NHS
Southport and Ormskirk Hospital
NHS Trust

AGENDA
STRATEGY AND OPERATIONS (S&O) COMMITTEE
To be held at 0900 on Wednesday 02 February 2022

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0900***
SO001/22 (P)	**Patient Story** *Purpose: To **receive** the patient story*	*No*	*L Barnes*	10 mins
SO002/22 (V)	**Chair's welcome and note of apologies** *Purpose: To **record** apologies for absence and confirm the meeting is quorate.*	*No*	*Chair*	
SO003/22 (V)	**Declaration of interests** *Purpose: To **record** any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
SO004/22 (D)	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 02 December 2021.*	No	*Chair*	5 mins
SO005/22 (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*	
RISK AND GOVERNANCE				**0915**
SO006/22	**Audit Committee AAA Highlight Report** *Purpose: To **receive** the Audit Committee AAA Highlight Report*	*No*	*I Clayton*	10 mins
SO007/22 (D)	**Board Assurance Framework** *Purpose: To **receive** the Board Assurance Framework*	*No*	*S Katema*	10 mins
INTEGRATED PERFORMANCE REPORT				**0945**
SO009/22 (D)	**Integrated Performance Report (IPR)** a) Quality and Safety b) Operations	*No*	*L Barnes* *K Clark* *L Neary*	30 mins

	c) Finance d) Workforce		*JMcLuckie* *J Royds*	
	*Purpose: To **receive and note** the IPR for assurance.*			
QUALITY & SAFETY				**1015**
SO010/22 (D)	**Quality and Safety Committee AAA Highlight Report** *Purpose: To **receive** the Quality and Safety AAA Highlight Report*	*No*	*G Brown*	10 mins
SO011/22 (D)	**CQC Action Plan** *Purpose: To **receive** the CQC Action Plan*	*No*	*L Barnes*	10 mins
WORFORCE				**1035**
SO012/22 (D)	**Workforce Committee AAA Highlight Report** *Purpose: To **receive** the Workforce Committee AAA Highlight Report*	*No*	*L Knight*	10 mins
SO013/22 (D)	**Gender Pay Gap Report** *Purpose: To **receive** the Gender Pay Gap Report*	*No*	*J Royds*	5 mins
FINANCE, OPERATIONS AND INVESTMENT				**1050**
SO014/22 (D)	**Finance, Performance and Investment Committee AAA Highlight Reports** *Purpose: To **receive** the FPI AAA Highlight Report*	*No*	*J Kozer*	10 mins
SO015/22 (P)	**Financial Planning 2022/23 Update** *Purpose: To **receive** the Financial Planning 2022/23 Update*	*No*	*J McLuckie*	10 mins
ITEMS FOR INFORMATION				**1110**
SO016/22 (D)	**Executive Management Committee Report** *Purpose: To receive the EMT AAA Report*	*No*	*AM Stretch*	10 mins
CONCLUDING BUSINESS				**1120**
SO017/22 (V)	**Questions from Members of the Public**		*Chair*	

*Purpose: To **respond** to questions from members of the public received in advance of the meeting.*

10 mins

SO018/22 (V) **Any Other Business**

Chair

*Purpose: To **receive** any urgent business not included on the agenda*

Date and time of next meeting:
0900 Wednesday 02 March 2022

1130 close

RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC

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

Chair: Richard Fraser

Draft Minutes of the Strategy and Operations Committee
Held on Microsoft Teams
Wednesday 01 December 2021
(Subject to the approval by the Strategy and Operations Committee on 02 February 2021)

Present

Richard Fraser	RF	Chair, StHK
Ann Marr	AM	Chief Executive Officer, S&O
Gill Brown	GB	Non-Executive Director, StHK
Nicola Bunce	NB	Director of Corporate Services, StHK
Kate Clark	KB	Medical Director, S&O
Ian Clayton	IC	Non-Executive Director, StHK
Val Davies	VD	Non-Executive Director, StHK
Sharon Katema	SK	Associate Director of Corporate Governance, S&O
Lisa Knight	LK	Associate Non-Executive Director, StHK
Jeff Kozer	JK	Non-Executive Director, StHK
Nikhil Khashu	NK	Director of Finance and Information, StHK
Bridget Lees	BL	Director of Nursing, Midwifery and Therapies, S&O
John McLuckie	JM	Director of Finance, S&O
Lesley Neary	LN	Chief Operating Officer, S&O
Rowan Pritchard Jones	RPJ	Medical Director, StHK
Nina Russell	NR	Director of Transformation, S&O
Rani Thind	RT	Non-Executive Director, StHK
Anne-Marie Stretch	AMS	Managing Director, S&O
Christine Walters	CW	Director of Informatics, StHK

In Attendance

Martin Abrams	MA	Hospital Chaplain, Freedom to Speak Up Guardian *(Item SO048/2 only)*
Geoffrey Appleton	GA	Board Advisor, StHK *(Part 2 only)*
Lynne Barnes	LB	Deputy Director of Nursing, Midwifery and Therapies
Sonya Clarkson	SC	Deputy Director of HR and Organisational Development, S&O
Tony Ellis	TE	Communications and Marketing Manager *(Part 1 only)*
Michelle Kitson	MK	Matron, Patient Safety *(Item SO039/21 only)*
Alan Sharples	AS	Board Advisor, StHK
Juanita Wallace	JW	Assistant to ADCG *(minute taker)*

Apologies

Rob Cooper	RC	Director of Operations and Performance, StHK
Paul Growney	PG	Non-Executive Director, StHK
Sue Redfern	SR	Director of Nursing, Midwifery and Governance, StHK
Jane Royds	JR	Director of HR and Organisational Development, S&O

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		

SO039/21 Patient Story

MK introduced the patient story which was provided by the patient's daughter and told of the patient's journey through assessment in the Emergency Department (ED), to admission as an inpatient. It was noted that whilst this had been the patient's third admission, this was the first time that his daughter, in her role as carer, had been able to support him. She commented

that, overall it had been a good experience, and that her father had been more settled during his stay in the ED as she had been able to remain with him. Furthermore, she commended the communication received regarding the patient's discharge, and welcomed the referral to the geriatrician which resulted in a holistic approach to patient care.

The patient's daughter had raised some concerns in her feedback including the patient receiving treatment in what appeared to be a stock room and the red Covid-19 posters within ED, MK advised that :

- The room had been identified as a secondary triage area and, on visiting the room there had been stock stored in the room. This had been addressed and alternative storage had been sourced within the ED for the stock.
- The red Covid-19 posters, whilst disconcerting, were required to warn of the level of risk as not all members of the public who visited the department were aware of the usage of each area. However, staff were able to explain the different areas and the meanings of the posters.

It was noted that the ongoing pressures on the ED were reflected in the Family and Friends Test feedback which had decreased when compared to the corresponding period the previous year. The latest initiatives to improve patient experience in the department included:

- A nursing workforce recruitment event had been held and resulted in offers of employment being made to five nurses. A second recruitment event was scheduled for the evening of 02 December.
- An enhanced Patient Advice and Liaison Service (PALS) was being offered in the ED which would allow for complaints to be addressed at the time and solutions to be offered.

VD queried if it was typical to allow carers to attend hospital with family members given the situation with Covid-19 and visiting restrictions and MK advised that each cased is risk assessed on an individual basis in line with the national guidance.

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

SO040/21 Chair's welcome and note of apologies

The Chair welcomed all in attendance and in particular welcomed AS to his first Strategy and Operations Committee meeting.

Apologies for absence were noted as detailed above.

SO041/21 Declaration of interests

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

SO042/21 Minutes of the previous Meeting

The Committee reviewed the minutes of the previous meeting held on 03 November 2021 and approved them as a correct and accurate record of proceedings subject to the following amendment:

- SO021/21 – to be amended to read 'IC commented that whilst, the document showed the risk appetite and tracking across the quarters there was a need for clarity around sources of assurance and in particular whether they were actual or perceived sources adding that these needed to be factored as part of the planned review. He noted that the Committee also needed to focus on addressing any gaps in controls so that there was effective assurance.'

RESOLVED
The Committee **approved** the minutes of the last meeting.

SO043/21 Matters Arising and Action Log

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

RESOLVED:
The Committee **approved** the Action Log.

INTEGRATED PERFORMANCE REPORT

SO044/21 Integrated Performance Report (IPR)

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 October 2021.

a) Quality and Safety Performance Report

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

- no Never Events and cases of MRSA were recorded
- five C.Diff positive cases reported
- Safer Staffing fill rate was 85.9% (90.73% Registered and 80.43% Un-Registered Nurses)
- VTE Prophylaxis Assessment remained ahead of target at 96.6%
- 10 hospital acquired pressure ulcers reported of which three Category 3 and seven Category 2
- Mortality screening rate increased to 90.4%
- The Patient Friends & Family Test percentage that would recommend is 87.3% for October, below the 94% target

KC advised that there had been a sharp increase in in the number of patients spending more than 12 hours in the ED due to the challenges in managing patient flow. It was noted that the Trust had a higher acuity of patients in the bed base when compared to the metrics nationally resulting in a higher number of complex discharges. LN advised that the Trust had successfully negotiated additional beds in the community to support discharges and were in discussions with system partners around additional capacity.

AM advised that there was concern nationally around the delivery of the 12 hour standard and the impact on ambulance handover times.

BL advised that going forward activity coordinators would be included in the health care assistant fill rates. The activity coordinators were receiving training with the Dementia and Delirium team and would be involved in one to one care of patients to prevent deconditioning whilst they were in the hospital.

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.

It was agreed that a meeting would be scheduled with senior clinicians and operational managers to review the challenges being experienced by Cancer Services, particularly with regards to Urology and Pathology services, and to highlight any areas for future collaboration between Southport & Ormskirk (S&O) NHS Trust and St Helens and Knowsley Teaching Hospitals (StHK) NHS Trust.

ACTION: LB to provide an update on actions concerning the Well-Led domain to ensure that the governance across the organisation met requirements

LB

RESOLVED
The Strategy and Operations Committee **received** the Quality and Safety Performance Report

b) Operational Performance Report

LN presented the report which provided a summary of operational activity against the constitutional standards and highlighted that:

- The demand for Urgent and Emergency Care had remained high increasing from 9,920 in September, to 10,671 in October. Overall

compliance against the Standard was 76.9%, however the trust compared positively against the C&M, North West and National position.

- There had been an increase in the number of 12-hour waits within the ED as well as a deterioration in ambulance handover times.
- Referral to Treatment (RTT) indicators was failing their assurance measures, however, the Trust compared positively to its peers.
- Elective recovery for October achieved 88.9% against a target of 90%.
- Whilst there had been an increase in two week waits for Cancer Services, five of the eight tumour sites had achieved target. The Cancer Improvement Plan and improvement trajectories had been presented at the Quality and Safety Committee.

A Multi Agency Discharge Event (MADE) with system partners was held at the beginning of November with teams being tasked with arranging suitable discharges for 10 patients who were ready for discharge and had the longest length of stay. It was noted that as a result of this event five long stay patients had been discharged. GB commented that there had been a marginal improvement in super stranded patients when compared to the same period in 2019 and that MADE events created an increased focus on discharges.

LN advised that complex patients required additional intervention before discharge which resulted in patients remaining in hospital for longer. The percentage of patients ready for discharge by pathway at S&O varied from the national averages. The most recent data suggested that 11% of the Trust's patients on the ready for discharge list were pathway zero (the simplest discharge). Nationally this is 50%. Conversely, the percentage of patients on pathway three (most complex discharge, often with 24-hour care required) was around 38% compared with national figures of 1%. This has posed significant challenges to the Trust.

The Trust had negotiated the use of additional transitional beds for patients awaiting packages of care prior to discharge with Sefton CCG and planned to negotiate a similar arrangement with West Lancs CCG. The ICS has been asked to provide assistance as well as an overview of the discharge issues faced by trusts. AM commented that a number of the issues that trusts faced were system based and the underdevelopment of the Integrated Care System (ICS) in C&M meant it was more challenging to address them with partners.

In response to IC's query on P2 patients and 52-week patients, LN advised that these were two different cohorts of patients with differing measures. P2 patients were those patients who have an urgent clinical need and should be seen within 28 days. The target set for C&M trusts is that 95% of P2 patients should be dated within 28 days. Those patients who have waited in excess of 52+ weeks have been clinically risk stratified as non-urgent (P3/P4 patients) and therefore wait longer. LN advised that whilst there had been deterioration in the number of P2's who had waited over 28 days the position was expected to improve.

JK commented that at the recent Finance, Performance and Investment (FP&I) Committee it had been noted that the Trust had been awarded capital funding to create a purpose built discharge lounge. JK asked if the new facility would provide more capacity and the ability to separate Covid-19 and non-Covid-19 patients. LN clarified that the new discharge lounge would be used for patients awaiting collection and that this would address some of the themes that had emerged following the MADE event to support timely discharge. AMS commented that she had spent an afternoon in the current small discharge lounge to observe patient discharges and had been impressed with the swift and efficient discharge processes.

In response to LK's query around the deterioration in the provision of one-to-one maternity care over the preceding six months, BL advised that the service had been impacted by vacancies and sickness absence. The position was expected to improve following successful recruitment within the department.

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:

- There was still uncertainty around the second half of the year (H2) allocations, but current information suggested a deficit position of up to £6.7m.
- There had been a £3.8m overspend on bank and agency and it was anticipated that there would not be any reduction in this spend during winter.
- Better Payment Practice Code (BPPC) had achieved 96% in month but the impact on the Trusts cash position was noted.
- £5.1m of CIP had been transacted at M7.

JMcL commented that ahead of e-rostering being centralised in January 2022, a best practice guide had been developed to ensure that all rota coordinators worked in a consistent way across all services.

With regards to the Cost Improvement Programme (CIP), it was noted that identifying the recurring CIP remained a challenge and the Finance team were working with the Clinical Business Units (CBUs) to identify potential savings.

RESOLVED

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

d) Workforce Performance Report

SC presented the Workforce Performance report advising that:

- There had been an increase in the completion of Personal Development Reviews (PDRs), and this was currently at the highest level in two years.
- Core mandatory training performance was 88.3% and ahead of target

AS queried if there were plans in place to address the Staff Survey given that less than half of the staff would recommend the Trust as a place to work. SC responded that whilst there were historical issues that may have impacted on this response, there were progressive improvements and the delivery of the S&O Our People Plan would be key in ensuring that there was sustained improvement.

RF requested that, when preparing the narrative summary, key metrics and any concerns/exceptions or points for escalation and the actions proposed needed to be highlighted by the lead Director as this would provide additional clarity for members.

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

QUALITY AND SAFETY

SO045/21 Quality and Safety Committee AAA Highlight Report

GB presented the AAA Highlight report and alerted the Committee to the challenges relating to Endoscopy and Diagnostic Cancer pathways. The Q&S Committee had been assured by the action plans in place to address the key challenges as well as the collaborative partnership working with StHK. It was noted that these plans would be monitored by the Executive and updates provided to the Q&S Committee.

AS commented that the target of 85% for Mandatory Training was not sufficient to provide assurance that all staff were appropriately trained and queried whether this target needed to be increased. Following a discussion around the issues affecting the completion of mandatory training and staff available for training, it was agreed that AS and AMS would discuss this offline.

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

WORKFORCE

SO046/21 Workforce Committee AAA Highlight Report

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

- An issue had been raised with the Guardian of Safe Working regarding consultants allegedly actively discouraging junior doctors from reporting breaches. This has been included on the Risk Register and the Executive had arranged for an audit to be completed and were in the process of developing an action plan.
- Concerns had been raised in relation to the Clinical Education Review and core mandatory training. The Executive was reviewing findings of the recent audit and an action plan was being developed.
- There was a recommendation that the Trust support the "NHS Employers Pledge for the Wellbeing of Our People"

LK noted that a number of actions had been agreed to clarify the role of the Workforce Committee and how it needed to operate to provide the required assurance.

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

SO047/21 Guardian of Safe Working Report

KC presented the Guardian of Safe Working (GOSW) Report which provided an update on the issues related to the safe working of trainee doctors for the period July - September 2021. The report detailed that:

- The current GOSW Dr. Gardner was leaving the position and a replacement had yet to be identified.
- Trainees were more engaged with the exception reporting process, but Supervisor meetings were not always happening in a timely manner and frequently the remedy is seen as additional pay rather than an opportunity to address problems.
- Trainees continued to stay late on medical wards more than in other areas.
- Issues had been raised around Phlebotomy Services not providing adequate ward cover.
- There remained two non-compliant rotas in Pediatric ED and Urology.
- Progress had been made in spending the Health Education England funding for the upgrade of mess facilities.

It was noted that there were ongoing discussions with the British Medical Association (BMA) around the two non-compliant rotas and a tangible plan was required to return the rotas to a compliant state. KC advised that one of the challenges was that additional investment in junior medical staff was

required for out of hours and weekend cover. The BMA had suggested that the frequency of cover be reduced, and a locum be appointed.

In response to GB's query around the issues with capacity within Estates to complete the work required on the facilities, KC advised that this had been discussed with the Estates Team and a group had been established to review capital requirements.

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

SO048/21 Freedom to Speak Up Quarterly Report

MA presented the Freedom to Speak Up Report for Q2 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 13 concerns had been raised during the period and covered the following themes:

- Support and advice for a victim of fraud
- HR process
- Behaviour of managers
- Unfair treatment of staff
- Culture of a team

The report also included a gap analysis completed by the newly appointed Freedom to Speak Up Guardian, Lin Douglas, and was based on the outcomes of the recent review at Blackpool Teaching Hospitals NHS Foundation Trust. The report advised that there were no areas of significant weakness identified with the FTSU process.

RF thanked MA for his contribution as the Freedom to Speak up Guardian for the past four years and welcomed Lin Douglas in her new role.

RESOLVED:
The Strategy and Operations Committee **received** the Freedom to Speak Up Quarterly Report

FINANCE, OPERATIONS AND INVESTMENT

SO049/21 Finance, Performance and Investment Committee AAA Highlight Report

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

- The finance plan had been submitted as breakeven, however the unmitigated risk to delivery is £6.9m., although discussions about the allocation of resources across the C&M system continued.

- It was advised that Estates work on the Endoscopy Unit at Ormskirk commenced on 29 November and that capital funding has been secured for a temporary solution to ensure no gaps in capacity whilst work was ongoing.

JK reported that the cyber security audit had now been completed and an action plan produced to respond to the recommendations included in the audit.

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

SO050/21 The Green Plan

JMcL presented the Green Plan which set out the recommendations of the Greener NHS programme issued in October 2020 and would be submitted to the ICS in January 2022. He advised that the report was a dynamic document recording previous achievements, future action plans and milestones which would be managed and routinely updated through the Sustainability Group, reporting as appropriate through the Executive Management Team.

A Sustainability Group has recently been established and members of the Joint Negotiating Council (JNC) had expressed interest in being involved in the group. JMcL stressed the importance of having the systems and processes in place to record the work being undertaken and both LK and JK expressed their interest in being involved in the process.

BL commented that there might be an opportunity for further collaboration across a number of portfolios including patient experience and community groups.

RESOLVED:
The Strategy and Operations Committee **approved** the Green Plan

ITEMS FOR INFORMATION

SO051/21 Executive Management Team Report

AMS presented the AAA Highlight report which detailed activity and reports considered by the EMT during November. She advised that EMT had discussed the proposed amendments to the Senior Manager on call report, which would ensure sustainable out of hours provision and maintain compatibility with the Trust's 'Our People Plan'.

The EMT had received the completed cyber security audit and reviewed the recommendations.

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

CONCLUDING BUSINESS

SO052/21 Questions from Members of the Public

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

SO053/21 Any Other Business

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 1124.

The next meeting would be held on **Wednesday 02 February 2022 at 09.00**.

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 Stapleton									✓			
Gill Brown							✓	✓	✓			
Nicola Bunce							✓	✓	✓			
Ian Clayton							✓	✓	✓			
Rob Cooper							✓	✓	A			
Val Davies							✓	✓	✓			
Paul Growney							A	A	A			
Nikhil Khashu							✓	✓	✓			
Lisa Knight							A	A	✓			
Jeff Kozer							A	✓	✓			
Rowan Pritchard Jones							✓	✓	✓			
Sue Redfern							✓	✓	A			
Alan Sharples									✓			
Anne-Marie Stretch							✓	✓	✓			
Rani Thind								✓	✓			
Christine Walters							✓	✓	✓			
S&O Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
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 28 January 2022

Southport and Ormskirk Hospital NHS Trust

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

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
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	03-Nov-21	Feb-22	**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	Green
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	~~01/02/2022~~ 01/03/2022	**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 avilablity to present the training.	Green
SCO025/21	03/11/2021	**Gender Pay Gap Report**	An updated Gender Pay Gap Report including benchmarking information to be presented in February 2022	J Royds	03/11/2021	Feb-22	**November Update:** Action progressing and not due **January Update:** Item included on Agenda. Action completed	Included on Agenda
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	Green
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	Mar-22	**November Update:** Action progressing and not due	Green
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	Green

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	**AUDIT COMMITTEE**
MEETINGS HELD:	**19 January 2022**
LEAD:	**Ian Clayton**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- None

ADVISE

- The Board Assurance Framework was reviewed, and members requested a review of risk scores and ensuring that the next iteration will reflect the collaboration agreement with StHK. The Executive Directors took an action to review the BAF to ensure the scores were fully reflective of the strategic risks to the achievement of the Trust's Strategic Objectives.
- The Committee had previously reported that it would need to consider any revision to the risk register and BAF as part of the ALTC. As part of this review, the Committee approved its Annual Workplan which reflects the collaboration with StHK and approved that the Risk Register would now fall within the remit of Strategy and Operations Committee.
- The Committee approved the Anti-Fraud Policy and Losses and Special Payments Policy which had both been reviewed to ensure they remained aligned with statutory and regulatory requirements.
- Mazars presented the External Audit Strategy Memorandum which summarised the audit approach, significant audit risks and other areas of key judgements for the year ending 31 March 2022. The Committee was advised that the accounting standard IFRS16, whose implementation date had been delayed for the public sector, would be applicable from April 2022.

ASSURE

- Internal Audit Follow Up Actions recommended in past audit reports had been completed and could be evidenced.
- The Internal Audit Progress Report detailed delivery of the 2021/22 plan and included two finalised reports relating to Professional Registrations & Right to Work and Patient Activity Data Capture.
- The Anti-Fraud Progress Report outlined activities undertaken in the year to-date in terms of both compliance with the Govt. Functional Counter Fraud Standard GovS:013, as well as across all elements of the agreed counter fraud workplan. The report was discussed and accepted with no substantial concerns around planned delivery in 2021-22.
- The Committee also received the Claims and Litigation, Losses and Special Payments Report and Waiver reports. There were no significant items to highlight from the reports.

New Risk identified at the meeting	None

Review of the Risk Register

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS COMMITTEE**	**Date**	**2 February 2022**
Agenda Item	**SO007/21**	**FOI Exempt**	**NO**
Report Title	**BOARD ASSURANCE FRAMEWORK (BAF)**		
Executive Lead	Sharon Katema, Associate Director of Corporate Governance		
Lead Officer	Sharon Katema, Associate Director of Corporate Governance		
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 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 ensuring that there is a clear updated position and that all actions are progressing in line with agreed timescales.

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

- All risks have been reviewed by Executive Director leads.
- There is one change in the scoring of **Risk ID3: Efficiently and productively provide care within agreed financial limits** which is now an Extreme Risk with a score of **20**.
- A new risk relating to the risk of major and sustained failure of essential IT systems, has been added to the Strategic Risk Register as an Extreme Risk at 20 against an Inherent Risk of 25.

Recommendations

The Strategy and Operations Committee is asked to **receive** the Board Assurance Framework and **approve** the inclusion of the Cyber Security Risk on the Strategic Risk Register.

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:**
Sharon Katema, Associate Director of Corporate Governance	Sharon Katema, Associate Director of Corporate Governance

Southport and Ormskirk Hospital NHS Trust

BOARD ASSURANCE OVERVIEW (UPDATED 27 January 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**	**16**	**12**	**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**	**20**	**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	

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 31/01/2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	3	4	12	2	4	8

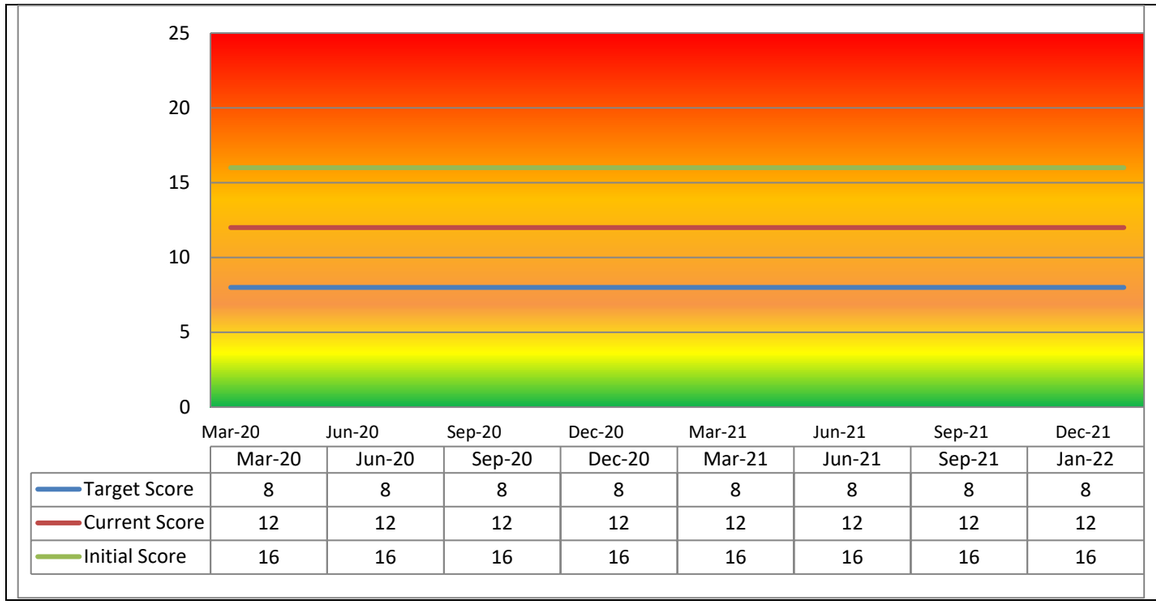
Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If quality is not maintained in line with regulatory standards this will impede clinical outcomes, patient safety and patient experience **CAUSE** • Ineffective governance and risk management processes • Ineffective understanding of minimum Clinical and Quality standards • Failure to recruit, retain and train clinical workforce • Failure of systems or compliance with policies • Ineffective use of resources to provide a clinically effective environment and access to equipment • Failure in operational or clinical leadership **CONSEQUENCE** • Failure to proactively respond to incidents and risk • Failure to deliver safe, high quality patient care and experience in the most appropriate environment • Failure to provide evidence of safe and effective care to commissioners and regulatory bodies • Failure to provide safe staffing levels with increasing dependency on high-cost temporary staff • Failure to provide staff with the appropriate skills and knowledge to deliver effective care • Failure to provide acute core services to our population • Reputational damage.	<u>Governance & Risk Management</u> • Incident reporting and investigation • Risk Management Framework. • Complaints, claims and PALS process • Single accountability framework for reviewing CBU areas for development/strengths. • Application of Patient Safety and other safety alerts. • Lessons Learnt process and learning from deaths • Cycles of business for governance meetings. <u>Clinical and Quality standards</u> • Quality priorities programme encompassing ten priority areas. • Patient Experience Strategy. • Quality impact assessments (QIAs) for all service changes that are considered. • Application of clinical pathways and guidelines. • CQC action plan to address areas of 'must do' and 'should do' highlighted on previous inspection. • Programmes in place for clinical standards and professional practice. • Patient Safety Specialists in post. • Medical examiners roles and fully established programme to review all deaths • Tendable (formerly Perfect Ward) audit programme • IPC audit programme and assurance framework in place. • Ockenden safety actions compliance and monitoring. • CNST compliance. • SOCAAS accreditation programme in place. • Clinical Audit cycle • Quality Improvement Plan which is monitored at Quality and Safety Committee <u>Clinical workforce</u> • Work plans for medical staff. • Clinical revalidation.	1. Expected outcomes and opportunities of partnership with StHK are still being explored 2. Clinical workforce strategy not fully developed. 3. Risk management strategy under review. 4. Nursing, midwife, AHP and support staff recruitment and retention programme needs further development. 5. CCG Quality contract needs review. 6. Ability to achieve targets for essential training. 7. Shaping Care Together programme is yet to define preferred option 8. Full cycle of business to support fragile services is yet to be agreed 9. Clinical risk relating to current estates and infrastructure continues to be defined	**LEVEL 1** (Operational Management) 1. Alert, Advise, Assure reports from Groups. • Harm free care panel • Serious Incident Review Group • Clinical Effectiveness • Patient Experience and Community Engagement • Resus Committee • End of Life Committee • Drugs and Therapeutics Committee • 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 Tendable (formerly Perfect Ward) dashboard. 7. Health and Safety Inspection Programme 8. IPC Assurance Framework 9. Health and safety/fire risk assessment/audit programme. 10. Medical Examiners process. 11. Learning from complaints and incidents. 12. Risk management deep dives and self-checks by the Integrated Governance team 13. Regular Risk Management Training for senior manager facilitated by the Risk Team **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. Fragile services update to S&O Committee 3. Quality and safety metrics 4. Mandatory and Essential skills training	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. ~~KPI dashboards for wards and CBUs to be reviewed, including visibility at key governance/committee meetings.~~ **COMPLETE** 2. Cycles of business to be reviewed for Trust-wide and CBU governance meetings. **Jan Update:** COB to be conducted for the 2022/23 cycle. To be completed by March 2022 3. ~~Quality improvement plan in process of being developed with internal engagement and external support. Strategy to be developed and rolled out – By end March 2021~~ **Complete December 2021 (Updates go through to QSC)** 4. Clinical workforce strategy to be completed in line with fragile services development and StHK partnership working: **Jan Update: Revised completion date Apr-21.** 5. ~~Nursing, midwife, AHP and support staff recruitment and retention programme to be fully developed.~~ **~~COMPLETE focus on HCA, AHP and ACP workforce to make workforce fit for the future~~** 6. ~~Risk management training with senior leaders in the organisation –~~ **COMPLETE – ongoing training in place and is now BAU** 7. Complete CQC Must and Should Do actions - **Jan 2022 update** – 20 actions remain Green and require further progress, 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. 8. ~~Review KPIs that goes to all governance meetings – COMPLETE April-21. All KPIs in IPRs reviewed.~~ 9. Enhance the sharing of lessons across the organisation and test that actions/changes are complete/ embedded into practice. ~~– By end of Jan 2021.~~

	• Increased cost to deliver services	• Training programme (mandatory and non-mandatory). • Nursing, midwife, AHP and support staff recruitment and retention programme in place. • Supervision and education of clinical staff across all professions. • Essential skills and mandatory skills training programme <u>Use of Resources</u> • 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 process. • Partnership arrangement with StHK. • Use of temporary staffing arrangements to maintain Unify Fill-rates of above 90%. • Shaping Care Together Programme • Review of fragile services • Estates and infrastructure review • Utilisation of digital technology • Data sharing and information governance <u>Leadership</u> • 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. • Quality contract with Commissioners. • Relationship meetings with CQC. • Implementation of Just and learning culture		5. Monthly Safe Staffing Report 6. Nurse establishment reviews 7. SOCAAS ward accreditation programme 8. Freedom to Speak Up Guardian reports 9. Guardian of Safe Working Report 10. Quality Improvement Plan presented bi-monthly at QSC and to the Board **LEVEL 3** (Independent/Semi-Independent) 1. CQC inspection visits 2. CQC Insight Report, Outlier Alerts and engagement meetings 3. NHSI/E oversight meetings 4. 5. CCG monthly quality and performance meetings 6. Internal/External Audit reports 7. Quality Account 8. Reports to Shaping care Together Programme Board <u>Potential Assurance</u> 9. GMC / NMC Reports 10. Royal College Reports / Visits 11. Healthwatch 12. Peer Reviews and accreditation. 13. Getting it right first time (GIRFT) programme		**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 off by Executives. yes 10. ~~Unify Fill-rates of above 90%. –~~ **COMPLETE** 11. Complete review of Risk Management Policies and develop a framework with associated training to bridge the gap on Risk Management Training in the Trust and a clear process. **Expected Completion March 2022.** **12.** Risk Management training launched September 2021 and being regularly reviewed and rolled out to staff across the Trust. **On-going** **13.** Launch Human Factors training in Q4 14. Review of Quality Contract with CCG in Q1 15. **Collaborative working with StHK.** 16. **Clinical Workforce Strategy that encompasses fragile services and partnership with StHK.** 17. **Completion of SCT programme to define preferred options for future sustainability of services**
	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: 7	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	**Update – Jan 2022** • The strategic risk and associated linked risks have been reviewed and this remains a **High Risk**. • New actions have been added around the partnership with StHK, management of the Risk Management Framework, training. Some recent



	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
Current Score	12	12	12	12	12	12	12	12
Initial Score	16	16	16	16	16	16	16	16

c) 2122 – Medicines Management
d) 2056 – Missing Patient appointments
e) 2226 – Inadequate staffing within Anaesthetics
f) 2074 – Consultant Medical Vacancies
g) 2218 – CQC compliance

developments have strengthened the action and some control around training is in place but further work on the framework should see this action completed by Q1.

- Since the BAF was last updated, six actions have been completed and have now been reviewed as either further controls or assurance and the relevant activity has been updated.
- A full controls review has been completed to review that all controls remain relevant.
- It's anticipated the completion of the remaining BAF actions will further enhance the controls and assurances with the aim of reducing the risk to achievement of the strategic objectives.

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 31/01/2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	4	4	16	2	4	8

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust cannot achieve its key performance targets it could lead to failure in delivering safe, high quality patient care and experience and failure to deliver contracts. **CAUSE** • COVID-19 causing delays in elective and diagnostic recovery, cancer pathways and patient discharge. • Continued rise in UEC demand and challenges with patient discharge due to insufficient/inconsistent alternative provisions across the system. • Reduction in the supply of suitably skilled and experienced staff across a number of services. • Ineffective use of resources to support improvements in productivity and improve clinical outcomes. • Failure in operational leadership **CONSEQUENCE** • Failure to deliver safe, high quality patient care • Reduced patient experience • Poor clinical outcomes • Over-reliance on temporary workforce due to current and projected workforce	<u>COVID-19 and Recovery</u> • 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. <u>UEC and Discharges</u> • 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. <u>Workforce</u> • Shaping care together programme. • Comprehensive trust service assessment completed to establish levels of fragility and core drivers <u>Use of Resources</u>	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. To be finalised in line with fragile services development and STHK partnership working **Jan 22 Update: Expected completion April 22** 2. COVID-19 and recovery plans in place. **Jan 22 Update:** RTT restoration plan being monitored on a weekly basis and reported to gold weekly and ETM monthly. **Ongoing.** **3.** ~~Develop sustainable plan to address validation issues in relation to the non-RTT tracker.~~ **~~Jan 22 Update:~~** ~~Plan developed and non RTT trackers in place to support the non RTT validation~~. **Action Completed.** 4. Develop cancer improvement plan to address performance across all cancer metrics by Dec 21. **Jan 22 Update:** Ongoing. Cancer improvement plan and trajectories signed off by QSC in Nov 21. Nov 21 position ahead of trajectory against all key cancer metrics. 5. Develop endoscopy Improvement Plan **Jan 22 Update:** Endoscopy improvement plan under development. To be signed off by Endoscopy Improvement Board in Feb 22. Reset endoscopy improvement board with COO/MD attendance. **Expected completion March 2022.** **6.** Develop plans for 2022/23 in line with national guidance **Jan 22 Update:** Planning for 2022/23 Business planning process in place, 'lite' in Q4 2020/21 full review due in Q1 2022/23 following national guidance. Priorities identified from the planning guidance. Operational planning group meeting in place weekly that will outline plan against priorities with Dep Directors' across all functions, key members/leads in the plan development.

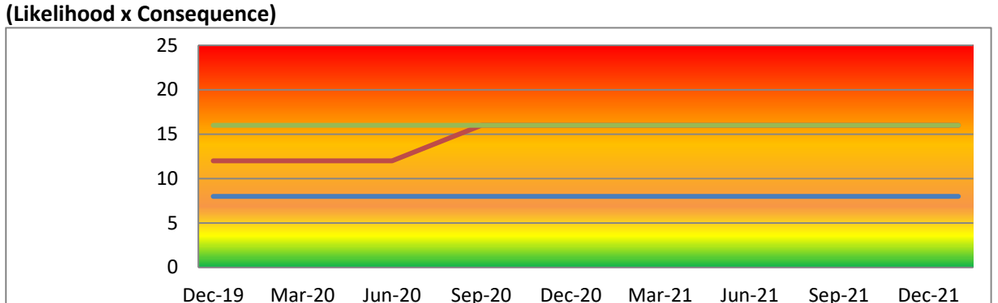
gaps leading to increasing costs and potential impact upon quality of patient care and experience. • Failure in delivery of national performance targets/plans which could lead to intervention by regulator(s)/ and/or commissioner(s) • Reputational damage and loss of public confidence. • Financial penalties 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 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. <u>Operational leadership</u> • Weekly Senior Operational Leadership (SOLT) Meetings • Monthly Senior Operational group (SOG) meetings with development plan in place • Essential skills and mandatory skills training programme • Daily RFD meetings with system partners in place. 3 x weekly exec led LLOS meetings in place with system partners. Weekly exec led 'Talk to us Tuesday - virtual event' in place to drive discharges.		14. NHS benchmarking data including Model Hospital Dashboard and Dr Foster reporting 15. Cancer alliance oversee delivery and performance regarding cancer metrics. 16. Internal and External Audit Reviews <u>Potential Assurance</u> 17. NHS England / Improvement meetings 18. CQC 19. Getting it right first time (GIRFT) programme.		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 compared with 13th Dec 21 baseline. **Jan 22 Update:** Daily RFD meetings with system partners in place. 3 x weekly exec led LLOS meetings in place with system partners. Weekly exec led 'Talk to us Tuesday - virtual event' in place to drive discharges.

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)**	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)	**Update – January 2022** • The strategic risk and associated linked risks have been reviewed this remains an **Extreme Risk.** • 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 • Since the BAF was last updated, one action has been completed and has been added as a further control with the relevant activity updated. • A full controls review has been completed to review that all controls remain relevant.



	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

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

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

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

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

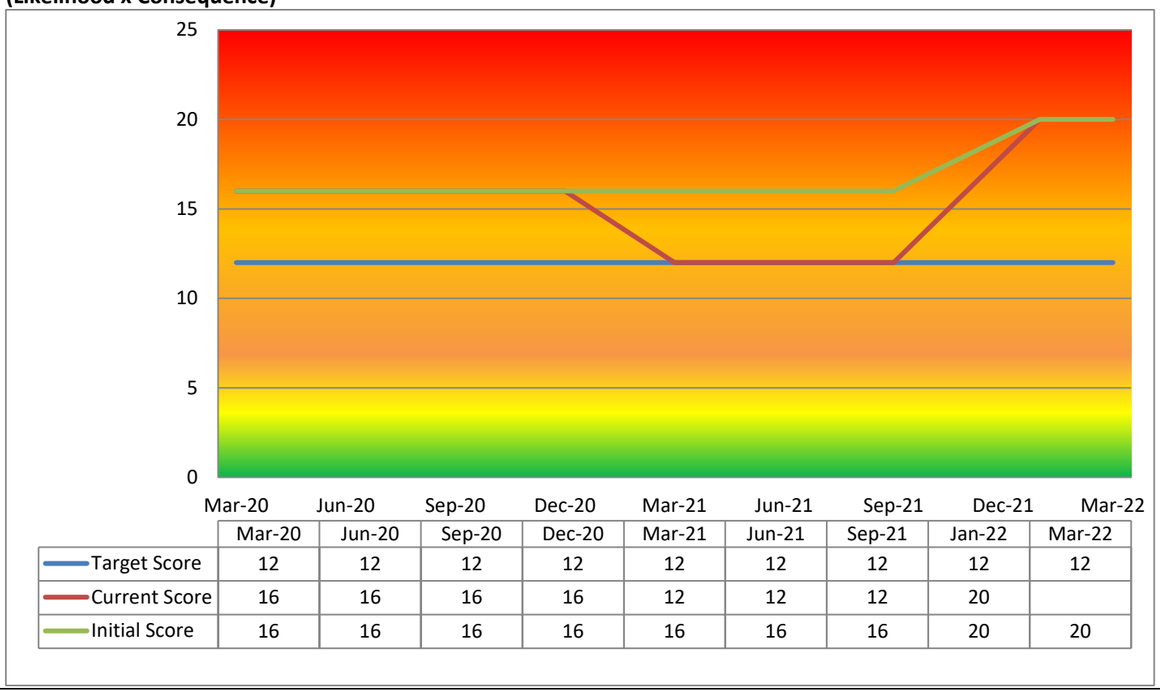
Inherent Risk			Risk as at 31/01/2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	5	4	20	3	4	12

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners **CAUSE:** • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to develop and deliver strategic financial plans • Failure to control costs or deliver CIP • Failure to stabilise Fragile Services • Failure to secure sufficient capital support to address significant backlog, and transformational requirements • Failure to ensure alignment of essential co-dependant clinical services • Failure to implement transformational change at sufficient pace • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV / NHS LTP) **EFFECTS:** • Failure to meet statutory duties • External Cash Support Requirements • NHS Single Oversight Framework Segmentation Status increase	• Operational Plan and HCP/ICS financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances Processes • Monthly financial reporting • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSEI annual provider Licence Declarations • Signed Contracts with all Commissioners • Signed SLAs with all partners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group • Increased collaboration across C&M to deliver transformational CIP contribution	• Currently no financial recovery plan that delivers break-even/ addresses drivers of the underlying financial position • Lack of medium & long-term financial plan, taking in to account current position and savings from any reconfiguration • Limited visibility, ownership, and accountability for financial performance • Lack of strategic capital plan • E-rostering system not fully utilised across the Trust. • Premium Rate Pay Control Panel across the CBUs, as well as centralising the management of rostering in process of being established • Demand and Capacity process to inform Operational Planning	**LEVEL 1** (Operational Management) • Performance, Improvement, Delivery and Assurance (PIDA) Boards • Monthly CBU FP&I meetings to be established • Use of Resources Programme Board • Corporate and CBU Efficiency Programme Group (EPG) meetings • Hospital Management Board • Monthly budget holder meetings **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) • Finance & Performance Committee • Audit Committee • Annual Financial Plan • Monthly Finance Reporting • IPR • Annual Accounts • SLR/PLICs update reports • UoR Reports • Internal Audit Programme • National costing returns • Shaping care together programme **LEVEL 3** (Independent/Semi-Independent) • NHS England/Improvement monthly reporting • CQC Reports • CCG Contract Review Meetings • Head of Internal Audit Opinion • External Audit reports inc VfM Assessment	• Ability to monitor trajectory against financial recovery plan until developed • Establishment of CBU FP&I meetings to ensure oversight, ownership, and accountability for delivery & performance • Demand and Capacity modelling to inform Operational Planning • Premium Rate Pay Control Panel across the CBUs in process of being established • Trust PMO capacity to support delivery of CIP, UoR Action Plan and service transformation	• Collaboration agreement in place with StHK • Develop scenario-based approach to Operational plan/budget setting for 2022/23 **Jan 2022 Update:** Action progressing with Final Plan Submission deadline **April 2022** • Development of Medium & Long-Term Financial Model & strategic capital plan – **Expected Completion June 2022** • Development and implementation of monthly financial reporting suite and forecasting model to drive ownership and accountability for performance – **Jan 22 Update: Expected Completion Date April 2022** • Establish processes for Capacity and Demand planning during 2022/23 • Implementation of SLR & PLICs to inform clinical understanding of cost drivers – deep dive analysis due **Target Implementation Date March 2022** • Establish processes for identifying, implementing, and monitoring delivery of efficiency/productivity (CIP) – **Expected Completion April 2022** • E-rostering system now being rolled out to remaining departments (~~**target completion date September 2021),**~~ **Jan 22 Update: Delayed by Covid and availability of required staff but Revised completion dates March 2022** • Establish a Premium Rate Pay Control Panel across the CBUs, as well as centralising the management of rostering – **Expected Completion April 2022** • Analysis of activity in relation to pbr to understand the drivers of changes, market share, and potential solutions – **Expected Completion March 2022** • Seek all possible sources of capital and revenue funding through national bids to support capacity and transformation - ongoing

	IMPACT: • Unable to deliver viable services • Loss of market share • Regulatory intervention					
	The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

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

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

RISK TRACKING	Linked Risks: 2	Comments
Risk Rating: Initial 5 x 4 = 20 Current 5 x 4 = **20** Target 3 x 4 = 12 **(Likelihood x Consequence)**  	1942: Eradicating Trust deficit by 2023/24 1688: Anaesthetic staffing	**Update – January 2022** • The strategic risk and associated linked risks have been reviewed and this is now an ***Extreme Risk***. • Review undertaken during January 2022 in order to focus on the longer-term financial sustainability risk to the Trust – resulting in the score increasing to 20. This risk had become a blended approach covering in-year risk and long-term risk • It's anticipated that the review of the Risk Management Framework and ongoing BAF training with will further enhance the BAF to ensure that controls and assurances remain effective with the aim of reducing the risk to achievement of the strategic objectives.

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

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

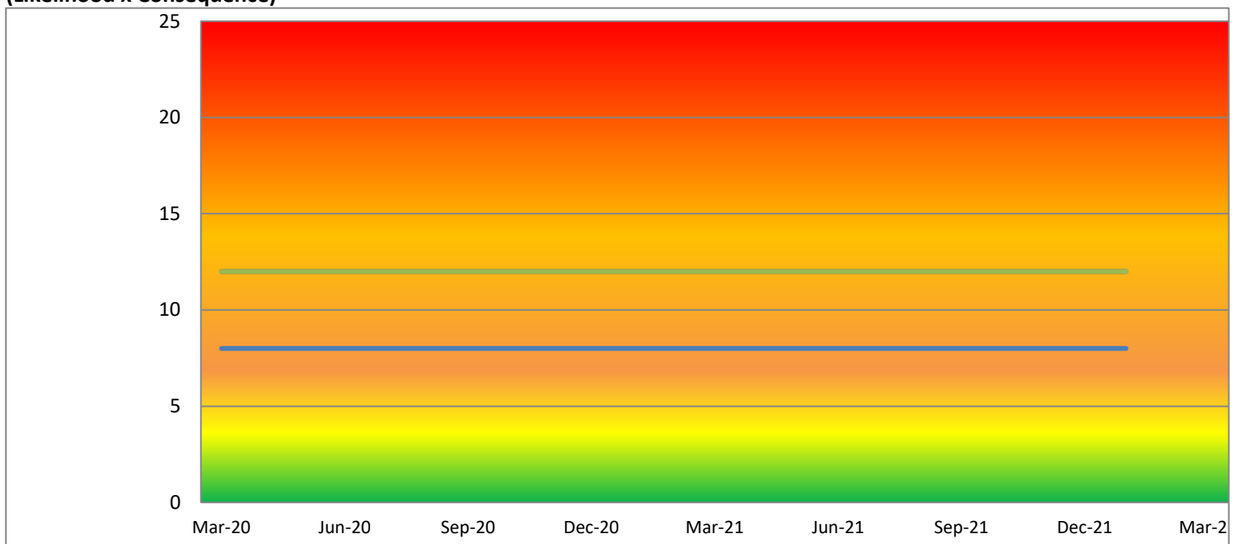
Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience **CAUSE** Shortage of appropriately trained clinical staff in certain specialties and professions; Trust's geographic location; Trust's 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	1. Our People Plan (Workforce and OD Strategy) aligned to NHS People Plan clearly outlines our intent. 2. Ambassador for Hope Mental Health training for staff, FTSU champions across the Trust, You Matter to us ED&I Campaign, Beat the Winter Blues Health and Wellbeing Campaign to support staff. 3. Our Resourcing Plan (Strategy supported by clinical workforce plan). 4. Inclusive recruitment and selection processes in place 5. Overseas Recruitment Campaign for Nurses have been successful in filling substantive roles and is continuing 6. Effective management of the junior doctor rotation programme and early indications of any shortages from the Lead Employer. 7. Job plans for medical staff. 8. Warm Welcome staff induction in place and feedback is positive from new starters to the organisation. 9. Quality PDR process and career development discussion being encouraged at all levels. 10. Flexible working options in place including team rostering 11. Ward/departments non-medical 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. People & Activity Group (PAG) has oversight of business cases for additional staffing and reports via Executive Team 12. Leadership development programmes & 360 feedback available to all staff across the Trust	1. Low number of applicants from BAME backgrounds successful at interview, which mirrors the community we serve. 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 10. Number of apprenticeships being taken up is slowing.	**LEVEL 1** (Operational Management) 1. Workforce Committee has cycle of business in place to constantly review progress again work plans 2. Workforce Improvement Group (WIG) oversees work and progress against the four operational priorities: 3. Agile working 4. Workforce systems 5. Clinical workforce plan 6. Change management 7. Quality and Safety Committee 8. Clinical Effectiveness Committee 9. Finance, Performance, and Investment Committee. 10. Risk and Compliance Group. 11. Clinical Effectiveness committee. 12. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 13. CBU Governance Meetings. **14.** All Committees listed from 3 to 9 above have a role to review, seek assurance and report issues of progress. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 15. Integrated Performance Report is presented to Board and Workforce Committee (monthly): This includes data on: 16. PDR completion. 17. Sickness Absence Data 18. Turnover Data 19. Vacancy Rate 20. Time to Hire monitoring and reporting. 21. Apprenticeship Levy/Programmes 22. Staff Survey & Quarterly Staff FFT/Survey 23. ED&I Annual Report to WFC 24. Gender Pay Gap to WFC 25. Communication Plan to WFC. **LEVEL 3** (Independent/Semi-Independent monitoring)	1. Sickness absence above target 2. Low compliance rates for PDR completion 3. High nursing vacancy rates 4. Several medical vacancies have been vacant for a long time 5. Delays in some AAC panels can lead to loss of candidates and longer time to hire rates for consultants.	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**~~. **Jan 22 Update:** Action revised: expected completion April 2022. 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**~~. **Jan 22 Update**: Action ongoing expected to commence mid-February 22. 3. Work with international colleagues as a bespoke group to support & develop career pathways to aid performance & retention. **Commencing January 2022** 4. Alignment of business planning to Job Planning Round 2021. **2021 Round still in progress but closing on 30 November and 2022 round will open on 14th December. 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 March 2022 due to COVID pressures, which means staff are unavailable for training**; 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**

	confidence in provision of services.	13. Apprenticeship programmes available to all staff from Level 2-7 qualifications and the Trust is focussing on increasing apprenticeships in order to avoid Levy loss. 14. Effective approach to supporting attendance to reduce sickness absence levels at all levels across the Trust. Partnership approach undertaken with support to all involved. 15. Updated Resourcing Plan required and planning to develop a clinical workforce plan in Quarter 2 of 2022/23 16. Lead Employer progression, building relationships with StHK and improving communication. 17. Internal transfer principles to be explored in order to allow flexibility of movement of workforce. 18. Core mandatory & essential skills training programmes in place and monitored via Risk Register, Risk & Compliance Group & Workforce Committee. 19. Clinical Education Review undertaken and being considered as to the best course of action for the Organisation.	11. Covid absence has had a considerable impact on staffing numbers and is not within our control when waves of Covid hit. 12. No Clinical Workforce Plan in place currently.	26. Internal/External Audit (MIAA) 27. Freedom To Speak Up Guardian (FTSUG) reports 28. Guardian of Safe Working Hours Report. 29. GMC Medical Staff survey – annual 30. Nursing temporary staffing fill rate/ NHSP contract performance <u>Potential Assurance</u> 31. NHS England / Improvement 32. CQC 33. CCG 34. NMC/GMC/HCPC and other professional regulators 35. Health Education England 36. Health Education Northwest		**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** 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.**~~ **January 2022 update:** Expected to continue throughout the winter period **(On-going)** 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**~~**. Updated – AAC in February 2022** 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. **Targeted completion by end of Q4** 10. Essential Skills Risk under review and action plan to be implemented to achieve Trust target. **Commence January 2022** **11.** Clinical Education Risk & Governance structure & processes under review by Executive Team. **Targeted completion of April 2022**
	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	Linked Risks: 3	Comments
Risk Rating: Initial 3 x4 = 12 Current 3 x 4 = 12 Target 2 x 4 =8 **(Likelihood x Consequence)**	1862: High level of nursing/HCA vacancies 2130: Clinical competency of the multi-professional workforce 2201: Covid 19 Workforce	**Update – January 2022** • 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



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

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**

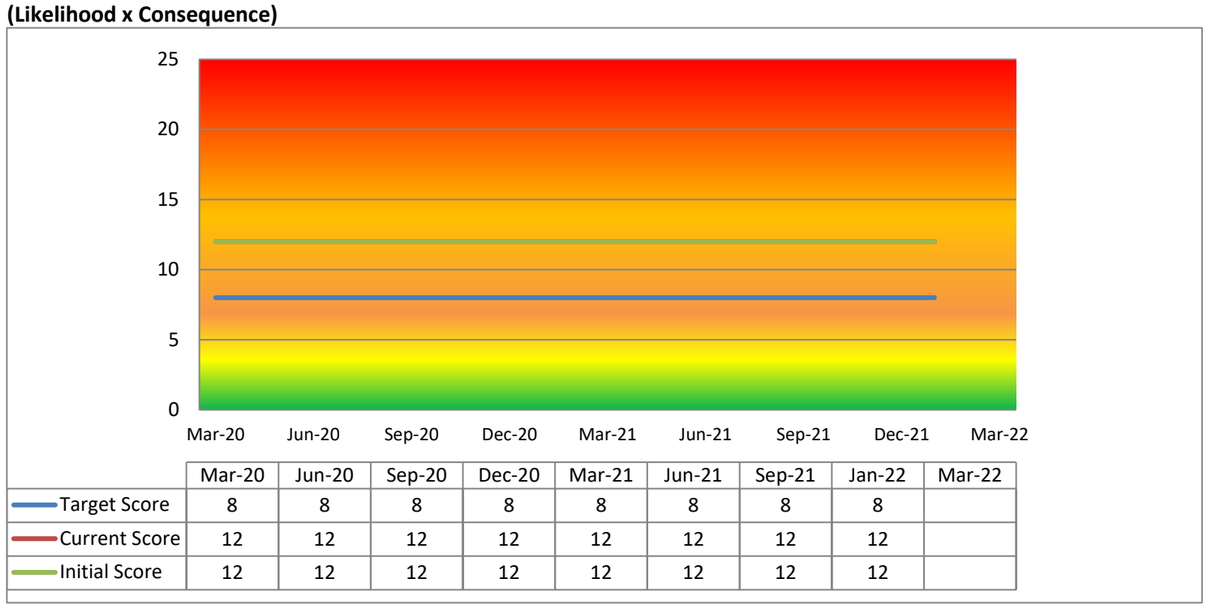
Inherent Risk			**Risk as at 31/01/2022**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	4	**12**	3	4	**12**	2	4	**8**

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. Increased Board visibility through: o Back to the floor sessions; o 15 steps walkabouts in wards and departments o Wellbeing Guardians assigned to hotspot ward areas o Ward Buddy initiative with Executive Directors and Deputies 17. ED&I Board Development sessions 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	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 Improvement Group (OPIG) oversees work against the two agreed priorities: 2. Appraisals 3. Values & Behaviours Framework 4. Review of HR risks at Risk and Compliance Group. 5. Workforce reports at Clinical Effectiveness committee. 6. Review of Workforce reports at CBU Governance Meetings 7. Workforce performance indicators discussed and Performance, Improvement, Delivery and Assurance (PIDA) Boards. 8. Quarterly Staff Survey launched in with regular monitoring of impact of the Valuing Our People (VOPIG) programme of work **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 9. Integrated Performance Report to Board and Workforce Committee (monthly): a. Mandatory training. b. PDR completion. c. Sickness rates. 10. Turnover. 11. Vacancies. 12. NHS staff Survey 13. Quarterly Staff Friends and family Test/Survey **LEVEL 3** (Independent/Semi-Independent) 14. GMC Medical Staff survey – annual 15. Freedom To Speak Up Guardian (FTSUG) reports to WFC and Board 16. Guardian of Safe Working Hours Reports to Workforce and Board	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. **January 2022 Update:** Currently on hold and will be reviewed to reflect the collaboration agreement with StHK. Expected to recommence in Q1 2022/23 2. ~~Schwartz Round facilitator regional training places secured and HR Business Partners to be upskilled to support team development intervention by **September 2021**. Update – now in implementation phase with an expected start date of **October 2021**.~~ **Jan 22 Update Action Completed** 3. Awaiting launch of national talent management/succession planning framework to apply at the Trust. **January 22 Update**: The Trust is adopting the Leadership Academy system, leadership competency framework and will undertake a self-assessment with leaders through a programme of work overseen by the Workforce Improvement group. Targeted completion date: End of Q4 22 4. Increased visibility for Board members with incentives such as • Back to Floor sessions reinstated for Board members; • ~~11 Wellbeing Guardians assigned to hotspot ward areas;~~ • ~~Ward Buddy initiative launched in July 2021 for each Executive Directors and Deputies partnered with a ward~~; • ~~increased presence of Executive Team at Ormskirk (permanent office base identified)~~. **January 2022 Update:** Due to visiting restrictions in Wards and the current escalated pressures, the Back to Floor sessions are currently awaiting impacted and await clearance from IPC. 5. Work programmes identified by the Valuing Our People Inclusion group from feedback from staff survey to improve staff

		20. Embedding Values and Behaviours in Induction and PDR processes. 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. 25. HR Business Partners upskilled as Schwartz Round facilitators who provide support team development intervention.		17. Internal Audit Reviews in line with Internal Audit Plan 18. Health Education England Dean's Visit and supporting Action Plan. <u>Potential Assurance</u> 19. NHS England / Improvement 20. CQC 21. CCG 22. NMC/GMC/HCPC and other professional regulators 23. Health Education England 24. Health Education Northwest		engagement score. ~~Quarterly Staff Survey launched in July 21 with support and regular monitoring of impact of the VOPIG programme of work~~. **Jan 22 Update**: Work programmes ongoing with updates presented to Workforce Committee. **Action Completed** 6. Increased engagement with the regional mediation service to assist in the informal resolution of relationship issues. Progress to be reviewed at VOPIG. Jan 22 Update: Stepped down in January with a view to recommence once meeting restrictions are eased.
	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 – January 2022** • 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. • The reinstatement of Valuing Our People through Inclusion Group continues to ensure progress against many of these actions and will also provide some accountability through the introducing a mechanism for staff to share their lived experiences, challenge progress of the priorities identified and shape further actions to drive improvement and enhance culture. • Risk rating remains unchanged due to the ongoing challenge with Covid 19 and focus on Fragile Services have had an impact on the participation by leaders in development programmes and staff in engagement activities. • One action relating to Schwartz Round facilitators has now been completed and is included in Controls

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

Risk Description: If the Trust 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

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: Strategy and Operations Committee
Executive Lead: Director of Transformation

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.

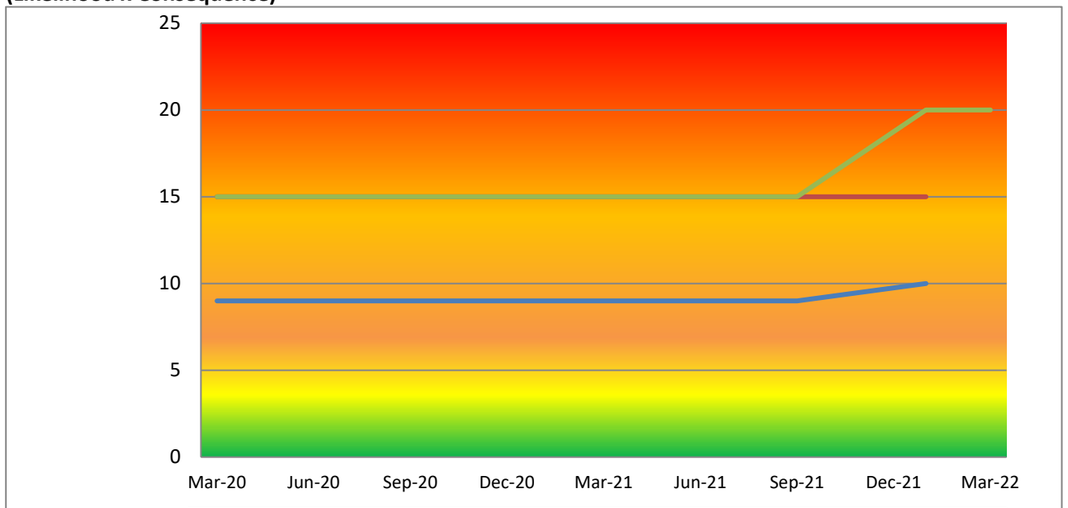
Inherent Risk			Risk as at 31/01/2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	5	20	3	5	15	2	5	10

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	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 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 governance structure	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	**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) **LEVEL 3** (Independent/Semi-Independent)	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. **Update:** ~~Second round of Models of Care Workshop completed to test out the clinical case for change, further workshops booked in June and new ways to collaborate online being developed~~ 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 **– 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 c. Endoscopy – develop 5 point plan by January 2022 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

	• Financial unsustainability due to increased costs • Poor estate utilisation due to inability to fully reconfigure services • Failure to provide acute core services to our population • Potential impact on neighbouring organisations if core acute services can no longer be delivered by the Trust • Reliance on other acute providers to support the delivery of clinical services • Reputational damage		priorities for 22/23 10. Cheshire and Merseyside Acute provider collaborative have not yet identified key clinical pathways for system collaboration.	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		
	The Strategy and Operations Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

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

RISK TRACKING	**Linked Risks: 3**	**Comments**
Risk Rating: Initial 4 x5 = 15 Current 3 x 5 = 15 Target 2 x 5 =10 **(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 remains an ***Extreme Risk*** • 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.



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

Strategic Objective: Major and sustained failure of essential IT systems

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

RISK ID	7	Risk Description	There is a risk of major and sustained failure of essential IT systems

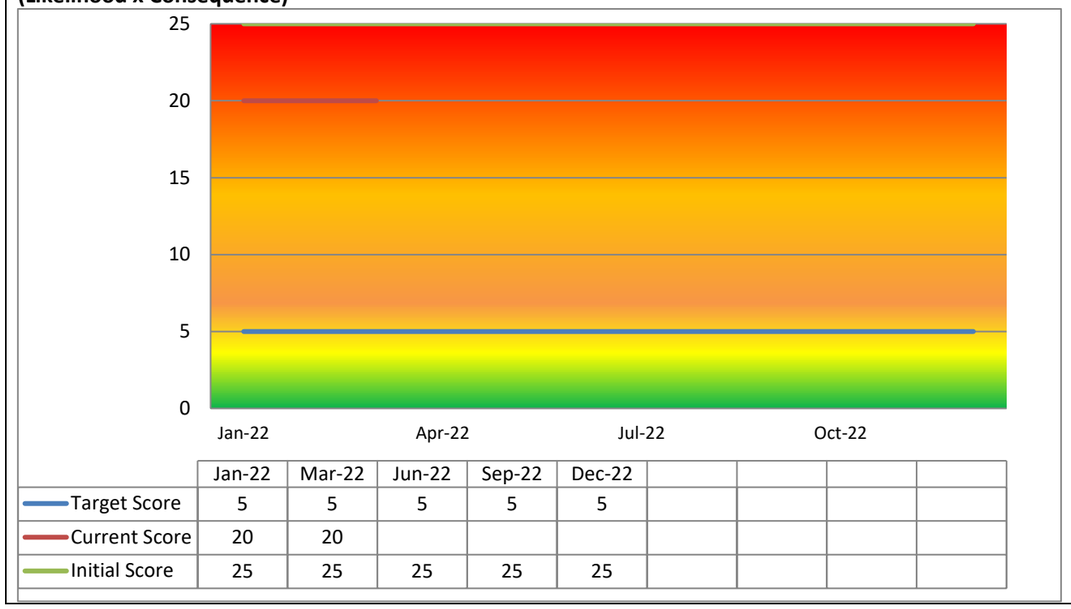
Inherent Risk			Risk as at 26/01/2022			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	5	25	4	5	20	1	5	5

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

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK There is a risk of major and sustained failure of essential IT systems. **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** • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity. • Loss of data or patient related information 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. Risk and Compliance Group 4. Information Governance Steering Group 5. Executive Management Committee 6. Information Asset Owner Framework 7. Benefits Realisation Framework monitoring 8. 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	1. Migration from end of life operating system ongoing and due to complete in March 2022 2. Implementation of Intrusion Prevention System (IPS) that detects cyber-attacks within the network. Planned for early 2022. 3. Cyber Essential Certification / Accreditation	

AMBITION: To provide sustainable IT service					
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 x 5 = 25 Current 4 x 5 = 20 Target 1 x 5 = 5 **(Likelihood x Consequence)**		This is a new risk which has been added to the Strategic Risk Register as an **Extreme Risk.**



	Jan-22	Mar-22	Jun-22	Sep-22	Dec-22				
Target Score	5	5	5	5	5				
Current Score	20	20							
Initial Score	25	25	25	25	25				

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS COMMITTEE**	**Date**	**02 February 2022**
Agenda Item	**SO009/22**	**FOI Exempt**	**NO**
Report Title	**INTEGRATED PERFORMANCE REPORT (IPR)**		
Executive Lead	Executive Management Team (EMT)		
Lead Officer	Michael Lightfoot, Head of Information Katharine Martin, Performance 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 December.

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;

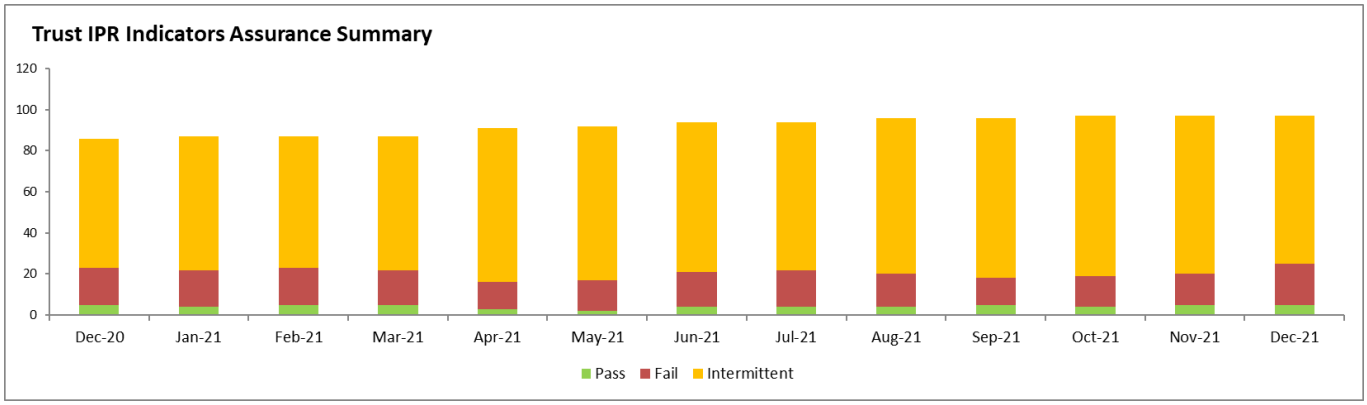
Quality - reflects those metrics aligned to Strategic Objective **S01** – *Improve clinical outcomes and patient safety to ensure we deliver high quality services*.

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.



Southport and Ormskirk Hospital NHS Trust

Harm Free, Infection Prevention & Control, Maternity, Mortality and Patient Experience

The CQC rated the Trust as **requires improvement** overall following its inspection in July/August 2019. The caring domain was rated as **good** and well-led, safety, responsive and effective domains rated as **requires improvement**. An unannounced CQC visit to Medicine and Emergency Care in March 2021 provided overall positive feedback with 9 'should-do' recommendations.

There were no Never Events in December 2021. (YTD = 0).
There were no cases of MRSA in December 2021. (YTD = 1).
There was 1 Hospital Onset Hospital Acquired C. Difficile (CDI) positive cases reported in December 2021.
There were 18 reported Hospital Acquired Covid infections reported in December.
The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for December 2021 was 89.3%. This is based on 93.1% for Registered Nurses and 84.9% for Un-Registered Nurses. The 2021-22 YTD rate is 88.8%.
The Trust remains ahead of target for VTE Prophylaxis Assessment at 98% for December and 97.8% YTD.
There were 2 category 3 and 7 category 2 hospital acquired pressure ulcers reported in December.
There were 3 falls resulting in moderate harm in December. All pressure ulcers and falls with harm are managed through the Harm Free Care panel.
The Trust remains ahead of the breastfeeding target at 62.3% in December (63.9% YTD).
Both caesarean and induction of labour rates remain above plan but the induction rate has reduced by 4% in December to 41.1% (43.1% YTD). The caesarean rate has increased in December to 39.6% (35.7% YTD).
Following several months of breaches of 1:1 care in labour, none were reported in December.
The SHMI remains as expected at 100.3 (latest data July 21) and the HSMR is well ahead of plan at 73.6.
The mortality screening rate has increased to 95.5% in the latest data month (November).
The Patient Friends & Family Test - % that would recommend has increased to 90.5% in December, and while it remains below the 94% target, is on an improving trajectory.

Operational Performance

Overall Accident and Emergency performance for December 2021 was 77.7% and YTD 79% (Adults ED 57.9%, Paeds ED 97.3% in December). Total attendances for December 2021 were 8,746 compared to 9,980 in November. 103 Ambulance Handovers were 30-60 mins in December compared to 118 in November, with 49 delayed for longer than 60 mins (28 in November).

Performance against the 62-day cancer standard was below the target of 85.0% in month (November 2021) at 66.9%. YTD 67.4%. This is an incremental increase on October which was 66.3%. The 31-day target was achieved in November 2021 with 97.2% performance in month against a target of 96%, YTD 98.4%. Performance in October 2021 was 96.9%. The 2-week rule target was not achieved in November 2021 with 78.5% in month and 81.6% YTD against a target of 93.0%. Performance in October 2021 was the same at 78.5%. Delays to diagnostics, in particularly Endoscopy, have affected the ability to meet the both the 2ww and 62-day cancer standards.

The average daily number of stranded patients in December 2021 was 171 compared with 168 in November. The number of super-stranded patients also increased from an average of 59 in November to 66 in December 2021. Both metrics were impacted by delays in care packages, availability of community beds and multiple Covid outbreaks in care homes.

Southport and Ormskirk Hospital NHS Trust

Operational Performance continued

The 18-week referral to treatment target (RTT) was not achieved in December 2021 with 80.1% compliance, a reduction on 81.6% reported in November, and YTD 82.3% (Target 92%). The Trust performs well in comparison to peers. There were 136 52+ week waiters. The diagnostic target was not achieved in December 21 with 42% patients waiting longer than 6 weeks compliance, a deterioration on 34.7% reported in November (Target 1%).

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

Financial Performance

The Trust is reporting a £2.6m deficit at Month 9 and is forecasting a deficit of £4.7m for 2021/22.

Income & Expenditure – reported position driven by £1.0m ERF income risk and a £4.2m gap in system allocations but partly reduced by £0.5m due to successful funding bid for winter schemes. The transparency and equity of H2 system allocations has not been resolved.

CIP – The Trust has delivered schemes totalling £5.8m to M9 and is assured of the delivery of the 2021/22 CIP plan. Although it should be noted that £3.7m is currently identified as non-recurrent.

Cash - Receipt of regional cash support of £1.0m per month agreed for Q3 (to be repaid in Q4). Cash balances have reduced to-date during 2021/22 as a result of the Trust improving its Better Payment Practice Code (BPPC) performance. Subject to conclusion of final system re-allocations for H2, the Trust would require external cash support during March 2022 (via the existing DHSC revenue loan route).

BPPC - The Trust's recovery plan submitted to NHSE/I set out an improvement trajectory to achieve 95% on a monthly basis by the end of March 2022. The Trust has reached 90% YTD to December.

Capital – Successful bids for additional capital funding have taken the 21/22 plan to £12.1m. The spend to the end of December is £3.7m and there are assurances with regard to the delivery in full by the end of the financial year. The Trust continues to pursue additional capital funding to address High Risk Critical Backlog Maintenance.

Workforce

Personal Development Review compliance has dipped slightly in December to 78.1% against the 85% target. Performance in November was 79.7%. Mandatory training compliance remains ahead of target and has increased in December to 88.7%.

In December overall sickness increased by 0.6% from the previous month to 7.4%. The rolling 12-month figure is 6.6% in December. This is forecast to increase in January as a result of the 4th wave of the Covid pandemic. The medical vacancy rate is now ahead of plan at 6.6% (target 7.4%) with 14 additional medical posts under offer to further improve this position. The Nursing vacancy rate has decreased to 11% in December (12% in November) due to the International Nursing recruitment programme. A recruitment drive is underway to recruit to HCA posts. Staff turnover has increased with an in-month figure of 1.1% (target 0.75%). The rolling 12-month figure is 15.3%, against a target of 10%. Although this figure is impacted by the rotations of the Foundation doctors.

Activity Summary – December 2021

NHS Southport and Ormskirk Hospital NHS Trust

Indicator Name	December 2019	December 2020	November 2021	December 2021	Trend
Overall Trust A&E attendances	10,825	7,520	9,980	8,746	▲
SDGH A&E Attendances	4,804	4,030	4,831	4,489	▲
ODGH A&E Attendances	2,900	1,242	2,863	2,197	▲
WLHP WIC Attendances	3,121	2,248	2,286	2,060	▼
SDGH Full Admissions Actual	988	1,041	999	976	▼
Stranded Patients AVG	183	148	168	171	▲
Super Stranded Patients AVG	69	42	59	66	▲
MOFD Avg Patients Per Day	71	42	54	53	▲
GP Referrals (*Exc. 2WW*)	2,296	1,864	2,058	1,767	▼
2 Week Wait Referrals	610	731	901	721	▼
Elective Admissions	152	139	184	170	▲
Elective Patients Avg. Per Day	5	4	6	5	▲

Activity Summary - December 2021

NHS Southport and Ormskirk Hospital NHS Trust

Indicator Name	December 2019	December 2020	November 2021	December 2021	Trend
Elective Cancellations	27	22	83	45	▲
Day case Admissions	1,757	1,251	1,529	1,248	▼
Day Case Patients Avg. Per Day	57	40	51	40	▲
Day Case Cancellations	39	28	148	124	▲
Total Cancellations (EL & Day Case)	66	50	231	169	▲
Total Cancellations (On or after day of admission, non clinical reasons)	8	1	11	0	▼
Outpatients Seen	19,868	18,825	22,640	19,011	▲
Outpatients Avg. Per Day	641	607	755	613	▲
Outpatients Cancellations	3,815	3,931	4,317	3,817	▼
Theatre Cases	534	434	591	464	▲
General & Acute Beds Avg. Per Day	363	346	344	350	▼
Escalation Beds Avg. Per Day	16	11	0	0	▼
In Hospital Deaths	103	87	68	84	▼

Southport and Ormskirk Hospital NHS Trust

Integrated Performance Report

Strategy & Operations Committee Report

December 2021

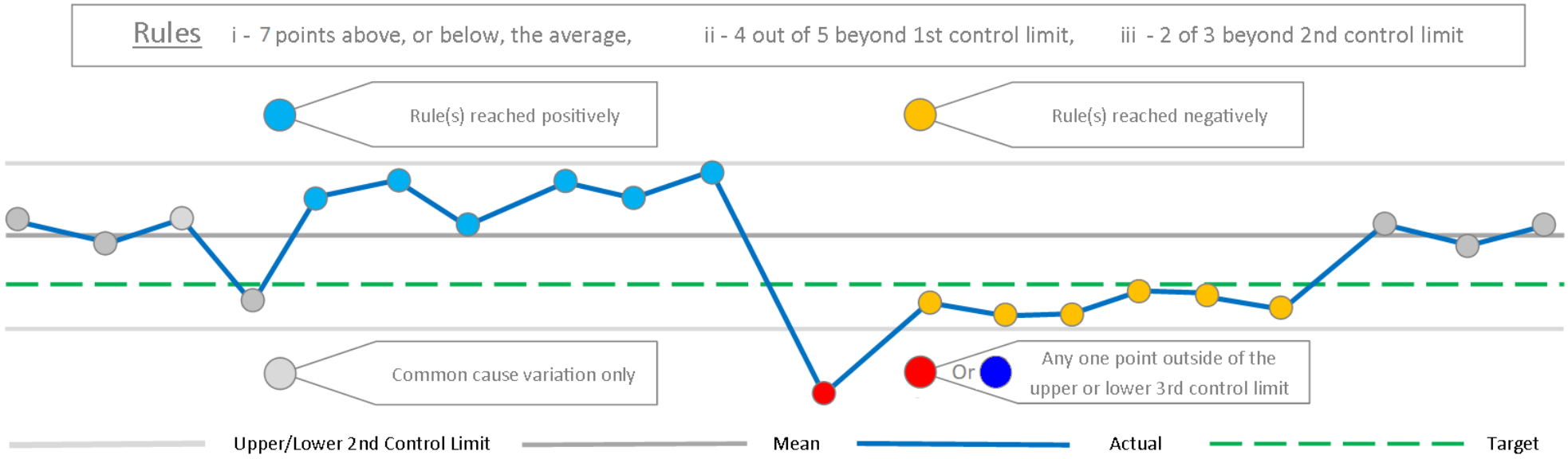
Guide to Statistical Process Control

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

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

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

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



Executive Summary

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

Assurance

Measures the likelyhood of targets being met for this indicator.

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

Variation (Past 3 Months)

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

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

Quality

Harm Free

Staffing

Issues
• The Trust has fallen short of the 90% target for this metric in December, by 0.7%.
• Care Hours per Patient Day (CHPPD) has achieved the target and the indicator remains assured.
• Issues remain reflective of the ongoing pandemic where staffing shortages due to isolation and sickness remain with recent higher-than-average rates of short-term sickness due to Omicron isolations. This has affected the substantive workforce and ability to use our NHSP nurse bank to fill shortfalls.
• Registered Nurses fill rate was 93.1% and Care Staff 84.9%.
• The acuity of patients has also impacted staffing requirements.

Management Action
• Proactive reviews of all daily staffing occurs twice daily with a particular overview that fill rates are acceptable and patient safety is maintained.
• While actual staffing versus planned staffing does fall short of the national 90% standard, we have utilised clinical staff in non-clinical roles to support areas with the highest shortfall to maintain staff support and preserve patient safety.
• We continue to escalate staffing levels through relevant channels daily.
• International nurse recruitment continues with high levels of success and local recruitment events are planned to bolster substantial staff numbers.
• The Trust has introduced an incentive scheme to support the staffing to support escalation and increased levels of sickness.

Hospital Acquired Pressure Ulcers

Issues
• Performance on the Hospital Acquired Category 2 metric is statistically as expected, although there has been an increase in December (7 reported) and the target has been breached.
• The Hospital Acquired Category 3 & 4 metric is performing statistically as expected and although there has been a reduction in December, remains more than the target.

Management Action
• All hospital acquired pressure ulcers are subject to root cause analysis which is presented at the Harm Free Care Panel.
• The recommendations which are being implemented include training for ward staff, purchasing new equipment such as mirrors and foot protectors and the introduction of the Care Flow Connect patient management system which enables digital images to be uploaded to aid earlier diagnosis.

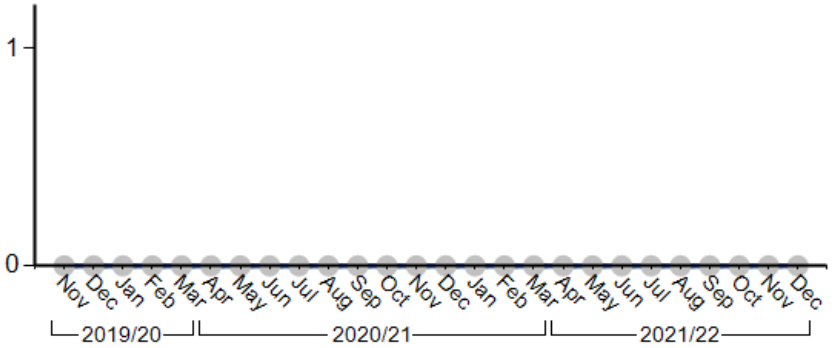
Patient Falls – Moderate/Severe/Death

Issues
• Performance on this metric is statistically as expected but has been on an upward trajectory since September and a further 3 falls with harm have been reported in December.

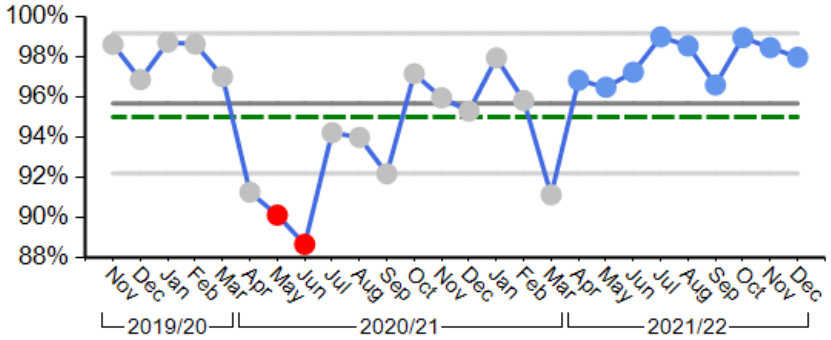
Management Action
• A thematic review of all falls with harm was carried out in November to ensure that the falls action plan encompasses all themes.
• A Quality walkabout took place in December to review patient information, including 40 patients on risk of falls and use of identifiable nonslip socks and wristbands.
• Falls are to be used as a theme on safety huddles on all wards.
• Documentation is being reviewed to support care planning and new low-profile beds were delivered in December.
• The Trust falls lead post has been appointed to but we await a start date.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Never Events	0	0	0	Dec 21		0	0	Nov 21	0	0	
VTE Prophylaxis Assessments	95%	98%	71	Dec 21	H	95%	98.4%	Nov 21	95%	97.8%	
Fractured Neck of Femur - Operated on within 36Hours	85%	72.2%	5	Dec 21		85%	42.9%	Nov 21	85%	68.5%	
WHO Checklist	100%	100%	0	Dec 21	H	100%	100%	Nov 21	100%	100%	
Safe Staffing	90%	89.3%	N/A	Dec 21		90%	91.4%	Nov 21	90%	88.8%	
Care Hours Per Patient Day (CHPPD)	7	8.9	N/A	Dec 21	L	7	8.4	Nov 21	7	8.8	P
StEIS	0	1	1	Dec 21		0	2	Nov 21	0	15	
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days	0.45	0.6	7	Dec 21		0.5	0.3	Nov 21	0.45	38	
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days	0.1	0.2	2	Dec 21		0.1	0.2	Nov 21	0.1	18	
Percentage of Patient Safety Incidents - Moderate/Major/Death(related)	2.1%	0.4%	3	Dec 21		2.1%	0.4%	Nov 21	2.1%	0.6%	P
Patient Falls - Moderate/Severe/Death - per 1,000 bed days	0.1	0.3	3	Dec 21		0.1	0.2	Nov 21	0.1	0.2	

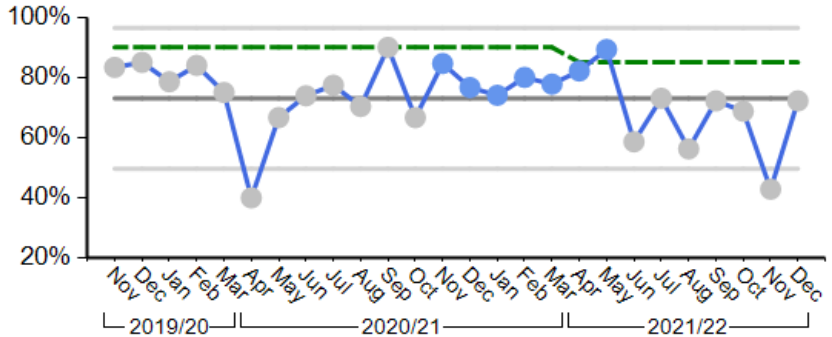
Never Events



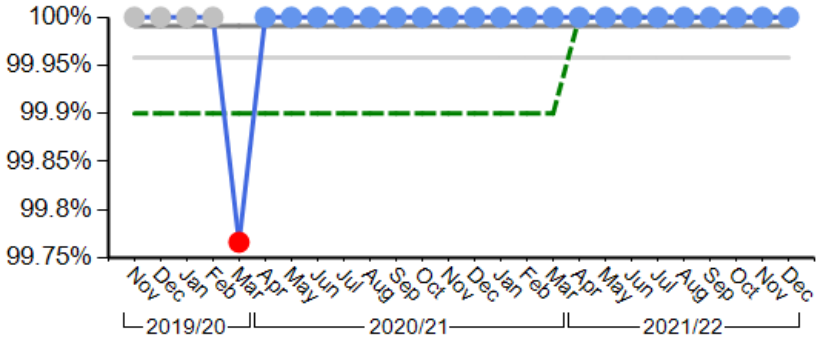
VTE Prophylaxis Assessments



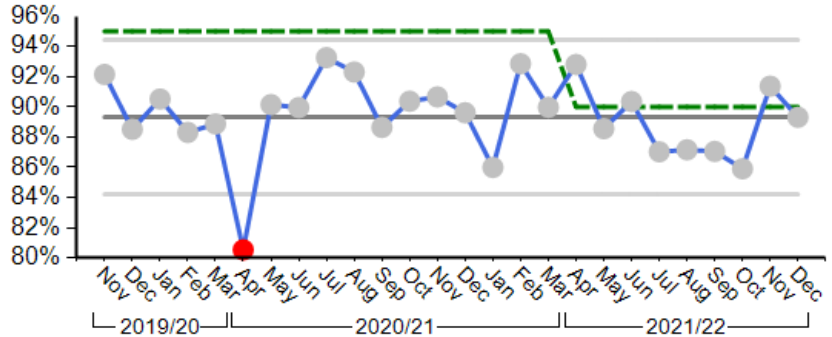
Fractured Neck of Femur - Operated on within 36Hours



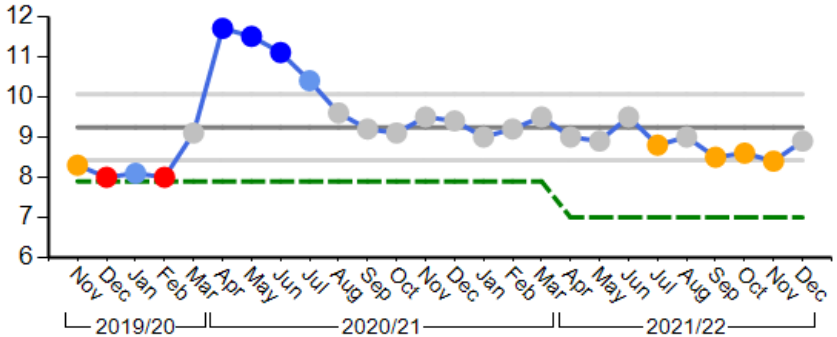
WHO Checklist



Safe Staffing



Care Hours Per Patient Day (CHPPD)



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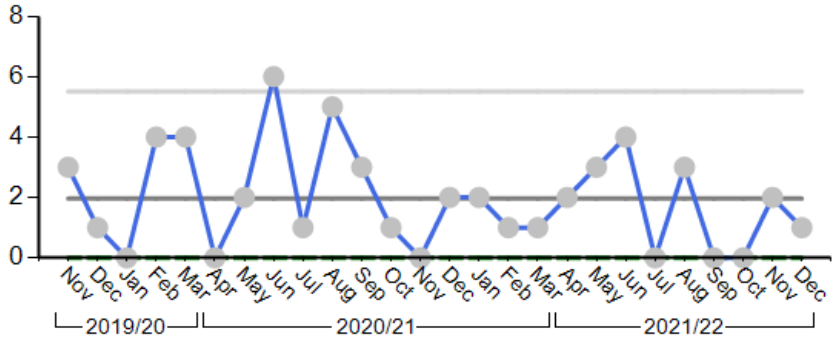
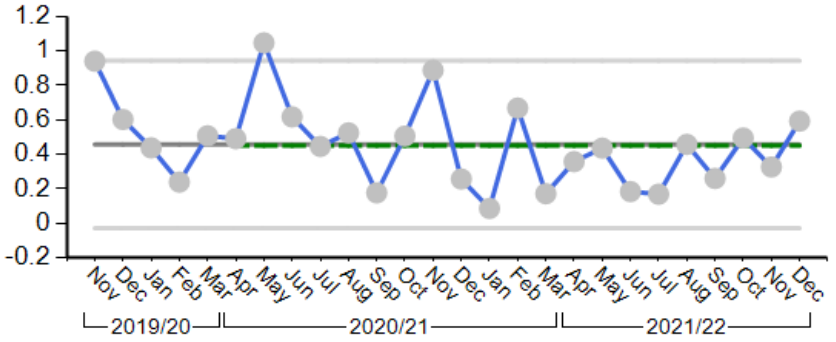
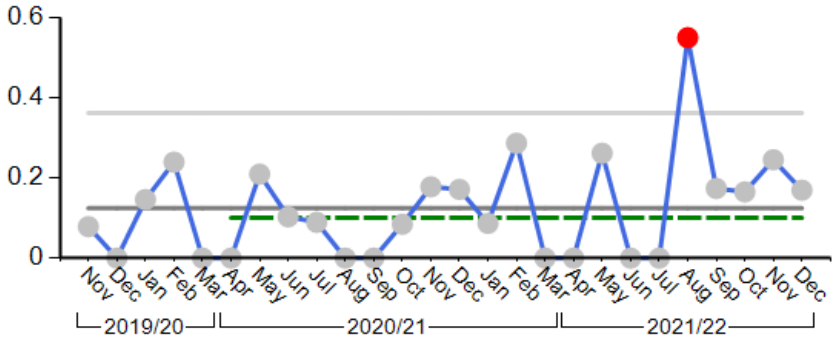


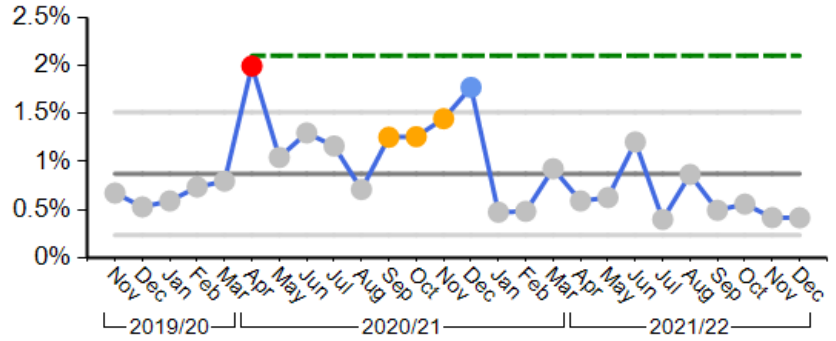
Hospital Acquired Category 2 Pressure Ulcers - per 1,000 bed days



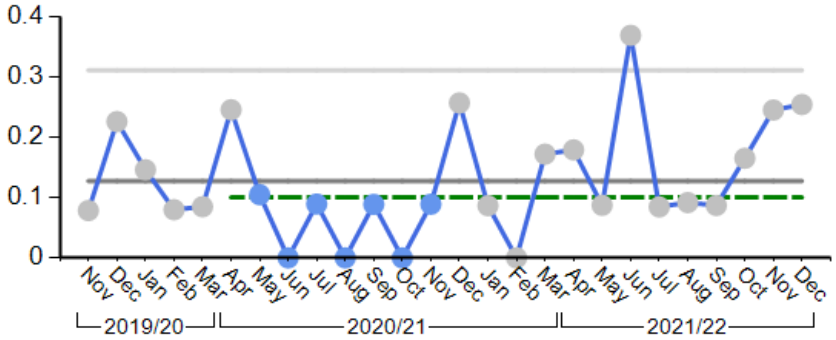
Hospital Acquired Category 3 & 4 Pressure Ulcers - per 1,000 bed days



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



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



Quality

Infection Prevention and Control

C.Diff

Issues
• The Trust continued the improving trajectory and was under target in December with one Hospital Onset Hospital Acquired infection reported.
• The annual Trust target of 27 has been exceeded by 12.
• Of the 39 cases 25 have no identifiable lapses in care; lapses in care include issues related to antimicrobial prescribing, delay in isolation of symptomatic patients, or delay in sample acquisition.

Management Action
• RCA's are completed for hospital acquired c.diff infections.
• Any issues with antibiotic use are reviewed with the Consultant and discussed in ward huddles with learning disseminated through the Governance meetings and education sessions.
• The antibiotic audits will continue.

E-Coli

Issues
• The Trust exceeded the target in December, with 3 hospital onset hospital acquired and 2 community onset hospital acquired cases reported.
• Despite being above target for two consecutive months figures remain within expected levels in month and is below the cumulative target by 12 cases YTD.

Management Action
• All of the patients are reviewed by their clinical teams with collaboration from the Consultant Microbiologist. The cases are also reviewed retrospectively by the IPC team.
• No apparent lapses in care in any of these patients.

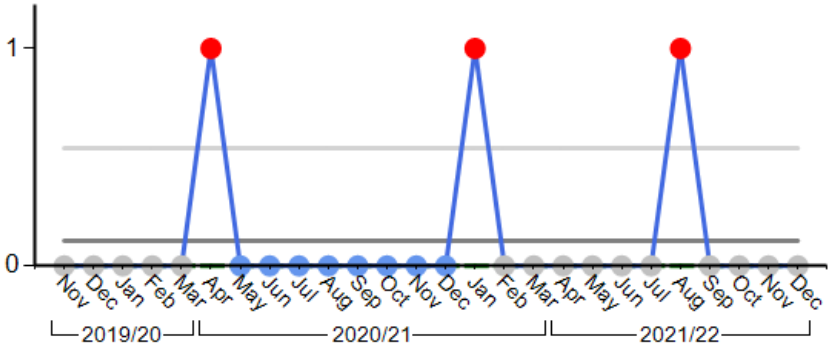
Covid

Issues
• Three reported outbreaks in December has resulted in 18 cases in December, resulting in this metric showing special cause concern.
• The Trust has responded extremely well in comparison to peers.

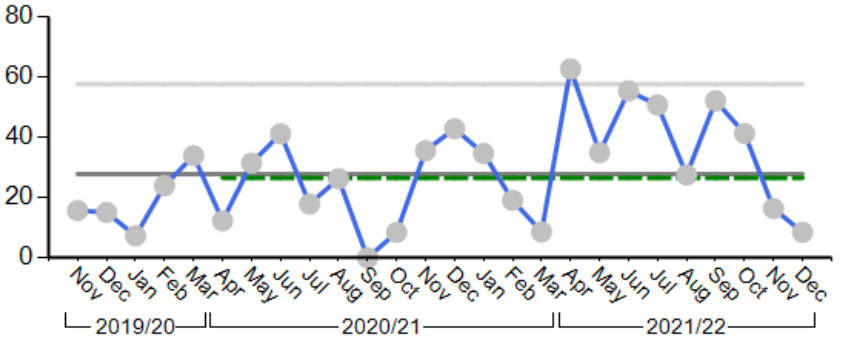
Management Action
• All patients are screened on admission and throughout their inpatient stay.
• Where there have been outbreaks, contacts have been isolated and tested on a daily basis to quickly identify and isolate positive cases.
• Positive cases are isolated on COVID wards and treated as required - most of the positive patients have been asymptomatic.
• The Trust is also implementing air purifiers with HEPA filters and UVC disinfection as well as CO2 monitors.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
MRSA	0	0	0	Dec 21		0	0	Nov 21	0	1	
Clostridium Difficile - per 100,000 bed days	26.5	8.5	1	Dec 21		26.5	16.3	Nov 21	26.5	38.4	
E. Coli - per 100,000 bed days	20.6	42.3	5	Dec 21		20.6	49	Nov 21	20.6	35.6	
MSSA - per 100,000 bed days	8.8	0	0	Dec 21		8.8	8.2	Nov 21	8.8	13.5	
Number of Hospital Acquired Covid Infections - Trust		18	18	Dec 21			0	Nov 21		36	

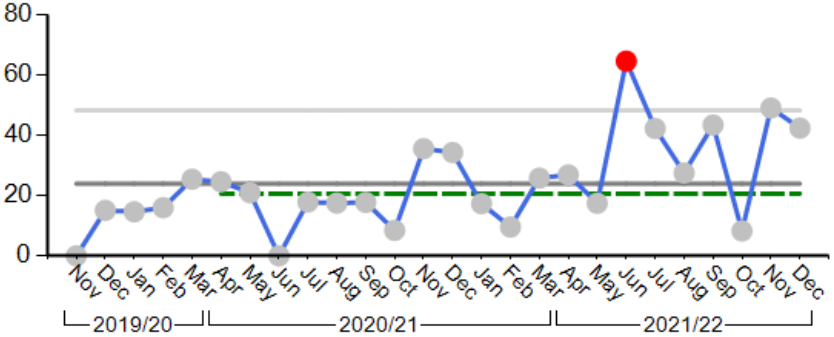
MRSA



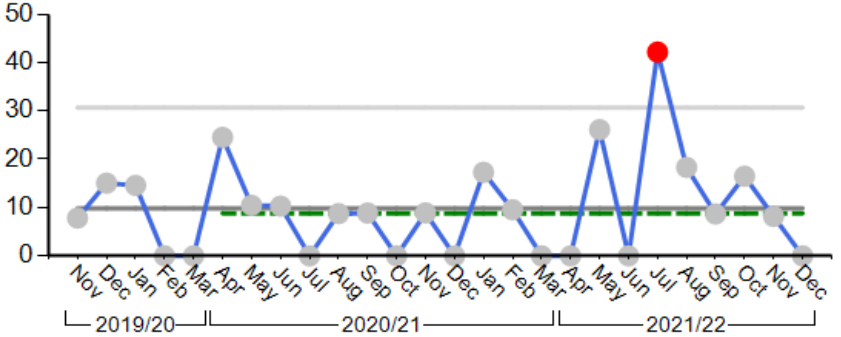
Clostridium Difficile - per 100,000 bed days



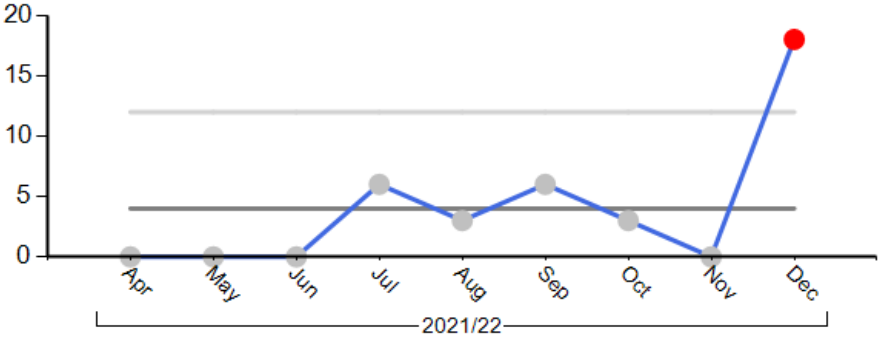
E. Coli - per 100,000 bed days



MSSA - per 100,000 bed days



Number of Hospital Acquired Covid Infections - Trust



Quality

Maternity

Induction Rates

Issues
• The Trust has been an outlier for Induction rates for several months in comparison to peers.
• The induction rate in December has reduced by 4% on the previous month and whilst this remains above the target, it is below average.
• An audit was undertaken to understand the reasons for induction and identified recommendations around large for gestational age babies and treatment for women with diabetes.

Management Action
• Guidelines revised in line with Northwest Regional Guideline for Reduced Fetal Movements.
• From November 2021 electronic GROW records are in place. The Trust Guidelines for LGA will be in place from December 2021.

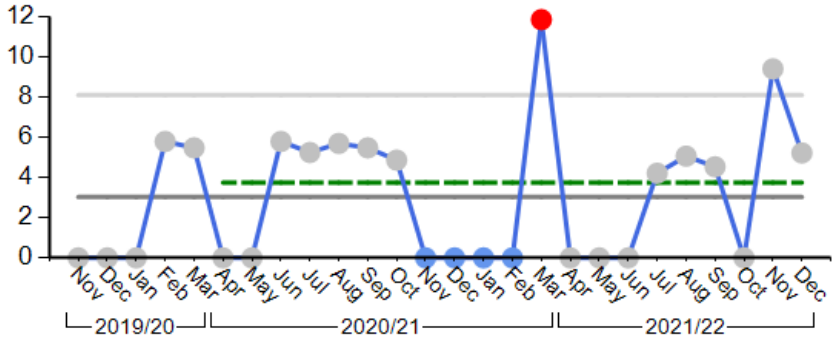
Caesarean Section Rates

Issues
• Whilst not statistically significant, the caesarean rate has increased in December and is more than 11% above the target.
• Rates have seen a notable increase in 2021/22, with the year-to-date figure currently 35.7%.
• Caesarean rates are on the increase nationally, with Maternity HES data showing an overall rate of 33.5% and the Northwest Coast Data Overall rate at 34.15%.
• The issue seems to be emergency C/Section rates.

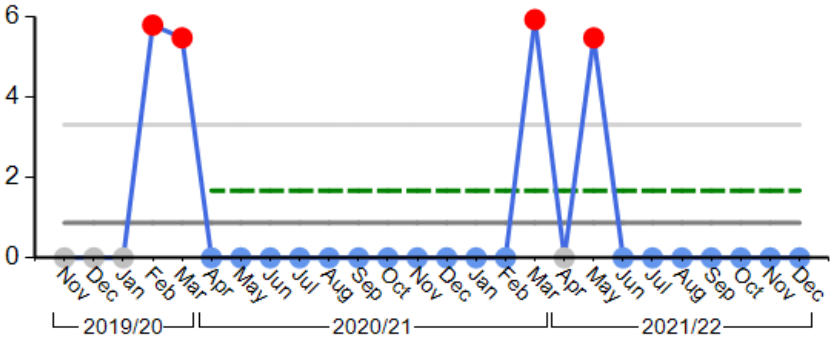
Management Action
• A Quality Improvement plan focussing on embedding the audit recommendations is being established. This will be discussed at CBU Governance and monitored through Clinical Effectiveness Committee.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Stillbirth Rate (per 1,000 births)	3.74	5.2	1	Dec 21		3.7	9.4	Nov 21	3.74	3.3	
Neonatal Mortality Rate (per 1,000 births)	1.67	0	0	Dec 21	L	1.7	0	Nov 21	1.67	0.6	
Number of Maternal Deaths	0	0	0	Dec 21		0	0	Nov 21	0	0	
Caesarean Rates	28.5%	39.6%	76	Dec 21		28.5%	34.3%	Nov 21	28.5%	35.7%	
Induction Rate	38%	41.1%	79	Dec 21		38%	45.1%	Nov 21	38%	43.1%	
Breastfeeding Initiation	62%	62.3%	72	Dec 21		62%	62.1%	Nov 21	62%	63.9%	
Percentage of Women Booked by 12 weeks 6 days	90%	94.9%	10	Dec 21		90%	94.5%	Nov 21	90%	90.9%	
Number of Occasions 1:1 Care Not Provided	0	0	0	Dec 21	H	0	3	Nov 21	0	12	
Maternity Complaints as % of Deliveries	0.7%	0.5%	1	Dec 21		0.7%	0.9%	Nov 21	0.7%	0.6%	
Percentage of 3rd/4th Degree Tears in Unassisted Vaginal Births	1.5%	0%	0	Dec 21		1.5%	2.6%	Nov 21	1.5%	2.2%	
Percentage of 3rd/4th Degree Tears in Assisted Vaginal Births	11%	7.1%	1	Dec 21		11%	8.3%	Nov 21	11%	4.5%	

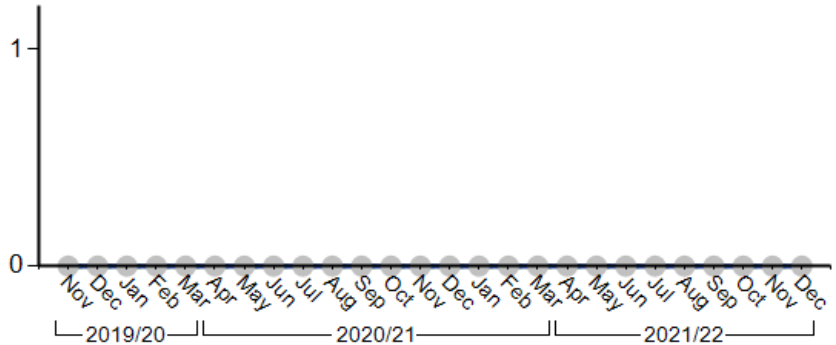
Stillbirth Rate (per 1,000 births)



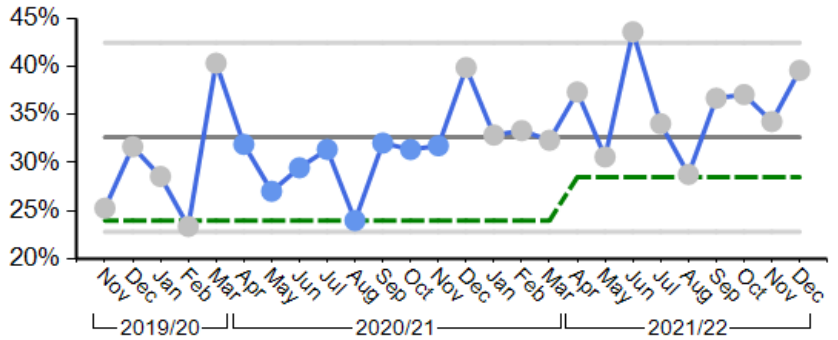
Neonatal Mortality Rate (per 1,000 births)



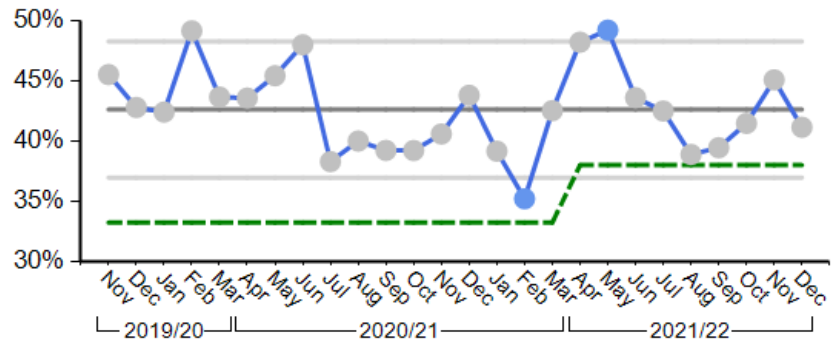
Number of Maternal Deaths



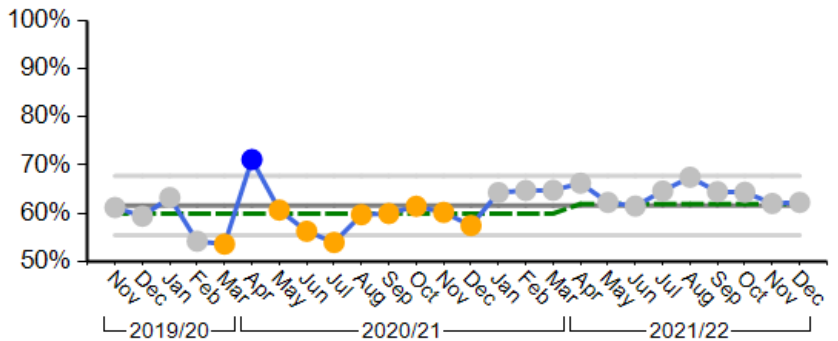
Caesarean Rates



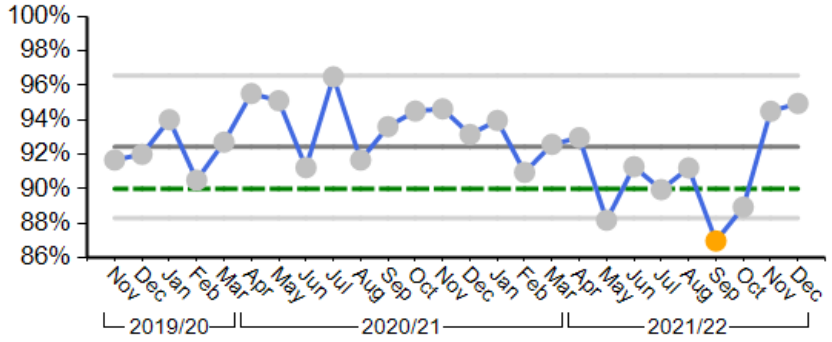
Induction Rate



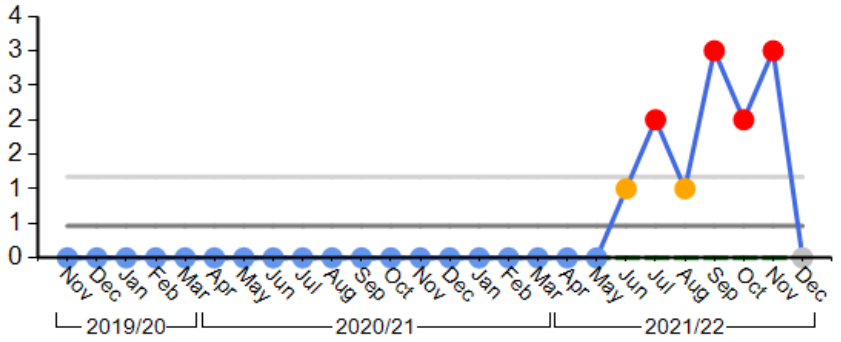
Breastfeeding Initiation



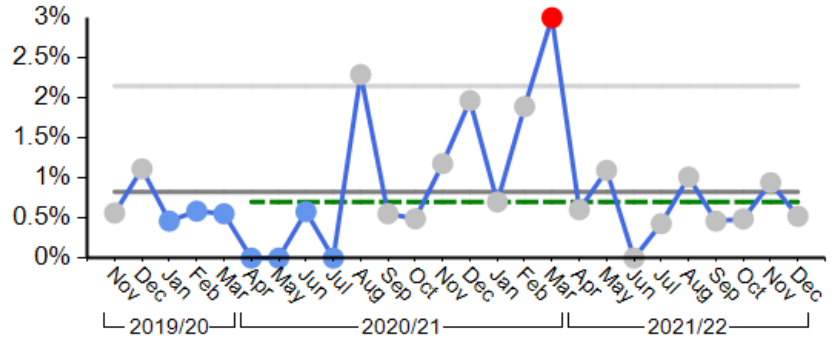
Percentage of Women Booked by 12 weeks 6 days



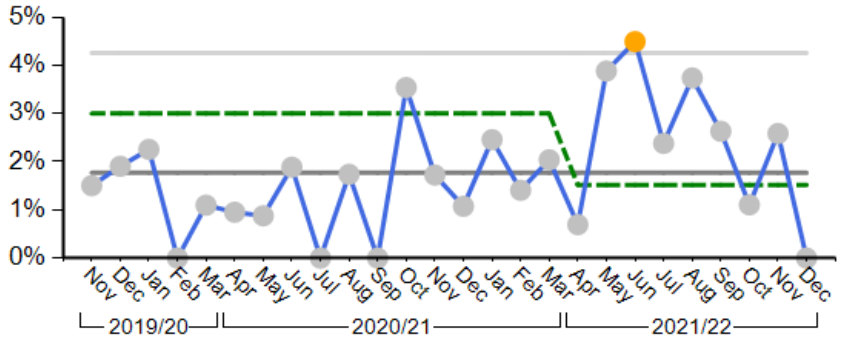
Number of Occasions 1:1 Care Not Provided



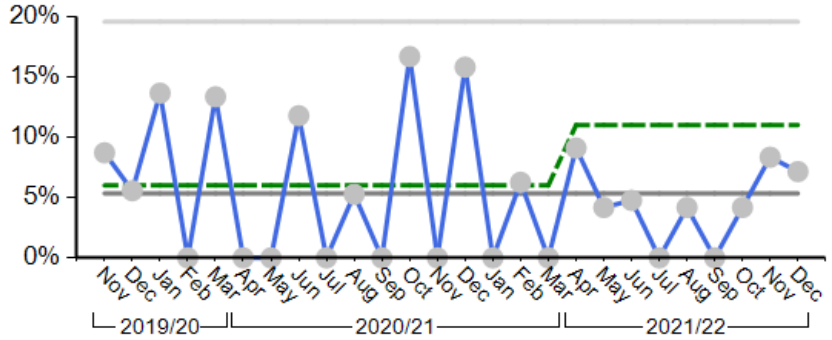
Maternity Complaints as % of Deliveries



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



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



Quality

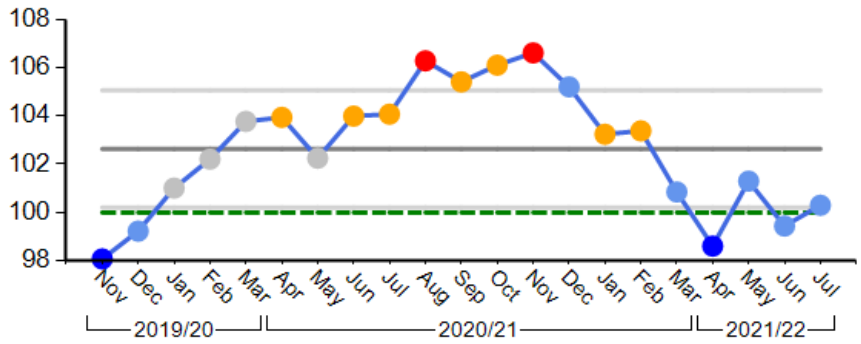
Mortality

Issues
- Both the HSMR and SHMI are showing special cause improvement.
- The HSMR continues to be assured with performance well below target.
- The SHMI has increased marginally in the latest data month (July) but it is in-line with the target.
- 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.

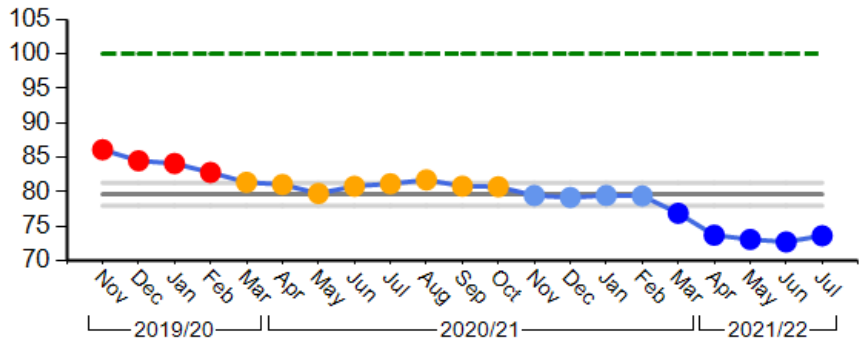
Management Action
- The Mortality Operational group continues to meet monthly to review the Mortality dashboard.
- The Mortality Screening falls under the Medical Examiner's Office, with a resulting increase in compliance with screening.
- The outcome of completed structured judgement reviews (SJR's) 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	100.3	N/A	Jul 21		100	99.4	Jun 21	100	99.9	
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)	100	73.6	N/A	Jul 21		100	72.7	Jun 21	100	73.6	
Percentage of Deaths Screened	100%	95.5%	3	Nov 21		100%	82.7%	Oct 21	100%	41.4%	
Perinatal Mortality Rate	5.4	5.2	5.21	Dec 21		5.4	9.4	Nov 21	5.4	3.8	

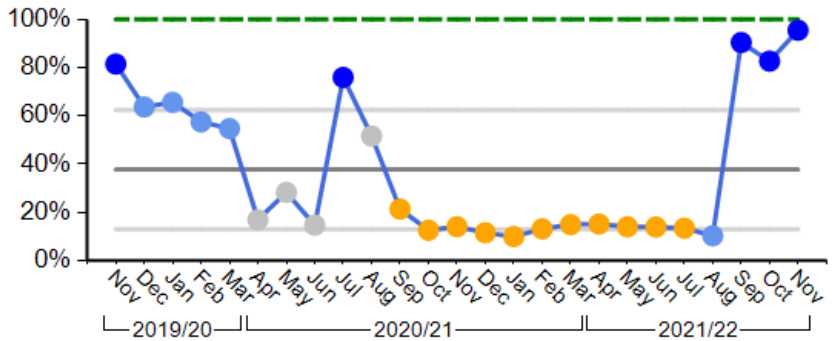
SHMI (Summary Hospital-level Mortality Indicator)



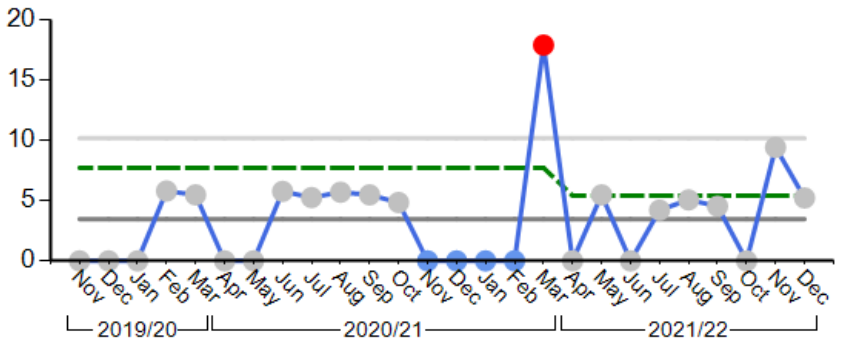
HSMR - Rolling 12 Months (Hospital Standardised Mortality Ratio)



Percentage of Deaths Screened



Perinatal Mortality Rate



Quality

Patient Experience

Complaints Response Times

Issues
• The Trust has failed to achieve the 80% target for this metric since February 2021.
• Performance in December has declined further, impacted by winter pressures and staffing constraints.

Management Action
• Medicine and Emergency Care, who account for the highest proportion of complaints, have taken an action to escalate open complaints on day 4 and to raise in the weekly meeting for the Lead Nurse to address with the relevant Matrons.

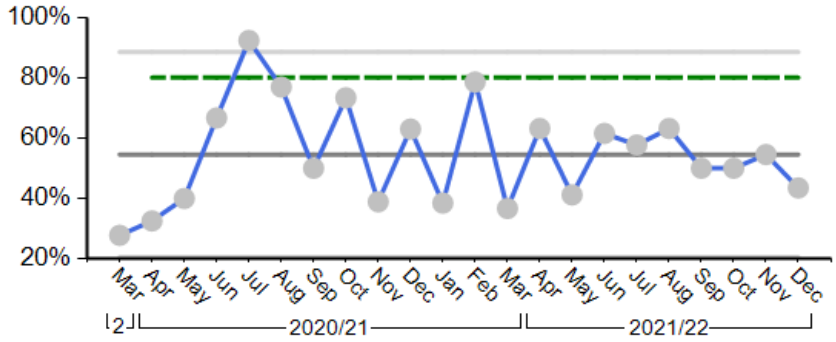
Friends & Family Test

Issues
• The Friends and Family - % that would recommend metric is showing special cause concern and since March 2021 has fallen below the target.
• The indicator has been on an improving trajectory since October but remains below Trust indicator of 94%.

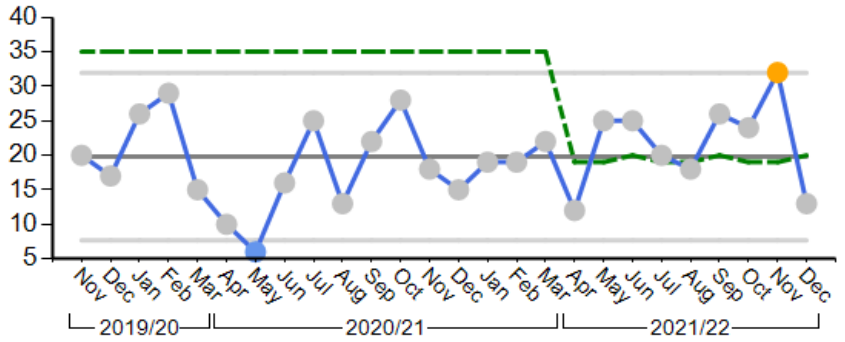
Management Action
• Friends and Family summaries shared with all matrons and ward /dept leaders and training is ongoing to support access to live data.
• Within Adult A+E the role of enhanced PALS officer is assisting with patient concerns during their time in the department. Two hourly hostess rounds have been introduced to support nutrition and hydration during extended waiting times.
• Work within the Medicine & Emergency Care FFT / National Inpatient Survey action plan continues. The Silent Night Campaign to reduce noise on wards at night launched. The CBU is now recording and scrutinising the number of bed moves a patient experiences particularly those living with dementia and a new communication care plan has been successfully piloted.
• Women's and Children's CBU are focussing on improving response rates particularly in antenatal and post-natal community through the provision of a QR code leaflet at defined points in the maternity journey.
• A number of new areas for FFT data collection have been launched within the sexual health team and the Community Children's Nurse Outreach team as to ensure all patients have an opportunity to offer feedback.
• FFT and the associated actions taken are monitored through the Patient Experience and Community Engagement Group along with any results of the National Patient Experience Surveys that have been completed.
• A broad selection of patient stories are presented to the Strategy and Operations Committee on a monthly basis for learning and action.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Complaints - % closed within 40 working days	80%	43.5%	N/A	Dec 21		80%	54.5%	Nov 21	80%	54.2%	?
Written Complaints	20	13	13	Dec 21	H	19	32	Nov 21	233	195	?
Friends and Family Test - Patients - % Response Rate	15%	23.9%	5459	Dec 21	H	15%	24%	Nov 21	15%		P
Friends and Family Test - Patients - % That Would Recommend - Trust Overall	94%	90.5%	162	Dec 21	L	94%	88.4%	Nov 21	94%	88.5%	?
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	83%	51.5%	N/A	Jul 21	L	83%	NTR	Jun 21	83%	51.5%	F
DSSA (Delivering Same Sex Accommodation) Breaches - Trust	0	1	1	Dec 21		0	4	Nov 21	0	35	?
Duty of Candour - Evidence of Discussion	100%	100%	0	Dec 21		100%	100%	Nov 21	100%	100%	?
Duty of Candour - Evidence of Letter	100%	100%	0	Dec 21	H	100%	100%	Nov 21	100%	100%	?

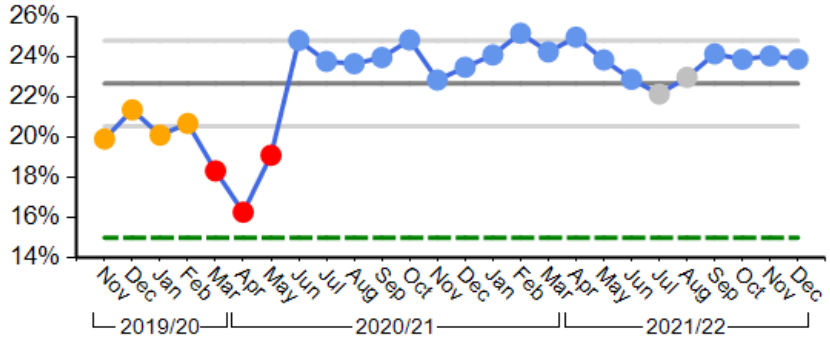
Complaints - % closed within 40 working days



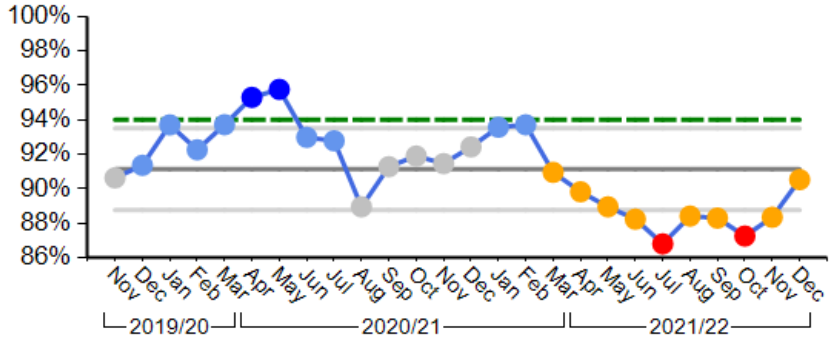
Written Complaints



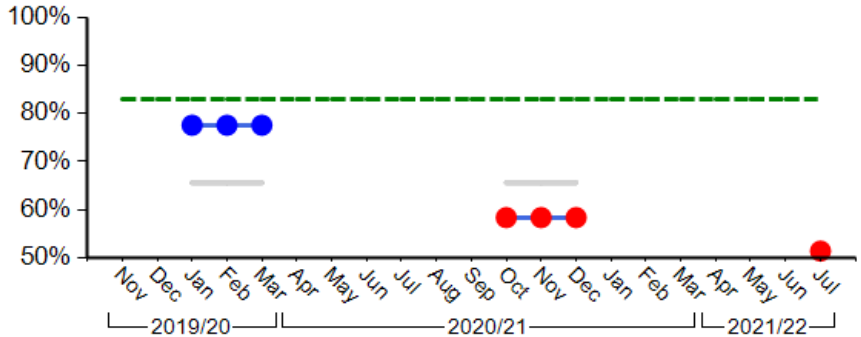
Friends and Family Test - Patients - % Response Rate



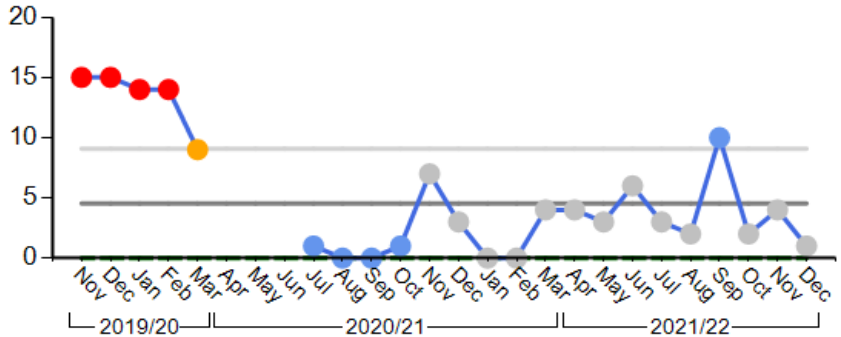
Friends and Family Test - Patients - % That Would Recommend - Trust Overall



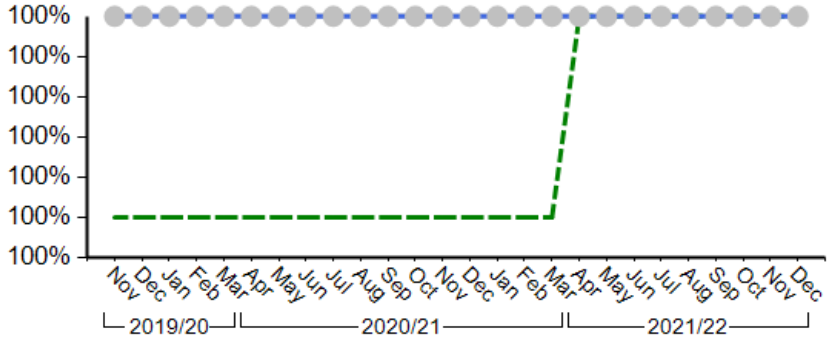
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



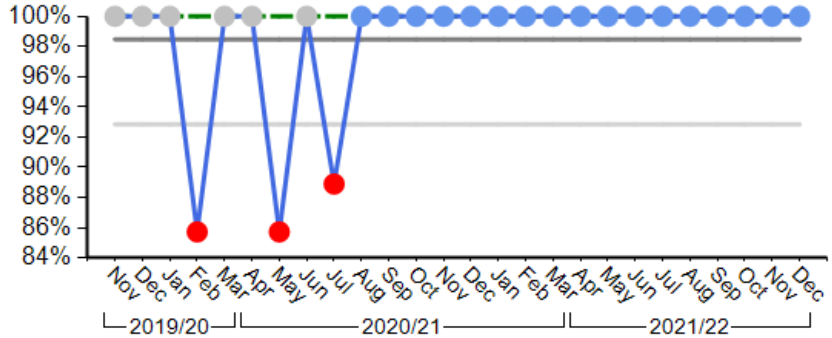
DSSA (Delivering Same Sex Accommodation) Breaches - Trust



Duty of Candour - Evidence of Discussion



Duty of Candour - Evidence of Letter



Operations

Access

A&E/Ambulance

Issues
• The A&E 4hr compliance metric continues to fail its assurance measure and show special cause concern and has declined marginally in December.
• The number and percentage of patients spending longer than 12 hours in the department shows special cause concern, although a marginal improvement is noted in December.
• The number of trolley waits continues to show special cause concern, albeit with a reduction from November.
• The pressures in A&E have had a resulting impact on Ambulance Turnaround times. The pressures experienced by A&E mirror the national picture, but the Trust continues to perform in the top 10 across the North of England and is regularly the top adult provider in Cheshire and Mersey.

Management Action
• A&E performance continues to be impacted by high bed occupancy, high levels of walk-in attendances and delays discharging patients due to pressures in the community.
• In order to support ambulance handover delays during periods of surge, the use of CDU has been flexed to assist with earlier release of cubicles in the main ED department on a number of occasions.
• The NHS 111 Deflection Tool (Care Navigator) came into effect at the beginning of December.
• AQUA QI events for flow and discharge commenced in December.
• Winter plans implementation continued.

Diagnostic Waits

Issues
• This indicator is failing the assurance measure and performance has deteriorated in December.
• The Trust is performing worse than peer Trusts with the most significant challenge being Endoscopy.
• Wait times in Endoscopy are increasing due to the demand of the 2ww waits and recent reduced/cancelled activity due to the sickness within the nursing team.
• The Trust Endoscopy waiting list has increased by 182% since November 2020.
• The Endoscopy nursing team staffing has continued to see an increase in sickness that has impacted on the running of sessions and waiting list sessions.

Management Action
• The Endoscopy Estates work is underway with a predicted completion date of Mid – March.
• EDSW for the surveillance scope fit test project has commenced in post.
• Nurse Endoscopists has been identified to contact patients to discuss Fit test results and next steps, clinics have been set up.
• Overarching modality specific improvement plan to be developed.

RTT

Issues
• Under performance against the elective restoration programme, impacted by the holiday period, bed pressures and covid impact on staffing levels.
• The Trust compares positively against peer Trusts.

Management Action
• Additionality being implemented
• Enhanced speciality management as the Trust manages Covid absence.

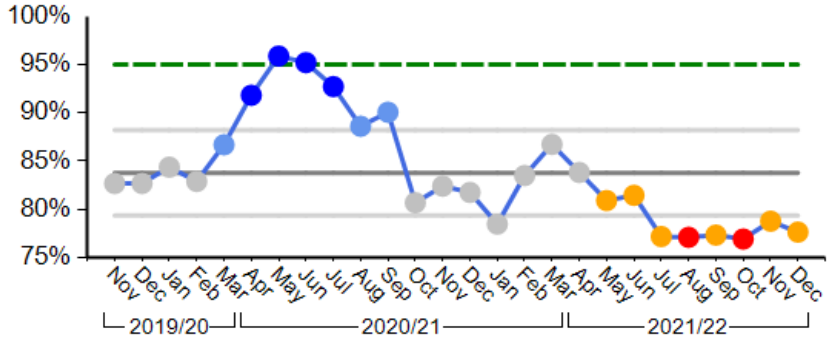
Stroke

Issues
• Performance against the 90% stay on a Stroke ward continues to be challenged.
• Despite an improvement in performance in November, the Trust has failed to meet the 80% target. This has been impacted by bed capacity issues and long LOS in ED.

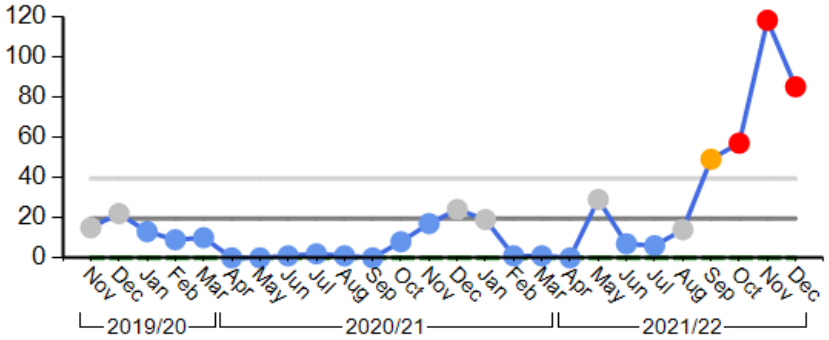
Management Action
• The Stroke Improvement Group continues to focus on quality improvement.
• A review is taking place of Trust process to ensure ring fenced beds are always available on the stroke ward.
• The SOP to ensure direct admission from ED to stroke ward is now in place.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Accident & Emergency - 4 Hour compliance	95%	77.7%	1987	Dec 21		95%	78.8%	Nov 21	95%	79%	
Accident & Emergency - 12+ Hour trolley waits	0	85	85	Dec 21		0	118	Nov 21	0	365	
Number of Patients spending 12+ Hours in ED - Trust		583	N/A	Dec 21			716	Nov 21		4529	
% of Patients spending 12+ Hours in ED - Trust		8.7%	N/A	Dec 21			9.3%	Nov 21		6.6%	
Ambulance Handover 30-60 Mins	0	103	103	Dec 21		0	118	Nov 21	0	692	
Ambulance Handover Over 60 Mins	0	49	49	Dec 21		0	88	Nov 21	0	253	
Diagnostic waits	1%	42%	2773	Dec 21		1%	34.7%	Nov 21	1%	29.6%	
Referral to treatment: on-going	92%	80.1%	2305	Dec 21		92%	81.6%	Nov 21	92%	82.3%	
Total RTT Waiting List - Trust		11580	11580	Dec 21			12348	Nov 21		11580	
Total 52 week waits – completed		38	N/A	Dec 21			49	Nov 21		648	
52 Week Waits	0	136	136	Dec 21		0	136	Nov 21	0	242	
Stroke - 90% Stay on Stroke Ward	80%	67.9%	9	Nov 21		80%	56.5%	Oct 21	80%	62.4%	
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	60%	16.7%	20	Dec 21		60%	25%	Nov 21	60%	24.5%	

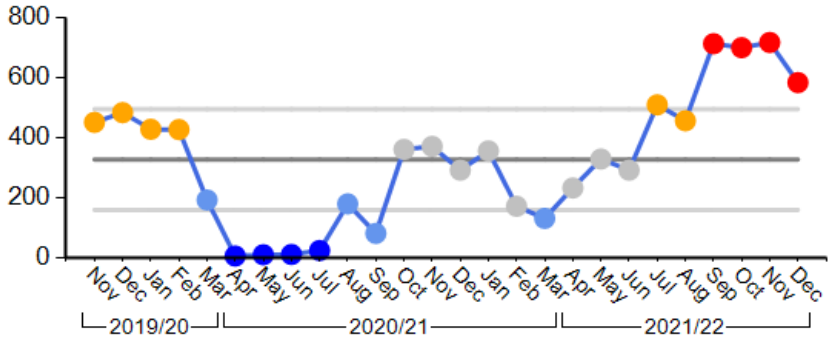
Accident & Emergency - 4 Hour compliance



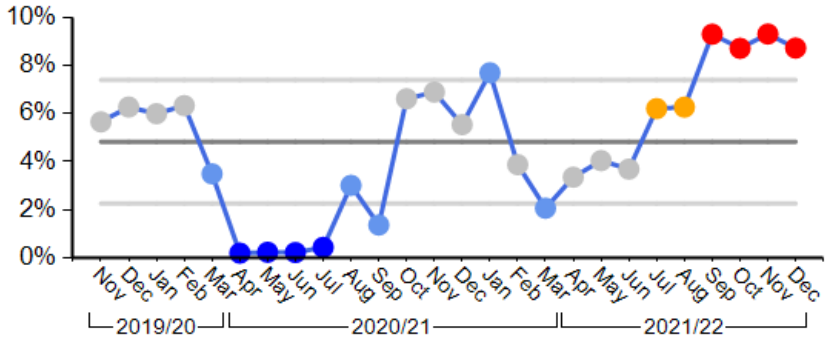
Accident & Emergency - 12+ Hour trolley waits



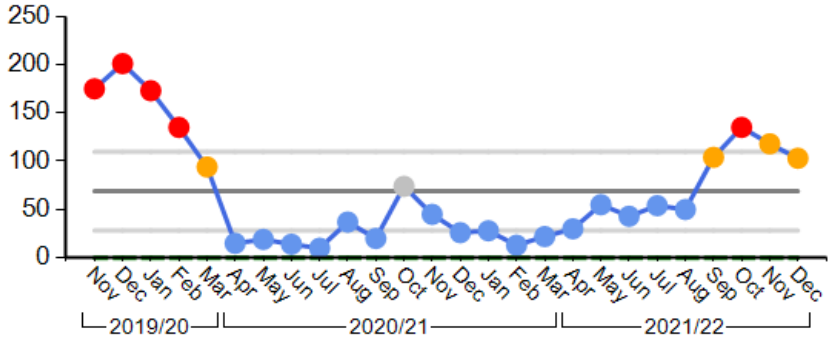
Number of Patients spending 12+ Hours in ED - Trust



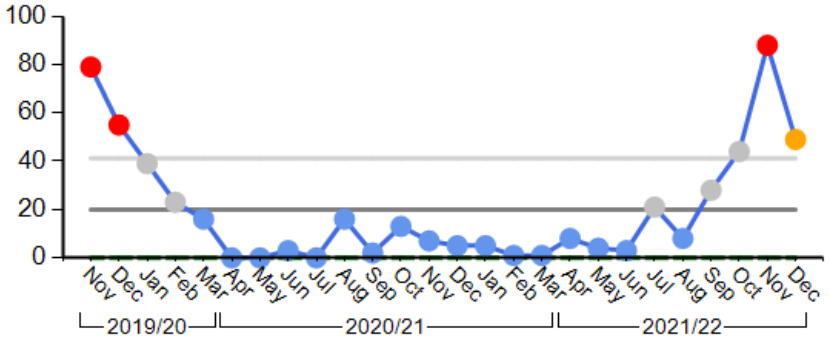
% of Patients spending 12+ Hours in ED - Trust



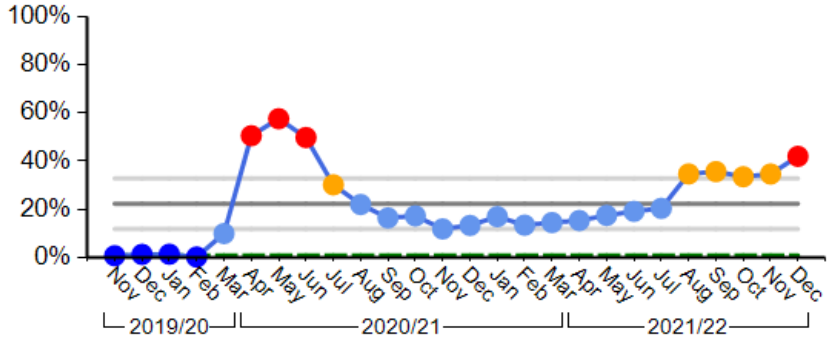
Ambulance Handover 30-60 Mins



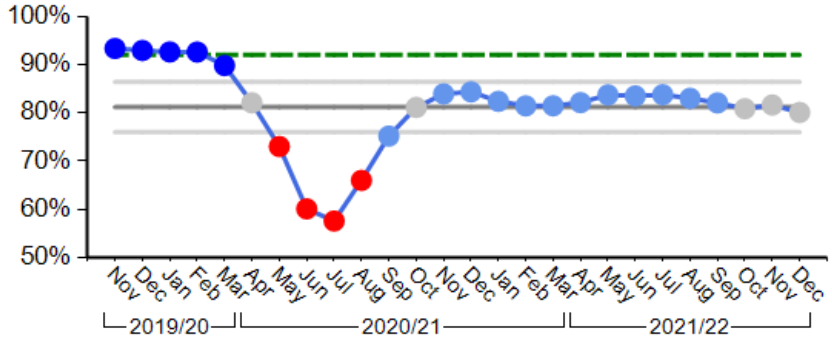
Ambulance Handover Over 60 Mins



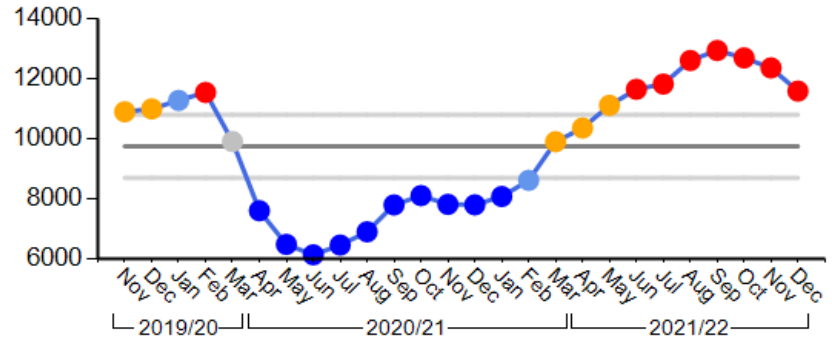
Diagnostic waits



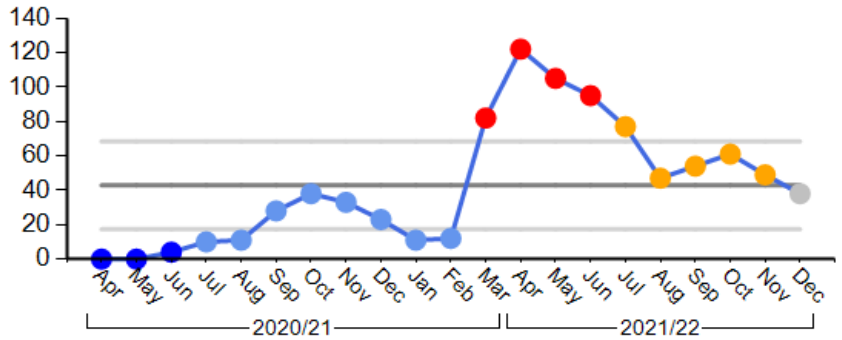
Referral to treatment: on-going



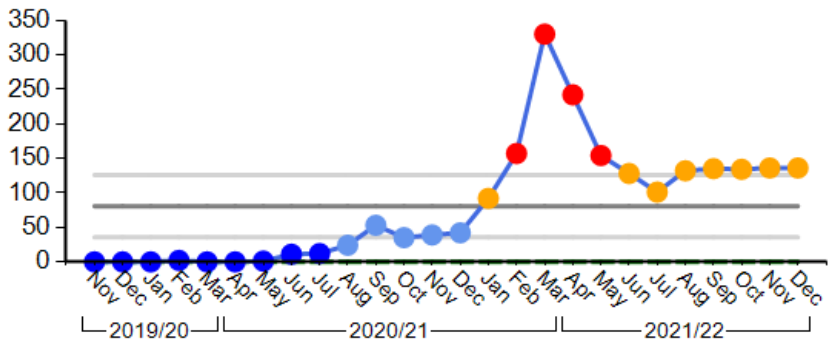
Total RTT Waiting List - Trust



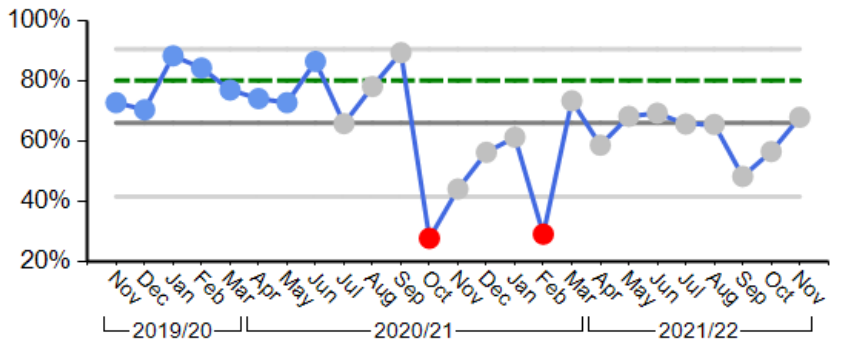
Total 52 week waits – completed



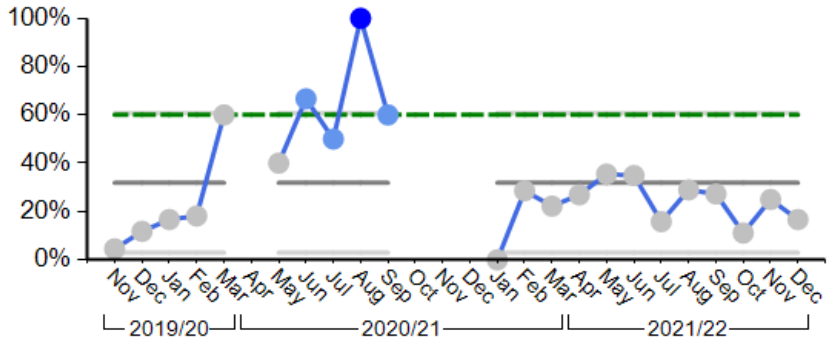
52 Week Waits



Stroke - 90% Stay on Stroke Ward



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



Operations

Cancer

Issues

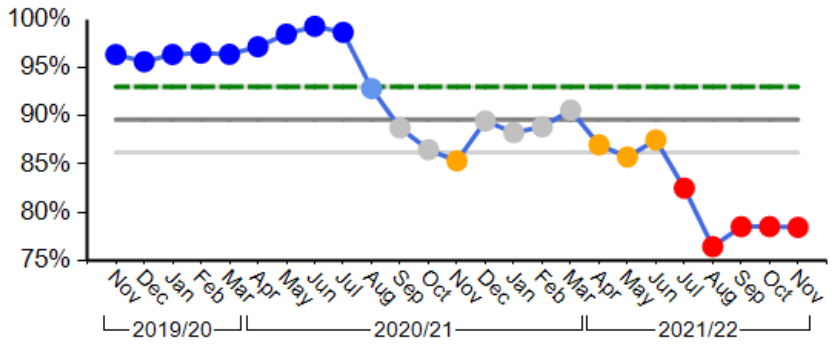
• 14-day GP referral to Outpatients metric continues to show special cause concern with performance remaining consistent with the previous month and below the 93% target.
• Diagnostic capacity continues to be the main challenge, in particularly in Endoscopy.
• Performance on the 62-day GP referral to treatment continues to show special cause concern although increased incrementally in November.
• Projections for the remainder of this financial year forecast gradual improvement but neither metric is expected to achieve the national targets.
• The trust continues to maintain 31-day performance for both first and subsequent treatments, which indicates timely provision of treatment for cancer patients internally.

Management Action

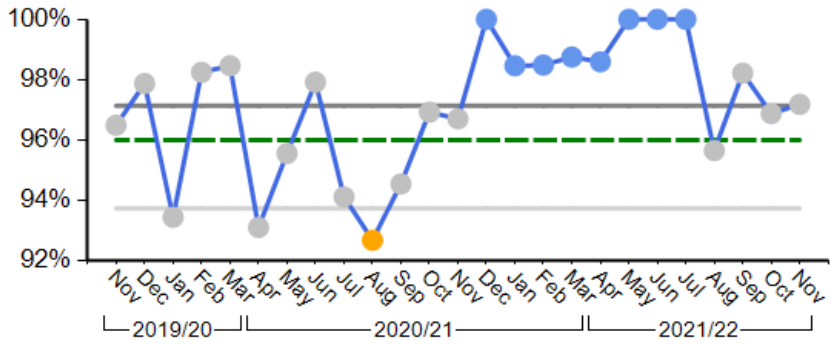
• The Endoscopy Improvement Board continue to meet monthly to discuss all aspects of the improvement plan, including the development of the estate and improving performance against the 14-day standard.
• The Trust are increasing the resource within the Cancer Navigator team, with new staff expected to start in post in February.
• An improvement plan, by tumour group is in place and a detailed paper, highlighting the risks, issues and current position by tumour group, which includes trajectories for the remainder of the financial year, was presented at Quality & Safety Committee in January 2022.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
14 day GP referral to Outpatients	93%	78.5%	266	Nov 21		93%	78.5%	Oct 21	93%	81.6%	
31 day treatment	96%	97.2%	2	Nov 21		96%	96.9%	Oct 21	96%	98.4%	
62 day GP referral to treatment	85%	66.9%	19.5	Nov 21		85%	66.3%	Oct 21	85%	67.4%	

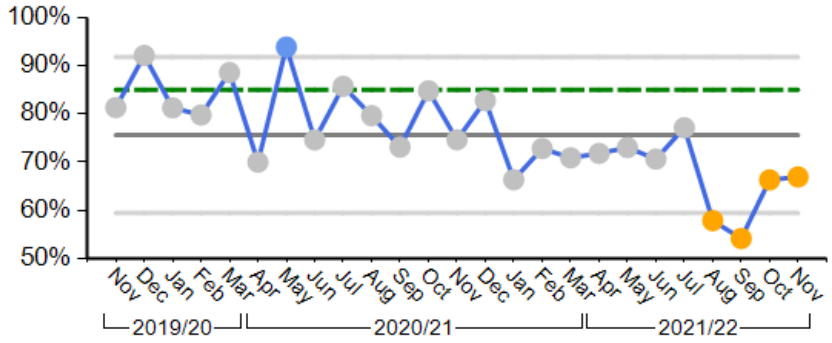
14 day GP referral to Outpatients



31 day treatment



62 day GP referral to treatment



Operations

Productivity

Stranded/Super Stranded Patients

Issues
• Both the stranded and super-stranded patient metrics are showing recent special cause concern and have been on a deteriorating trajectory for the last 4 months.
• Impacted by delays in care packages, availability of community beds and multiple Covid outbreaks in care homes.

Management Action
• Several actions are in place to support safe discharge.
• AQUA QI events have commenced in December.
• The Trust has established command and control, Point Prevalence and MADE events.

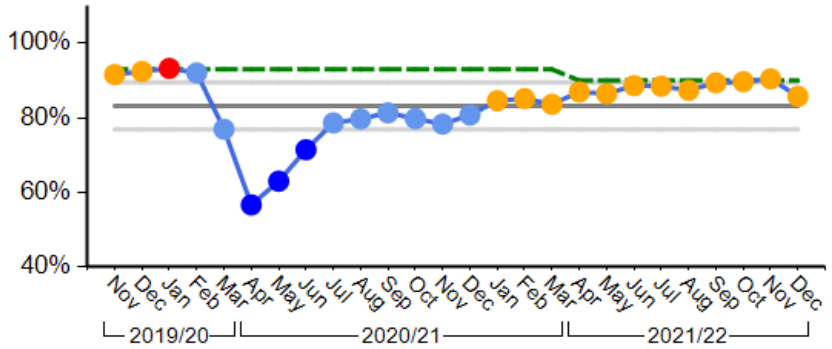
Outpatient Slot Utilisation

Issues
• Outpatient Slot Utilisation is showing recent special cause improvement although has declined marginally in December.
• Cancellation of clinics have increased due to shortages and sickness which will have impacted on the filling of short notice empty slots.
• Limited staffing in the Access office due to Covid.
• Some clinics, such as the TIA clinics run daily as they are for 24-hour post TIA, these are not always fully utilised as there may be no relevant patients to be seen.

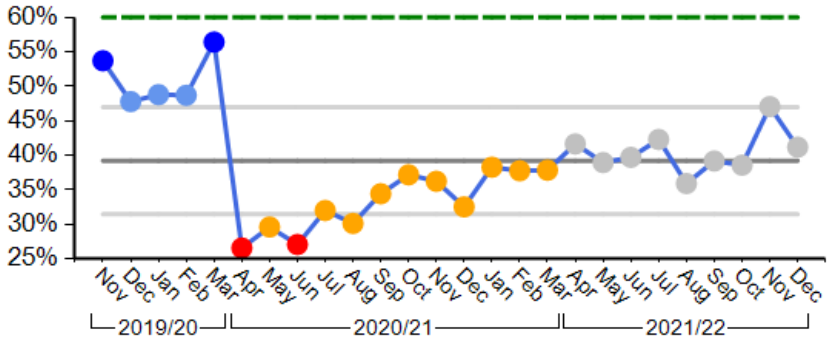
Management Action
• The Outpatient Improvement Group meets monthly to review clinic slot utilisation.
• The Group will review all the less than six week notice reasons with the CBU’s.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Bed Occupancy - SDGH	90%	85.8%	N/A	Dec 21	H	90%	90.4%	Nov 21	90%	88.1%	?
Bed Occupancy - ODGH	60%	41.2%	N/A	Dec 21		60%	47.1%	Nov 21	60%	40.5%	F
Stranded Patients (>6 Days LOS)	163	171	171	Dec 21	H	163	168	Nov 21	163	1434	?
Super Stranded Patients (>20 Days LOS)	53	66	66	Dec 21	H	53	59	Nov 21	53	449	?
OP Slot Utilisation	95%	90.4%	N/A	Dec 21	H	95%	92.4%	Nov 21	95%	93.2%	?
New:Follow Up	2.63	2.3	N/A	Dec 21	L	2.6	2.3	Nov 21	2.63	2.4	?
DNA (Did Not Attend) rate	7%	8.1%	1641	Dec 21		7%	6.8%	Nov 21	7%	6.7%	?
Theatre Utilisation - SDGH	75%	66.8%	N/A	Dec 21	H	75%	56.7%	Nov 21	75%	66.5%	?
Theatre Utilisation - ODGH	75%	67.9%	N/A	Dec 21	H	75%	72.6%	Nov 21	75%	71.1%	?
Southport A&E Conversion Rate	28%	23.1%	1040	Dec 21	L	28%	19.8%	Nov 21	28%	21.1%	?

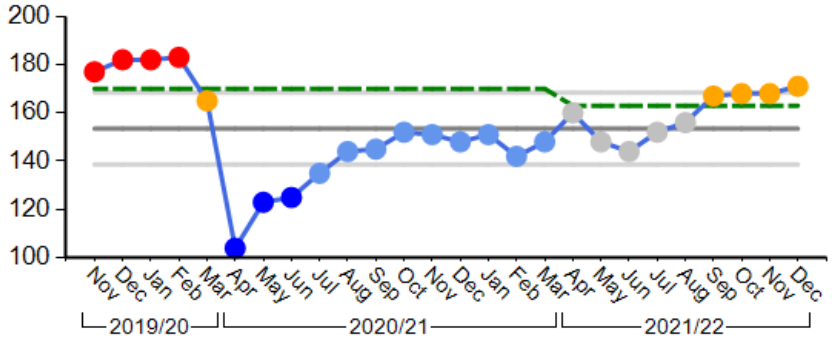
Bed Occupancy - SDGH



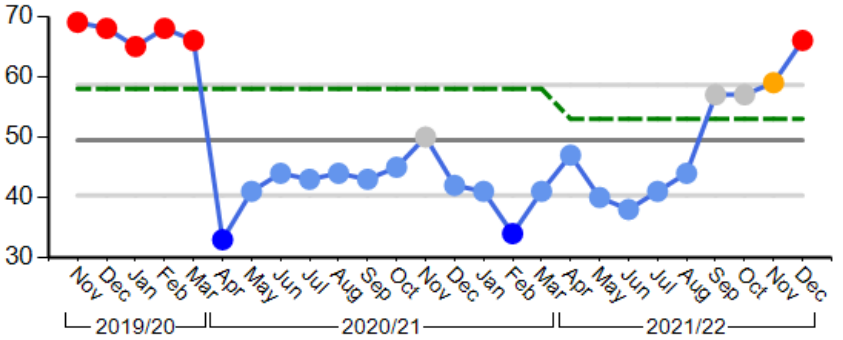
Bed Occupancy - ODGH



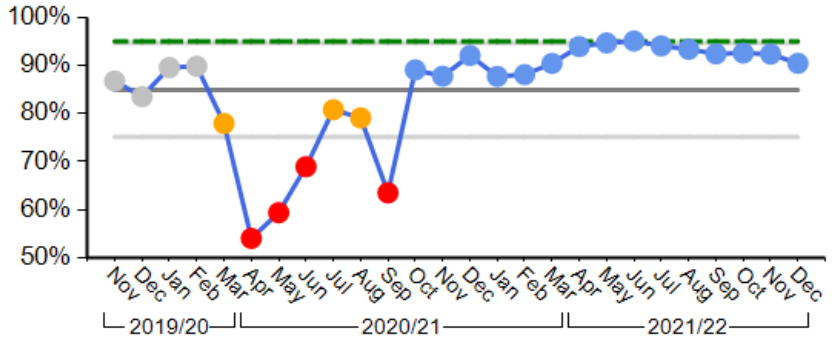
Stranded Patients (>6 Days LOS)



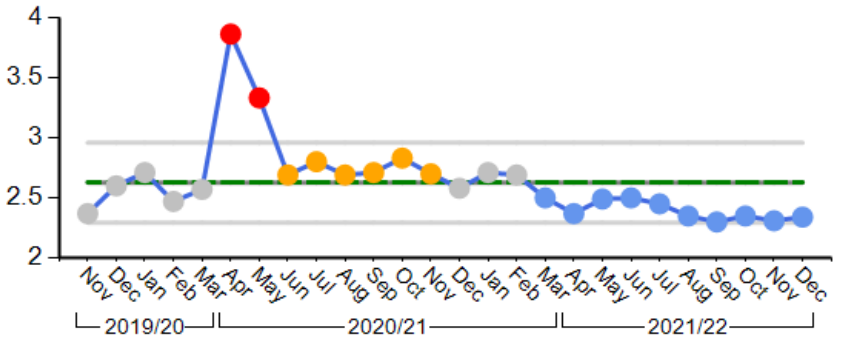
Super Stranded Patients (>20 Days LOS)



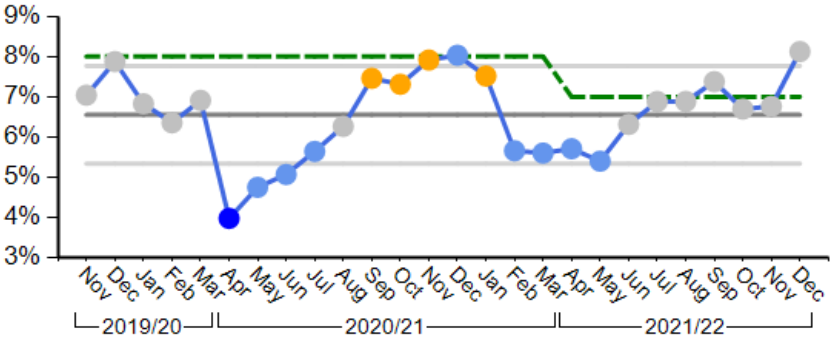
OP Slot Utilisation



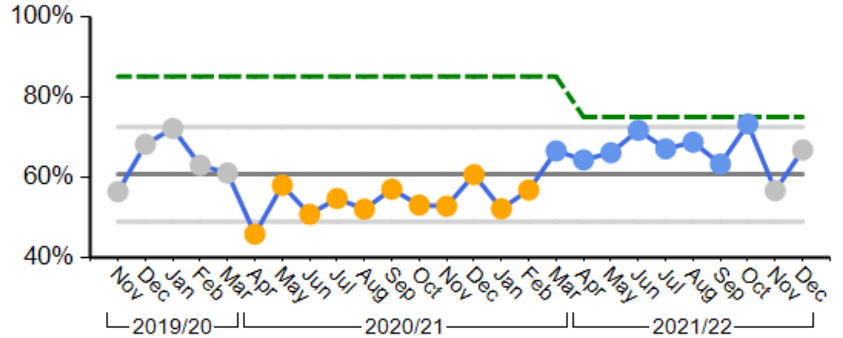
New:Follow Up



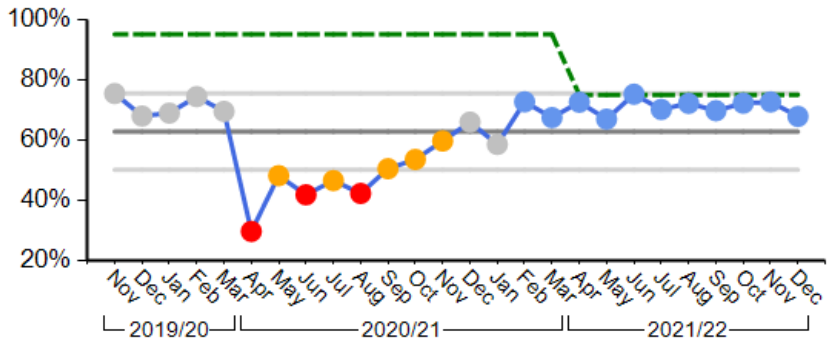
DNA (Did Not Attend) rate



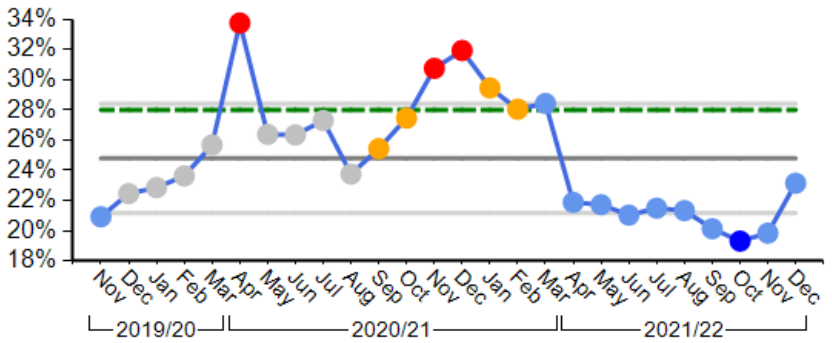
Theatre Utilisation - SDGH



Theatre Utilisation - ODGH



Southport A&E Conversion Rate



Finance

Finance

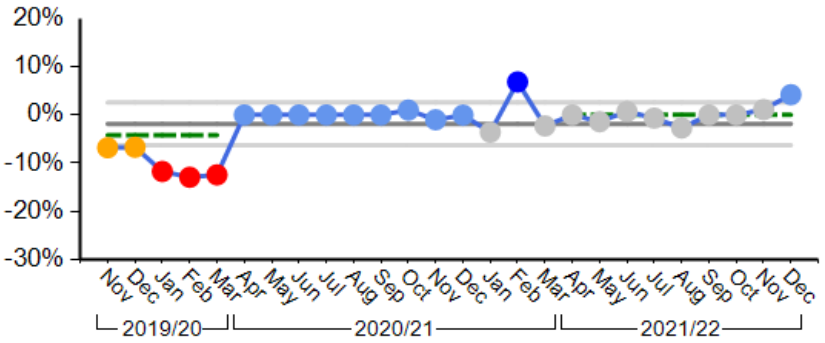
Issues
- The Trust is reporting a £2.6m deficit at Month 9 and is forecasting a deficit of £4.7m for 2021/22.
- Reported position driven by £1.0m ERF income risk and a £4.2m gap in system allocations.
- Transparency of H2 system allocations.
- Subject to conclusion of final system re-allocations for H2, the Trust would require external cash support during March 2022.

Management Action
- Successful funding bid for winter schemes (already included in plan).
- The Trust has challenged the H2 systems allocations and awaits feedback from the ICS.
- The Trust is assured of the delivery of 21/22 CIP.
- Receipt of regional cash support of £1.0m per month agreed for Q3 (to be repaid in Q4).
- Cash balances have reduced to-date during 2021/22 as a result of the Trust improving its Better Payment Practice Code (BPPC) performance.
- 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 reached 90% YTD to December.
- Successful bids for additional capital funding.
- The Trust continues to pursue additional capital funding to address High Risk Critical Backlog Maintenance.

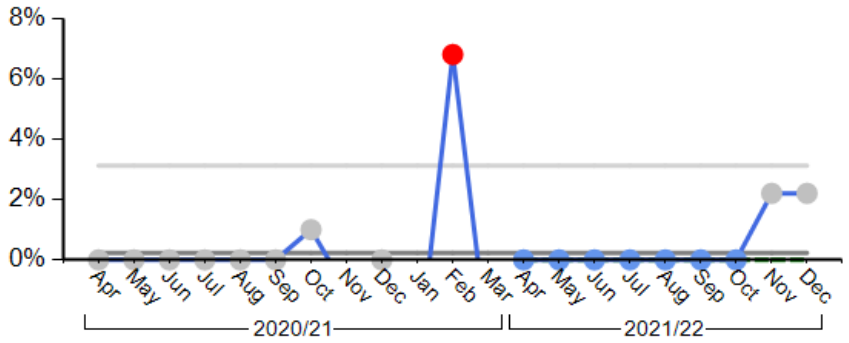
	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
I&E surplus or deficit/total revenue	0%	4.2%	N/A	Dec 21	H	0%	1.1%	Nov 21	0%	2%	?
Finance - I&E Surplus or Deficit/Total Revenue – Forecast Outturn	0%	2.2%	N/A	Dec 21	L	0%	2.2%	Nov 21	0%	2%	?
Pay Run Rate - Trust	£14,200K	£13980K	N/A	Dec 21	H	£14,200K	£13966K	Nov 21	£125,080K	£123,540K	F
Non Pay Run Rate - Trust	£5,800K	£5944K	N/A	Dec 21		£6,270K	£6550K	Nov 21	£50,600K	£51,900K	F
Year to date Budget in balance		No	N/A	Dec 21			No	Nov 21		Yes	?
Budget in balance - forecast year end		No	N/A	Dec 21			No	Nov 21		No	?
Bank & Agency Run Rate - Trust		£2252K	N/A	Dec 21			£2213K	Nov 21		£20,210K	?
Bank & Agency Staff Run Rate (%)		16.1%	N/A	Dec 21			15.9%	Nov 21		16.4%	?

Agency Staff Run Rate (Cost)		£720K	N/A	Dec 21			£815K	Nov 21		£700K
% Agency Staff (cost)		5.1%	N/A	Dec 21			5.8%	Nov 21		5.7%
Year To Date Reduction in Premium Rate pay		£00K	N/A	Dec 21			-£200K	Nov 21		-£200K
CIP – Performance against Plan	£600K	£600K	N/A	Dec 21		£600K	£600K	Nov 21	£5,300K	£5,300K
CIP – Forecast Outturn	£6,300K	£6300K	N/A	Dec 21		£6,300K	£6300K	Nov 21	£6,300K	£6,300K
CIP on Target		Yes	N/A	Dec 21			Yes	Nov 21		Yes
Capital Spend – Actual in Month	£500K	£600K	N/A	Dec 21		£700K	£1100K	Nov 21	£4,900K	£3,700K
Capital Spend – Forecast Outturn	£12,100K	£12100K	N/A	Dec 21		£7,500K	£9500K	Nov 21		
Cash Balance	-£300K	£3800K	N/A	Dec 21		£1,900K	£4000K	Nov 21		

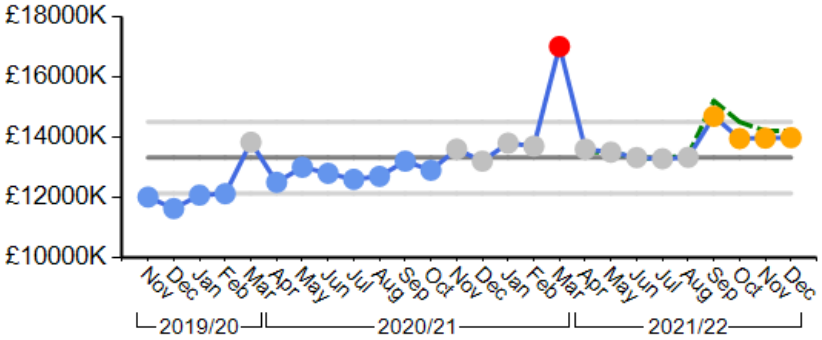
I&E surplus or deficit/total revenue



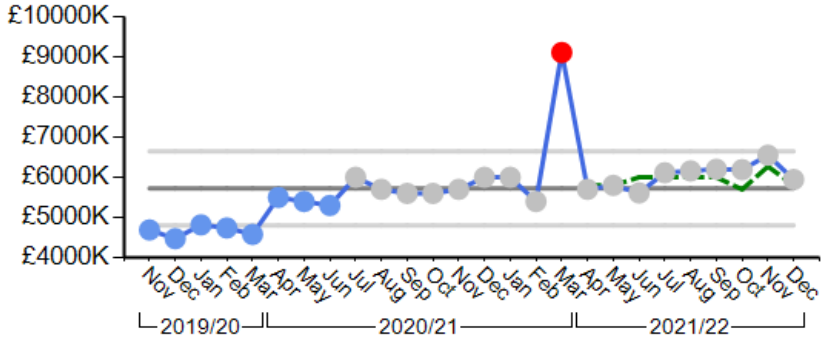
Finance - I&E Surplus or Deficit/Total Revenue – Forecast Outturn



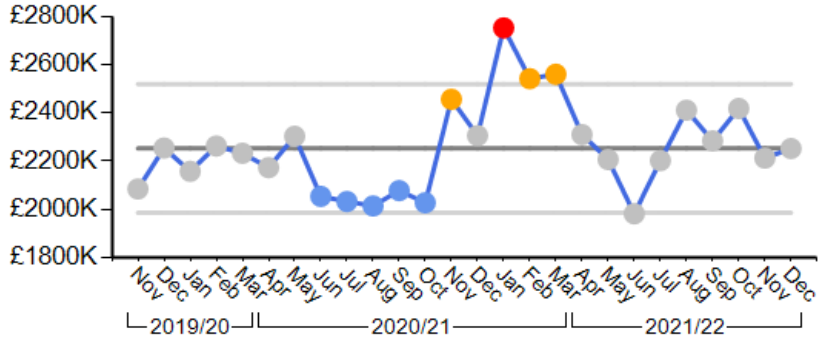
Pay Run Rate - Trust



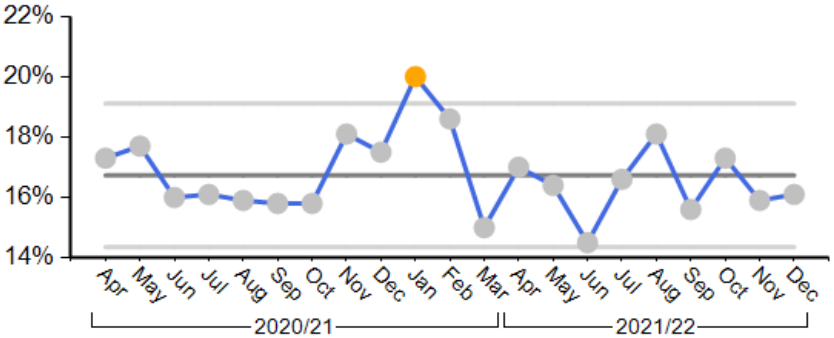
Non Pay Run Rate - Trust



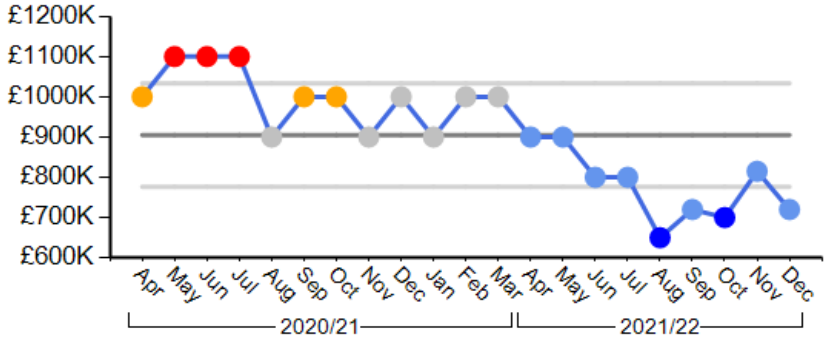
Bank & Agency Run Rate - Trust



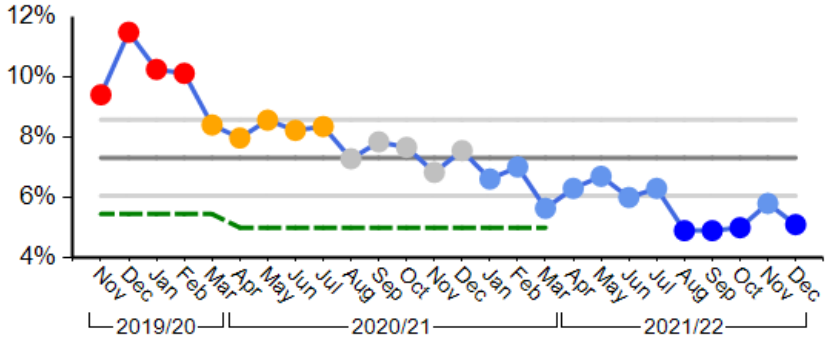
Bank & Agency Staff Run Rate (%)



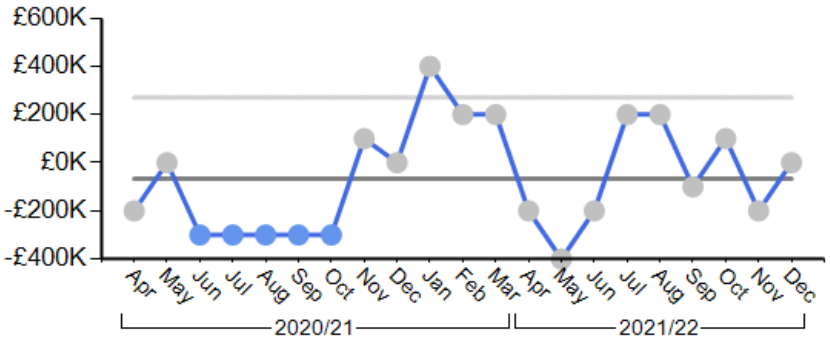
Agency Staff Run Rate (Cost)



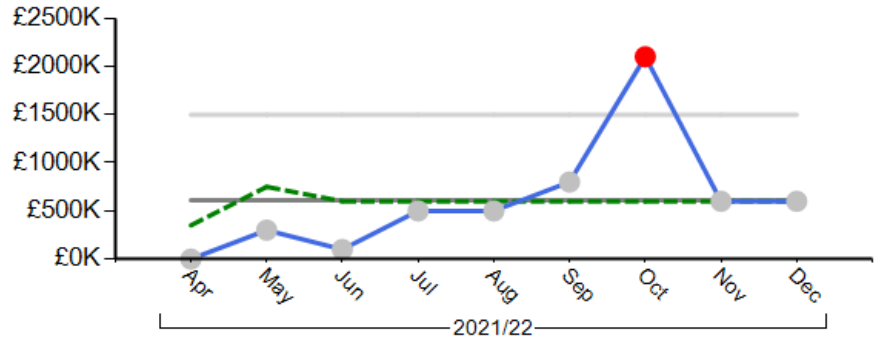
% Agency Staff (cost)



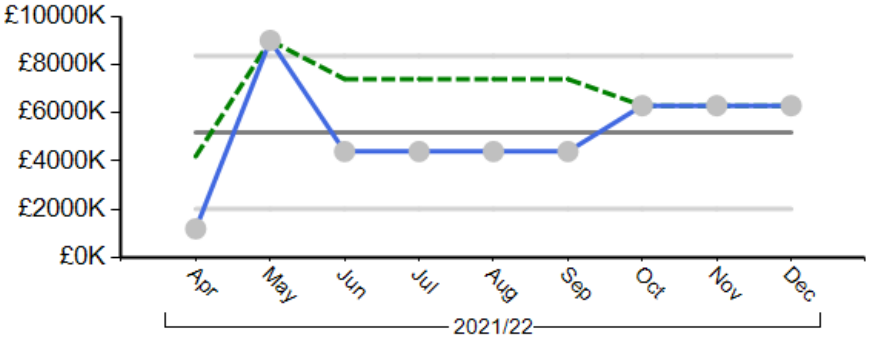
Year To Date Reduction in Premium Rate pay



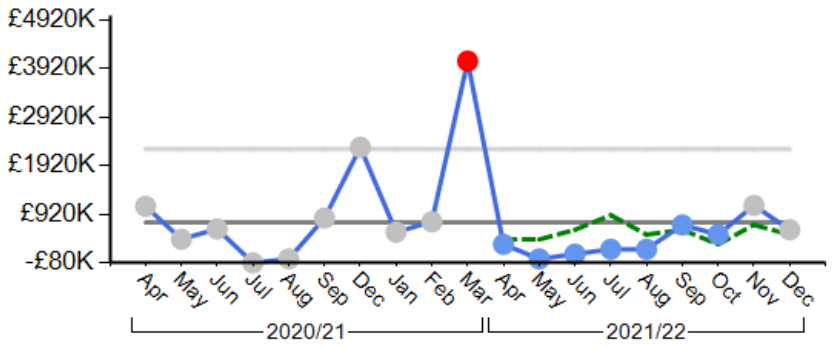
CIP – Performance against Plan



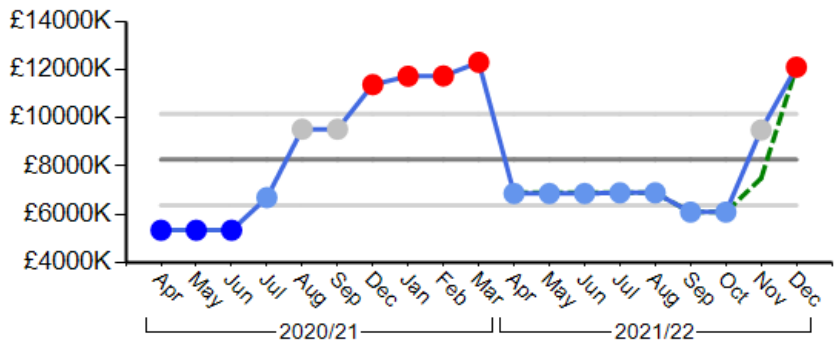
CIP – Forecast Outturn



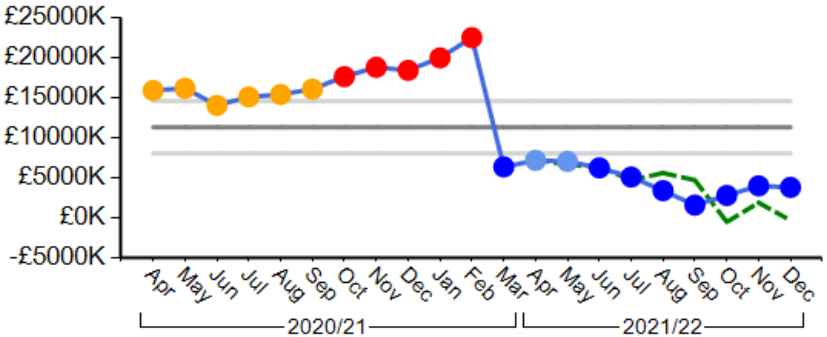
Capital Spend – Actual in Month



Capital Spend – Forecast Outturn



Cash Balance



Workforce

Organisational Development

Personal Development Reviews

Issues
• The Trust has been on an improving trajectory for PDR's since March 2021 and, despite a 1.6% reduction in December, continues to show special cause improvement although falling short of the 85% target.
• Performance in December has been impacted by staff sickness/isolation and the winter pressures faced by the Trust.

Management Action
• HR Teams continue to work with managers to provide weekly compliance data.
• New starters now must have a completed PDR by three months in post.
• Data in ESR continues to be reviewed to ensure accurate reporting.

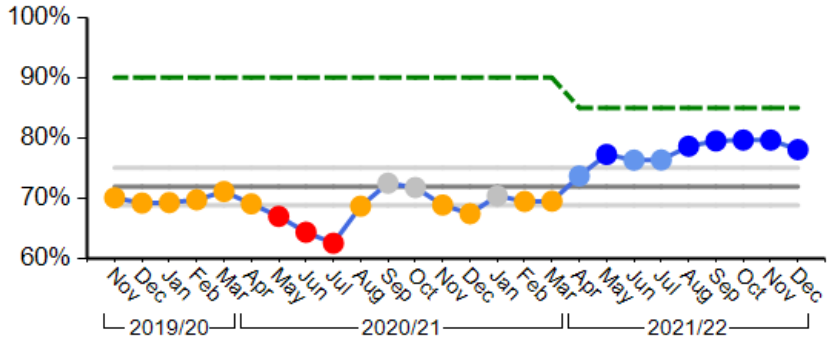
Mandatory Training

Mandatory training continues to be assured and performs ahead of target with a further 0.5% increase in December.

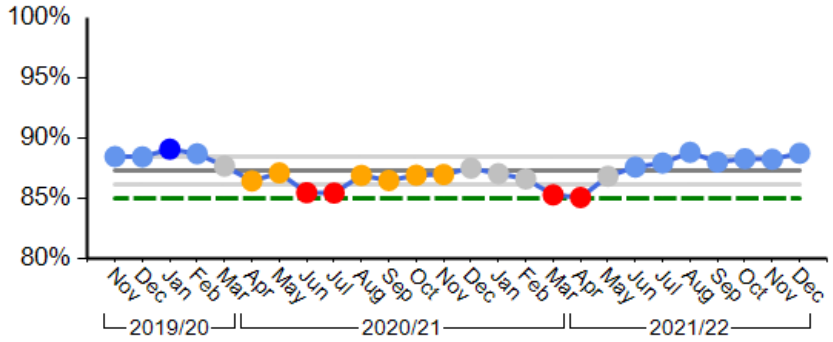
Staff Survey – the results of the Annual Staff Survey will be published in March.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Personal Development Review	85%	78.1%	N/A	Dec 21		85%	79.7%	Nov 21	85%	77.7%	
Mandatory Training	85%	88.7%	N/A	Dec 21		85%	88.2%	Nov 21	85%	87.7%	
Staff Survey - I would recommend my organisation as a place to work	67%	49.9%	N/A	Jul 21		67%	59.8%	Dec 20	67%	49.9%	

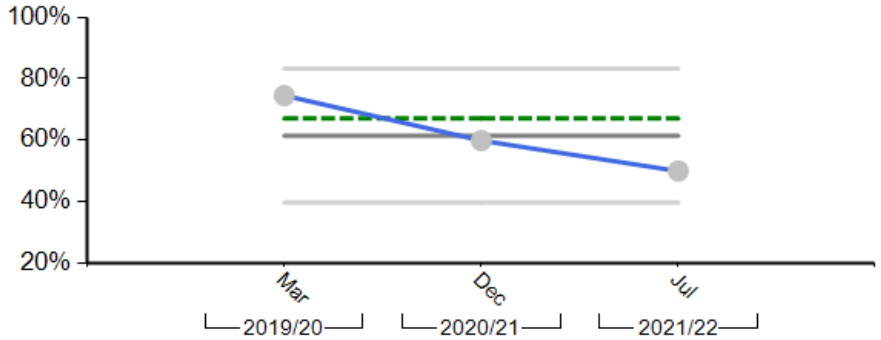
Personal Development Review



Mandatory Training



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



Workforce

Sickness, Vacancy and Turnover

Sickness Absence

Issues
• Sickness rates in December have been impacted by the 4th wave of the Covid pandemic.
• The rolling 12-month sickness rate and sickness rates for Nursing staff are failing their assurance measure and showing special cause concern.
• The in-month overall sickness has increased by 0.6% and is significantly above target, however this remains statistically as expected.
• Medical sickness rates have increased by 0.8% but remain below the target.

Management Action
• Managers are undertaking attendance management training with hot-spot areas being targeted to attend although attendance at this is being impacted by the winter pressures.
• The HR team continues to work with managers to focus on long-term sickness.
• HR team and managers are focussed on persistent short term and multiple covid related absences.
• HWB initiatives include ‘Hello, how are you discussions’; appropriate management referrals and the individual restoration programme with EHU.

Vacancy Rate

Issues
• Medical vacancy rate continues to show special cause improvement and is ahead of plan
• The Nursing vacancy rate shows special cause improvement and has improved in December as a direct result of the international nursing recruitment programme.
• The overall vacancy rate is failing its assurance measure and remains above plan. This has been caused due to the masking of vacancies by the international nurses within the HCA posts.

Management Action
• 14 Medical posts are under offer to further improve the Medical vacancy rate.
• The international nursing recruitment programme will continue this year.
• Currently running a recruitment drive to ensure HCA posts are filled quickly.

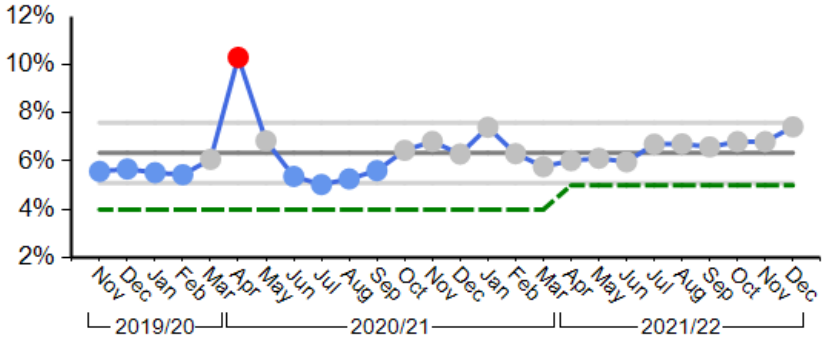
Turnover

Issues
• The rolling staff turnover and Medical staff turnover are failing their assurance measure and are both well above plan.
• Flexibility of working has been identified as a key reason for leaving.
• The Medical staff turnover figure contains the Foundation doctors, this will always inflate the turnover rate as they are here for a fixed term as part of their career development.

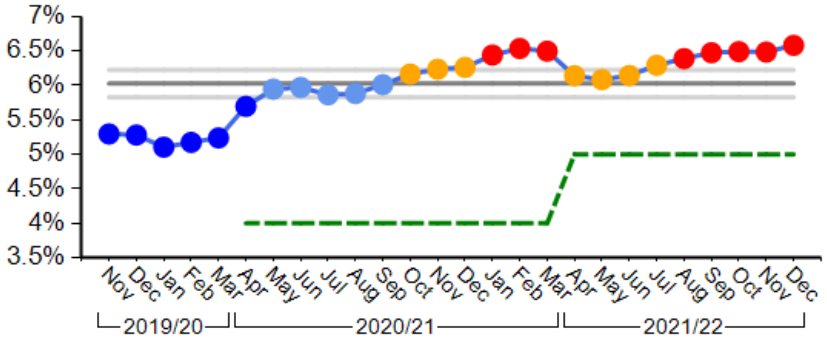
Management Action
• Actively focussing on retention with one of the key workstreams focusing on flexibility of working.

	Latest					Previous			Year to Date		
Indicator	**Plan**	**Actual**	**Patients**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Sickness Rate	5%	7.4%	N/A	Dec 21		5%	6.8%	Nov 21	5%	6.6%	
Sickness Rate (Rolling 12 Month)	5%	6.6%	N/A	Dec 21	H	5%	6.5%	Nov 21	5%	6.3%	F
Sickness Rate - Medical Staff	5%	2.7%	N/A	Dec 21		5%	1.9%	Nov 21	5%	2%	
Sickness Rate - Nursing Staff	5%	8.8%	N/A	Dec 21	H	5%	8.6%	Nov 21	5%	8.5%	F
Sickness Rate (not related to Covid 19) - Trust		5.7%	N/A	Dec 21	H		6.2%	Nov 21		5.8%	
Trust Vacancy Rate – All Staff	6.8%	10.2%	N/A	Dec 21		6.8%	10.7%	Nov 21	6.8%	9.7%	F
Vacancy Rate - Medical	7.4%	6.6%	N/A	Dec 21	L	7.4%	6.3%	Nov 21	7.4%		F
Vacancy Rate - Nursing	9%	11%	N/A	Dec 21	L	9%	12%	Nov 21	9%		F
Staff Turnover	0.75%	1.1%	N/A	Dec 21		0.8%	1%	Nov 21	9%	6.8%	
Staff Turnover (Rolling)	10%	15.3%	N/A	Dec 21	H	10%	14.7%	Nov 21			F
Staff Turnover - Nursing	0.8%	1.3%	N/A	Dec 21		0.8%	0.6%	Nov 21	9.6%	1.3%	
Time to Recruit	55	57	N/A	Dec 21		55	56	Nov 21	55	56	

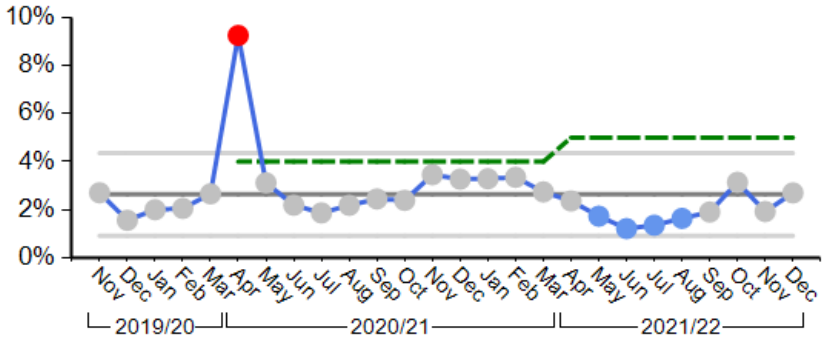
Sickness Rate



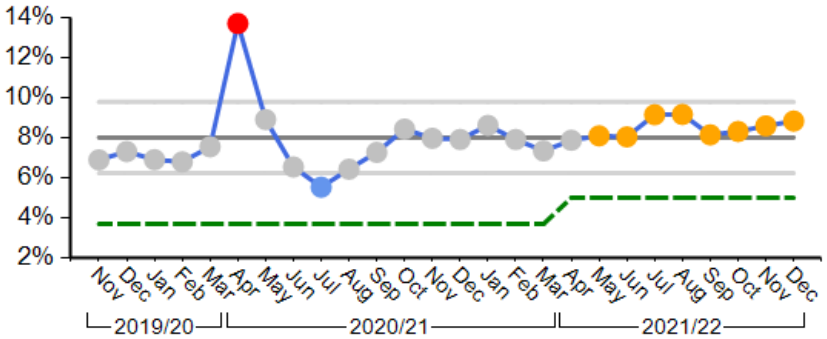
Sickness Rate (Rolling 12 Month)



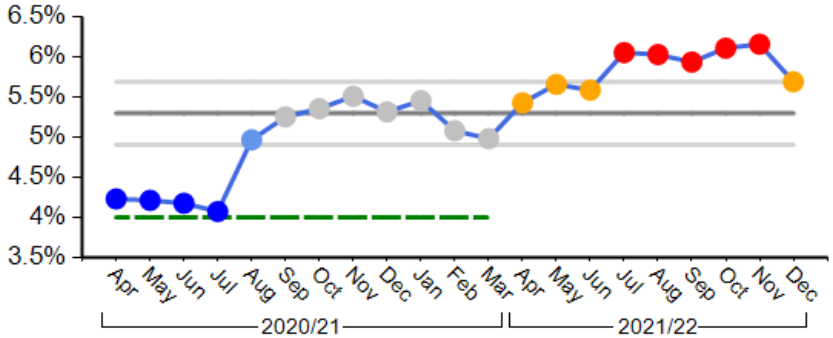
Sickness Rate - Medical Staff



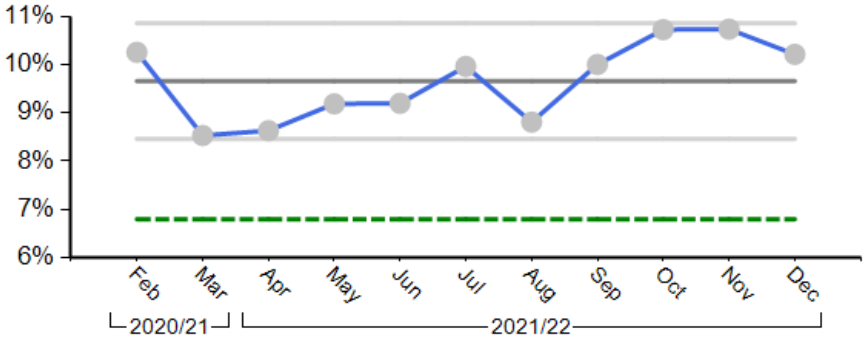
Sickness Rate - Nursing Staff



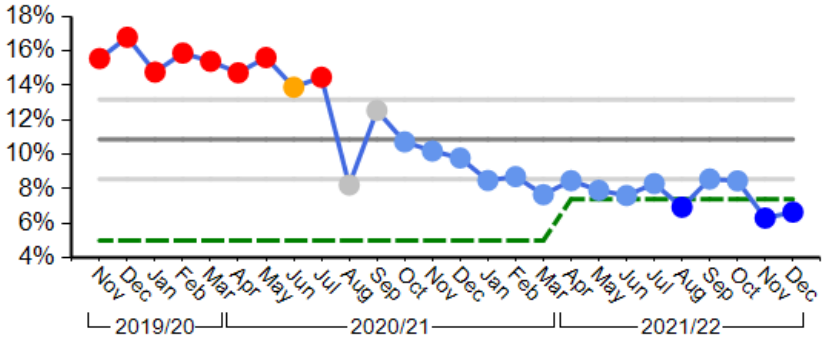
Sickness Rate (not related to Covid 19) - Trust



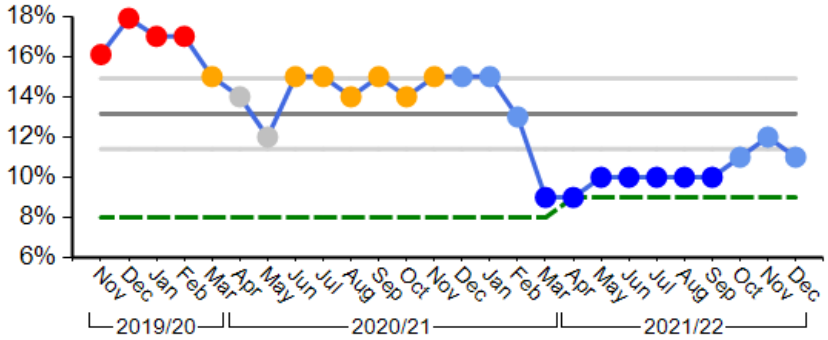
Trust Vacancy Rate – All Staff



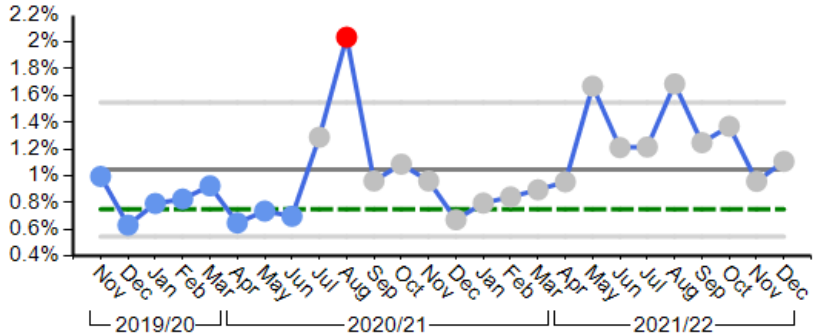
Vacancy Rate - Medical



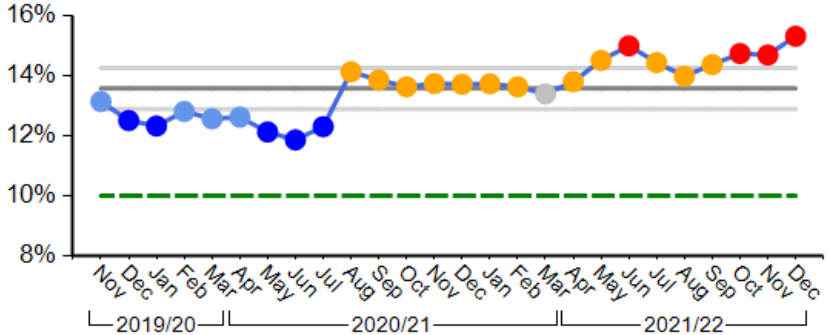
Vacancy Rate - Nursing



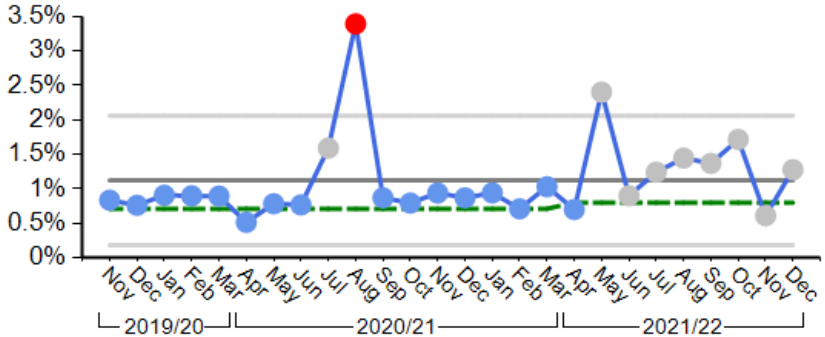
Staff Turnover



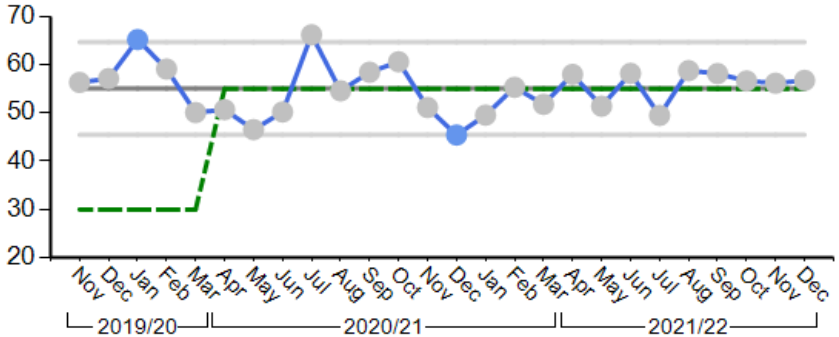
Staff Turnover (Rolling)



Staff Turnover - Nursing



Time to Recruit



ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	**Quality and Safety Committee (QSC)**
MEETING DATE:	24 January 2022
LEAD:	Gill Brown

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- No items identified

ADVISE

- Board Assurance Framework SO1- document reviewed and a full review/deep dive will be undertaken in March 2022
- CQC Activity - discussed whistleblowing incidents, increased incidence of staff absence due to back pain, and medical rosters.
- LUFT CQC Well Led Themes - Committee acknowledged the need for structured integrated work by a project team, and to ensure the communication of the ALTC is delivered to staff effectively.
- AAA Reports noted for
  - Clinical Effectiveness Committee – alerts included Impact of VCOD and SALT service delivery risk
  - Patient Experience Committee
- Patient Safety Monthly Update was noted with significant acknowledgement to the necessity of estates driving quality.
- SOCAAS - one ward failed to meet standard. Issues mainly relate to documentation/recording issues, not training

ASSURE

- Operational Update and Cancer Improvement Plan – received and challenges noted
- Integrated Performance Report – Metrics reviewed
- Medicine and Emergency Care update including Dementia presentation – Team were congratulated by the Committee for the positive work being undertaken. Discussion of funding.
- Extreme Risk Register – Noted.
- Patient Safety Monthly Update – Noted.
- IPC BAF – Noted.
- Quality Improvement Plan – Noted
- Meeting Effectiveness feedback: Positive. Length of the meeting needs to be reviewed, and high level areas should be focussed on.

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)

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS COMMITTEE**	**Date**	**02 February 2022**
Agenda Item	**SO011/22**	**FOI Exempt**	**NO**
Report Title	**CARE QUALITY COMMISSION (CQC) UPDATE AND ACTION PROGRESS**		
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 ongoing engagement and progress with the Care Quality Commission (CQC) regulators and the 2019 report 'must do' and 'should do' actions.

Executive Summary

The current outcome for the Trust is requires improvement (RI). Safe, effective, responsive, and well-led have a current rating of RI; caring is good.

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.

Our recent CQC Engagement meetings have provided us with an opportunity to discuss our progress and highlight any areas for further improvement, we have also discussed our response to Covid-19, pressures in AED and safe staffing. Next month the focus will be RTT, recover planning and Governance Framework for new partnership arrangements with St Helen's and Knowsley Hospitals (StHK) Trust.

The report also provides a summary of the paper presented at the latest Quality & Safety Committee summarising areas for improvement highlighted in the post-merger CQC Inspection Report for Liverpool University Hospitals Foundation Trust (LUHFT) with a specific focus on any opportunities for learning as we work more closely and develop our long-term collaboration with StHK. The highlighted areas for improvement will support the development of our CQC Well-Led programme approach.

Recommendations

The Strategy and Operations Committee is asked to receive The CQC Update and Action Plan.

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

Southport and Ormskirk Hospital NHS Trust

Care Quality Commission (CQC) Update and Action Progress – January 2022

1. INTRODUCTION

The current outcome for the Trust is requires improvement (RI). Safe, effective, responsive, and well-led have a current rating of RI; caring is good.

This report provides an update in relation to our ongoing action, engagement, and activity with the Care Quality Commission (CQC). Following our inspections in 2019 and 2021, several actions and themes for improvement were highlighted and all have been incorporated and monitored through the Quality Assurance Panel (QAP) and Quality Improvement (QI) workstreams.

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 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 '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.

2. ASSURANCE PROCESS

To monitor progress from the 2019 inspection 'must do' and should do', we have a monthly Quality Assurance Panel (QAP) chaired by the Director of Nursing or Deputy Director of Quality, Risk and Compliance. Action owners propose a BRAG rating and presents the evidence of improvement or compliance. Most actions are now complete and evidence in place for assurance purposes. During the coming months, the aim is to fully complete all actions and return to a business as usual for the key lines of enquiry.

In addition, 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. The latest update was presented in January 2022.

We also continue to meet with CQC colleagues monthly with a joint agenda to discuss any areas of focus and enquiries. The engagement meetings provide an opportunity to resolve any issues in a timely manner.

3. PROGRESS TO DATE

Our Quality Improvement workstreams include:

- Safer Discharges
- DNACPR / Capacity Assessments
- Deteriorating Patient
- Nutrition & Hydration
- Medicines Safety
- Falls & Pressure Ulcers
- 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 a some of the areas to ensure progress is embedded and sustained, therefore it is anticipated some of the workstreams will remain quality priorities for 2022/23. Organisational objectives will also be incorporated and set by the Managing Director.

4. CQC ENGAGEMENT

We continue to further develop our positive relationship with our CQC Inspection Team. Our last engagement meeting was held on 26 January 2022. This provided our CQC colleagues with an opportunity to meet with new senior appointments including Lynne Barnes, Interim Director of Nursing Midwifery and Therapies (also CQC Nominated Individual) and Stephen Mellars, Interim Deputy Director of Nursing. The key focus of this meeting was Covid-19 and recovery plan, staffing and pressures within A&E. For the February / March 2022 meeting the agenda will include the partnership arrangements with St Helen's and Knowsley Hospitals Trust and elective recovery position of the Trust.

We also discussed recent CQC enquiries, since December 2021 we have received six enquiries in relation to complaints, patient safety and safer staffing – this included two whistleblowing concerns, three have been closed and three remain open, however CQC were satisfied with progress at the recent January engagement meeting.

5. LEARNING FROM RECENT CQC INSPECTIONS

At the January Quality and Safety Committee, a paper was presented summarising areas for improvement highlighted in the post-merger CQC Inspection Report for Liverpool University Hospitals Foundation Trust (LUHFT) published 27 October 2021, with a specific focus on any opportunities for learning and action as we work more closely and develop our long-term collaboration with St Helens & Knowsley Hospitals Trust (StHK). Although not all areas identified for improvement were as a result of the recent merger, there were key themes emerging from the CQC LUHFT report which may be fundamental in any organisation, including S&O, which will be assessed through the Well Led domain.

Themes and actions for focus in relation to partnering include:

- Communication and Engagement with Staff to ensure the narrative to support future sustainability clearly defines the rationale for the long-term collaboration with STHK, the role of the shaping care together programme and our approach to finding sustainable solutions for our fragile services.
- Visibility and capability of the Board and its Senior Leadership Teams
- Effectiveness of our governance processes and the ability to share information and use it to support decision-making and share good practice
- Alignment of digital strategies to support data sharing and information governance compliance

It is important we address these and any additional areas for improvement from the CQC key characteristics through developing a Well-Led programme approach. A Well-Led self-assessment will be completed and further discussed with the Executive Team.

6. RECOMMENDATIONS

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

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Workforce Committee
MEETING DATE:	25 January 2022
LEAD:	Lisa Knight

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- N/A

ADVISE

HR Risk Register
Review has been undertaken which has resulted in 3 risks being reduced, and 3 risks closed but are linked to new risk 2424, which needs to be approved by the Risk and Compliance Group.

Sickness Absence
Whilst sickness rates not related to Covid-19 have decreased from 6.2% in November 2021, to 5.7% in month, the overall sickness rate and rolling 12 month have increased. Nursing and Medics sickness rates have increased in month, but rates for HCA's has decreased. The main reasons for sickness not related to Covid-19 are anxiety and depression, and cold and flu. The Trust's rates compare adequately to the region, sit mid-table and are not an outlier.

HCA Vacancy Rate
The Trust has a high vacancy HCA vacancy rate due to the masking of vacancies by the international nurses within the HCA posts. The organisation is currently running a recruitment drive to ensure HCA posts are filled.

ASSURE

Mandatory Training
Compliance is above target and increased slightly from last month from 88.2% to 88.7%.

Equality, Diversity and Inclusion Annual Report
Noted.

Gender Pay Gap Report – Benchmarking Report
Noted.

MIAA Audit - Professional Registration and Right to Work Review (Presentation)
Noted.

New Risks identified at the meeting: None

Review of the Risk Register:

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS COMMITTEE**	**Date**	**02 February 2022**
Agenda Item	**SO013/22**	**FOI Exempt**	**NO**
Report Title	**GENDER PAY GAP REPORT 2021 – BENCHMARKING**		
Executive Lead	Jane Royds, Director of HR and Organisational Development		
Lead Officer	Sonya Clarkson, Deputy Director of HR and Organisational Development		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ☐ **To Receive**	

Purpose

To provide the Committee with the benchmarking NHS Trust information relating to the 31 March 2020 Gender Pay Gap data and inform the Committee of any subsequent actions added to the 2021-22 action plan from the findings.

Executive Summary

All organisations are required by law to report on Gender Pay in line with the Equality Act (Gender Pay Gap Information) Regulations 2017 as part of their public sector equality duty. The government have provided specific guidance on the calculation of the data and what is required.

Using Model Hospital (a data-driven improvement tool that supports health systems and Trusts to benchmark outcomes), this report details where the Trust sits against other NHS organisations who have reported their Gender Pay Gap data for 2020-21

Recommendations

The Strategy and Operations Committee is asked to note the Gender Pay Gap 2021 – Benchmarking

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:**
Jane Royds, Director of HR and Organisational Development	Sonya Clarkson, Deputy Director of HR and Organisational Development

Southport and Ormskirk Hospital NHS Trust

Gender Pay Gap Report 2021 - Benchmarking

1. Purpose

To provide the Committee with the benchmarking NHS Trust information relating to the 31 March 2020 Gender Pay Gap data and inform the Committee of any subsequent actions added to the 2021-22 action plan from the findings.

2. Gender Pay Gap

Gender pay gap shows the difference in the average pay between all men and women in a workforce. If a workforce has a particularly high gender pay gap, this can indicate there may be a number of issues to deal with, and the individual calculations may help to identify what those issues are.

3. Trust year on year comparison

Table 1

	Mean hourly rate pay gap position	**Median hourly rate pay gap position**
2019-20 position	25.1%	7.6%
2020-21 position	21.7%	5.6%
Difference	-3.40%	-2.00%

Mean - Good performance is a lower percentage. The Trust's % mean hourly rate has decreased by 3.4% from 2019-20 position.

Median - Good performance is a lower %. The Trust's % median hourly rate has decreased by 2% from 2019-20 position.

4. NHS Reporting of Gender Pay

4.1 Comparison of mean and median hourly pay gap

Table 2 below details where the Trust sits against other NHS organisations who have reported their Gender Pay Gap data for 2020-21.

Table 2

Pay gap metrics	**Trust value**	**StHK value**	**Recommended Peer median (out of 9)**	**National median**	**Sector quartile**	**Regional rank (out of 14)**
% Mean hourly pay gap	21.7	23.3	27.1	22.6	Q2 Mid-Low	3
% Median hourly pay gap	5.6	16.1	13.9	10.0	Q1 - Lowest	2

[Source: Model Hospital]

Good performance is a low %, ranking and Quartile 1 of all NHS organisations.

Mean – Lower %, ranked 3 out of 10 regionally and sits within Quartile 2.

Median - Lower %, ranked 2 out of 10 regionally and sits within Quartile 2.

4.2 Comparison of lower and top quartiles

Table 3 below details where the Trust sits against other NHS organisations who have reported their Gender Pay Gap data for 2020-21.

Table 3

Pay gap metrics	Trust value	StHK value	Recommended Peer median	National median
% males in lower quartile	29.0	14.5	15.3	18.7
% females in lower quartile	71.0	85.5	84.7	81.3
%males top quartile	21.7	27.9	30.1	31.7
% females in top quartile	78.3	72.1	69.9	68.3

[Source: Model Hospital]

Quartiles are the % split between male and female staff. The Trust has a larger % of males in the lower quartile compared to other NHS organisations and a smaller % of males in the top compared to other NHS organisations.

Summary of findings and recommendations

The Trust is performing well in respect of Gender Pay Gap within the sector, and this could be due to the proportion of males and females in the bottom and top quartiles compared to other NHS organisations.

However, the 2020 data shows that there remain differences in pay between males and females at S&O. In light of the benchmarking activity, the actions from the previous report have been reviewed and the findings serve to reinforce the approach proposed in the previous report:

- Ensure options for employment flexibility are open to all staff and are not driven by gender i.e. part time working available to males
- Availability of development opportunities to support career progression in the workplace, including targeted mentoring and coaching programmes.
- Work in partnership to identify and remove barriers to progression, starting with improvements to the recruitment and selection process and development of career pathways.
- Learn from lived experiences of staff to improve and shape employment practices, providing opportunity for staff to be actively involved in various Trust groups and committees.
- Continue to raise awareness, encourage personal insight and empathy towards each other in order to change own behaviours and practices, through training (such as unconscious bias), cultural awareness campaigns and interventions (such as Schwartz Rounds).

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Finance, Performance, and Investment Committee
MEETING DATE:	24 January 2022
LEAD:	Jeff Kozer

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- At month 9 the forecast deficit has reduced from £5.2m to £4.7m due to emergency care funding of £0.5m There has been no further progress with regard to the equitable distribution of funding for h2. There is a meeting taking place on 28 January with all Directors of Finance across Cheshire and Merseyside and the Health and Care Partnership with the aim of agreeing the actions to achieve a balanced h2 forecast across the system and for individual organisations.
- A&E performance in December 2021 was significantly below the national standard but compared positively to peers. The Trust however is an outlier with 12 hour breaches.
- Both the 62 day and 14 day cancer standards were not achieved in November 2021 but were improved against October 2021 position and above the Trust improvement trajectories. Whilst there are a number of challenged pathways, upper & lower GI and H&N continue to be the most challenged in terms of performance.
- The Omicron variant has been responsible for an increase in Covid-19 admissions which has impacted significantly upon operational delivery both from an urgent and emergency care perspective and an elective recovery perspective.

ADVISE

- Discussions are ongoing with NHSE/I with regard to the potential reinstatement of financial undertakings as part of a licence breach, in which the Trust was originally placed in September 2018.
- Work is ongoing with regard to the endoscopy upgrade at Ormskirk, and the cabling replacement and discharge lounge at Southport. All will be completed before the end of March.

ASSURE

- The Trust's capital forecast for 2021/22 has increased from £7.4m at month 8 to £12.1m at month 9. The increase includes an additional £2m to resolve the cabling replacement work required at the Southport site and to commence some of the fire prevention work at Ormskirk. The majority of the remaining £2.7m relates to IT schemes to tackle network remediation and core capabilities. Further successes will be reported at month 10.
- The cyber risk has been updated and will appear on the BAF once it has gone through the internal governance processes.
- ERF activity for November 2021 and December 2021 was at 97.4% and 102.7% respectively compared with an activity plan of 89%.
- 52+ week performance positively below trajectory
- Zero 104+ week breaches

New Risks identified at the meeting: None

Review of the Risk Register: No action taken

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	**EXECUTIVE MANAGEMENT TEAM**
MEETINGS HELD:	**December and January 2022**
LEAD:	**Anne-Marie Stretch**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- No alerts to raise.

ADVISE

- The Executive Management Team hold weekly meetings which are chaired by the Managing Director. Discussions in the meeting vary but the main focus is always on the themes of quality and safety, workforce, financial and operation performance as well as risk and governance.
- A regular agenda item during this period has been the Staff Winter Wellness Programmes and Vaccination as a Condition of Deployment.
- Agenda items considered during December and January 2022 included:
    - The Elective Restoration Operation Plan and the Urgent Care Performance Reports.
    - Capital Funding
    - Use of Resources Framework and Forward Planning.
    - Time to Shine Awards
    - Policy Management Report
    - COVID-19 Nosocomial Infection Weekly Update
    - Spend associated with the use of contingent labour
- The Executive Directors reviewed the Trust's approach following receipt of the *NHSE/I Reducing the burden of reporting and releasing capacity to manage the Covid-19 pandemic* and agreed that:
    - all Board and Committee meetings are streamlined where possible and focus on essential reporting and governance issues.
    - All non-essential items are deferred to enable clinical and operational colleagues to focus on the Covid-19 response

ASSURE

- Following the Audit Committee and Assurance Committees held in January, the Executive Management Committee conducted a full review of the Board Assurance Framework with particular focus on the risk scores, controls in place to manage strategic risks, and the level and effectiveness of assurance provided by and through those controls. This iteration of the BAF has seen an increase in scoring against *the Risk ID3: Efficiently and productively provide care within agreed financial limits* which is now an Extreme Risk with a score of 20. A new Cyber Security risk has also been added to the Strategic Risk Register as an Extreme Risk. A deep dive on the BAF is planned in March.
- The Assurance Committee Terms of Reference have been revised and endorsed by the EMT. It is expected that these will be included in the February Committee Meeting Cycle.

• The Chief Operating Officer presented a report outlining the potential impact of Omicron and other escalating winter pressures. As part of the forward planning and in readiness for the potential impact, an update against each of the actions was received and noted.	
New Risk identified at the meeting	None
Review of the Risk Register	