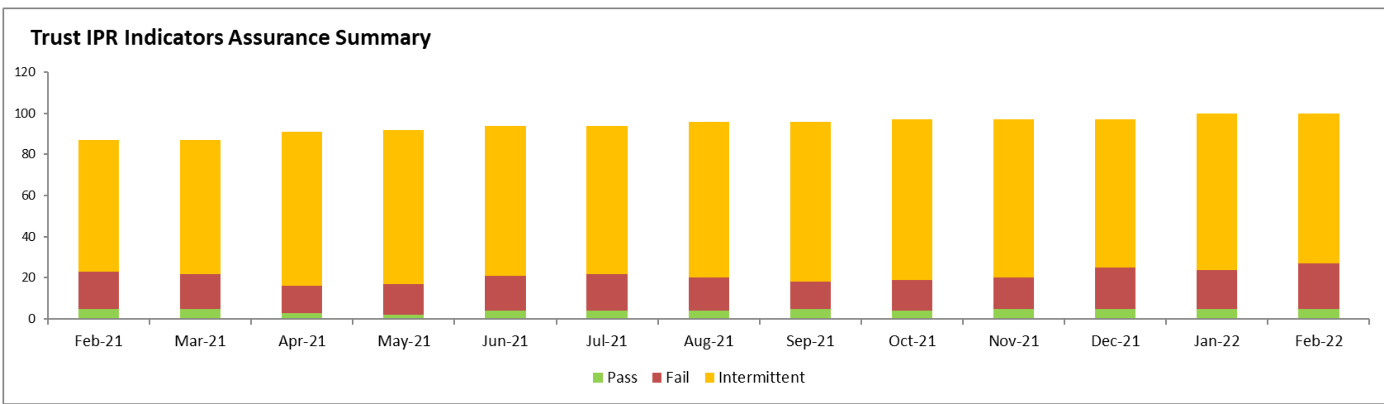
Quality - reflects those metrics aligned to Strategic Objective **S01** – *Improve clinical outcomes and patient safety to ensure we deliver high quality services*.

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.



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 February 2022. (YTD = 0).
There were no cases of MRSA February. (YTD = 2).
There was one Hospital Onset Hospital Acquired C. Difficile (CDI) positive case reported in February 2022.
There were 40 reported Hospital Acquired Covid infections reported in February.
The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for February 2022 was 91.7%. This is based on 98.6% for Registered Nurses and 83.6% for Un-Registered Nurses. The 2021-22 YTD rate is 89%.
The Trust remains ahead of target for VTE Prophylaxis Assessment at 96.5% for February and 97.5% YTD.
There were 2 category 3 and 4 category 2 hospital acquired pressure ulcers reported in February.
There was 1 fall resulting in moderate harm in February. 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 3.3% in February to 42.4% (42.7% YTD). The Caesarean section metric has been removed as per the guidance from NHSE/I.
The SHMI remains as expected at 100.9 (latest data Sept 21) and the HSMR continues to be ahead of plan at 76.9.
The mortality screening rate continues its improving trajectory and was 98.6% in January.
The Patient Friends & Family Test - % that would recommend was 90.4% in January, a marginal increase on the previous month, against a response rate of 25.4%.
The % of complaints responded to within timescales has improved in February to 47.6% but remains below the 80% target.

Operational Performance

Overall Accident and Emergency performance for February 2022 was 74.8% and YTD 78.4% (Adults ED 52.2%, Paeds ED 97.2% in February). Total attendances for February 2022 were 8,578 compared to 8,475 in January. 192 Ambulance Handovers were 30-60 mins in February compared to 108 in January, with 98 delayed for longer than 60 mins, an increase on the 49 reported in January.

Performance against the 62-day cancer standard was below the target of 85.0% in month (January 2021) at 67.7%. YTD 66.8%. This is an increase on December which was 62.2%. The Trust achieved the 96% 31-day target in January 2021 with 100% performance in month (December 93.1%), YTD remains ahead of target at 98.1%. The 2-week rule target was not achieved in January 2022 with 82.4% in month and 81.3% YTD against a target of 93.0%. Performance in December 2021 was 77.2%.

The average daily number of stranded patients in February 2022 increased to 212 from 191 in January. The number of super-stranded patients also increased, from an average of 64 in January to 90 in February. Both metrics were impacted by delays in care packages, availability of community beds and multiple Covid-19 outbreaks in care homes.

Operational Performance continued

The 18-week referral to treatment target (RTT) was not achieved in February 2022 with 79.1% compliance, a similar position to the 79.2% reported in January, and YTD 81.7% (Target 92%). The Trust continues to perform well in comparison to peers. There were 159 52+ week waiters, an increase on the 140 reported in January. The diagnostic target was not achieved in February 2022 with 35.6% patients waiting longer than 6 weeks compliance, an improved position on the previous month (42.2%) against a target of 1%.

The Covid-19 crisis has had a significant impact on RTT and diagnostic performance, as all routine operating, outpatient and diagnostic activity had to be cancelled. All patients have been, and continue to be, clinically triaged to ensure urgent and cancer patients remain a priority for treatment.

Financial Performance

The Trust is forecasting financial breakeven from M11 following confirmation of additional System Top Up Funding secured for 2021/22.

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, and funded through System Top up allocations. The Trust has secured a further £6m system allocations arising for 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

The Trust is advised that further system allocations could be made available for 2021/22.

CIP - The Trust has delivered schemes totalling £6.2m to M11 and is forecasting delivery of the full year target.
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 February was £13.4m which includes £6.0m of temporary regional cash support and £4.7m of top up funding.
Remaining capital PDC allocations totalling £8.61m, and £6.0m additional System Top Up funding have subsequently been drawn down during March 2021.
Cash flow risks previously highlighted to Committee have therefore been mitigated in 2021/22 and revised forecasts anticipate year-end cash balances of £19m heading into 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 has maintained 90% YTD to January.

Capital - £6.1m original capital plan for 2021/22, with successful bids for additional capital funding taking the 2021/22 plan to £13.5m. Year to date investment to the end of February of £7.7m, reflecting 58% of the annual budget, with assurances provided by IM&T and Estates & Facilities schemes over delivery in full by 31 March 2022
In addition, the Trust continues to pursue capital funding of £68m in order to address High Risk Critical Backlog Maintenance.

Workforce

Personal Development Review compliance has reduced in February to 75.6% against the 85% target. Performance in January was 761%. Mandatory training compliance remains ahead of target and was 89.2% in February.

The results of the 2021 Annual Staff Survey and the Q4 Pulse Survey are included this month. The Percentage of staff who would recommend the Organisation as a place to work was 53.9% in the Annual Survey and 49.2% in the Q4 Pulse Survey, this is against a Trust comparator figure of 59% (based on the Annual Survey). The Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation was 53.8% in the Annual Survey and 49.4% in the Q4 Pulse Survey, this is against a Trust comparator figure of 68% (based on the Annual Survey).

In January overall sickness reduced to 7.1% from the 9.2% reported in January. The rolling 12-month figure is 6.8% in February. The medical vacancy rate continues to be ahead of plan at 4.6% (target 7.4%). The Nursing vacancy rate has increased to 11% in February (10% in January) impacted by un-registered nurse vacancies. There are 33 Un-Registered Nurse vacancies under offer with a recruitment event being planned. In-month Staff turnover has decreased to 0.9% in February from 1.4% in January (target 0.75%). The rolling 12-month figure is 15.7%, against a target of 10%.

Integrated Performance Report

Strategy & Operations Committee Report

February 2022

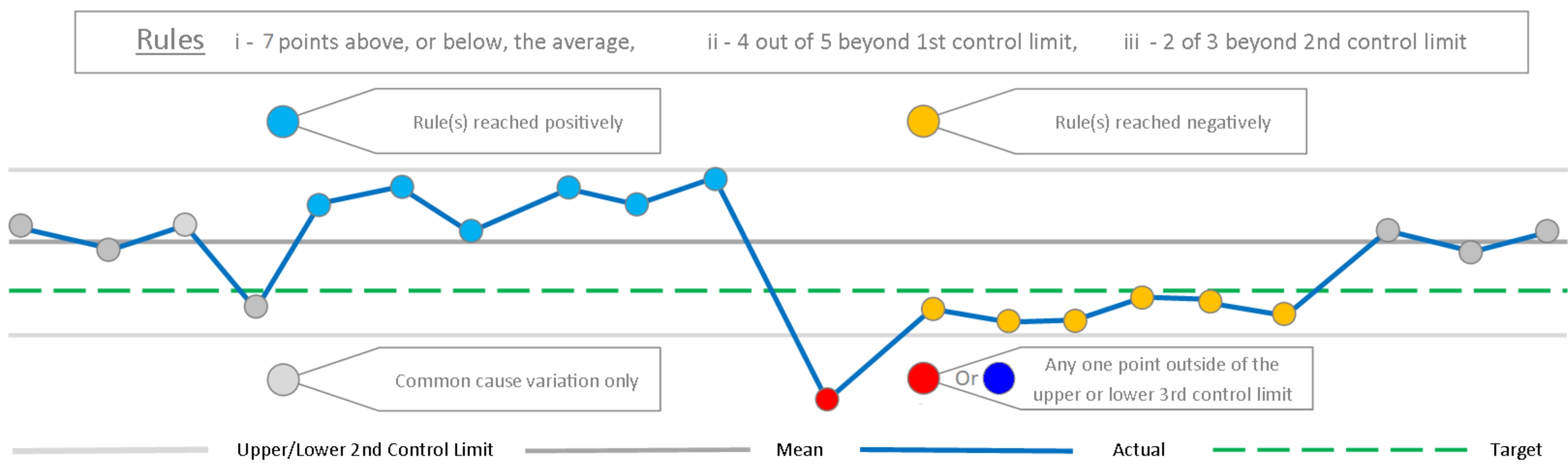
Guide to Statistical Process Control

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

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

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

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



Executive Summary

		Assurance			Variation				
		F	P	?	H	L	H	L	
Quality	Mortality	1	1	2	0	0	1	2	1
	Patient Experience	1	1	6	0	2	2	0	4
	Infection Prevention and Control	0	0	6	1	0	0	0	5
	Harm Free	0	2	11	2	1	2	1	7
	Maternity	0	0	11	0	0	0	1	10
Operations	Cancer	0	0	3	0	1	0	0	2
	Access	8	0	5	8	2	0	0	3
	Productivity	1	0	9	4	0	2	2	2
Finance	Finance	5	0	12	1	0	1	3	12
Workforce	Organisational Development	1	1	1	0	0	2	0	1
	Sickness, Vacancy and Turnover	5	0	7	6	0	0	2	4

Assurance

Measures the likelihood of targets being met for this indicator.

Icon	Meaning
?	Indicates that this indicator is inconsistently passing and falling short of the target.
P	Indicates that this indicator is consistently passing the target.
F	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.

Icon		Meaning
		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

Staffing

Issues

- 90% target achieved in February. Year to date 89% due to fluctuations in staffing due to increased nurse sickness levels.
- Overall rate continues to be impacted by care staff fill-rate. Registered Nurses achieved 98.6% with Care Staff 83.6%.
- 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

- International nurse recruitment is on target to deliver all 150 nurses within Pan Mersey agreement by April 2022.
- Further 11 nurses awaiting recruitment through previously agreed S&O funding, with further 9 to be recruited through Pan Mersey 2022/23.
- Plan to set up robust and succinct recruitment programme that supports local talent including offering of positions to our own students and reduce reliance on International Nurse Recruitment programme.
- Non-registered nurse vacancies require working into definite numbers as often positions are held for upcoming Care Support Workers due to qualify.
- Continued minute scrutiny over staffing levels on twice daily basis to support shortfall fill rate, which in turn has a direct impact on Care Hours per Patient per day.

Patient Falls – Moderate/Severe/Death

Issues

- One fall with harm was reported in February, which is below the average.

Management Action

- Falls lead now in post and review of current plan for rapid, medium- and long-term actions to reduce patient risks.
- Review of post falls actions on moving of patients and observations.
- Meeting with both community and secondary care Falls lead colleagues across local system to compare current actions and potential adoption of actions for the Trust

Hospital Acquired Pressure Ulcers

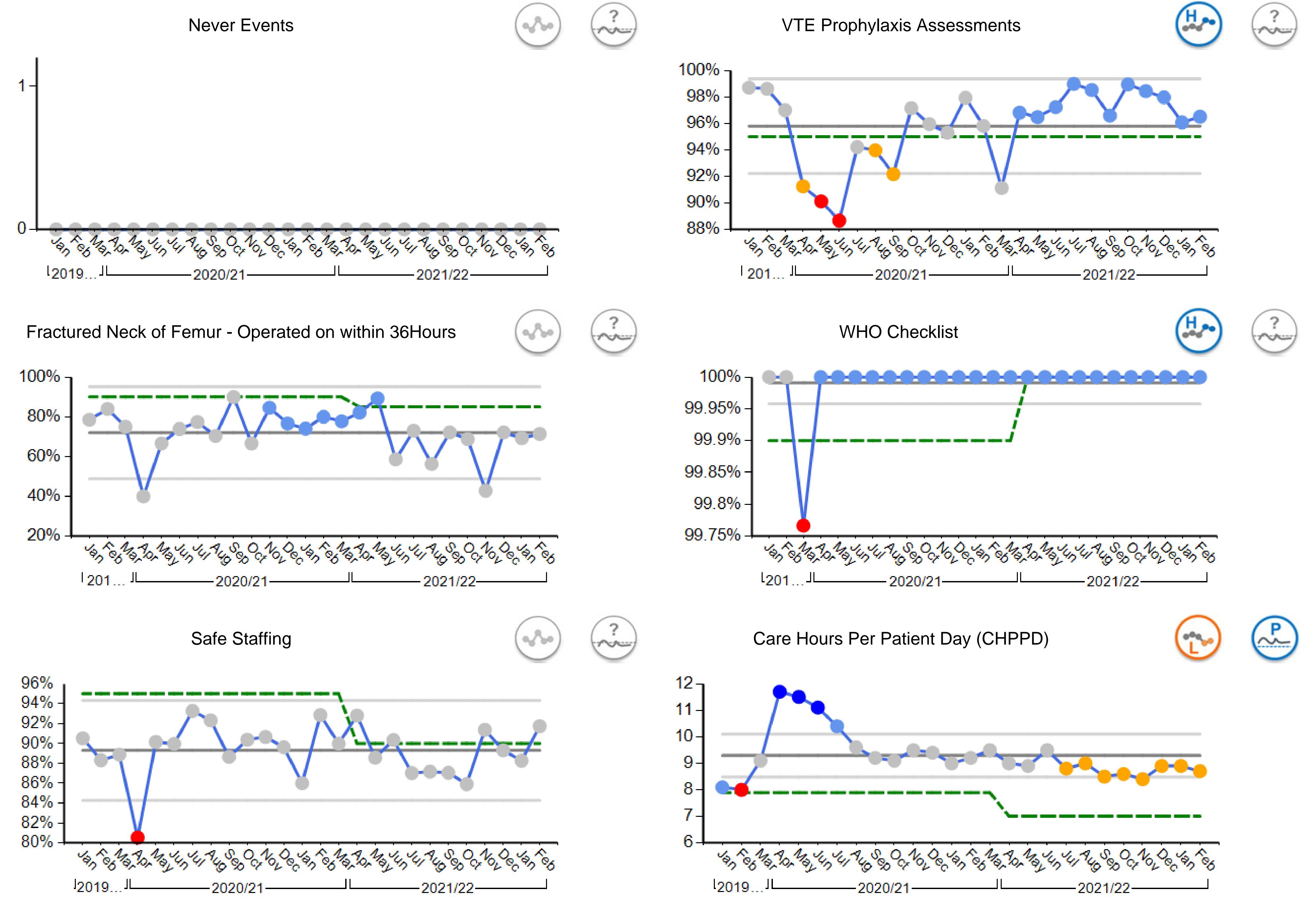
Issues

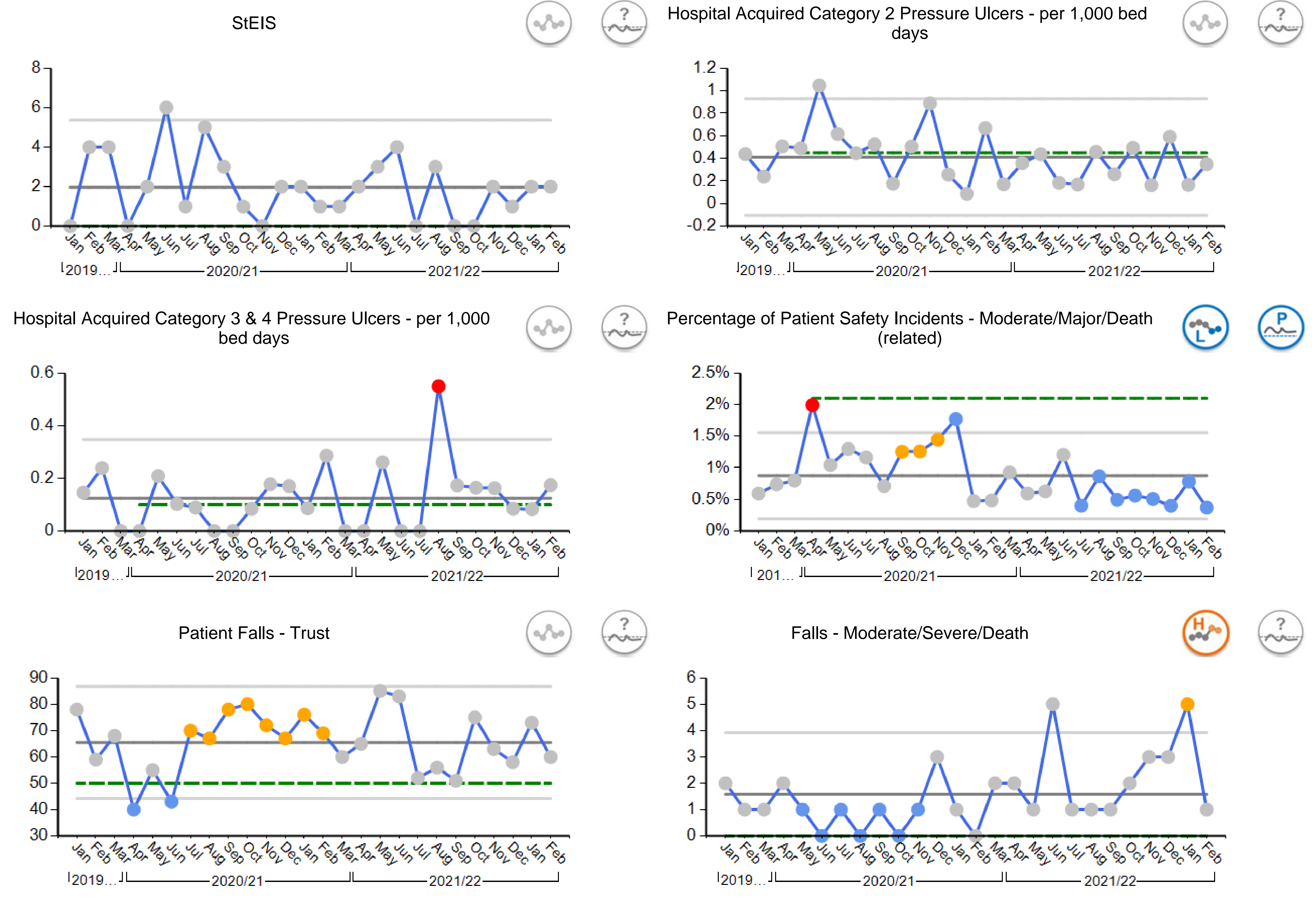
- Both metrics are performing statistically as expected, although there has been an increase in both the number of category 2 and category 3 HAPU's reported in February.
- Hospital Acquired Category 3 pressure ulcers have breached the target in February with 2 reported.
- One category 2 and one category 3 are yet to be investigated.

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.

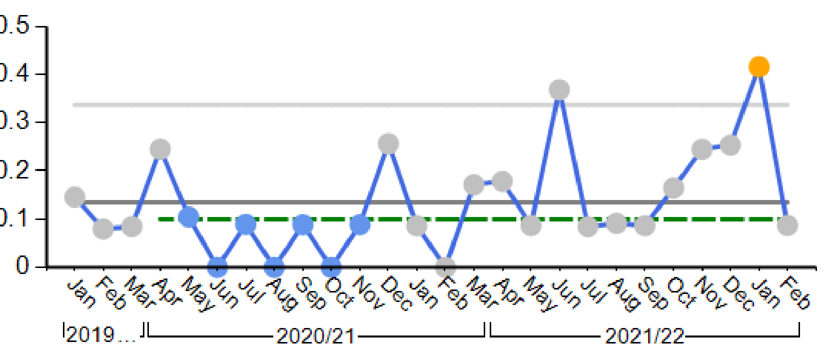
Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
Never Events	0	0	0	Feb 22		0	0	Jan 22	0	0	?
VTE Prophylaxis Assessments	95%	96.5%	117	Feb 22	H	95%	96.1%	Jan 22	95%	97.5%	?
Fractured Neck of Femur - Operated on within 36Hours	85%	71.4%	6	Feb 22		85%	69.2%	Jan 22	85%	68.8%	?
WHO Checklist	100%	100%	0	Feb 22	H	100%	100%	Jan 22	100%	100%	?
Safe Staffing	90%	91.7%	N/A	Feb 22		90%	88.3%	Jan 22	90%	89%	?
Care Hours Per Patient Day (CHPPD)	7	8.7	N/A	Feb 22	L	7	8.9	Jan 22	7	8.8	P
StEIS	0	2	2	Feb 22		0	2	Jan 22	0	19	?
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days	0.45	0.3	4	Feb 22		0.5	0.2	Jan 22	0.45	42	?
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days	0.1	0.2	2	Feb 22		0.1	0.1	Jan 22	0.1	19	?
Percentage of Patient Safety Incidents - Moderate/Major/Death(related)	2.1%	0.4%	3	Feb 22	L	2.1%	0.8%	Jan 22	2.1%	0.6%	P
Patient Falls - Trust	50	60	60	Feb 22		50	73	Jan 22	600	721	?
Falls - Moderate/Severe/Death	0	1	1	Feb 22	H	0	5	Jan 22	0	25	?
Patient Falls - Moderate/Severe/Death - per 1,000 bed days	0.1	0.1	1	Feb 22	H	0.1	0.4	Jan 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)
2019…
2020/21
2021/22



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
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019...
2020/21
2021/22

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



Infection Prevention and Control

C.diff

Issues
• One Hospital Onset Hospital Acquired case was reported in February. This is below the average and statistically as expected.

Management Action
• All c.diff infections are subject to root cause analysis (RCA) investigation which are presented at the weekly Harm Free Care panel. The review into the February case identified excellent clinical treatment and a good outcome for the patient. No lapses in care were identified.

E-Coli

Issues
• 5 cases were reported in February; 1 Hospital Onset Hospital Acquired and 4 Community Onset Hospital Acquired.
• This is a reduction on the previous month but remains above target and average.

Management Action
• Each of the E coli cases were reviewed by the Microbiologist and the patient's doctor and were prescribed appropriate antimicrobials.
• No apparent lapses in care were identified. Each of the HOHA and COHA patients had extensive medical problems that had been responded to appropriately.

MSSA

Issues
• 4 reported cases of Hospital Onset Hospital Acquired MSSA in February.
• This is the highest number reported since July 2021.

Management Action
• Each of the patients suffering from MSSA bacteraemia were assessed by the Microbiologist in collaboration with the medical team and appropriate diagnostic testing requested and antimicrobial treatment prescribed.

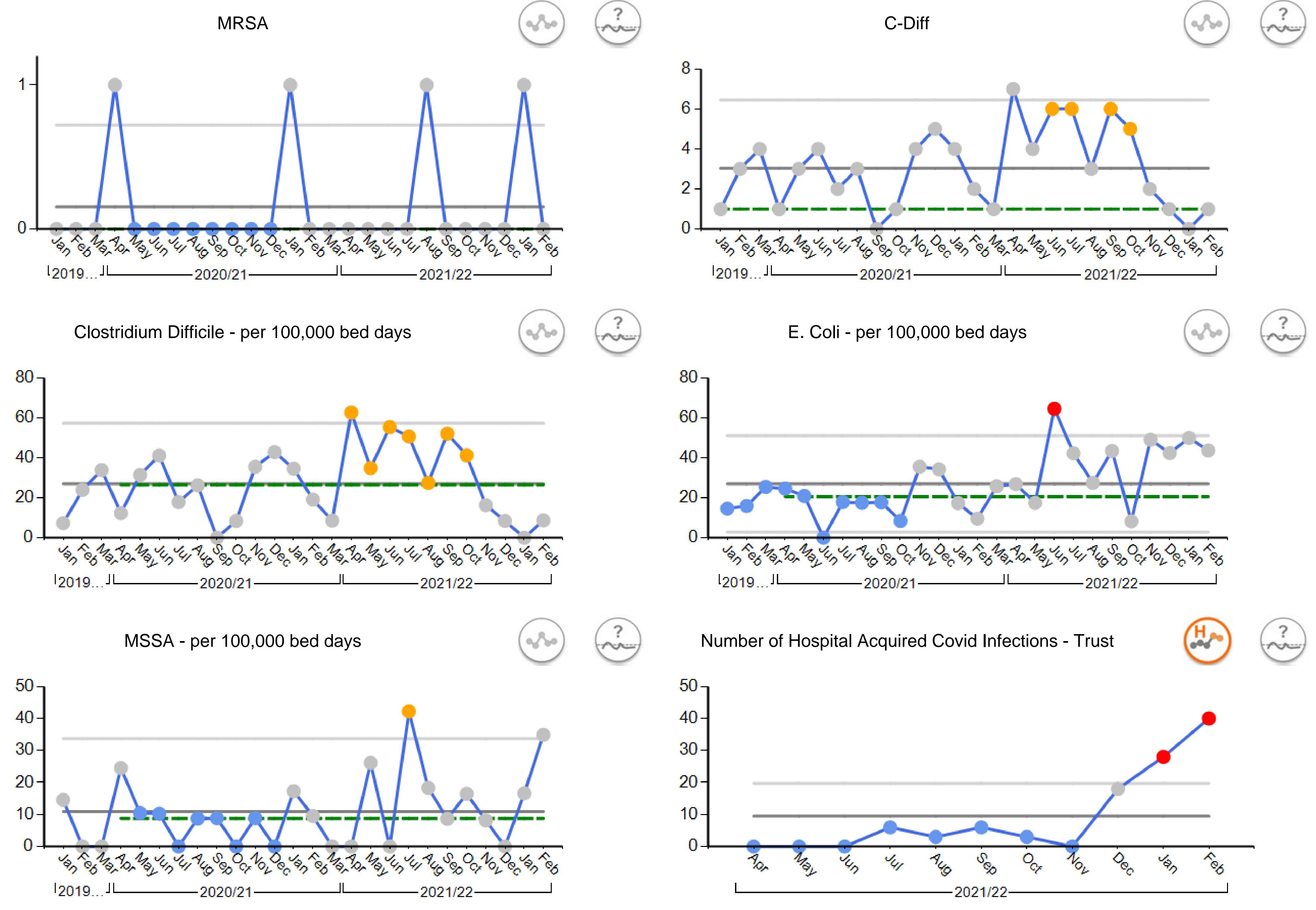
Covid

Issues
• There were 40 reported hospital acquired Covid cases in February (23 definite and 17 probable), an increase on the previous month and resulting in the metric showing special cause concern.
• The cases relate to 6 outbreaks and resulted from either transmission from visitors or transmission from patients with asymptomatic carriage that tested negative on admission then within 3-5 days were found to be positive - this combination resulted in onward transmission.
• The other aspect of these cases was transmission occurring on wards with medium to long-term patients with some of the patients having delayed discharges due to external delays in arranging placements or packages of care.

Management Action
• The Trust continue to test patients for COVID-19 by PCR test on admission, at 3 days and 5 days post admission and then every 5 days thereafter. Where contacts are identified then these patients are isolated and tested daily for 10 days and if they become positive are then isolated on a COVID ward.
• The Trust continues with IPC Bronze outbreak meetings daily including updates at the weekend to the bed management and on-call teams.
• The report and actions from these meetings are escalated through Silver and Gold Command within the hospital. The weekday meetings include a representative from the CCG and NHSEI and UKHSA are informed of all the incidences.
• In addition to isolation, testing and cleaning the Trust is also installing air purifiers and CO2 monitors in multi-patient rooms that are reliant on natural ventilation.

There were no MRSA cases reported in February.

Indicator	Latest					Previous			Year to Date		
	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
MRSA	0	0	0	Feb 22		0	1	Jan 22	0	2	?
C-Diff	1	1	1	Feb 22		1	0	Jan 22	15	41	?
Clostridium Difficile - per 100,000 bed days	26.5	8.7	1	Feb 22		26.5	0	Jan 22	26.5	32.1	?
E. Coli - per 100,000 bed days	20.6	43.6	5	Feb 22		20.6	49.9	Jan 22	20.6	37.6	?
MSSA - per 100,000 bed days	8.8	34.9	4	Feb 22		8.8	16.6	Jan 22	8.8	15.7	?
Number of Hospital Acquired Covid Infections - Trust		40	40	Feb 22	H		28	Jan 22		104	?


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
2019...
2020/21
2021/22

Quality

Maternity

Induction Rates

Issues
• Performance remains statistically as expected. An increase in February but performance is in line with 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.

Management Action
• Induction rates discussed at Governance meetings.
• 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.

Caesarean Rates

At the request of NHSE/I, the metric measuring Caesarean rates has been removed from the IPR. The Robson criteria will be used to understand the trends with Caesarean sections. The BI team are currently working to establish the reporting metrics for the Robson criteria.

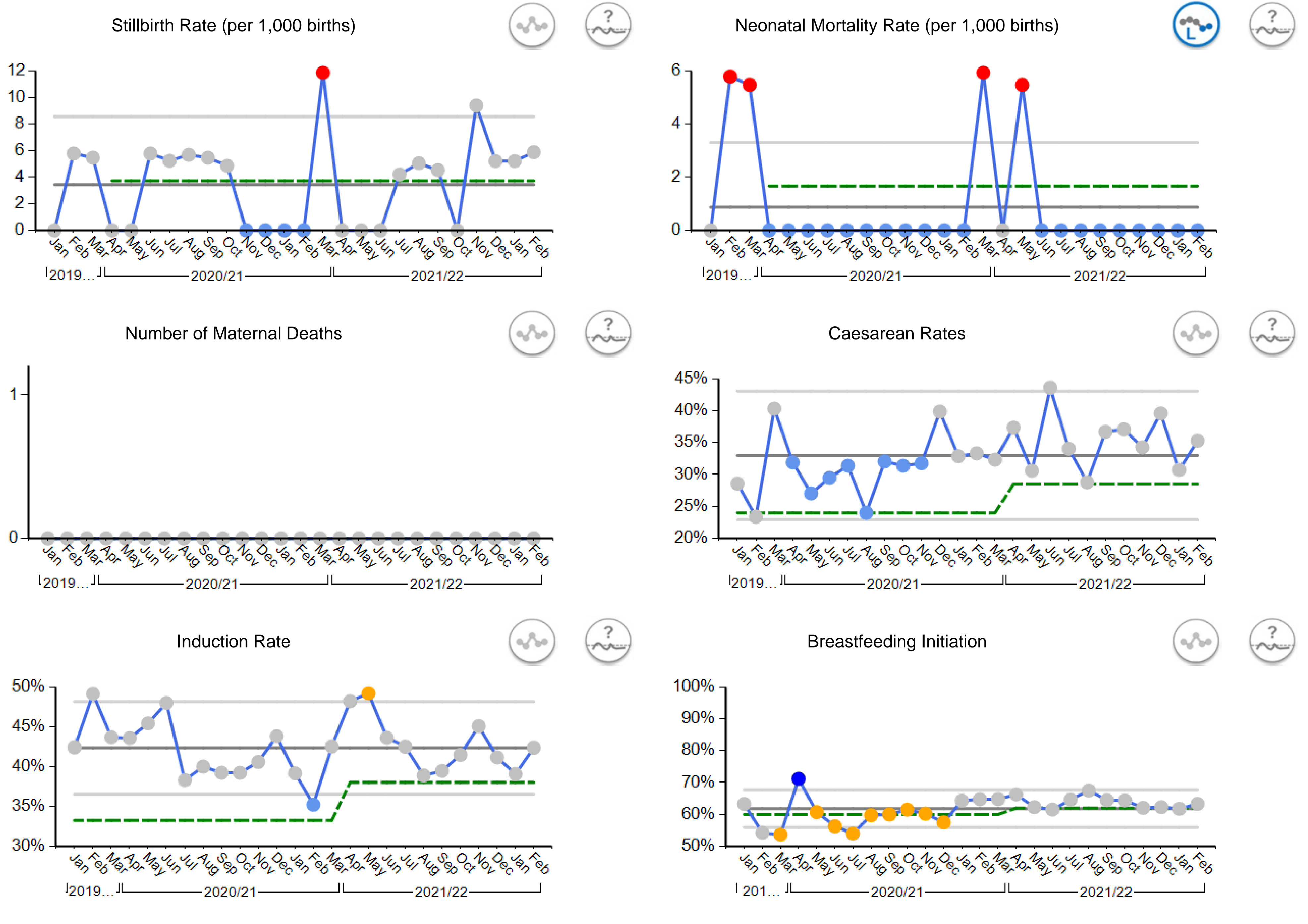
3rd and 4th Degree Tears

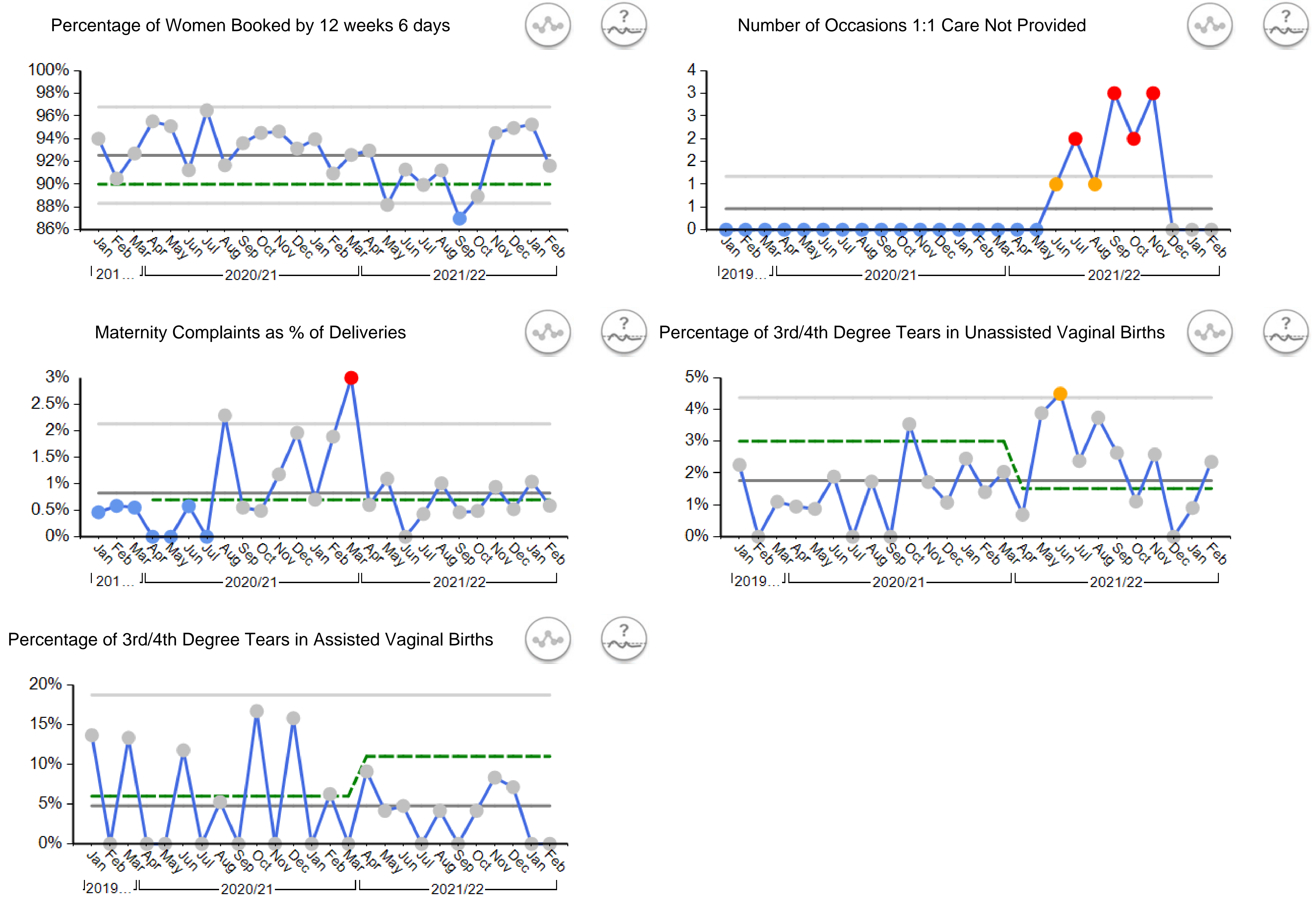
Issues
• Whilst there has been an increase in February, this is not statistically significant.
• The Trust is doing better in comparison to our peers and has been asked to share practice regionally.

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

One stillbirth was reported in February. This is currently undergoing a Perinatal Mortality Review.

Indicator	Latest: Plan	Latest: Actual	Latest: Patients	Latest: Period	Latest: Variation	Previous: Plan	Previous: Actual	Previous: Period	Year to Date: Plan	Year to Date: Actual	Assurance
Stillbirth Rate (per 1,000 births)	3.74	5.9	1	Feb 22		3.7	5.2	Jan 22	3.74	3.7	?
Neonatal Mortality Rate (per 1,000 births)	1.67	0	0	Feb 22	L	1.7	0	Jan 22	1.67	0.5	?
Number of Maternal Deaths	0	0	0	Feb 22		0	0	Jan 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%	42.4%	72	Feb 22		38%	39.1%	Jan 22	38%	42.7%	?
Breastfeeding Initiation	62%	63.3%	62	Feb 22		62%	61.8%	Jan 22	62%	63.7%	?
Percentage of Women Booked by 12 weeks 6 days	90%	91.6%	16	Feb 22		90%	95.3%	Jan 22	90%	91.4%	?
Number of Occasions 1:1 Care Not Provided		0	0	Feb 22			0	Jan 22	0	12	?
Maternity Complaints as % of Deliveries	0.7%	0.6%	1	Feb 22		0.7%	1%	Jan 22	0.7%	0.6%	?
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Births	1.5%	2.4%	2	Feb 22		1.5%	0.9%	Jan 22	1.5%	2.1%	?
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births	11%	0%	0	Feb 22		11%	0%	Jan 22	11%	3.6%	?


Stillbirth Rate (per 1,000 births)
Neonatal Mortality Rate (per 1,000 births)
Number of Maternal Deaths
Caesarean Rates
Induction Rate
Breastfeeding Initiation
2019...
2020/21
2021/22


Percentage of Women Booked by 12 weeks 6 days
100%
98%
96%
94%
92%
90%
88%
86%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201...
2020/21
2021/22
Number of Occasions 1:1 Care Not Provided
4
3
3
2
2
1
1
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019...
2020/21
2021/22
Maternity Complaints as % of Deliveries
3%
2.5%
2%
1.5%
1%
0.5%
0%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201...
2020/21
2021/22
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Births
5%
4%
3%
2%
1%
0%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019...
2020/21
2021/22
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births
20%
15%
10%
5%
0%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019...
2020/21
2021/22

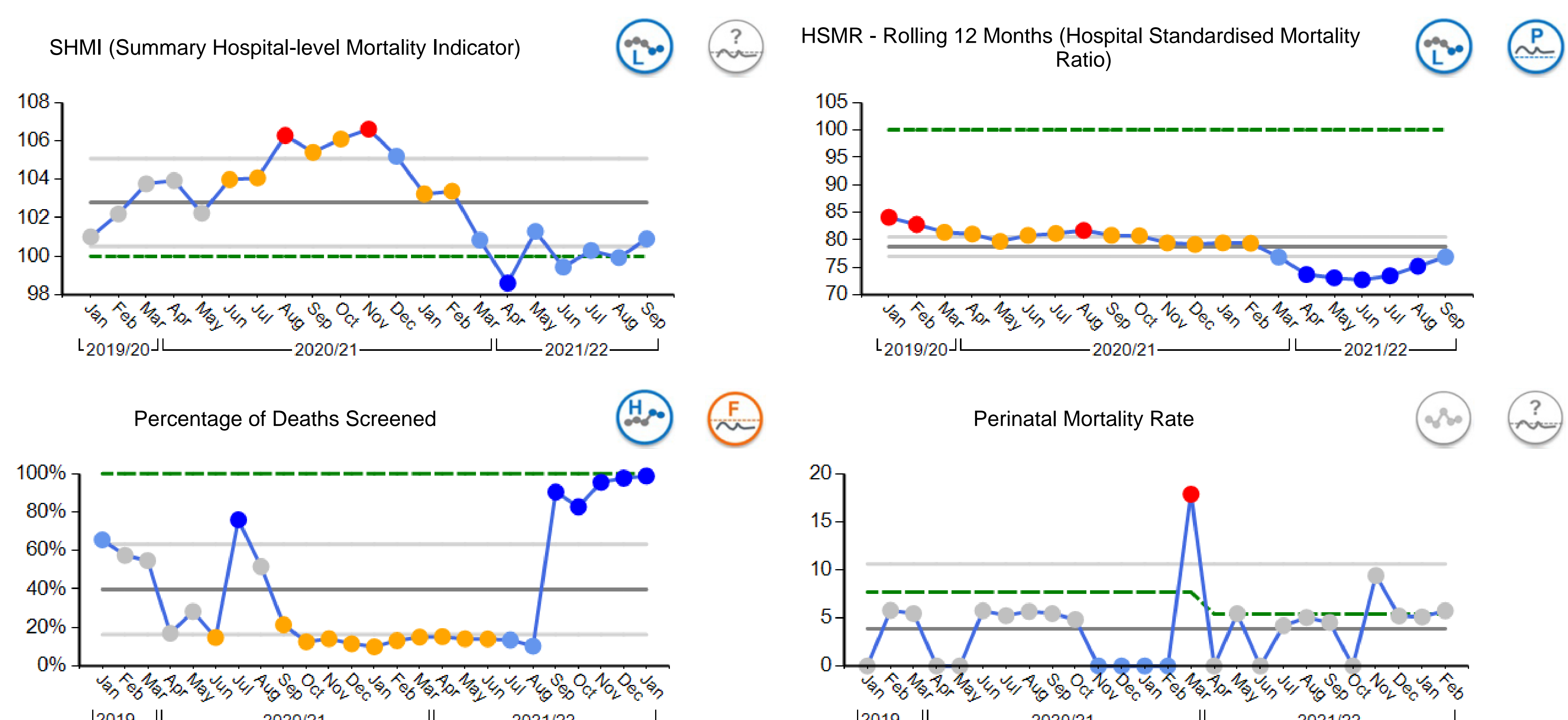
Quality

Mortality

Issues
• Both the HSMR and SHMI are showing special cause improvement.
• The HSMR continues to be assured with performance well below target.
• The SHMI has increased marginally in the latest data month (September) but remains 'as expected'.
• All local SMR's remain below 100.
• Following several months of performing well below the target, impacted by Covid and constraints in the Bereavement room, the mortality screening metric is showing 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	Sep 21	L	100	99.9	Aug 21	100	100.1	?
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	76.9	N/A	Sep 21	L	100	75.2	Aug 21	100	76.9	P
Percentage of Deaths Screened	100%	98.6%	1	Jan 22	H	100%	97.6%	Dec 21	100%	54.6%	F
Perinatal Mortality Rate	5.4	5.8	5.75	Feb 22		5.4	5.1	Jan 22	5.4	4.1	?


SHMI (Summary Hospital-level Mortality Indicator)
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)
Percentage of Deaths Screened
Perinatal Mortality Rate
2019/20
2020/21
2021/22

Patient Experience

Complaints - % closed within 40 working days

Issues
• There has been an 11.6% improvement in February and although this is not statistically significant it remains below average and significantly below target.
• The metric has been impacted by operational pressures throughout winter.

Management Action
• The new Complaints Manager has implemented changes to ensure timely complaint responses.
• This includes clear timescales for complaints to be investigated, improved complaints monitoring through Datix and reduced bottlenecks in the complaints quality assurance processes.
• The new Complaints Manager will be working closely with the CBU's to improve the timeliness of complaints response and explore alternative methods of complaint resolution.

Friends & Family Test

Issues
• Overall Trust score for those that have rated their experience as 'very good/good' continues to show special cause concern although has increased slightly to 90.42% in February. This remains below target. Both Women's and Children's (91.06%) and Medicine and Emergency Care (88.45%) CBU's require improvement.
• FFT within the Adult Accident and Emergency department remains low - 84.89%, however when compared to regional and national NHSE data the department is currently performing above average.

Management Action
• Focused work commenced in March to improve response rates in Antenatal and Post- Natal community settings including implementation of QR codes, Maternity staff training on ENVOY to embed a 'You said… We did' approach and assessment of the re-introduction of FFT postcards with service provider.
• To improve the patient experience in A&E the following has been implemented: addition of an enhanced PALS officer, recruitment to Housekeeper roles, re-introduction of A+E volunteers and 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.
• FFT is monitored through the Patient Experience and Community Engagement group where CBU updates and actions to improve FFT are provided.

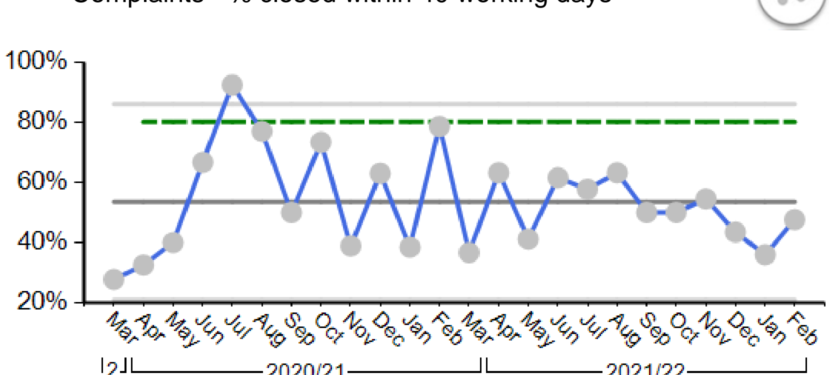
Staff Friends & Family Test

Issues
• The Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation has been updated with the results of the 2021 Annual Staff Survey and the Q4 Pulse Survey.
• The results are based on a response rate of 41.8% for the Annual Staff Survey and 10% for the Quarter 4 Pulse Survey.
• The metric is failing its assurance measure and showing special cause concern.

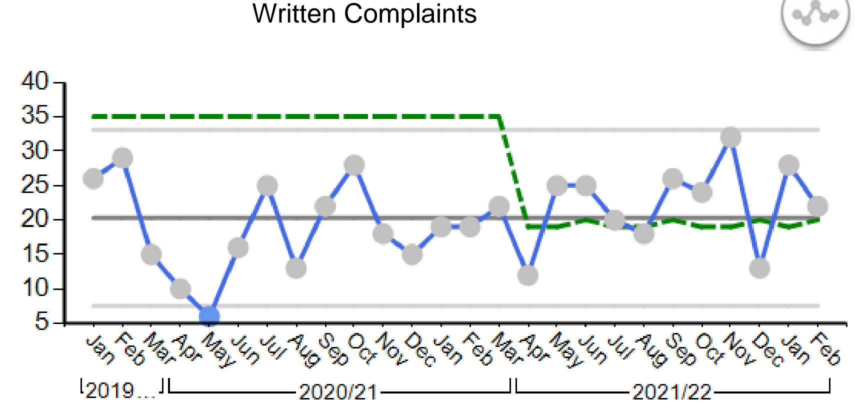
Management Action
• It is very disappointing that 54% would be happy with the standard of care provided by the Trust if their friend or relative needed it. Whilst our comparators have also seen a similar reduction in positive responses for this question, our response rate is not acceptable to us.
• Deeper 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.
• Listening to our staff to inform our actions needs to become 'business as usual' and the Annual Staff Survey should not be relied upon as the only source of hearing from our staff.
• 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.

Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
Complaints - % closed within 40 working days	80%	47.6%	N/A	Feb 22		80%	36%	Jan 22	80%	51.4%	?
Written Complaints	20	22	22	Feb 22		19	28	Jan 22	233	245	?
Friends and Family Test - Patients - % Response Rate	15%	25.4%	5214	Feb 22	H	15%	25.7%	Jan 22	15%		P
Friends and Family Test - Patients - % That Would Recommend - Trust Overall	94%	90.4%	170	Feb 22	L	94%	90.2%	Jan 22	94%	88.8%	?
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	0	0	Feb 22		0	6	Jan 22	0	41	?
Duty of Candour - Evidence of Discussion	100%	100%	0	Feb 22		100%	100%	Jan 22	100%	100%	?
Duty of Candour - Evidence of Letter	100%	100%	0	Feb 22	H	100%	100%	Jan 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 January to 43.3%.
• Compliance 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 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 6 of the 17 breaches. 3 were 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
• Performance against the TIA seen within 24hrs of symptom onset remains extremely low at 6.9%.
• 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.

Management Action
• Challenge reporting against this metric to reflect performance against true TIA referrals only.
• General teaching for TIA referrers to reduce inappropriate TIA referrals.

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 72.6%, North West 69.8% and National 73.3%.
• 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
• CDU is routinely used as an escalation area for patients awaiting admission to inpatient wards. Whilst this improves flow it impacts the 4hr compliance for non-admitted patients.
• Work is ongoing to look at opportunities to increase streaming at the front door to ambulatory pathways where clinically appropriate.
• ESCIT QI events for ED and discharge commenced, improvements will form part of operational plan objectives for SDEC and discharge processes.
• All specialty reviews, post take consultant reviews and further senior reviews were undertaken in ED to ensure that admission was the most appropriate pathway prior to transfers to wards being completed.
• 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).
• The end of February saw the implementation of the new NWAS delayed handover checklist at Southport, which adds further support for using ‘fit to sit’ initiatives as well as ensuring a standardised approach for the occasions that there are delays in completion of handover
• Meetings have also been held with NWAS and there is a planned relaunch of direct streaming from NWAS to ACU in April 2022.

Diagnostics

Issues
• Diagnostic waits continues to fail its assurance measure and show special cause concern but there has been a significant improvement (6.6%) on the previous month.
• The Trust overachieved against the target of 89% of 19/20 activity in month, achieving 108% for both scopes and scans.

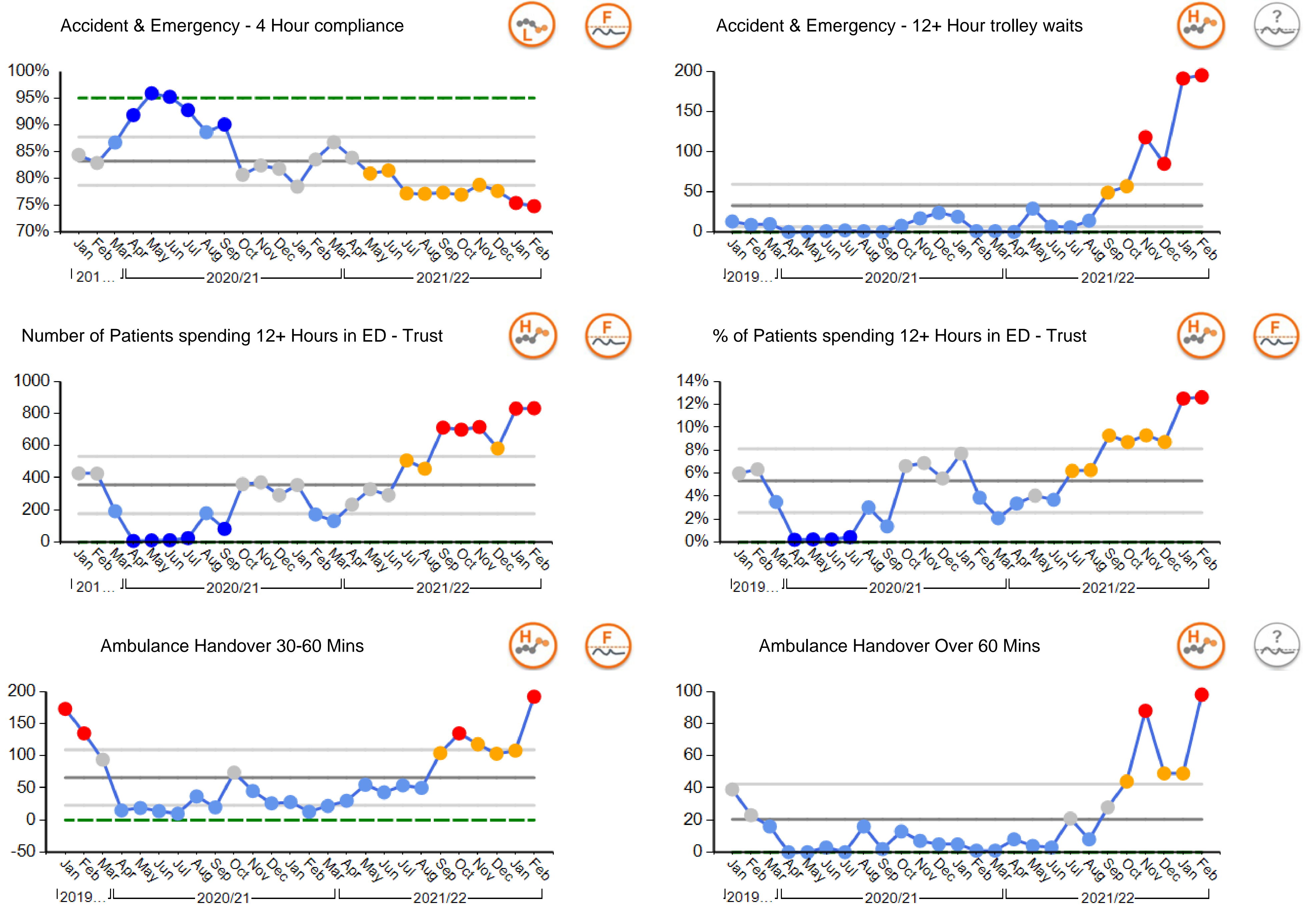
Management Action
• Endoscopy Estates work for phase 1 is now complete.
• Fit-test project commenced in January.
• The re vamped Endoscopy Efficiency Meeting has commenced which reviews session utilisation.
• Work has commenced on the reasons for late starts.

RTT

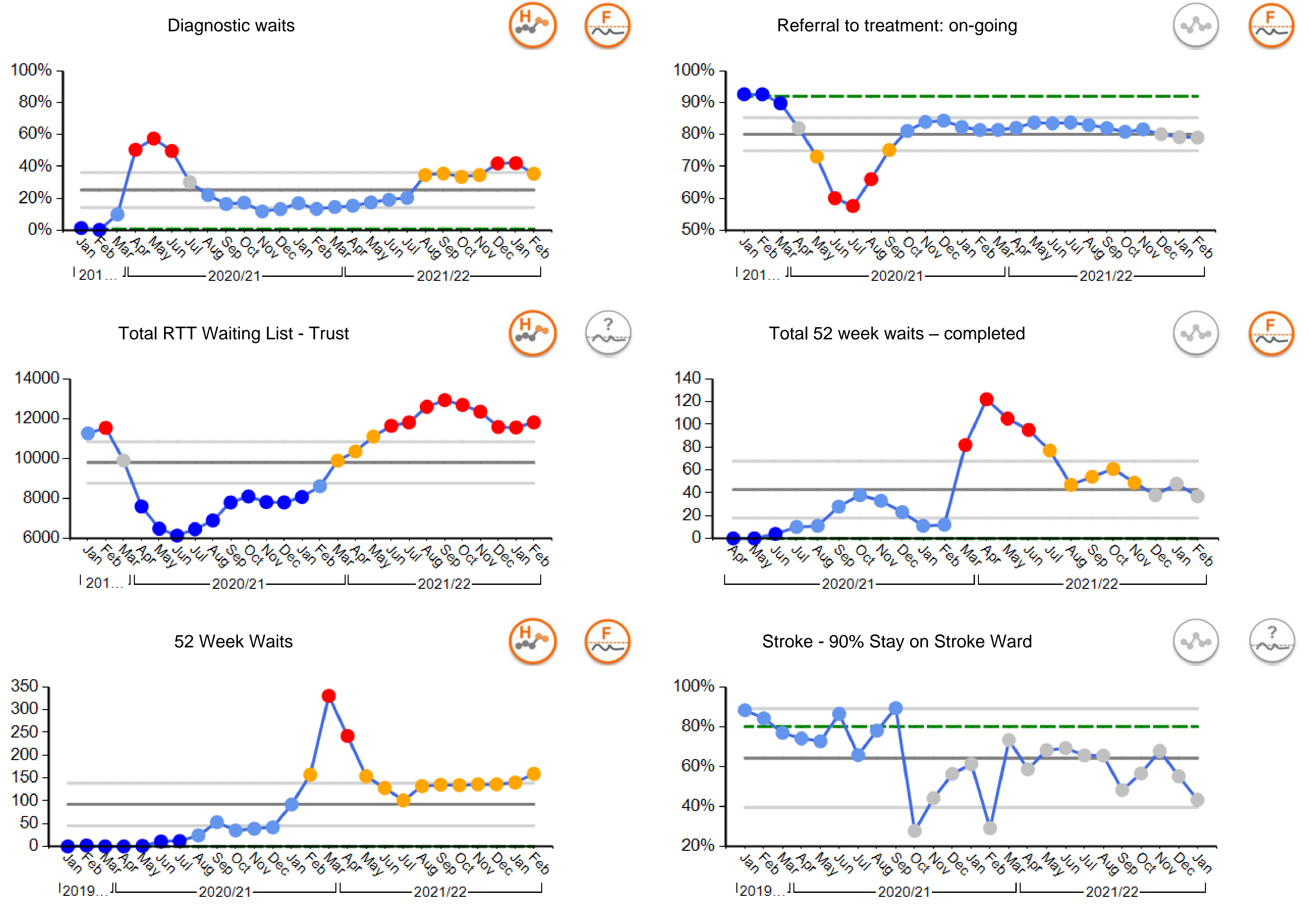
Issues
• The Referral to treatment: on-going metric continues to fail the assurance measure but performance in month is statistically as expected at 79.1% against the 92% target.
• Against the ERF target to achieve 89% of 19/20 activity, the Trust achieved 73% for RTT – Admitted and 84% for RTT – Non-admitted. The overall RTT ERF position was 82.3%.
• The 30-, 42- and 52-week waiter indicators are all showing recent negative variation. All long-waiters have increased in February.
• Covid continues to have a significant impact on elective restoration plans due to bed capacity and staffing challenges.
• The Trust continues to perform well compared to peers.

Management Action
• Continued risk stratification of the waiting list.
• Additionality being implemented.
• Enhanced speciality management as the Trust manages Covid absence.

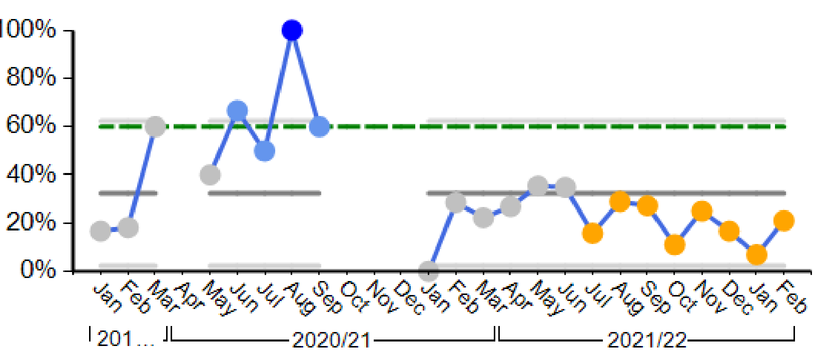
Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
Accident & Emergency - 4 Hour compliance	95%	74.8%	2198	Feb 22	L	95%	75.4%	Jan 22	95%	78.4%	F
Accident & Emergency - 12+ Hour trolley waits	0	195	195	Feb 22	H	0	191	Jan 22	0	751	?
Number of Patients spending 12+ Hours in ED - Trust	0	832	N/A	Feb 22	H	0	830	Jan 22	0	6191	F
% of Patients spending 12+ Hours in ED - Trust	0%	12.6%	N/A	Feb 22	H	0%	12.5%	Jan 22	0%	7.6%	F
Ambulance Handover 30-60 Mins	0	192	192	Feb 22	H	0	108	Jan 22	0	992	F
Ambulance Handover Over 60 Mins	0	98	98	Feb 22	H	0	49	Jan 22	0	400	?
Diagnostic waits	1%	35.6%	2387	Feb 22	H	1%	42.2%	Jan 22	1%	31.5%	F
Referral to treatment: on-going	92%	79.1%	2469	Feb 22		92%	79.2%	Jan 22	92%	81.7%	F
Total RTT Waiting List - Trust		11815	11815	Feb 22	H		11554	Jan 22		11815	?
Total 52 week waits – completed	0	37	N/A	Feb 22		0	48	Jan 22	0	733	F
52 Week Waits	0	159	159	Feb 22	H	0	140	Jan 22	0	242	F
Stroke - 90% Stay on Stroke Ward	80%	43.3%	17	Jan 22		80%	55.2%	Dec 21	80%	59.6%	?
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	60%	21.1%	15	Feb 22	L	60%	6.9%	Jan 22	60%	23%	?



Accident & Emergency - 4 Hour compliance
100%
95%
90%
85%
80%
75%
70%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201...
2020/21
2021/22
Accident & Emergency - 12+ Hour trolley waits
200
150
100
50
0
2019...
2020/21
2021/22
Number of Patients spending 12+ Hours in ED - Trust
1000
800
600
400
200
0
% of Patients spending 12+ Hours in ED - Trust
14%
12%
10%
8%
6%
4%
2%
0%
Ambulance Handover 30-60 Mins
200
150
100
50
0
-50
Ambulance Handover Over 60 Mins
100
80
60
40
20
0


Diagnostic waits
100%
80%
60%
40%
20%
0%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201…
2020/21
2021/22
Referral to treatment: on-going
100%
90%
80%
70%
60%
50%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201…
2020/21
2021/22
Total RTT Waiting List - Trust
14000
12000
10000
8000
6000
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201…
2020/21
2021/22
Total 52 week waits – completed
140
120
100
80
60
40
20
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2020/21
2021/22
52 Week Waits
350
300
250
200
150
100
50
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019…
2020/21
2021/22
Stroke - 90% Stay on Stroke Ward
100%
80%
60%
40%
20%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan
2019…
2020/21
2021/22

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



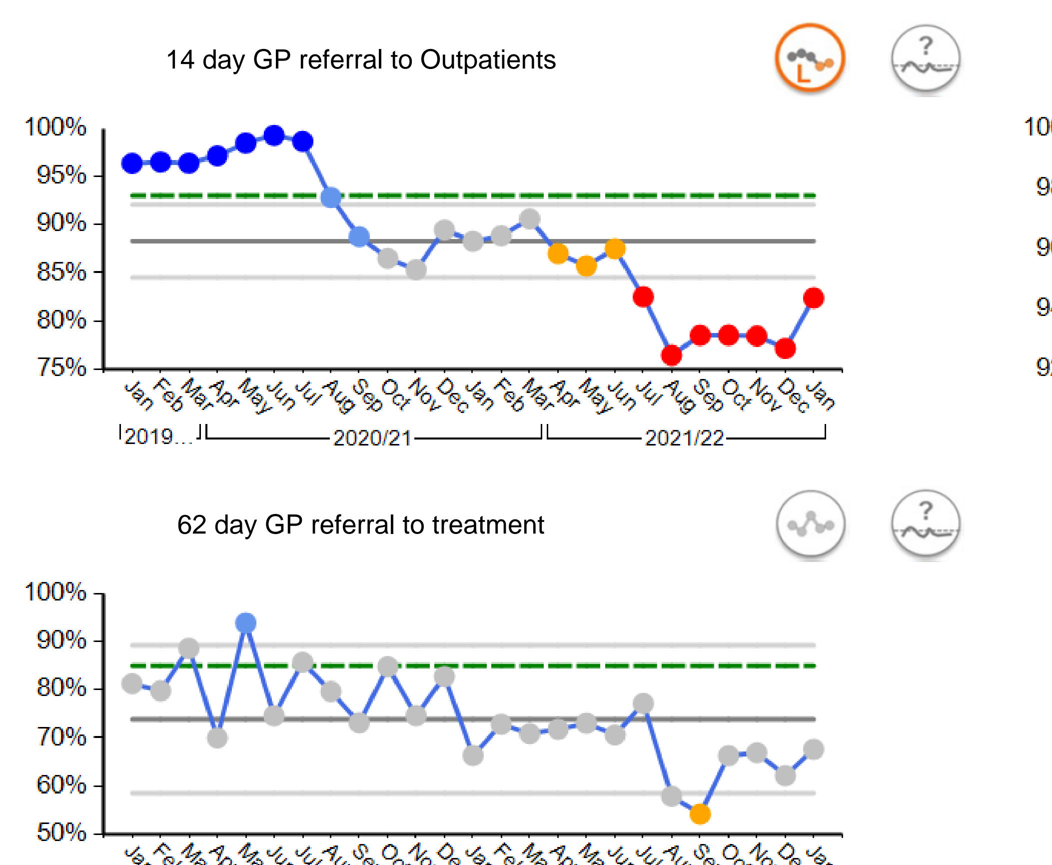
Operations

Cancer

Issues
• Performance against the two week wait standard improved to 82.4% against the 93% target, an increase of 5.2%, however the metric continues to show special cause concern.
• Referrals rose slightly in January compared to the previous month but continue to be lower than the 6 months prior to this.
• Capacity constraints resulted in all tumour sites, except dermatology, breaching this target in month, with upper and lower GI remaining the significant outliers.
• The 31-day target measures how effectively the Trust can deliver cancer treatment in a timely manner. The Trust has recovered its position against the 31-day first treatment target and continues to maintain 100% compliance against the 31-day targets for subsequent treatments.
• Challenges remain for the Trust around the 62 day target, however a small recovery was seen in January, with the overall number of accountable breaches falling from 22.5 to 16 (a 5.5% improvement overall).

Management Action
• 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%	82.4%	172	Jan 22	L	93%	77.2%	Dec 21	93%	81.3%	?
31 day treatment	96%	100%	0	Jan 22		96%	93.1%	Dec 21	96%	98.1%	?
62 day GP referral to treatment	85%	67.7%	16	Jan 22		85%	62.2%	Dec 21	85%	66.8%	?



31 day treatment

100%
98%
96%
94%
92%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan
2019...
2020/21
2021/22

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 with a further significant increase in February.
• The number of super-stranded patients has also increased by 40% from January to February and is showing special 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

• ESCIT QI events for ED and discharge commenced, improvements will form part of operational plan objectives for SDEC and discharge processes.
• Continued command and control, point prevalence and MADE events.
• Continued implementation of the winter plan.

Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
Bed Occupancy - SDGH	90%	87.8%	N/A	Feb 22	H	90%	86.2%	Jan 22	90%	87.9%	?
Bed Occupancy - ODGH	60%	46.8%	N/A	Feb 22		60%	40.1%	Jan 22	60%	41%	F
Stranded Patients (>6 Days LOS)	163	212	212	Feb 22	H	163	191	Jan 22	163	1839	?
Super Stranded Patients (>20 Days LOS)	53	90	90	Feb 22	H	53	64	Jan 22	53	604	?
OP Slot Utilisation	95%	90.6%	N/A	Feb 22	H	95%	89.8%	Jan 22	95%	92.6%	?
New:Follow Up	2.63	2.2	N/A	Feb 22	L	2.6	2.5	Jan 22	2.63	2.4	?
DNA (Did Not Attend) rate	7%	7.6%	1500	Feb 22	H	7%	8.1%	Jan 22	7%	6.8%	?
Theatre Utilisation - SDGH	75%	71.6%	N/A	Feb 22		75%	61.2%	Jan 22	75%	66.4%	?
Theatre Utilisation - ODGH	75%	67.6%	N/A	Feb 22	H	75%	67.1%	Jan 22	75%	70.7%	?
Southport A&E Conversion Rate	28%	21.8%	961	Feb 22	L	28%	21.8%	Jan 22	28%	21.2%	?

Bed Occupancy - SDGH

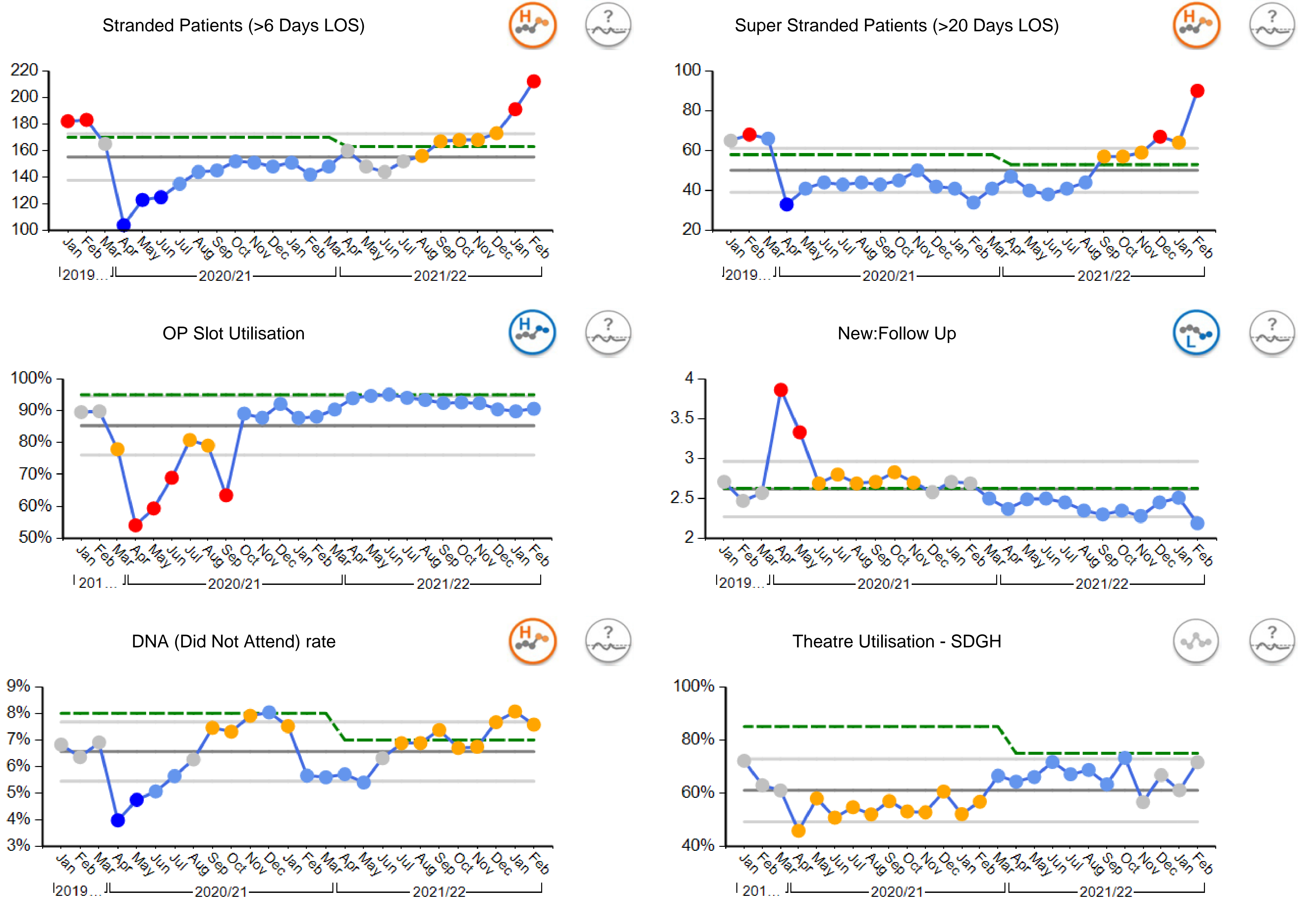
H ?

100%
80%
60%
40%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201… 2020/21 2021/22

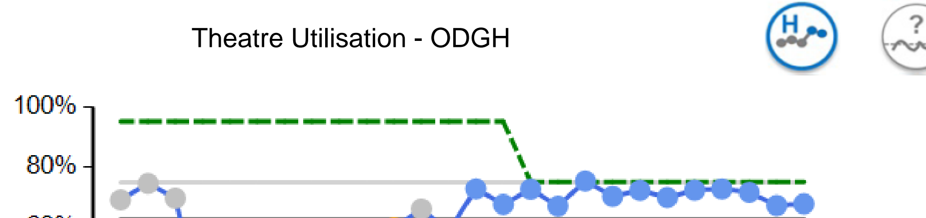
Bed Occupancy - ODGH

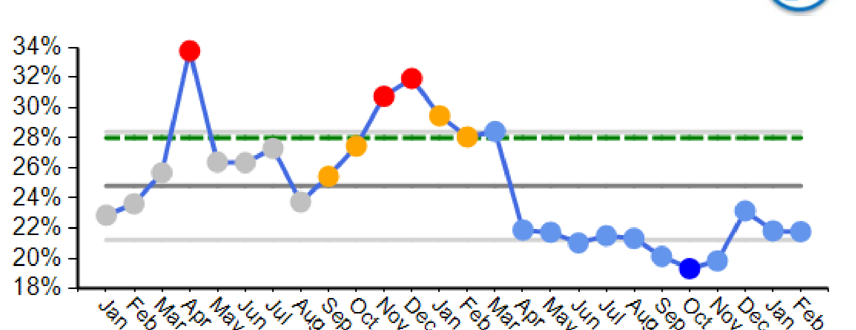
F

60%
55%
50%
45%
40%
35%
30%
25%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019… 2020/21 2021/22



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
2020/21
2021/22


Theatre Utilisation - ODGH
100%
80%
60%
40%
20%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201…
2020/21
2021/22


Southport A&E Conversion Rate
34%
32%
30%
28%
26%
24%
22%
20%
18%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019…
2020/21
2021/22

Finance

Finance

The Trust is forecasting financial breakeven from M11 following confirmation of additional System Top Up Funding secured for 2021/22.

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, and funded through System Top up allocations.

The Trust has secured a further £6m system allocations arising for 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

The Trust is advised that further system allocations could be made available for 2021/22.

CIP
The Trust has delivered schemes totalling £6.2m to M11 and is forecasting delivery of the full year target.
It should be noted that £3.8m is currently 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.

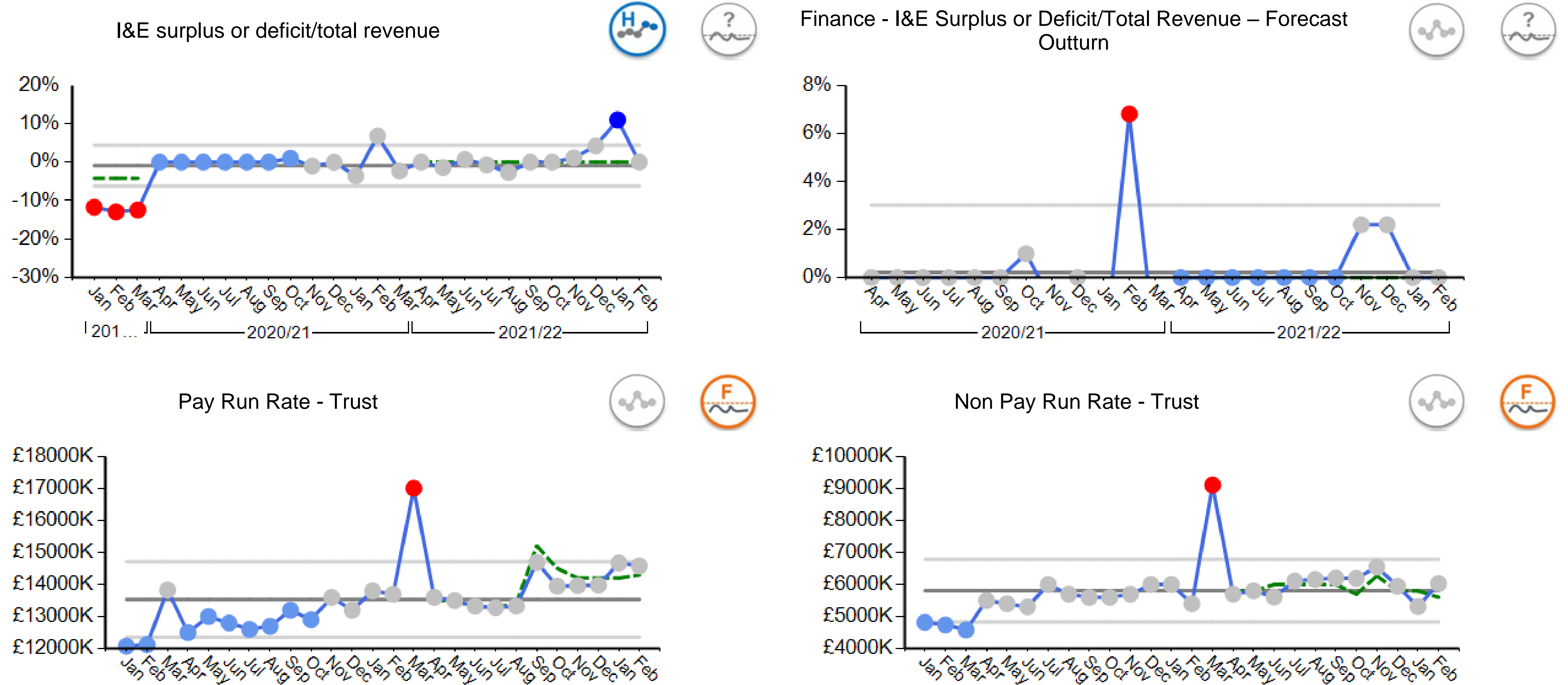
Cash The cash balance at the end of February was £13.4m which includes £6.0m of temporary regional cash support and £4.7m of top up funding.
Remaining capital PDC allocations totalling £8.61m, and £6.0m additional System Top Up funding have subsequently been drawn down during March 2021.
Cash flow risks previously highlighted to Committee have therefore been mitigated in 2021/22 and revised forecasts anticipate year-end cash balances of £19m heading into 2022/23.

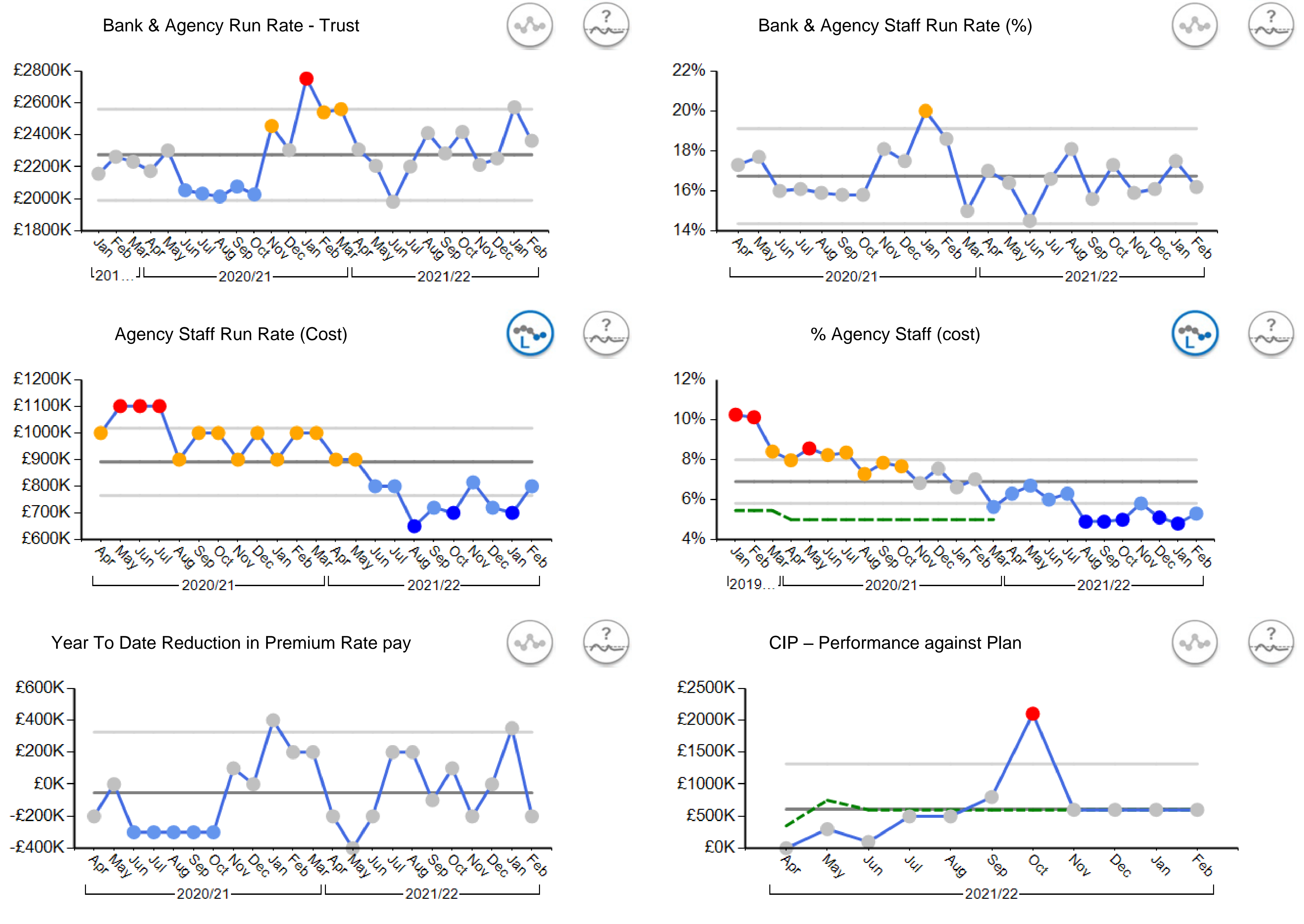
BPPC – The Trust's recovery plan submitted to NHSEI set out an improvement trajectory to achieve 95% on a monthly basis by the end of March 2022. The Trust has maintained 90% YTD to January.

Capital - £6.1m original capital plan for 2021/22, with successful bids for additional capital funding taking the 2021/22 plan to £13.5m. Year to date investment to the end of February of £7.7m, reflecting 58% of the annual budget, with assurances provided by IM&T and Estates & Facilities schemes over delivery in full by 31 March 2022
In addition, the Trust continues to pursue capital funding of £68m in order to address High Risk Critical Backlog Maintenance.

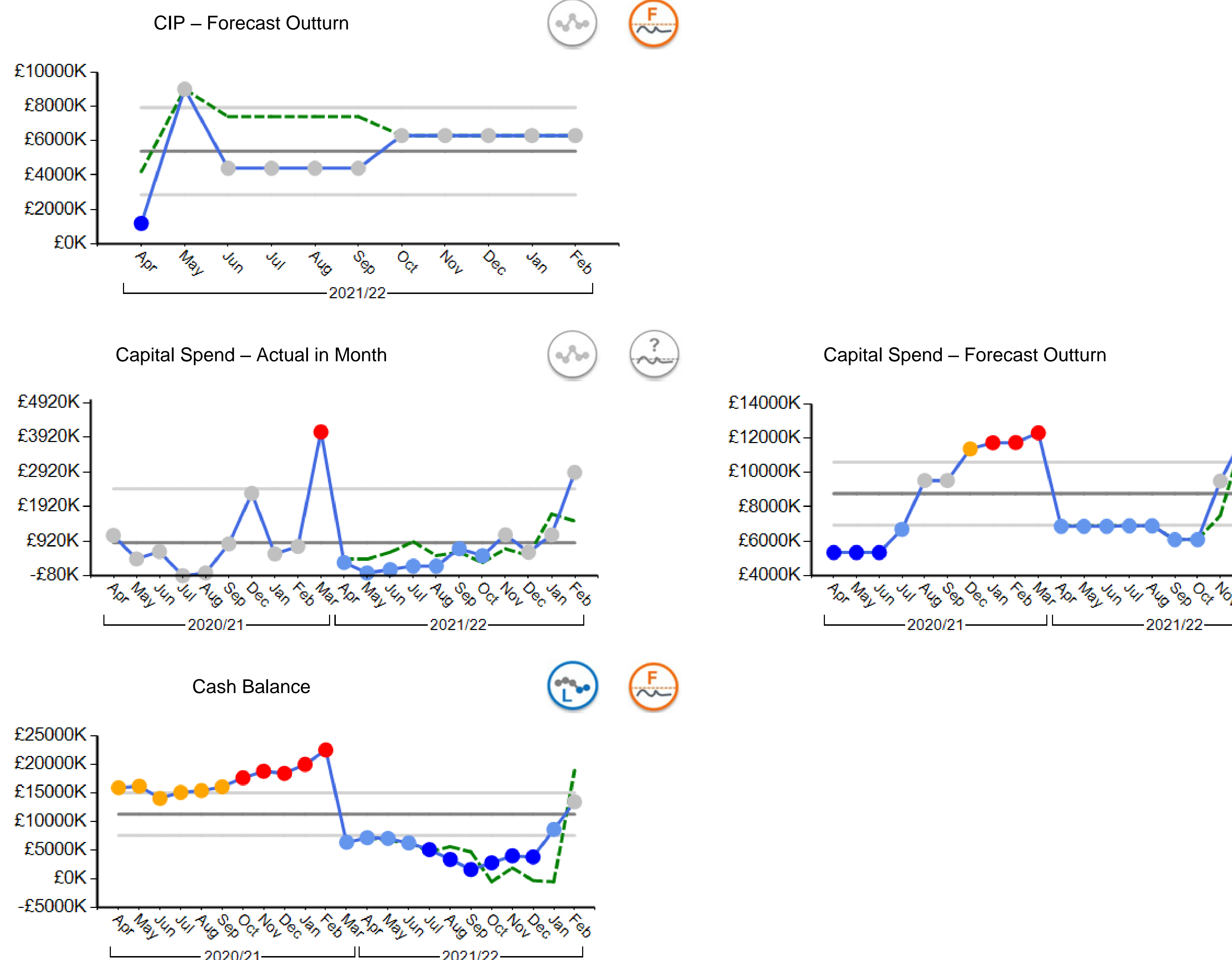
	Latest					Previous			Year to Date		
Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
I&E surplus or deficit/total revenue	0%	0%	N/A	Feb 22	H	0%	11%	Jan 22	0%	0%	?
Finance - I&E Surplus or Deficit/Total Revenue – Forecast Outturn	0%	0%	N/A	Feb 22		0%	0%	Jan 22	0%	0%	?
Pay Run Rate - Trust	£14,300K	£14582K	N/A	Feb 22		£14,200K	£14671K	Jan 22	£153,600K	£152,800K	F
Non Pay Run Rate - Trust	£5,600K	£6030K	N/A	Feb 22		£5,800K	£5310K	Jan 22	£62,000K	£63,300K	F

Year to date Budget in balance		Yes	N/A	Feb 22			No	Jan 22		Yes	
Budget in balance - forecast year end		Yes	N/A	Feb 22			Yes	Jan 22		Yes	
Bank & Agency Run Rate - Trust		£2363K	N/A	Feb 22			£2572K	Jan 22		£20,210K	
Bank & Agency Staff Run Rate (%)		16.2%	N/A	Feb 22			17.5%	Jan 22		16.5%	
Agency Staff Run Rate (Cost)		£800K	N/A	Feb 22			£700K	Jan 22		£8,500K	
% Agency Staff (cost)		5.3%	N/A	Feb 22			4.8%	Jan 22		5.5%	
Year To Date Reduction in Premium Rate pay		-£200K	N/A	Feb 22			£350K	Jan 22		-£50K	
CIP – Performance against Plan	£600K	£600K	N/A	Feb 22		£600K	£600K	Jan 22	£5,800K	£5,800K	
CIP – Forecast Outturn	£6,300K	£6300K	N/A	Feb 22		£6,300K	£6300K	Jan 22	£6,300K	£6,300K	
CIP on Target		Yes	N/A	Feb 22			Yes	Jan 22		Yes	
Capital Spend – Actual in Month	£1,500K	£2900K	N/A	Feb 22		£1,700K	£1100K	Jan 22	£8,200K	£7,700K	
Capital Spend – Forecast Outturn	£13,500K	£13500K	N/A	Feb 22		£13,500K	£13500K	Jan 22			
Cash Balance	£18,900K	£13400K	N/A	Feb 22		-£500K	£8600K	Jan 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
2020/21
2021/22



Bank & Agency Run Rate - Trust
£2800K
£2600K
£2400K
£2200K
£2000K
£1800K
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
201…
2020/21
2021/22
Bank & Agency Staff Run Rate (%)
22%
20%
18%
16%
14%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2020/21
2021/22
Agency Staff Run Rate (Cost)
£1200K
£1100K
£1000K
£900K
£800K
£700K
£600K
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2020/21
2021/22
% Agency Staff (cost)
12%
10%
8%
6%
4%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019…
2020/21
2021/22
Year To Date Reduction in Premium Rate pay
£600K
£400K
£200K
£0K
-£200K
-£400K
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2020/21
2021/22
CIP – Performance against Plan
£2500K
£2000K
£1500K
£1000K
£500K
£0K
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2021/22


CIP – Forecast Outturn
£10000K
£8000K
£6000K
£4000K
£2000K
£0K
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2021/22
Capital Spend – Actual in Month
£4920K
£3920K
£2920K
£1920K
£920K
-£80K
2020/21
2021/22
Capital Spend – Forecast Outturn
£14000K
£12000K
£10000K
£8000K
£6000K
£4000K
2020/21
2021/22
Cash Balance
£25000K
£20000K
£15000K
£10000K
£5000K
£0K
-£5000K
2020/21
2021/22

Workforce

Organisational Development

Personal Development Reviews

Issues
• The indicator continues to show special cause improvement although there has been a 0.4% decline in February.
• Performance in February has been 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 February has been on trying to ensure that any PDRs out of date in month are completed initially prior to any 'out of date' requirements. This has been broadly successful and will be replicated in March.

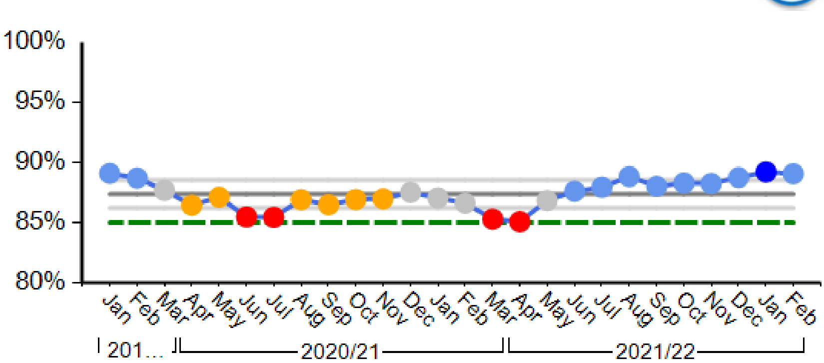
Staff Friends & Family Test

Issues
• The Staff Survey metric has been updated with the results of the 2021 Annual Staff Survey and the Q4 Pulse Survey.
• The results are based on a response rate of 41.8% for the Annual Staff Survey and 10% for the Quarter 4 Pulse Survey.

Management Action
• It is very disappointing that only 54% of staff would recommend this Trust as a place to work. Whilst our comparators have also seen a similar reduction in positive responses, our response rate is not acceptable to us.
• Deeper 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.
• Listening to our staff to inform our actions needs to become 'business as usual' and the Annual Staff Survey should not be relied upon as the only source of hearing from our staff.
• 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.

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%	75.6%	N/A	Feb 22	H	85%	76%	Jan 22	85%	77.3%	F
Mandatory Training	85%	89.1%	N/A	Feb 22	H	85%	89.2%	Jan 22	85%	88%	P
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%	?



100%
80%
60%
40%
Mar Dec Jul Oct Jan
2019/20
2020/21
2021/22

Workforce

Sickness, Vacancy and Turnover

Sickness

Issues
• Sickness rates in February continue to show special cause concern although have reduced by 2.1% from the January position.
• The rolling 12-month sickness rate continues to fail its assurance measure and at 6.8% is the highest reported.
• Sickness rates for Nursing staff are failing their assurance measure and showing special cause concern although have reduced by 3.2% in month.
• Medical sickness rates have decreased by 0.4% and remain below the target.
• Trust absence rate tracking just above regional and national levels for February after having been at the same point in January.

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.
• The spike in January of non-registered nurse absence was primarily due to covid related matters. There were 146 separate absences in the month and 75 were covid related. Compared to 121 in December of which only 36 were covid related.

Vacancies

Issues
• Overall Trust vacancy rate continues to fail its assurance measure. Performance in February remains the same as the previous month.
• Medical vacancy rates are showing special cause improvement with a 1.8% reduction in February.
• Nursing vacancy rates have increased in month but continue to show special cause improvement, although levels remain below the target. The increase in overall nursing vacancies is impacted by HCA vacancies.

Management Action
• Whilst the overall vacancy rate is above target, the Trust has 194 posts under offer and this will have a significant impact on this number in the next 3 months as this equates to 6% of the workforce.
• 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.
• Slight drop in registered Nursing vacancies in month due to international nurses which had been in Band 3 and 4 posts receiving their PIN Number.
• Currently 33 HCA posts under offer with 26 currently on the CSWD programme via NHSP who will be shortly by ready for Trust post
• A call with NHSE is scheduled for the end of March to look at improvement in both recruitment and retention.

Turnover

Issues
• Overall staff turnover levels are performing as expected.
• The rolling staff turnover is failing the assurance measure and shows special cause concern.
• The Nursing staff turnover has reduced in February and is below target.

Management Action
• Senior HR team working on retention schemes to reduce this level, and looking at increasing flexibility alongside this.
• We are acutely aware of the age of the medical workforce, with 5 retirements before August 2022 which will affect Medical turnover.

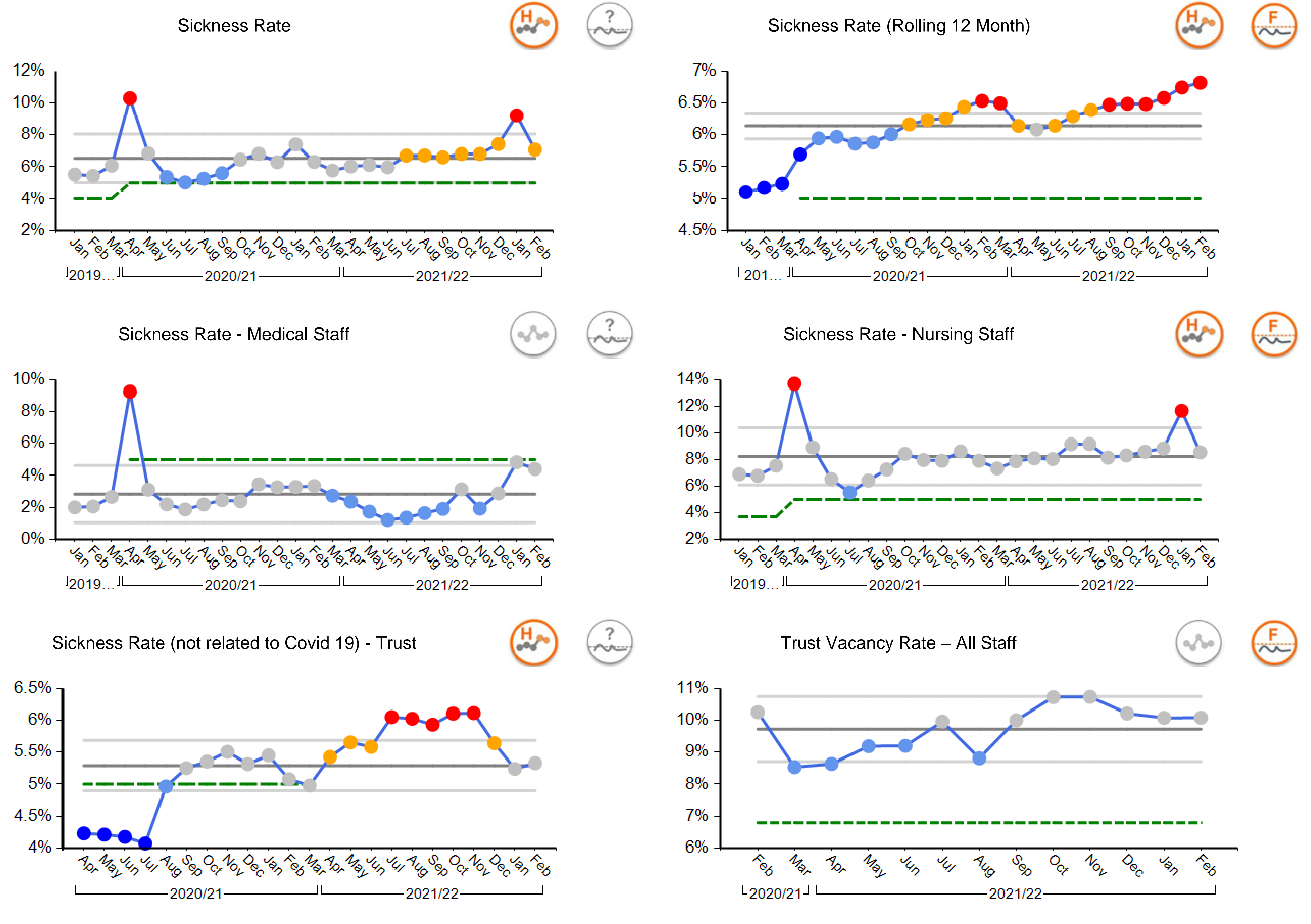
• Further work required to support flexible working and retire and return to retain essential skills.

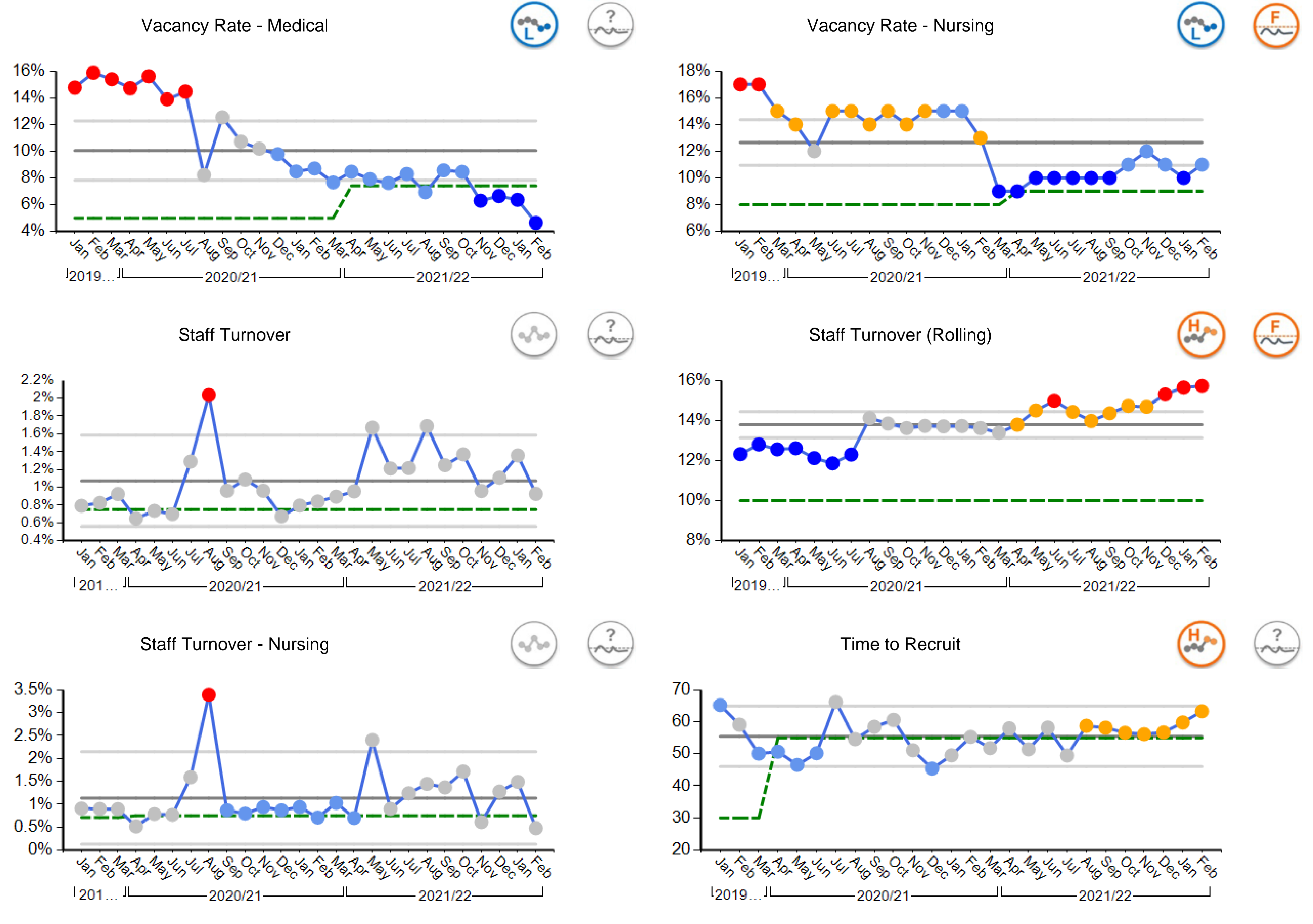
Time to Recruit

Issues
• The overall metric is showing special cause concern and is performing in excess of the target.
• Performance has been impacted by 4 candidates taking in excess of 120 days each due to awaiting completion of higher training and relocation.

Management Action
• Monthly deep drive undertaken, and team have reviewed.
• Operation green still in progress.

Indicator	Latest: Plan	Latest: Actual	Latest: Patients	Latest: Period	Latest: Variation	Previous: Plan	Previous: Actual	Previous: Period	Year to Date: Plan	Year to Date: Actual	Assurance
Sickness Rate	5%	7.1%	N/A	Feb 22	H	5%	9.2%	Jan 22	5%	6.9%	?
Sickness Rate (Rolling 12 Month)	5%	6.8%	N/A	Feb 22	H	5%	6.7%	Jan 22	5%	6.4%	F
Sickness Rate - Medical Staff	5%	4.4%	N/A	Feb 22		5%	4.8%	Jan 22	5%	2.5%	?
Sickness Rate - Nursing Staff	5%	8.5%	N/A	Feb 22	H	5%	11.7%	Jan 22	5%	8.8%	F
Sickness Rate (not related to Covid 19) - Trust		5.3%	N/A	Feb 22	H		5.2%	Jan 22		5.7%	?
Trust Vacancy Rate – All Staff	6.8%	10.1%	N/A	Feb 22		6.8%	10.1%	Jan 22	6.8%	9.8%	F
Vacancy Rate - Medical	7.4%	4.6%	N/A	Feb 22	L	7.4%	6.4%	Jan 22	7.4%		?
Vacancy Rate - Nursing	9%	11%	N/A	Feb 22	L	9%	10%	Jan 22	9%		F
Staff Turnover	0.75%	0.9%	N/A	Feb 22		0.8%	1.4%	Jan 22	9%	6.8%	?
Staff Turnover (Rolling)	10%	15.7%	N/A	Feb 22	H	10%	15.6%	Jan 22			F
Staff Turnover - Nursing	0.75%	0.5%	N/A	Feb 22		0.8%	1.5%	Jan 22	0.8%	1.2%	?
Time to Recruit	55	63	N/A	Feb 22	H	55	60	Jan 22	55	57	?


Sickness Rate
12%
10%
8%
6%
4%
2%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019...
2020/21
2021/22
Sickness Rate (Rolling 12 Month)
7%
6.5%
6%
5.5%
5%
4.5%
201...
2020/21
2021/22
Sickness Rate - Medical Staff
10%
8%
6%
4%
2%
0%
2019...
2020/21
2021/22
Sickness Rate - Nursing Staff
14%
12%
10%
8%
6%
4%
2%
2019...
2020/21
2021/22
Sickness Rate (not related to Covid 19) - Trust
6.5%
6%
5.5%
5%
4.5%
4%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2020/21
2021/22
Trust Vacancy Rate – All Staff
11%
10%
9%
8%
7%
6%
Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2020/21
2021/22


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 (QSC)**
MEETING DATE:	28 February 2022
LEAD:	Gill Brown

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- No alerts.

ADVISE

- **AKI Presentation** - demonstrated progress being made, current position and plan presented. Quality Priority for 2022/23
- **Terms of Reference** - recommended for submission to the Strategy and Operations Committee for approval with minor amendments
- **Operational Update** - noted increased Covid-19 admissions and continued pressures
- **Quality Accounts and QI priorities** - five priorities accepted noting reference needs to be made to continued work to ensure appropriate recording and response to elevated NEWS2. The five agreed priorities are:
  - Reducing falls
  - Reducing pressure ulcers
  - AKI; Nutrition and hydration
  - Communication with patients and families
  - Continuity of carer
- **CQC Insight Report** - latest published information presented and compared to latest data. Agreed to bring back further work to provide assurance regarding patients waiting in ED
- **Patient Safety Monthly Update** - one fall associated with harm noted
- **IPR** - Increase in nosocomial Covid19 infections noted. Improvements were noted in several metrics. There was a discussion re SPC use and interpretation
- **Orthopaedic Review** - Update on progress noted

ASSURE

- **CQC Registration and Action plan progress** – content noted including work required to assess culture of both STHK and S&O to support future collaboration
- **AAAs received:**
  - IPCAG
  - Safeguarding Assurance Group
  - Patient Experience and Community Engagement Group

New Risks identified at the meeting: No new risks were identified at the meeting.

Review of the Risk Register:

(List any risks reviewed at the Committee meeting and state any adjustments to the scores, why they were adjusted, and any actions agreed for improvement)

Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 April 2022
Agenda Item	SO055/22	FOI Exempt	NO
Report Title	CQC PROGRESS, ACTIONS, ENGAGEMENT AND WELL-LED IMPROVEMENT JOURNEY		
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

To provide an update in relation to our Care Quality Commission (CQC) progress, actions, engagement and Well-Led Improvement Journey.

Executive Summary

This report provides an update in relation to our ongoing engagement with the Care Quality Commission (CQC) and how we monitor our actions and quality improvements.

The report also provides a summary on progress in relation to our well led recommendations highlighted in our 2019 CQC Inspection. Whilst progress has been made, there is a need to focus on specific key areas including:

- Strengthening engagement with staff in relation to Trust Vision & Strategy
- Continue ongoing of promotion and monitoring of 'Our People Plan'
- Drive Cultural Change across the Trust
- Continue promotion of Patient Engagement Strategy and develop plans to involve patients in the Codesign and Co-production of service improvements

The report also incorporates any opportunities for learning or action as we work more closely and develop our long term collaboration with St Helens & Knowsley Hospitals Trust (StHK). This was shared at Quality & Safety Meeting in January 2022. Although not all areas identified for improvement were as a result of the recent merger, there are key themes emerging from the CQC LUHFT report which may be fundamental in any organisation, including ourselves, which will be assessed through the 'Well Led' domain.

We are currently in the process of undertaking a comprehensive well-led self-assessment across all 8 well led domains using the CQC key characteristics, we anticipate the timescale for this review will be three months , a well-led improvement plan will be developed and monitored through the Trust's committee structure.

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	
Recommendations	
The Strategy and Operations Committee is asked to receive the update in relation to the CQC progress, actions, engagement and well-led improvement journey.	
Previously Considered By:	
☐ **Finance, Performance & Investment Committee** ☐ **Remuneration & Nominations Committee** ☐ **Charitable Funds 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:**
Jo Simpson, Assistant Director of Quality	Lynne Barnes, Director of Nursing, Midwifery and Therapies

<u>**Care Quality Commission (CQC) Update & Well Led – March 2022**</u>

1. PURPOSE OF THE REPORT

This report provides an update in relation to our Care Quality Commission (CQC) progress, actions, engagement and Well-Led Improvement Journey

2. CQC IMPROVEMENT PLAN AND ASSURANCE

Following our CQC inspections in 2019 and 2021 several actions and themes for improvement were identified and all have been incorporated and monitored through clinical audit or Quality Improvement (QI) workstreams. A progress report was presented at Strategy & Operations Committee (SOC) in February 2022.

Our Quality Improvement workstreams for 2021/22 have included:

- Safer Discharges
- DNACPR / Capacity Assessments
- Deteriorating Patient
- Nutrition & Hydration
- Medicines Safety
- Falls & Pressure Ulcers
- Improving Safety Culture
- End of Life Care
- Safe Staffing
- Patient Experience

We have made significant progress during 2021/22, however further improvement is still required in some areas to ensure progress and improvements are embedded and sustained. It is anticipated a number of the workstreams will remain quality priorities for 2022/23. A paper was presented to Executive Management Team for review and consensus on 21st March 2022 outlining the draft Quality Priorities for 2022/23, the following were agreed:

- Reduction in Falls
- Reduction in pressure Ulcers
- Acute Kidney Injury, Nutrition & Hydration
- To improve communications with families prior to discharge or End of Life
- Continuity of Carer (Maternity)

Organisational objectives will also be incorporated and set by the Managing Director and quality priorities will have a direct link to objectives for the Executive Team.

Under the CQC's new monitoring framework there is a move away from the reliance on comprehensive onsite inspections as the trigger for assessing quality and issuing ratings. Instead, there is more reliance on a risk assessment and good quality data from a variety of sources, including

service users' feedback, combined with focused onsite inspections where necessary, to assess quality and change a rating.

Through this new framework the Trust successfully completed two CQC 'core services' monitoring templates in 2020 for Maternity and Medicine core services. Following submission, the CQC were satisfied with evidence submitted and requested no further information or action.

3. ASSURANCE PROCESS

We have a 'check and challenge' process to ensure that for any actions we have closed the improvements remain embedded and sustained - this includes Quality and Safety Walkabouts, SOCAAS (Southport & Ormskirk Clinical Assessment and Accreditation Scheme) and use of the Tendable (previously known as Perfect Ward) audit programme. We also utilise the Ward Quality Dashboard and metrics from the IPR to triangulate and identify any areas that may need additional assistance to support improvement.

All areas for improvement identified at previous inspections have been incorporated into our QI workstreams and reported into the Quality and Safety Committee.

4. CQC ENGAGEMENT

We also continue to meet with CQC colleagues bi-monthly with a joint agenda to discuss any areas of focus and enquiries. The engagement meetings provide an opportunity to resolve any enquiries in a timely manner. Our next engagement meeting was due to be held on 24th March 2022, however, was cancelled by CQC due to inspection commitments. The focus of our next meeting will be Covid-19 and recovery plan, A&E quality and performance and the new Governance structure for the Trust following the partnership arrangements with St Helen's & Knowsley NHS Trust.

5. 2019 CQC WELL LED SELF-ASSESSMENT PROGRESS

An initial self-assessment paper was first presented to the Board in May 2020 highlighting the Trust's progress in relation to the Well Led recommendations from the 2019 CQC Inspection, this has been revisited every sixth months with the last update in May 2021. Changes at executive leadership level delayed the process in Q3 2021-22 and this is now back on track. The initial self-assessment concluded that whilst there are areas of improvement, the Trust would continue to strengthen assurance across the eight 'well-led domains'.

The table at Appendix A provides an update against the CQC identified actions and recommendations from the 2019 Well Led Inspection as well as identifying the next steps and additional actions to facilitate our improvement journey.

6. CONCLUSION & NEXT STEPS

Whilst progress has been made, there is a need to focus on specific key areas including

- Build on existing engagement with staff in relation to Trust Vision & Strategy
- Continue ongoing promotion and monitoring of 'Our People Plan'

- Drive Cultural Change across the Trust
- Continue promotion of Patient Engagement Strategy and develop plans to involve patients in the Codesign and Co-production of service improvements

In addition to reviewing our progress since 2019 CQC Well Led Inspection the Trust has also reviewed the Liverpool University Hospitals Foundation Trust (LUHFT) post-merger CQC Inspection report published in October 2021. The Trust wanted to identify any opportunities for learning given the development of our long term collaboration with St Helens & Knowsley Hospitals Trust (StHK). This was shared at Quality & Safety Meeting in January 2022. Although not all areas identified for improvement were as a result of the recent merger, there are key themes emerging from the CQC LUHFT report which may be fundamental in any organisation, including Southport & Ormskirk Hospital, which will be assessed through the ‘Well Led’ domain. Any themes and actions for focus will be incorporated into our new Well Led Improvement Plan.

To support the improvement journey, the Trust also in the process of undertaking a comprehensive Well-Led self-assessment across all 8 well led domains using the CQC key characteristics. A template was sent to Executive colleagues week commencing 14th March 2022 for completion. Evidence submitted for the current Well-Led improvement plan will be used to inform the self-assessment. The timescales for the review are

- Executive Response by Friday 8th April 2022
- Review of the evidence with working group 19th April – 28th April 2022
- Present findings to Executive Management Team in May 2022
- Agree governance and reporting framework
- Present final report including draft rating and improvement plan to Quality & Safety Committee June / July 2022

6. RECOMMENDATIONS

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

Appendix A **Update Against CQC Identified Actions from 2019 Well Led Inspection** **March 2022**

Ref	Domain	Identified Actions	Progress
W1	Is there the leadership capacity and capability to deliver high-quality, sustainable care?	• Board to agree strategic intentions for the sustainability model to inform the rest of the Well Led Domain	• *The Shaping Care Together (SCT) programme continues to progress, this has been further supported by the agreement for long term collaboration with St Helens & Knowsley Trust (STHK) supported by NHSE/I.* • *The Trust has clear set of strategic objectives which are supported by annual corporate objectives are in development for 2022/23. These will be shared using a communication plan developed by the Trust board with a launch event planned for April/May 2022.* • *SCOPE Values remain in place.*
		• Evaluation of and structured plan required for Board visibility arrangements and communications both internally and externally.	• *Monthly Trust Brief Live became virtual supported by a video recording shared after the event. This approach has seen a big increase in attendance to the extent Trust Brief is now a weekly online event.* • *Back to the floor remains in place whereby Executives are given the opportunity to work with clinical and corporate teams.* • *The Executive Team now has a permanent presence across both sites. In addition, plans are now in place to ensure that each Ward has a named Exec buddy who will be presenting updates to ETM meeting.* • *The Big Brew ran virtually during the pandemic by a member of the Executive team or Senior Managers across the Trust – these provided the opportunity for staff to connect and chat with an exec informally and ask any questions that they wish. The Executive Team will consider reinstating these as part of the Listening Plan under development.*

Ref	Domain	Identified Actions	Progress
		• Milestones to be reported for Workforce and OD strategy against Well Led domain criteria.	• *A refreshed OD and Workforce strategy 'Our People Plan' was approved by Workforce Committee in January 2021 and by the Board in February 2021* • *There is emphasis within 'Our People Plan' on the role of leaders play in setting the right cultural and behavioural tone, empowering others to make their own unique contribution. As such development of leadership skills remains a key programme of work under the strategy.* • *Plan in place to implement culture change.* • *Evaluation of culture –Our Listening Plan being developed.*
		• Q3/4 peer review required for Medicine Core Service against original rating of inadequate for Well Led domain.	*Completed as an unannounced Medicine core service CQC inspection was undertaken from 3 to 5 March 2021, a marked improvement in Well-Led was noted.* • *A Medicine Core Service CQC Monitoring Template was completed in December 2021 as part of the CQCs new monitoring framework. No further information was requested by CQC following submission.*

Ref	Domain	Identified Actions	Progress
		• Pharmacy reporting and governance arrangements to be moved to a clinical business unit to ensure appropriate risk, governance and escalation arrangements.	*Pharmacy now sits within Specialist Services Clinical Business Unit (CBU), also in place are:* • *Pharmacy Governance & Performance meeting* • *Medicines Safety Committee* • *Drugs & Therapeutics Committee* • *CD Oversight Group*
W2	Is there a clear vision and credible strategy to deliver high quality sustainable care to people and robust plans to deliver?	• Current strategies to be assessed to ensure they are fit for purpose and aligned to strategic direction and priorities. Board Development to agree strategic direction and priorities.	• *The Shaping Care Together (SCT) programme continues to progress, this has been further supported by the agreement for long term collaboration with St Helens & Knowsley Trust (STHK) supported by NHSE/I.* • *SCOPE Values remain in place.* • *The Trust has clear set of strategic objectives which are supported by annual corporate objectives which are in development for 2022/23. These will be shared using a communication plan developed by the Trust board with a launch event planned for April/May 2022.*
		• Communication plan to be agreed to ensure stakeholders are informed and involved in the above	*Full communication plan for SCT programme remains in place.* *Communication plan is in development to confirm the strategic objectives and vision and launch the supporting corporate objectives and Quality Priorities for 2022/23.*

Appendix A **Update Against CQC Identified Actions from 2019 Well Led Inspection** **March 2022**

Ref	Domain	Identified Actions	Progress
W3	Is there a culture of high quality, sustainable care?	• Strengthen and broaden Equality and Diversity structures to ensure oversight, continuous improvement	*Trust is currently promoting the Staff Networks for BAME LGBT+ Disability / Long-term condition the aim is to recruit staff from the network groups and offer training for those that would like to receive it, opportunities will also be offered to Trust allies (An ally is an individual who doesn't identify as BAME LGBT+ Disability / Long-term condition but believes that staff should experience full equality in the workplace) Training opportunities have been sourced and will cover the following sessions:* ○ *Disability Awareness* ○ *LGBT* ○ *Transgender* ○ *Unconscious bias* ○ *Equality Impact Assessment* ○ *Carers* ○ *Cultural Awareness*
		• Evaluate the impact of Leadership and Development strategies	• *'Our People Plan' out OD and workforce strategy is monitored and reviewed through Workforce Committee.* • *Currently developing 'Our Listening Plan' - a tailored approach to local trust needs and give staff a voice to share lived experiences.*

Ref	Domain	Identified Actions	Progress
		• Evaluate the impact of this on culture and staff engagement	• *Quarterly Pulse checks in place.* • *Improvement Plan being developed following the last staff survey.* • *In process of commissioning a culture survey for all staff.* • *Further embed just and learning principles, with awareness across all staff of the keystone behaviours – civility and respect.* • *Supporting our workforce to promote a supportive and inclusive environment (including the introduction of Schwartz Rounds, compassionate leadership development programme and enhanced person-centred wellbeing support).*
		• Assess whether there are robust plans in place to support any concerns regarding staff engagement and culture	• *SCOPE Values remain in place.* • *Freedom to Speak Up (FTSU) process in place reporting to Workforce Committee and SOC.* • *Targeted cultural improvement work undertaken in Theatres and Maternity.*

Appendix A **Update Against CQC Identified Actions from 2019 Well Led Inspection** **March 2022**

Ref	Domain	Identified Actions	Progress
W4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?	• Evaluate existing governance arrangement that have been imbedded as part of a cycle of business	• *Work plans and Terms of Reference (TORS) are in place and reviewed annually for all committees and reporting groups and work plans / cycles of business in place.* • *Single Accountability Framework is now in place and provides a mechanism for performance and accountability.* • *PIDA Boards TORs have been refreshed– there is more focus on accountability and deliverability of finance & performance indicators* • *Risk and compliance group is now chaired by the Medical Director and there is positive evidence of improvements in relation to risk management with a significant reduction in the number of extreme risks.*
		• Review reporting arrangements, particularly for Pharmacy	• *Pharmacy now sits within the Specialist Services CBU.* • *Pharmacy risks are overseen by the CBU and at Risk and Compliance Group, chaired by the CEO.* • *Pharmacy performance is monitored via the Specialist Services CBU at PIDA.*

Appendix A **Update Against CQC Identified Actions from 2019 Well Led Inspection** **March 2022**

Ref	Domain	Identified Actions	Progress
W5	Are there clear and effective processes for managing risks, issues and performance?	• Once embedded, review all new risk, performance and compliance arrangements as part of the business cycle.	• *Board Assurance Framework (BAF) fully revised with clear measurable and deliverables that will be monitored and reported to sub-committees of the board in line with the cycles of business.* • *Actions from the BAF are reviewed monthly at ETM to ensuring there's a platform for execs to review other actions and offer challenge were appropriate.* • *Risk Management Framework is currently under Executive review for comment before going through governance process for adoption.* • *The Quality Improvement (QI) Programme Board has met monthly since July 2021 to review and discuss progress on the Quality Priorities and QI Workstreams, this feeds into QSC on quarterly basis.*
		• Standarise CBU Risk and Governance arrangements and consider an external peer review of new arrangements as part of continuous improvement	• *Risk Management Training for managers in place.* • *The Trust's risk management strategy and policies are currently under review.*

Appendix A **Update Against CQC Identified Actions from 2019 Well Led Inspection** **March 2022**

Ref	Domain	Identified Actions	Progress
W6	Is appropriate and accurate information being effectively processed, challenged and acted upon?	• Development of IM&T and Data Quality Strategies	• *There is now an 18 month work plan in plan for the Information Technology (IT) Programme covering Strategy, Electronic Patient Record (EPR), Interfaces, Core Infrastructure and Cyber Security. The Head of IT is the owner of this work plan.* • *The EPR Programme Board has now been established and reports into IM&T Committee. This continues to monitor progress of the EPR programme of work and rollout of all remaining modules (Clinical Narrative and Workspace).* • *The Trust is now rolling out Careflow Connect for electronic handovers and Clinical Narrative for electronic forms. All will be fully integrated into the EPR and will reduce paper based processes.* • *The Trust will be going live with EPMA later this year in collaboration with St Helens and Knowsley NHS Trust.* • *The new IM&T Strategy has been developed and has Trust Board approval.* • *The Trust Chief Clinical Information Officer chairs a monthly Clinical Digital Board to ensure clinical engagement, guidance and leadership across the entire digital programme.*

Ref	Domain	Identified Actions	Progress
			• *All outstanding risks are monitoring through the IM&T Committee which is chaired by the Director of Finance who is also Trust SIRO. Deputy Chair is the Associate Director of Digital who is also Deputy SIRO.* • *The Trust has received substantial assurance rating from MIAA.* • *The Informatics function has achieved Level 1 Excellence in Informatics and will be working towards Level 2 this year. These accreditation regard personal and professional development of informatics staff within the Trust. The award demonstrates our proactive and positive approach to leadership and development.* • *The Trust has been actively engaging with NHSI's 'Making Data Count' team to continue development of both its CBU level PIDA IPR's and Trust level IPR's. The Head of Information and Performance & Delivery Manager regularly attend collaborative seminars with performance leads from across the NHS to share methodology and promote best practice.*

Appendix A **Update Against CQC Identified Actions from 2019 Well Led Inspection** **March 2022**

Ref	Domain	Identified Actions	Progress
W7	Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	• Launch new Patient Experience Strategy and Plan following external review. • Strengthen Patient Experience reporting arrangements at CBU and Board level • Test co-design principles and inclusion maturity with stakeholders	• *New Patient Engagement Strategy was developed and launched in 2021. Workplan shared quarterly through PECE group.* • *A Communications engagement calendar is under development and due to be produced to map when activities and events will be taking place.* • *CBU Patient Engagement objectives and plans have been developed and reporting has been agreed by Associate Directors of Nursing through to Patient Experience and Community Group monthly.* • *Patient Experience Partners / representatives are actively engaged with the Trust's work and further plans are in place to involve patients in the Codesign and Co-production of service improvements i.e Alzheimers Society/Dementia UK/Sefton Advocacy / Healthwatch. A second patient experience conference is planned for summer 2022.*

Ref	Domain	Identified Actions	Progress
			• *Stakeholders and patients event - plan to host virtually involving patients in 'service change' and remodelling of services - link to QIA & EIA i.e Shaping Care Together.* • *Awards made monthly in two schemes SO Proud (for individuals) and Thanks a Bunch (for teams) where staff nominate each other for "going above and beyond".* • *Monthly filmed patient stories taken to PECE and then up to SOC.* • *Senior staff in wards/ departs have access to own live friends and family test data to inform local improvements at ward/dept level to enable a 'You said we did' approach.* • *Carer representation on Admiral Nurse Steering Group.* • *Online engagement event with Healthwatch Sefton planned for May 2022.* • *National Patient Experience Surveys completed – action plans reported through PECE and QSC.* • *Patient Experience Facilitator role commenced end of February 2022. Role will incorporate local patient survey projects.* • *PALS service embedded and is also currently supported by an enhanced PALS officer role in the Accident and Emergency Department.*
		• Test relationships with external partners, MPs, commissioners and evidence partnership working.	• *Monthly Contract and Clinical Quality Review Meeting (CCQRM) in place with commissioners.* • *Managing Director and Chief Executive Officer (CEO) meet local MPs on regular basis.*

Ref	Domain	Identified Actions	Progress
W8	Are there robust systems and processes for learning, continuous improvement and innovation?	• Evaluate whether there are structures and processes in place that report on / promote quality improvement, innovation and celebration of achievements and a cycle of continuous improvement?	• *Quality Improvement Programme Board in place to monitor progress in relation to Quality Priorities and QI work streams.* • *SOCAAs Ward Accreditation scheme in place.* • *Programme of Quality Assurance audits in place using Tendable App (formally Perfect Ward).* • *The Trust has introduced a new Integrated Performance Report (IPR) which moves the Trust to measuring improvement through Statistical Process Charts from RAG status. This is in line with best practice and has been endorsed by the NHS England.* • *Quality Improvement Hub (virtual) in place and AQuA quality improvement training available to all staff.* • *New Head of Research in place, monitoring reported through Clinical Effectiveness Committee.* • *Just & Learning Culture and Human Factors awareness available.* • *Awards made monthly in two schemes SO Proud (for individuals) and Thanks a Bunch (for teams) where staff nominate each other for “going above and beyond”.*

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Workforce Committee
MEETING DATE:	29 March 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. Improvement trajectories have been set and are continuing to be monitored by the PIDA Boards.

Sickness Absence
Whilst the overall sickness rate decreased in February 2022, the rates non-related to Covid-19 have increased. Despite this, it is hoped sickness will continue to subside.

Guardian of Safe Working
The Trust continues to try and recruit a Guardian of Safe Working. STHK offered their Guardian to speak with senior clinicians to make the role more attractive. Junior Doctor Forum meetings have been proactively arranged to take place on a fixed date through the year to encourage increased attendance. There are still issues with underreporting.

Annual Staff Survey 2021
The Committee were presented with a summary of the 2021 Staff Survey results. Identified themes, both improvements and deteriorations, were presented. In particular, the Committee noted the deteriorations in questions Q21c (staff recommending the Trust as a place to work) and Q21d (would staff be happy with the standard of care provided by the Trust if their friend or relative needed it).

ASSURE

Workforce Committee Terms of Reference
The Workforce Committee recommended the ToR for endorsement to Strategy and Operations Committee.

Medical Vacancies
The Trust's current vacancy level is down to 18.17 and have 26 posts currently under offer. Recently, five consultants were appointed in one day, and future Appointment Advisory Committees have been proactively arranged to prevent delays. The Recruitment team are ensuring appointed medics are onboarded carefully for retention.

Nursing Vacancies
Rates have increased in month but continue to show special cause improvement, although levels remain below the target. The increase in overall nursing vacancies is impacted by HCA vacancies due to international recruitment.

Driving Culture Change at S&O
The Committee were presented with the Trust's plan/key steps to driving culture change at the organisation, and the role Board will play in making this happen. The presentation generated a lengthy open and honest discussion amongst the membership.

Freedom to Speak Up Annual Board Self-Assessment 2022
The Annual Board Self-Assessment 2022 FTSU Report was presented to the Committee and noted. The Trust's speaking up culture was discussed.

Employee Relations
The Committee noted and were assured by impact of using Just and Learning Culture in employee relations cases.

Turnover
Despite the rolling staff turnover indicator failing the assurance measure and showing special cause concern, the Committee were assured by the explanation that 17 out of 40 junior medical leavers returned to the Trust to continue their training.

New Risks identified at the meeting: None

Review of the Risk Register: Yes

Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 April 2022
Agenda Item	SO056/22	FOI Exempt	YES
Report Title	OUR PEOPLE PLAN UPDATE		
Executive Lead	Jane Royds, Director of HR & OD		
Lead Officer	Sonya Clarkson, Deputy Director of HR & OD		
Action Required	☐ To Approve ☐ To Assure	✓ To Note ☐ To Receive	

Purpose

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

Executive Summary

The themes arising from the 2020 Staff Survey helped to inform the key *Our People Plan* deliverables for 2021/22 (Appendix 1). Progress against the 23 key deliverables (compared to last report in September 2021) is as follows:

- 7 have been completed (+2)
- 13 are in progress (-1)
- 3 have identified issues (-)
- 0 is not yet started (+1)

Despite the impact of winter pressures and limited capacity, it is commendable that the momentum has been maintained. The deliverables that have been affected over the winter period are:

- policy development framework
- launch of anti-racism/bystander training
- introduction of reverse mentoring.

A People Plan Integrated Performance Report (IPR) has now been developed and included in this report (Appendix 2) aiming to measure the impact of *Our People Plan* programmes of work against the aspirational targets to be achieved by 2023.

The data shows a continued downward trend of the number of formal employee relations cases, due to the just and learning practices being adopted and the positive impact of specific wellbeing interventions in ensuring non-covid related absence has remained below 6% throughout winter. Recent analysis from NHS England/Improvement supports further that the Trust's total absence % is now the same as both C&M ICS and NW region. This has not happened since early 2020 when it was between 20%-25% higher.

It is clear from the WRES and WDES data that there needs to be more focussed attention on improving the experience for individuals with these protected characteristics. Overall staff engagement indicators also remains disappointing. Whilst the NHS has a whole has experienced a decline, the Trust remains committed to improving morale and motivation of our staff.

The key deliverables will be updated by the Valuing Our People through Inclusion Group against themes gathered from a multiple of sources of staff feedback to inform the priority activities for 2022/23.

In addition, the Workforce Improvement Group will take stock of the four key programmes of work overseen by this group in light of the introduction of the new Finance, Improvement and Performance groups established to drive delivery of the Trust's six key priorities for 2022/23.	
Recommendations	
The Strategy and Operations Committee to note the progress being made to provide assurance on delivery of the Trust's *Our People Plan* and actions to address the key themes that arising from fresh intelligence gathered from staff feedback.	
Previously Considered By:	
☐ **Finance, Performance & Investment Committee** ☐ **Remuneration & Nominations Committee** ☐ **Charitable Funds 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:**
Sonya Clarkson, Deputy Director of HR & OD	Jane Royds, Director of HR & OD

***Our People Plan* – Quarterly Progress Update**

1. Purpose

This report provides the quarterly update on the progress against the key programmes of work identified in the Trust's *Our People Plan* and actions from the Staff Survey 2020.

2. Background

The Board approved the Trust's *Our People Plan* in February 2020 outlining the key programmes of work over the next two years to ensure the Trust remains a great place to work.
The themes arising from the 2020 Staff Survey helped to inform the key deliverables for 2021/22 (Appendix 1).

3. Our People Plan – Key Deliverables 2021/22

Progress against the 23 key deliverables (compared to last report in September 2021) is as follows, 7 have been completed (+2), 13 are in progress (-1), 3 have identified issues (-) and 0 is not yet started (+1). Despite the impact of winter pressures and limited capacity, it is commendable that the momentum has been maintained. Specifically, since the last report;

- Along with Sefton Place partners, the Trust held its second Schwartz Round on 15th March 2022
- 'Supporting You' drop-in sessions have been provided to ward managers by HR and Occupational Health, as well as bite size sessions to managers
- The Trust's 'Warm Welcome' and clinical induction now has a significant focus on Trust values and behaviours, helping to embed the Just and Learning principles.
- Work has commenced to develop a Nursing workforce plan and STAR workforce planning methodology is being trialled in Urology and Obs & Gynae.

The deliverables that have been affected over the winter period are – policy development framework, launch of anti-racism/bystander training and introduction of reverse mentoring.

4. Our People Plan – Measures of Success

A People Plan Integrated Performance Report (IPR) has now been developed and included in this report (Appendix 2) aiming to measure the impact of *Our People Plan* programmes of work against the aspirational targets to be achieved by 2023.

The data shows a continued downward trend of the number of formal employee relations cases, due to the just and learning practices being adopted.

In addition, the Trust has managed to maintain non-covid related sickness absence levels below 6% throughout the winter period. Recent analysis from NHS England/Improvement supports further that the Trust's total absence % is now the same as both C&M ICS and NW region. This has not happened since early 2020 when it was between 20%-25% higher. The investment in a Winter Wellness programme for staff and the adoption of a more person centred, 'people not process' approach to supporting attendance are contributory factors to this. It is anticipated the reduction in vacancy levels starting to be seen and the wider promotion of a flexible working culture, will help sustain and improve this further over the coming year.

Whilst long term absence has not yet reached the target 40% split, there is confidence this will improve further over the next quarter as more staff access the pilot individual restoration programme supported by Edge Hill University and Hurlston Hall.

It is clear from the WRES and WDES data that there needs to be more focussed attention on improving the experience for individuals with these protected characteristics. Whilst we have some active staff networks established, increased Board commitment is required to drive the EDI agenda. An Exec Sponsor has now been identified for EDI, and a roots and branch review of the Trust's recruitment and selection processes has commenced with the intention to engage staff to help identify the current barriers in place.

Overall staff engagement indicators remain disappointing. Whilst the NHS has a whole has experienced a decline, the Trust remains committed to improving morale and motivation of our staff.

5. Key deliverables 2022/23

The key deliverables will be reviewed by the Valuing Our People through Inclusion Group against themes from a multiple of sources (including the 2021 Staff Survey results, Freedom to Speak Up data and feedback gathered through staff engagement events such as the recent Quality Priorities presentation and 'Talk to Us Tuesdays') with an updated programme of work identified for 2022/23 responding to key themes.

In addition, the Workforce Improvement Group will take stock of the four key programmes of work overseen by this group (Agile working & digitisation / Workforce Systems Development / Clinical Workforce Plan / Transformational leadership development) in light of the introduction of the new Finance, Improvement and Performance groups established to drive delivery of the Trust's six key priorities for 2022/23.

6. Recommendations

Strategy and Operations Committee to note the progress being made to provide assurance on delivery of the Trust's *Our People Plan* and actions to address the key themes that arising from fresh intelligence gathered from staff feedback.

Appendix 1 ***Our People Plan* – Key Deliverables 2021/22**

Key Areas of Focus	Key deliverables 2021/22	Links to Staff Survey Themes	June'21 progress rating	Sept'21 progress rating	Mar'22 progress rating
Looking after our people	Enhanced wellbeing support to support recovery and reset	Staff Health and Wellbeing	Green	Green	Green
	Revise and align staff engagement strategy '*Our Engagement Plan'*	Advocacy	Green	Blue	Blue
	Re-establish Valuing Our People (Inclusion) Group	Equality, Diversity and Inclusion	Blue	Blue	Blue
	Delivery of *Our Engagement Plan*	Advocacy	Green	Green	Green
	Align Trust values to staff recognition strategy	Advocacy	Green	Green	Green
	Implement Schwartz Rounds	Staff Health and Wellbeing	Amber	Green	Blue
	Continue with 'Back to Floor'	Advocacy	Amber	Amber	Green
	Develop an annual HR Policy Development framework	Advocacy	Amber	Green	Amber
	Embed Just and Learning principles	Quality of care / Advocacy	Amber	Green	Green
	Develop bitesize sessions for managers for induction and appraisal	Advocacy	Amber	Green	Blue
Belonging to the NHS	Launch the first Trust Diversity calendar of events	Equality, Diversity and Inclusion	Amber	Blue	Blue
	Incorporate Anti-Racism / Active Bystander training	Equality, Diversity and Inclusion	Green	Green	Amber
	Establish Staff Networks	Equality, Diversity and Inclusion	Amber	Blue	Green
	Revise and align leadership development strategy and develop succession planning framework	Equality, Diversity and Inclusion / Advocacy	Amber	Green	Green

	Introduce reverse mentoring	Equality, Diversity and Inclusion	Green	Amber	Amber
New ways of working	Increase opportunities for flexible working	Staff Health and Wellbeing	Green	Green	Green
	Develop HR systems roadmap	Quality of Care / Staff Health and Wellbeing	Green	Green	Green
	Develop Trust Clinical Workforce Plan	Quality of Care	Amber	Amber	Green
	Deliver PDR Improvement Plan	Advocacy / Quality of Care	Amber	Green	Green
Growing for the future	Revise and align Recruitment Plan 'Our Resourcing Plan'	Quality of Care / Staff Health and Wellbeing	Green	Blue	Blue
	Deliver on nurse recruitment plan (150 international nurses)	Quality of Care / Staff Health and Wellbeing	Green	Green	Blue
	Increased placements offered to medical, nursing and AHP students with Edge Hill and UCLAN	Quality of Care	Green	Green	Green
	Extend collaborative bank to Allied Health Professionals	Quality of Care / Staff Health and Wellbeing	Not started	Not started	Green

Integrated Performance Report

People Plan

February 2022

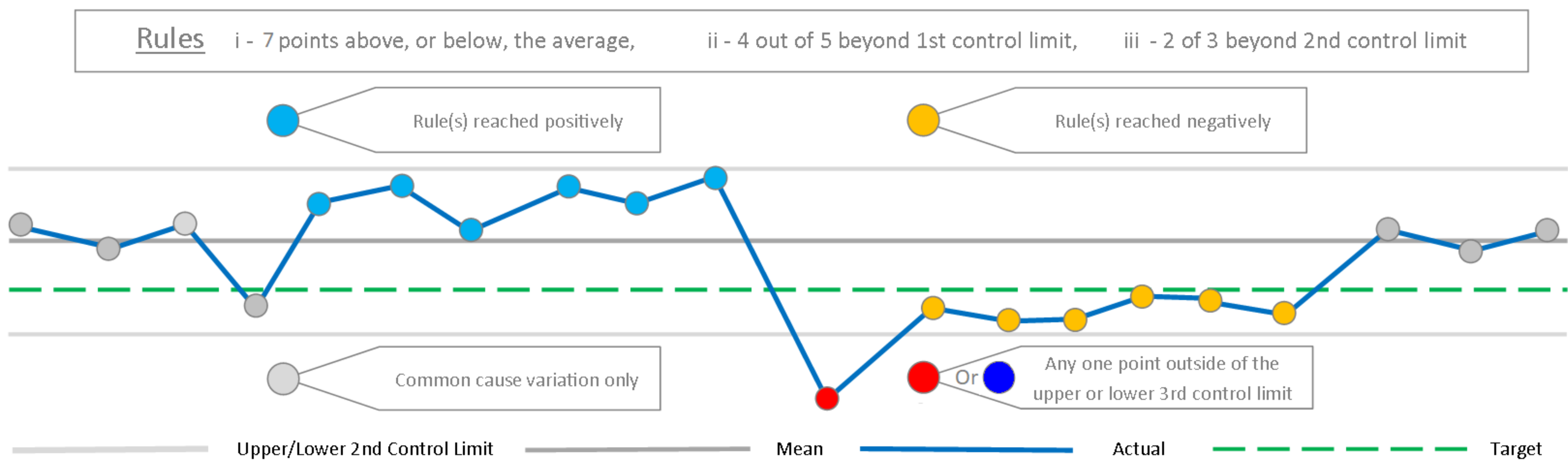
Guide to Statistical Process Control

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

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

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

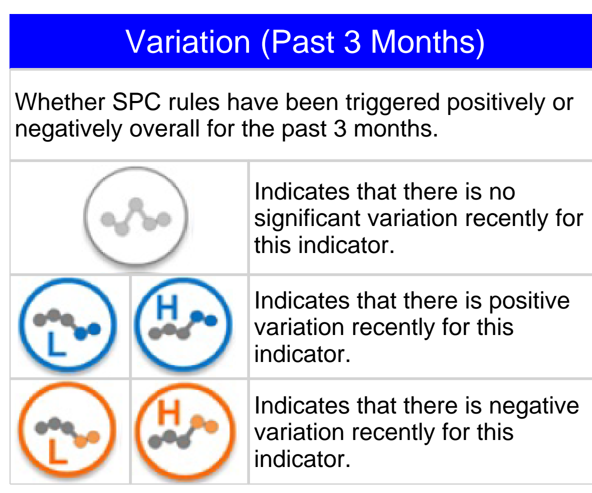
The report then uses the SPC icons developed by NHS Improvement to summarise the messages from SPC charts - an explanation of these icons can be found on the Executive Summary page of the report.



Executive Summary

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

Assurance	
Measures the likelyhood of targets being met for this indicator.	
?	Indicates that this indicator is inconsistently passing and falling short of the target.
P	Indicates that this indicator is consistently passing the target.
F	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.
L	H	Indicates that there is positive variation recently for this indicator.
L	H	Indicates that there is negative variation recently for this indicator.

People Plan

Looking after our people

Indicator	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
HR - Employee Relations - Number of new cases in month	4	1	Jan 22	L	4	1	Dec 21	48	9	P
HR - Employee Relations - Number of ongoing cases	10	7	Jan 22	L	10	8	Dec 21	120	141	?
HR - Employee Relations - Number of issues dealt with by JLC principles	2	1	Jan 22		2	2	Dec 21	24	13	?
Sickness Rate (not related to Covid 19) - Trust		5.3%	Feb 22	H		5.2%	Jan 22		5.7%	?
HR - Sickness Absence Rate - % Long Term - Trust	40%	48.7%	Feb 22	L	40%	44.1%	Jan 22	40%	66%	F
Staff Survey - Trust takes an interest in and action on health & wellbeing/Pulse Survey - My organisation is committed to looking after the people who work here	57%	44.1%	Jan 22					57%	56.9%	?

HR - Employee Relations - Number of new cases in month

HR - Employee Relations - Number of ongoing cases

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

Sickness Rate (not related to Covid 19) - Trust

HR - Sickness Absence Rate - % Long Term - Trust

Staff Survey - Trust takes an interest in and action on health & wellbeing/Pulse Survey - My organisation is committed to looking after the people who work here

Belonging to the NHS

Indicator	Latest				Previous			Year to Date		
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
WRES - Recruitment - likelihood of appointing from shortlisting - BME	15%	16.9%	Mar 21		15%	15.2%	Mar 20	15%	16.9%	
WRES - % of staff believing the Trust provides equal opportunities for career progression or promotion - BME	72.5%	71.9%	Mar 21		72.5%	78.3%	Mar 20	72.5%	71.9%	
WDES - % of Disabled Staff who say employer made adequate adjustments	70%	77.6%	Mar 21		70%	70.5%	Mar 20	70%	77.6%	

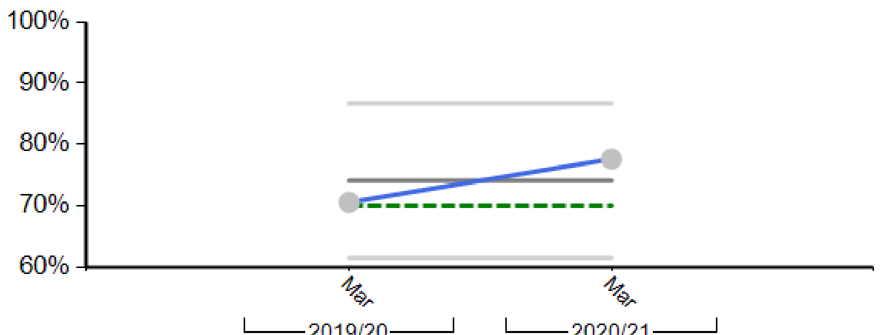
WRES - Recruitment - likelihood of appointing from shortlisting - BME

20%
18%
16%
14%
12%
Mar
Mar
2019/20
2020/21

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

100%
90%
80%
70%
60%
Mar
Mar
2019/20
2020/21

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



New ways of working and delivering care

Indicator	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
Mandatory Training	85%	89.1%	Feb 22	H	85%	89.2%	Jan 22	85%	88%	P
Essential Skills Training - Trust	85%	78%	Feb 22		85%	76.9%	Jan 22	85%	78%	F
Personal Development Review	85%	75.6%	Feb 22	H	85%	76%	Jan 22	85%	77.3%	F
HR - Flexible Working Requests Submitted	16	9	Feb 22		16	4	Jan 22	200	37	?

Mandatory Training

Essential Skills Training - Trust

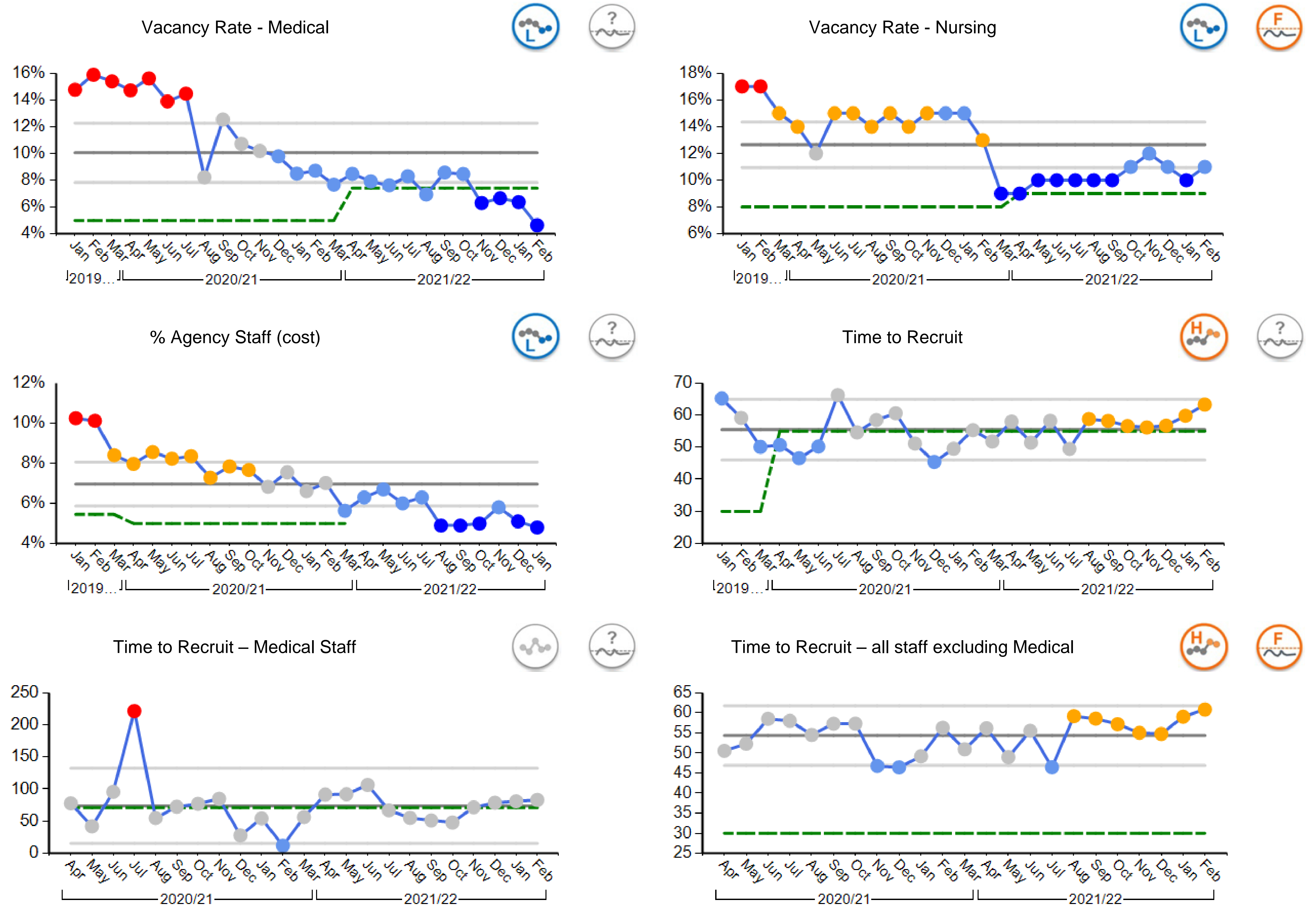
Personal Development Review

HR - Flexible Working Requests Submitted

People Plan

Growing for the future

Indicator	Latest Plan	Latest Actual	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
Vacancy Rate - Medical	7.4%	4.6%	Feb 22	L	7.4%	6.4%	Jan 22	7.4%		?
Vacancy Rate - Nursing	9%	11%	Feb 22	L	9%	10%	Jan 22	9%		F
% Agency Staff (cost)		4.8%	Jan 22	L		5.1%	Dec 21		5.6%	?
Time to Recruit	55	63	Feb 22	H	55	60	Jan 22	55	57	?
Time to Recruit – Medical Staff	71	83.2	Feb 22		71	81	Jan 22	71	75.1	?
Time to Recruit – all staff excluding Medical	30	60.8	Feb 22	H	30	59	Jan 22	30	55.6	F

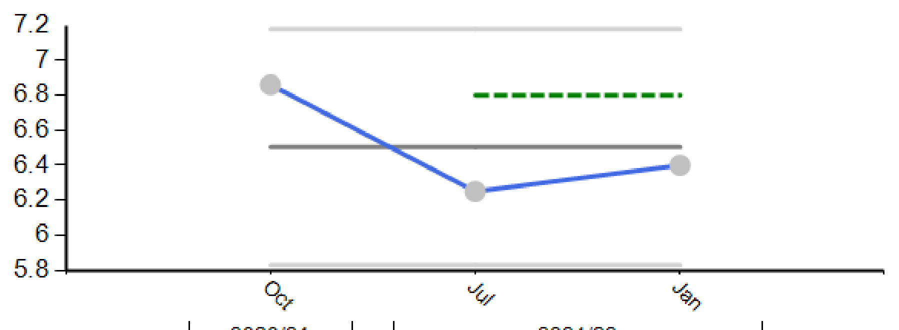


Vacancy Rate - Medical
16%
14%
12%
10%
8%
6%
4%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019... 2020/21 2021/22
Vacancy Rate - Nursing
18%
16%
14%
12%
10%
8%
6%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019... 2020/21 2021/22
% Agency Staff (cost)
12%
10%
8%
6%
4%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan
2019... 2020/21 2021/22
Time to Recruit
70
60
50
40
30
20
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2019... 2020/21 2021/22
Time to Recruit – Medical Staff
250
200
150
100
50
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2020/21 2021/22
Time to Recruit – all staff excluding Medical
65
60
55
50
45
40
35
30
25
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb
2020/21 2021/22

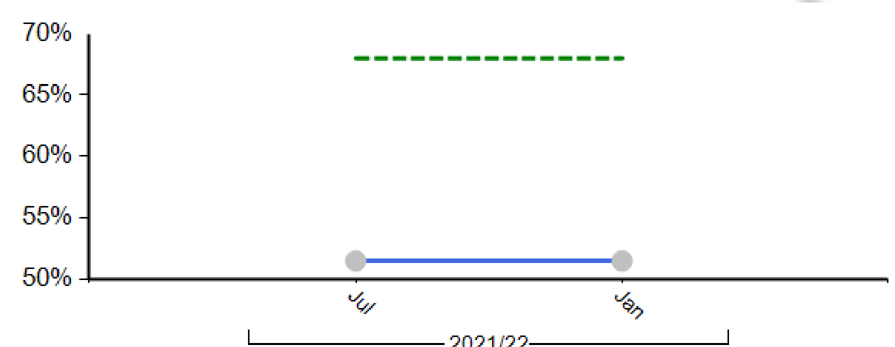
Staff Engagement

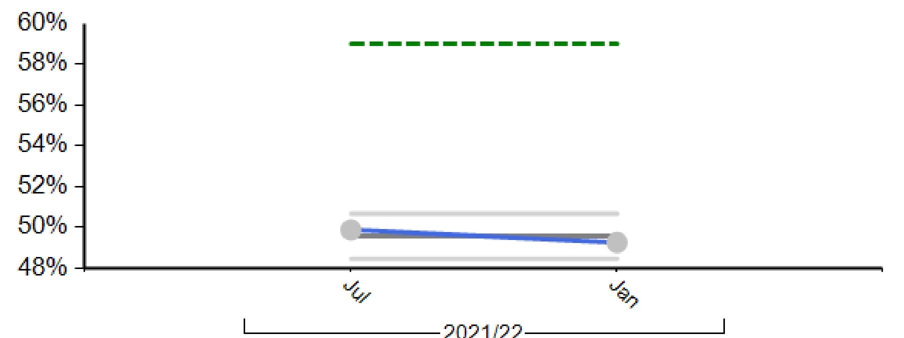
Indicator	Latest				Previous			Year to Date		
	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Staff Survey - Staff Engagement Score	6.8	6.4	Jan 22		6.8	6.3	Jul 21	6.8	6.7	
Pulse Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	68%	51.5%	Jan 22		68%	51.5%	Jul 21	68%	53.8%	
Pulse Survey - I would recommend my organisation as a place to work	59%	49.2%	Jan 22		59%	49.9%	Jul 21	59%	53.9%	
Pulse Survey - Care of patients / service users is my organisation's top priority	75%	63.5%	Jan 22		75%	70.2%	Jul 21	75%	68.4%	

Staff Survey - Staff Engagement Score

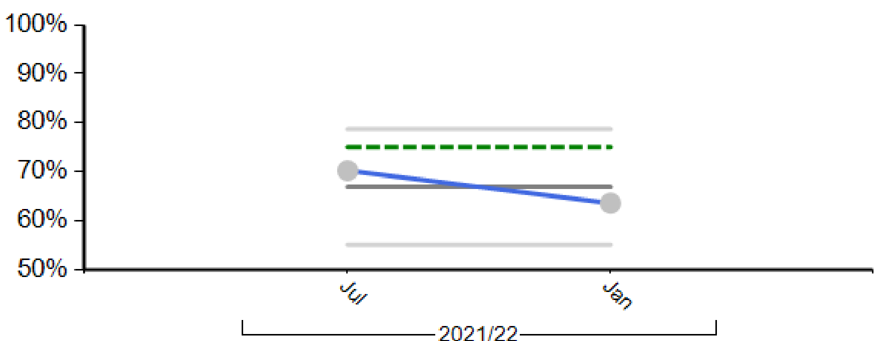


Pulse Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation





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



Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 April 2022
Agenda Item	SO057/22	FOI Exempt	NO
Report Title	FREEDOM TO SPEAK UP ANNUAL SELF-ASSESSMENT		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Linda Douglas, Freedom to Speak Up Guardian		
Action Required	☐ To Approve ✓ To Assure	☐ To Note ☐ To Receive	

Purpose

The Strategy and Operations Committee is asked to receive this report to note the Freedom to Speak Up Annual Self-Assessment.

Executive Summary

The Trust's 'Freedom to Speak Up: 'Raising Concerns approach is to promote an open and transparent culture across the organisation to ensure that all members of staff feel safe, supported, and confident to speak out. The approach and supporting strategy are aligned to the Trust's objective of delivering the best possible patient care.

New requirements from NHSE/I stipulate that trust boards must have oversight of their 'Freedom to Speak Up' arrangements and undertake a comprehensive annual self-assessment.

The Trust works in partnership with the National Guardian's Office and Northwest Regional Network of Freedom to Speak Up Guardians to enhance staff experience with raising concerns. The Trust recorded a mean Freedom to Speak Up Index score of 77.0% in 2020 (published in 2021), an increase from 74.6% for the previous year. The Trust score is slightly below the national average by 0.9% than the national mean score for acute trusts of 77.9%, confirming the continuing need for growth in promoting a positive culture for raising concerns.

MIAA undertook a FTSU review 2021/22 (date of issue 21st September 2021) and advised that there is **High Assurance.** Their executive comment is:
"There was a strong system of internal control which had been effectively designed to meet the system objectives, and that controls were consistently applied in all areas reviewed."

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

This self-assessment document also provides assurance of the significant improvement journey that *speaking up* has made since the National Guardian's Office case review in summer 2017.

Recommendations

The Strategy and Operations Committee is asked to receive the Freedom to Speak Up Annual Self-Assessment Report for assurance.	
Previously Considered By:	
☐ **Finance, Performance & Investment Committee** ☐ **Remuneration & Nominations Committee** ☐ **Charitable Funds 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:**
Linda Douglas, Freedom to Speak Up Guardian	Lynne Barnes, Director of Nursing, Midwifery and Therapies

Freedom to Speak Up review tool for NHS trusts and foundation trusts

2022

Southport and Ormskirk NHS Trust.

Summary of the expectation	Evidence to support a 'full' rating		Principal actions needed in relation to a 'not' or 'partial' rating
	Compliance		
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Fully	• Trust FTSU Vision and Strategy 2021-22, emphasises the commitment to attract and develop, caring, highly skilled staff. • Trust Strategic Objectives SO1: Improve clinical outcomes and patient safety to ensure we deliver high quality services • SO4: Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated encourages staff to speak up • Visibility of Executive Team members through service visits and communication channels Back to the Floor • Non-Executive team members, it has been difficult for NEDs to have direct contact with service teams during the last two years because of the pandemic • Regular communication to appreciate work of staff members – Thank you emails, Managing Director Communications, Team Brief and Board meeting reports highlighting staff appreciation. • SOCAS- ceremonies, highlights success • Positive staff survey results published in 2021. Changes made to improve areas based on feedback from survey. • CQC inspection published 2019 "well led" domain reported positive comments on FTSU • Further improvement in 2020 Freedom to Speak up Index 77.0% (published in 2021) from 2019 (74.6%).	
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and non-executive leads responsible for speaking up • speaking up and other cultural issues are included in the board development programme • they welcome workers to speak about their experiences in person at board meetings • the trust has a sustained and ongoing focus on the reduction of bullying, harassment, and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made • the trust continually invests in leadership development • the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative, and engaging communication strategy to tell positive stories about speaking up.	Fully	• Director of Nursing, Midwifery and AHPS (Executive lead for FTSU) review of FTSU concerns and actions • Strong culture and promoting openness and honesty at Board sessions. • FTSU report presented to Workforce Committee every quarter • FTSU report presented to Strategic and Operations Committee every quarter • Continuous evaluation of FTSU model and raising concerns options. • Continued communication with staff members of methods for 'Speaking Up Raising Concerns' • FTSU Guardian attended Team brief take over, staff encouraged to "Speak Up" by the executive team • Continued recruitment of FTSU Champions • FTSU and HR collaboration in reviewing any cases with detriment / bullying allegations. • Communication to support changes made because of speaking up. • MIAA undertook a FTSU review 2021/22 (date of issue 21st September 2021)	

Summary of the expectation	Evidence to support a 'full' rating		Principal actions needed in relation to a 'not' or 'partial' rating
	Compliance		
		There is a **High Assurance.** Their executive comment is: *"There was a strong system of internal control which had been effectively designed to meet the system objectives, and that controls were consistently applied in all areas reviewed. "*	
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	**Fully**	• Clear and consistent Trust vision, encompassing speaking up and embedded throughout the Trust. • Speaking up integrated into Trust values and objectives, supported in delivery by the nominated executive lead. • Safety Culture been a successful QI priority for 21/22. Reporting through QI Board and CQC. • CQC whistle blowing incidents are also reported as part of CQC insight report via Quality and Safety Committee. • Board members updated with progress made regarding FTSU through scheduled regular reports. • Provision of several channels for staff to raise concerns including internal and external routes, this includes Guardians, speak in confidence. • Further improvement in 2020 Freedom to Speak up Index 77.0% (published in 2021) from 2019 (74.6%).	
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively • the Guardian has been given time and resource to complete training and development • there is support available to enable the Guardian to reflect on the emotional aspects of their role • there are regular meetings between the Guardian and key executives as well as the non-executive lead. • individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner • they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes • the Guardian is enabled to develop external relationships and attend National Guardian related events	**Fully**	• The Guardian is supported by the Executive Lead for FTSU to complete any necessary training required for the role. • The Guardian is supported with time for FTSU activities. • Identified FTSU Deputy Guardian, will ensure FTSU function is covered for periods of annual leave etc. • Regular meetings and updates between Lead Guardian and key executives and Managing Director. • The Guardian is an active participant of the North West FTSU Group and the National FTSU Group. • Guardian has developed external relationships with local networks. • Internal collaboration with HR, Patient Safety Teams and Guardian for Safe Working. • Appointed FTSU Specialist administrator, supporting the FTSU Guardian and function	
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • that the policy is up to date and has been reviewed at least every two years	**Fully**	• Freedom to Speak Up: Raising Concerns – Policy and Procedure in place • Quarterly update on speaking up in confidence usage provided to Trust Workforce Committee, and SOC • MIAA undertook a FTSU review 2021/22 (date of issue 21st September 2021)	

Summary of the expectation	Evidence to support a 'full' rating		Principal actions needed in relation to a 'not' or 'partial' rating
	Compliance		
• reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.		The opinion offered is there is **High Assurance.** Their executive comment is: *"There was a strong system of internal control which had been effectively designed to meet the system objectives, and that controls were consistently applied in all areas reviewed. "*	
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance • assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances • you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection • you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.	Fully	• Assurance of consistent reporting of concerns using various methods • The Trust has dedicated email for Speaking up, and has a telephone line, and direct mobile number to access the Guardian which provides staff access to report any concerns, • 2020 Freedom to Speak up Index 77.0% (published in 2021) from 2019 (74.6%). • Appointed FTSU specialist administrator/Champion also reviews speaking up emails and offers administrative supports the Guardian and Deputy • Contact with individuals, teams, HR and relevant to ensure that changes made has a positive impact. • Risks identified are reported to risk register appropriately. • Feedback from individuals on their experience and support from FTSU/ Raising concerns procedures. • Feedback from FTSU events and training on the processes used by the Trust. • The Guardian has also forged strong links with staff side and staff side lead.	
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	Fully	• The Guardian presents a report presented to Strategic and Operations Committee every quarter	

The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	Fully	• Current Guardian appointed to Freedom to speak up role
		• Functional role and responsibilities matched against national job description and guidance.
		• The Trusts FTSU Guardian is independent and impartial, holding the Trust to account in its action around "Speaking up"
		• FTSU champions recruited in accordance with NGO guidance April 2021 presented in Q1 report to WFC and SOC.
		The NGO offers the following principles for the role of Champions, whose role is seen as not case holders:
		  • Awareness raising – being visible and accessible
		  • Signposting and support – understanding when to sign post, when to escalate and when to seek support
		  • Feedback – understanding the importance of feedback
		  • Learning – mechanisms to be in place to ensure that issues/themes are captured and communicated sensitively for wider learning
		• New FTSU Champions recruitment activity ongoing.	

Summary of the expectation	Evidence to support a 'full' rating		Principal actions needed in relation to a 'not' or 'partial' rating
	Compliance		
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	Fully	• Case review findings discussed during Guardian meetings and Executive lead meetings • Gap analysis completed submitted to Q2 SOC against Blackpool Victoria Hospital to which we were fully compliant	
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report • content on the trust's website • discussion at the public board • welcoming engagement with the National Guardian and her staff	Fully	• Freedom to speak up and Raising Concerns reports shared with Trust Strategic Operational Committee and Workforce Committee. • MIAA undertook a FTSU review 2021/22 (date of issue 21st September 2021) The opinion offered is there is **High Assurance.** Their executive comment is: *"There was a strong system of internal control which had been effectively designed to meet the system objectives, and that controls were consistently applied in all areas reviewed. "* • Continued improvement scores of NHS Staff surveys on ability to raise concerns. • Information and contact details of Guardians on the Trust intranet. • Active membership and participation in the Northwest FTSU network. • Freedom to speak up information as content in annual quality accounts • Local FTSU Champion Network meeting quarterly	
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	Fully	• As members of the Executive team, we fully committed to the principles of our SCOPE values (being open and honest) in "Speaking Up" • Appraisals to include how the Executive and Non-Executive members have supported speaking up.	

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT

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

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Significant increase in Covid-19 admissions, accounting for 21% of the bed base, managed over 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 February 2022 was significantly below the national standard but compared positively to peers. The Trust however is an outlier with 12 hour breaches and delivered care in escalation areas in ED.
- Both the 62 day and 14 day cancer standards were not achieved in January 2022. However, there was improvement on the previous month. Whilst there are a number of challenged pathways, upper & lower GI and H&N continue to be the most challenged in terms of performance.
- Elective activity for February 2022 was below the 89% ERF target at 82%.
- The draft financial plan for 2022/23 was presented with an overall deficit of £28m. The context of this is as an Integrated Care System (ICS) at draft plan stage has a deficit of £219m with the majority of the problem lying with the Acute sector. An analysis was provided that bridged the 2021/22 forecast to the expenditure plan for 2022/23. The expenditure budget of £251.9m was recommended for approval. It was noted that this included a CIP requirement of 3.5%, which is challenging but achievable. The Committee noted that although this was a realistic financial plan for 20222/23, and was integrated with operational requirements, there were concerns about how the Trust plans for a sustainable financial position longer term. The capital plan figure included in the draft plan totalled £34.6m, which was in line with the ICS guidance to the Trust. Subsequently the Trust has received feedback from the NHSE/I estates visit and it's been made clear that any backlog safety requirements will need to be funded from within the ICS capital plan. The ICS will need to agree with the Trust as to what level of capital is available in addition to the internally generated resources, to be able to rectify backlog safety issues. Its be noted that some elements of income are subject to further review by the ICS, and therefore may change ahead of the final plan submission. Based on a deficit of £28m for 2022/23 there is a requirement for loans of £15m, which have been built into the plan.
- Following the visit by the Lancashire Fire Safety Officer on 07 March 2022 an action plan was produced to meet the safety issues raised. As part of that a business case was presented at FP&I on 28 March 2022 for £262.4k mainly relating to theatre storage at Ormskirk and it is recommended to the Strategic and Operations Committee that this be approved in line with the scheme of delegation. It is to be noted that this scheme was not captured as a requirement within the £68m backlog safety assessment.
- Following a concern about the four boiler house chimneys at Southport following recent high winds, our CHP provider inspected them. As a result two have been removed to be inspected offsite and the remaining two will be removed soon. If they need replacing the liability rests with the Trust. It is to be noted that the chimneys were not captured as a requirement within the £68m backlog safety assessment.

ADVISE

- The ground works for the discharge lounge are completed with the modular build now onsite, expected completion end April 22.
- An update on actions pertaining to the 'red' fragile services was presented and the Committee was advised of the change to service delivery for Orthodontics.
- 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.

ASSURE

- Work has been completed with regard to the endoscopy upgrade at Ormskirk. This now means that the unit can run lists that are no longer single sex.
- Endoscopy performance has improved at 108% of 2019/20 levels. Delivering 10 point per list, planned 12 points per list 01 April 2022 so expect further improvements.
- At month 11 the Trust is reporting a favourable variance of £25k and a yearend forecast of breakeven. The cash balance at yearend is forecast to be £19m.
- The Committee was assured that the £13.5m capital programme will be fully delivered in 2021/22.

New Risks identified at the meeting: None

Review of the Risk Register: No action taken

Title of Meeting	STRATEGY AND OPERATIONS COMMITTEE	Date	06 April 2022
Agenda Item	SO058/22	FOI Exempt	YES / NO
Report Title	DRAFT FINANCIAL PLAN 2022/23		
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 provide an update on the Draft Financial Plan for 2022/23.

Executive Summary

The Trust's draft financial plan for 2022/23 gives a deficit of £28.0m. Of this, £15.2m relates to income shortfalls, and £20.6m relates to pressures - partly offset by assumed CIP of £7.8m (3.5% of turnover).

Financial arrangements are still being agreed and discussed with the Health & Care Partnership (HCP). Mechanisms for all partners to breakeven have yet to be agreed.

The 2022/23 financial plan includes fixed planned income available for elective activity via a block mechanism.

The Trust submitted an indicative capital expenditure plan of £34.6m, including £26m critical backlog maintenance. System capital allocations remain subject to ICS approval ahead of Final Plan submission.

Systems are asked to develop fully triangulated plans across activity, workforce and finances for the 2022/23 financial year. The Trust's final organisational plan will be submitted to NHSEI on 28 April.

Recommendations

The Committee is asked to:

- note the draft financial plan for 2022/23, noting that the income position may vary depending on discussions with the ICS around funding flows.
- approve the expenditure budget.
- note draft capital plans are consistent with the assumptions adopted by the ICS, including S&O critical backlog maintenance, and discussions are ongoing regarding final allocations for 2022/23.

Previously Considered By:

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

Strategic Objectives

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

☐ **SO2** Deliver services that meet NHS constitutional and regulatory standards	
✓ **SO3** Efficiently and productively provide care within agreed financial limits	
☐ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	
☐ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Andy Large, Deputy Director of Finance	John McLuckie, Director of Finance

1. Executive Summary

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

1.2 Financial arrangements are still being agreed and discussed with the Health & Care Partnership (HCP). Mechanisms for all partners to breakeven have yet to be agreed.

1.3 The Trust's draft financial plan for 2022/23 gives a deficit of £28.0m. Of this, £15.2m relates to income shortfalls, and £20.6m relates to pressures - partly offset by assumed CIP of £7.8m (3.5% of turnover).

2021/22 Forecast Surplus/Deficit	0.0
Income	
Tariff Uplift	3.7
Covid Funding	(10.3)
System Allocations	(15.6)
22/23 ERF	5.3
Out of Area Activity	1.6
HEE Adjustment	(0.2)
Car Park Income to 19/20	0.4
TOTAL INCOME PRESSURES	**(15.2)**
NATIONAL PRESSURES	
Inflation	(7.0)
CEAs	(0.2)
Energy Costs	(1.6)
PDC	(0.5)
SYSTEM PRESSURES	
Activity to 104%	(2.7)
LOCAL PRESSURES	
Contingency	(1.2)
Statutory / Quality Investments	(2.1)
Service Changes	(0.5)
OTHER	
Non-Recurrent CIP	(3.8)
NR Balance Sheet Mitigations	(1.0)
CIP	
National (2%)	4.5
Local pressures (0.9%)	2.0
Covid (0.6%)	1.3
TOTAL EXPENDITURE PRESSURES	**(12.8)**
2022/23 Surplus/DEFICIT	**(28.0)**

1.4 The Trust has submitted an indicative capital expenditure plan of £34.6m, including £26m critical backlog maintenance. System capital allocations remain subject to ICS approval ahead of Final Plan submission.

1.5 Systems are asked to develop fully triangulated plans across activity, workforce and finances for the 2022/23 financial year. The Trust's final organisational plan will be submitted to NHSEI on 28th April.

2. 2022/23 Financial arrangements

2.1 System envelopes will include a 2.8% uplift for inflation, including 3% pay inflation. This is assumed to cover the 22/23 increase in employer NICs. It is assumed that any pay award impact above this 3% will be funded in addition to current envelopes.

2.2 System envelopes will include a deduction in funding based on a national efficiency assumption of 1.1%.

2.3 System funding will be reduced by a 'convergence adjustment' to move towards fair share allocations, replacing the Financial Improvement Trajectories in place pre-Covid to bring Trusts with underlying deficits back to balance. For C&M this equates to a reduction of 0.9%.

2.4 System level Covid funding allocations will also be reduced.

2.5 Signed contracts between NHS providers and NHS commissioners will be required before 31st March.

2.6 The following services will continue to be funded outside of system funding envelopes:

- Specialised high-cost drugs and devices
- Specific COVID-19 services
- Elective services recovery funding
- Non-clinical services contracted by NHSE/I
- National service development funding (SDF)

2.7 Systems will have access to the following additional funding:

- National ERF if system/Trust exceeds 104% of 19/20 activity
- Additional funding for Community Diagnostic Centres
- Additional funding for rollout of virtual wards

2.8 Systems will need to plan collaboratively to determine the distribution of the system resources and all systems are expected to report a balanced position.

3. Contracting arrangements

3.1 Signed contracts between NHS providers and NHS commissioners will be required for 2022/23.

3.2 Details of 2022/23 CQUIN schemes have now been confirmed. The fixed element of elective funding will be set to include CQUIN funding of 1.25% of the contract value, with payment of this element to be deducted from providers if not delivered.

3.3 2021/22 CCG block payments values will be used as the baseline for 2022/23 contract values, adjusted for national assumptions of 2.8% inflation and 1.1% efficiency requirement.

4. Other Income

4.1 During 2021/22, NHS England and NHS Improvement provided additional income support to NHS providers to recognise the impact of COVID-19 on non-NHS income streams. In 2022/23, NHS providers are required to recover their positions – either through recovery of non-NHS income streams, utilisation of capacity for NHS activity to be funded through the Elective Recovery Fund or decommissioning of costs associated with these income streams.

4.2 Car Parking income is assumed to increase when staff charges come back into force in 2022/23.

4.3 Wales contract arrangements have yet to be concluded. The basis under local discussion being in line with that of CCGs (i.e. H2 2021/22 block contracts with inflationary increases).

4.4 Local authority income will be based on local negotiations. The outcomes of pay reviews are yet to be concluded.

5. Expenditure plan

5.1 As at Month 9 2021/22, the Trust's forecast outturn expenditure for 2021/22 was £239.1m. The following table shows the movements from this 2021/22 forecast outturn position to the current draft expenditure plan for 2022/23 of £251.9m.

EXPENDITURE £m	Draft 17/03/22	Comments
2021/22 EXPENDITURE	(239.1)	2021/22 M9 FOT
NATIONAL PRESSURES		
Inflation	(7.0)	Pay & Non-Pay = 2.8% per National Planning Guidance
CEAs	(0.2)	National Pressure - guidance issued January 2022
Energy Costs	(1.6)	National Pressure - Submission notes £5m risk if Gazprom contract is ended prior to 31 March 2023
PDC	(0.5)	Increased PDC reflected from M10
SYSTEM PRESSURES		
Activity to 104%	(2.7)	Assumes cost @ 50% of ERF Income in line with StHK
LOCAL PRESSURES		
Contingency	(1.2)	Executive Contingency - suggest inclusion in Statutory/Quality for purposes of ICS & National Return
Statutory / Quality Investments	(2.1)	Includes: CQUIN / Fire Safety / Ockenden / Other
Service Changes	(0.5)	Known impacts for: Community Paed Service / ESD / Vascular
OTHER		
CIP	7.8	3.5% of income
Non-Recurrent CIP	(3.8)	Non - Recurrent Delivery in 21/22 re-instated
NR Balance Sheet Mitigations	(1.0)	Balance sheet items released in 21/22 to achieve H1 Breakeven
2022/23 EXPENDITURE	(251.9)	

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

5.3 The expenditure plan above includes Exec contingency of £1.2m.

6. Cost Improvement Plans (CIP)

6.1 The expenditure budget shown above includes an assumed 2022/23 CIP target of 3.5% of turnover (£7.8m).

6.2 The Trust's assumed CIP target of 3.5% consists of:

- 1.1% national efficiency assumption
- 0.9% C&M convergence adjustment (replaces pre-Covid Financial Improvement Trajectory regime to bring Trusts with underlying deficits back to balance)
- 0.9% to fund internal pressures outlined above
- 0.6% relating to the reduction in Covid funding – noting funding reduction of £10.3m versus forecast expenditure at M9 of £2.5m.

6.3 22/23 CIP schemes are in development:

- c£7.8m schemes identified as outlined below, of which £1.3m RAG rated green as low risk and £4.9m RAG rated as purple based on there being a genuine opportunity which needs further developing.
- A number of the £6.2m Trust wide schemes targets have been devolved to CBU level and performance will be monitored through the CBU FP&I meetings. As an example Medicine and Emergency Care are accountable for £1.7m of the £7.8m target.
- Schemes to be developed through Use of Resources and CBU Efficiency Meetings and reported to FP&I

2022/23 CIP DEVELOPMENT £m	Theme	Exec Lead	MEC	Planned Care	Specialist & Support	Corporate/ Central Budgets	TOTAL
Trust Wide Schemes							
Activity to 104%	Delivery of 104% Activity target within £2.7m assumed expenditure budget	Lesley Neary	0.1	0.8	0.1	0.0	1.0
Coding & Counting Opportunities	Audit opportunity / linked to 104%	Lesley Neary	0.0	0.0	0.0	0.0	0.0
Covid Expenditure	57% Reduction against £2.5m planned expenditure	Lesley Neary	0.0	0.0	0.0	1.4	1.4
Quality Initiatives	Delivery of 22/23 CQUIN targets within £0.5m assumed expenditure budget	Lynne Barnes	0.0	0.0	0.0	0.5	0.5
CNST Premium Reduction	22/23 Premium Confirmed by NHS Resolution	Lynne Barnes	0.0	0.0	0.0	0.4	0.4
CRAB/GIRFT Opportunities	£3.4m outlined in Proposal presented to ETM	Kate Clark	0.0	0.0	0.0	0.0	0.0
Premium Rate Pay	Establish Premium Rate Pay Council & In-House Bank to address £26.7m Bank and Agency Expenditure	Jane Royds	1.2	0.4	0.2	0.2	2.0
Procurement	c£1.0m Schemes Identified	John McLuckie	0.0	0.0	0.5	0.4	0.9
TOTAL			**1.3**	**1.2**	**0.8**	**2.9**	**6.2**
Operational Schemes							
Medicine & Emergency Care	< 1% of Expenditure Budget	Lesley Neary	0.4	0.0	0.0	0.0	0.4
Planned Care	< 1% of Expenditure Budget	Lesley Neary	0.0	0.4	0.0	0.0	0.4
Specialist & Support Services	< 1% of Expenditure Budget	Lesley Neary	0.0	0.0	0.3	0.0	0.3
Corporate Services	< 1% of Expenditure Budget	All	0.0	0.0	0.0	0.5	0.5
TOTAL			**0.4**	**0.4**	**0.3**	**0.5**	**1.6**
TOTAL	**3.50%**		**1.7**	**1.6**	**1.1**	**3.4**	**7.8**

2022/23 CIP DEVELOPMENT	£m
Fully Developed	1.3
Plans in Progress	0.0
Opportunity	4.9
Unidentified	1.6
TOTAL	**7.8**

6.4 As in previous years, schemes will be assessed to ensure that there are no patient safety or quality concerns via the quality impact assessment (QIA) process.

6.5 The cost improvement plans and associated target will be included within the Trust's final income and expenditure plans. Therefore, any underachievement against the CIP target will impact the overall I&E performance of the Trust.

6.6 To support the delivery of the CIP programme, the Trust will utilise the skills and expertise from the CBUs, Corporate Support Services and PMO. This will be supplemented by PLICS, Model Hospital and Getting it Right First Time (GIRFT) reports in year as well as any system-wide initiatives. There is an expectation that some of this information will need to be historic because of the COVID-19 pandemic and that costs and activity returns will be significantly impacted for comparison purposes.

6.7 Potential schemes identified in 2021/22 but not yet delivered, and non-recurrent schemes delivered in 2021/22 will be reassessed in the context of the 2022/23 planning and financial guidance to ensure they remain deliverable or are replaced with alternative schemes, in order to meet the CIP target.

7. Income Plan

7.1 Income of £224m is included in the draft plan. A £28.0m deficit position is currently being reported within this submission based on the expenditure plan above.

7.2 The draft income plan includes the following values provided by the C&M HCP:

- £5.3m Elective Recovery Funding (ERF) to support delivery of 104% elective activity restoration. This envelope is currently being validated and will require delivery against elective recovery targets before it is confirmed. Performance above planning guidance requirements will be funded over and above this if delivered.

- £8.0m System COVID support based on H2 2021/22 multiplied by 2, adjusted by a 57% reduction in recognition of the reduced COVID activity within healthcare settings - noting funding reduction of £10.3m versus forecast expenditure at M9 of £2.5m.

- £20.6m Up Front Top Up support based on H2 2021/22 multiplied by 2, adjusted by C&M HCP 0.9% convergence, to support managing resource allocations back to within target at a C&M HCP level. Convergence will be in a staged approach over time with 0.9% being stage one commencing 1st April 2022.

- System funding reductions for S&O total £26.3m – equating to 12% of the overall HCP reduction to Covid, System Top Up and additional system allocations received in 2021/22.

- £0.6m for low volume CCG activity.

- £57.5m income from CCGs outside the C&M HCP (26% of total Trust income)

- The 2021/22 central funding arrangement for other income streams such as car parking will no longer be in place for 2022/23.

7.3 Guidance is still being updated and yet to be concluded associated with ERF and Aligned Payment Incentive Rules to support restoration of elective activity.

8. Statement of Financial Position (SOFP / Balance Sheet) including liquidity

8.1 Based on current planning assumptions, the balance sheet would reduce by £2.1m from a restated opening value of £97.6m (restatement includes new assets recognised under the lease standard IFRS 16) to £95.5m.

8.2 There is a downward movement of £28m caused by the deficit and an upward movement of £26m (assuming public dividend capital investment in critical backlog maintenance).

8.3 The impact of the new lease standard (IFRS16) is included within the 2022/23 plan. This brings additional assets onto the SOFP, with corresponding adjustments that increase depreciation and lease borrowing.

8.4 The Trust does not have sufficient cash resources to cover the deficit in 2022/23 and will therefore need to borrow money from DHSC.

8.5 It is expected the Trust will need to borrow c£15m with a first request of £1.0m arising in September 2022 followed by monthly requests of £2.33m thereafter.

8.6 Whilst the Trust will commence the year with £19m of cash resources, this will be impacted by 2021/22 capital expenditure, and it is expected that this will result in cash outflows of £5m to settle end of year capital credits.

8.7 The projected cash position for 2022/23 can be summarised as follows:

	£m
Opening balance	19
Capital creditors	-5
Deficit	-28
DHSG	15
Closing balance	**1**

8.8 The draft plan assumes no material movements on inventories or receivables, subject to an assessment of year end balances ahead of final plan submission.

9. Interest, tax, depreciation and amortisation (ITDA)

9.1 Depreciation and amortisation have increased in 2022/23 and this is a combination of increased depreciation associated with the 2021/22 capital programme and depreciation in line with the accounting treatment of IFRS 16 assets from 2022/23.

9.2 The £26m investment in backlog maintenance is unlikely to have a material impact on depreciation in 2022/23 but will be captured from 2023/24 (c£0.3m impact).

9.3 PDC dividend at 3.5% has been calculated based on the projected opening and closing balance sheet values and shows an increase on 2021/22 of £0.25m.

10. Capital

10.1 Capital plans submitted as per regional guidance on 17th March is broken down as follows;

	£m
Internally generated	5.8
PDC	26.0
IFRS 16	2.8
	34.6

10.2 It should be noted that NHSE/I have currently committed to additional capital investment of £3.2m which is made up of a pre-commitment from 2021/22 of £1.2m and a further emergency capital investment of £2.0m. Confirmation has been received that the Trust's capital requirements must be met within the ICS capital limits, and so discussions are ongoing to agree the capital resource available for 2022/23.

10.3 The balance sheet and cash flow will continue to be updated accordingly for the next iteration of the 2022/23 plan.

11. Risks

11.1 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

12. Recommendation

The committee are asked to:

12.1 note the draft financial plan for 2022/23, noting that the income position may vary depending on discussions with the ICS around funding flows.

12.2 approve the 2022/23 expenditure budget.

12.3 note draft capital plans are consistent with the assumptions adopted by the ICS, including S&O critical backlog maintenance, and discussions are ongoing regarding final allocations for 2022/23.

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Executive Management Team
MEETINGS HELD:	March 2022
LEAD:	Anne-Marie Stretch

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Major Incident Network Outage (15.03.22) – Paul Chadwick, Associate Director of Digital, presented a report to ETM explaining the reasons for the outage, the immediate actions taken, and the actions learnt following the Incident Debrief. One of the mitigations will be an agreed process so that IT engineers from S&O can contact STHK network on-call colleagues out of hours to strengthen the incident response and management.

ADVISE

- Regular weekly updates regarding Covid-19 Nosocomial Infections.
- Presentation by Associate Director of Performance and BI regarding the use of Statistical Process Control (SPC) charts for performance monitoring and to provide assurance.
- Update on the Quality Priorities 2021/22 and feedback from the 'Have Your Say' staff engagement event held which was an opportunity to ask staff about what they think should be included in the Quality Priorities Programme for 2022/23.
- Update on 2022/23 Draft Plan before national submission on 17 March 2022.
- Endoscopy Service update on the actions being taken to improve activity.
- ETM agreed the reintroduction of carparking fees with effect from 01 April 2022, following confirmation received in the 2022/23 Planning Guidance that confirmed that central financial support for carparking is to be withdrawn.
- CQC Well-Led Action Plan update.
- First of a regular monthly staffing update for assurance was received by ETM on 21 March 2022.
- Presentation by the Deputy Director of HR &OD on a piece of work to drive culture change at S&O and in line with the SCOPE values.
- C&M Elective Recovering Capital Process – following a submission by the Trust for funding it has been confirmed that the Trust will receive monies but at this stage it is not known exactly how much but the money will be used to support elective restoration.
- Risk and Compliance Group AAA report received.
- Received the confidential Estates Review Report.
- Received an update on Policy Management.

ASSURE

- The monthly Contract and Clinical Quality Review (CCQRM) Meeting Agenda is reviewed by ETM for assurance regarding what items are discussed at the meeting with the CCGs.
- Freedom to Speak Up Self-Assessment was received for assurance.

New Risk identified at the meeting	None
Review of the Risk Register	