NHS
Southport and Ormskirk Hospital
NHS Trust

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

To be held at 0930 on Wednesday 01 February 2023

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0930***
SO001/23 (P)	**Patient Story** *Purpose: To **receive** the patient story*	*No*	*L Barnes*	15 mins
SO002/23 (V)	**Chair's welcome and note of apologies** *Purpose: To **record** apologies for absence and confirm the meeting is quorate.*	*No*	*Chair*	
SO003/23 (D)	**Declaration of interests** *Purpose: To **record** any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
SO004/23 (D)	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 07 December 2022.*	No	*Chair*	10 mins
SO005/23 (D)	**Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions.*	*No*	*Chair*	
STRATEGIC AND GOVERNANCE				**0955**
SO006/23 (D)	**Audit Committee AAA Highlight Report** *Purpose: To **receive** the Audit Committee Highlight Report from the meeting held on 18 January 2023*	*No*	*I Clayton*	10 mins
SO007/23 (D)	**Charitable Funds Committee AAA Highlight Report** *Purpose: To **receive** the Charitable Funds Committee AAA Highlight Report from the meeting held on 13 December 2022*	*No*	*TBA*	10 mins
SO008/23 (D)	**Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework*	*Yes*	*N Bunce*	15 mins

SO009/23 (D)	**Corporate Risk Register** *Purpose: To **receive** the Corporate Risk Register*	*Yes*	*K Clark*	10 mins
INTEGRATED PERFORMANCE REPORT				**1040**
SO010/23 (D)	**Integrated Performance Report (IPR)** a) Quality and Safety b) Operations c) Finance d) Workforce *Purpose: To **receive and note** the IPR for assurance.*	*No*	*L Barnes* *K Clark* *L Barnes* *L Neary* *J McLuckie* *J Royds*	20 mins
QUALITY & SAFETY				**1100**
SO011/23 (D)	**Quality and Safety Committee AAA Highlight Report** *Purpose: To **receive** the Quality and Safety AAA Highlight report from the meeting held on 23 January 2023*	*No*	*G Brown*	10 Mins
SO012/23 (D)	**CQC Action Plan Progress Report** *Purpose: To **receive** and **note** the CQC Action Plan Progress Report*	*No*	*L Barnes*	10 mins
SO013/23 (D)	**Progress in delivering the 2022/23 Quality Improvement Priorities** *Purpose: To **receive** and **note** the Quality Improvement Priorities Update*	*No*	*L Barnes* *K Clark*	10 mins
SO014/23 (D/P)	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4 Compliance** *Purpose: To **approve** the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4 Compliance*	*No*	*L Barnes*	15 mins
WORKFORCE				**1145**
SO015/23 (D)	**Workforce Reports** a) Committee AAA Highlight Report from the meeting held on 24 January 2022 b) 2022/23 People Plan Progress Report *Purpose: To **receive** the Workforce reports*	*No* *No*	*L Knight* *J Royds*	20 Mins

SO016/23 (D)	**Guardian of Safe Working Report** *Purpose: To **receive** the Guardian of Safe Working Report for assurance*	*No*	*K Clark*	10 mins
FINANCE, OPERATIONS AND INVESTMENT				**1215**
SO017/23 (D)	**Finance, Performance and Investment Reports** a) Committee AAA Highlight Report from the meeting held on 23 January 2023 *Purpose: To **receive** the Finance, Performance and Investment Reports*	*No*	*J Kozer*	10 mins
CORPORATE				**1225**
SO018/23 (D)	**Executive Committee AAA Highlight Report** *Purpose: To **receive** the Executive Committee AAA Highlight Report for meetings held in December 2022 and January 2023*	*No*	*AM Stretch*	10 Mins
CONCLUDING BUSINESS				**1235**
SO019/23 (V)	**Questions from Members of the Public** *Purpose: To **respond** to questions from members of the public received in advance of the meeting.*		*Chair*	*5 mins*
SO020/23 (V)	**Any Other Business** *Purpose: To **receive** any urgent business not included on the agenda*		*Chair*	*5 mins*
	Date and time of next meeting: 0930 Wednesday 01 March 2023			***1245 close***

RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC

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

Chair: Richard Fraser

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	AUDIT COMMITTEE
MEETINGS HELD:	18 January 2023
LEAD:	Gill Brown on behalf of Ian Clayton

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The meeting was not quorate
- **Counter Fraud Champion** - it was agreed to approach the newly appointed Deputy Director of HR and OD to be the Trusts new Counter Fraud Champion.

ADVISE

- **The Audit Committee Cycle of Business** - for 2023/24 would be circulated to the members for approval.
- **Internal Audit Report -** five audits from the 2022/23 internal audit plan were at the fieldwork stage and would be completed in Q4
- **Internal audit follow up reviews –** there was one outstanding action and one partially completed action from previous reviews.
- **Healthcare Financial Management Association (HFMA) Checklist Report** – Internal audit had been mandated to audit the Trust's HFMA checklist submission, and this had confirmed the self-assessment score. The trust had also put in place action plans to address any elements with a score of less than 3. It was expected that this exercise would be repeated in future years.
- **Anti-Fraud Progress** – there had been three new referral queries and no new investigations opened since the last Audit Committee. Two referral queries and one investigation remained open. The Trust was rated green for 11 of the 13 Counter fraud functional standards. The two areas rated as amber related to the appointment of a new Counter Fraud Champion and the actions being taken to improve compliance with the conflicts of Interest policy.
- **External Audit Report** - provided information about changes to the audit regulations which would impact the 2022/23 audit. Daniel Watson attended the meeting as the new lead auditor for the Trust.
- **Declaration of Interests (DoI) –** Actions had been taken to improve compliance with the DoI policy, although the manual process had only achieved marginal gains. Plans to move to ESR for reporting DoI were being piloted from February as part of the agreed roll out and the DoI policy had been updated to reflect this change.
- **Appraisal Process Update** – the Director of HR presented the action plan that had been put in place since the limited assurance audit report in 2020/21. Committee was assured by the work undertaken to improve compliance rates, although noted that despite these actions performance remained below target.

ASSURE

- **Internal Audit Progress** report noted that the following planned reviews on the 2022/23 audit plan had been finalised:
  - Corporate Response to Ockenden – substantial assurance
  - Emergency Preparedness, Resilience and Response (EPRR) – high assurance
  - Risk Management Core Controls – high assurance
  - Healthcare Financial Management Association (HFMA) Checklist Controls Checklist
- **Losses and Special Payments Q1 & 2 Report** – was received

• **Aged Debt Report –** total aged debt had decreased and Non-NHS Debt over 90 days had reduced as a % of total over 90 day debt. • **Tenders and Quotation Waivers** report was received	
New Risks identified at the meeting	None
Review of the Risk Register? No	

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Charitable Fund Committee
MEETING DATE:	13 December 2022
LEAD:	Neil Mason, Chair

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- It was noted that the Charitable Funds Manager would be leaving the Trust in January 2023 and the role would go out for recruitment.

ADVISE

- The Committee discussed the financial performance to the end of November 2022 and noted the receipt of a significant legacy and personal donation.
- The potential process around the combination of the S&O and the St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) Trust Funds was noted resulting from the outcome of the full transaction business case.
- The Committee received the Fundraising Update which included an update on the early successes for the Campaign fundraising 'wish list' as well as the significant realised legacy and an 'in memory' donation.
- The Committee reviewed the Charitable Funds Request related to the nurse lead unit on 11a and following a discussion the Committee agreed that the request would be referred back to the Executive Committee for further discussion.

ASSURE

- The Committee approved the final accounts and annual report for 2021/22 and authorised the Chief Executive Officer to sign these off on behalf of the Charity.
- The Committee approved the request for funding for the Critical Care Showers.
- The Investment Advisors report was received and a yield of 2.87% for the quarter was noted.
- The NHS Charities Together report had been submitted and feedback on the Stage Three Schwartz Round grant is expected by July 2023.

New Risks identified at the meeting: None

Review of the Risk Register: No action taken

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**01 February 2023**
Agenda Item	**SO008/23**	**FOI Exempt**	**NO**
Report Title	**BOARD ASSURANCE FRAMEWORK – QUARTERLY REVIEW**		
Executive Lead	Nicola Bunce, Director of Corporate Services		
Lead Officer	Nicola Bunce, Director of Corporate Services		
Action Required	✓ **To Approve** ✓ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

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

Executive Summary

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

Since presentation at the last meeting, the BAF has been reviewed by the lead executive for each strategic risk and the individual risks have been presented to the relevant assurance committees. Progress has been made against the actions, but there are no proposed changes to the risk scores.

Key to changes:
~~Scored through text~~ = deletions
Blue text = additions/updates
Red Text = overdue actions

Recommendations

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

Previously Considered By:

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

Strategic Objectives

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

✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Richard Weeks, Corporate Governance Manager	Nicola Bunce, Director of Corporate Services

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

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

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

Inherent Risk			Risk as at Feb 2023			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	5	20	3	5	15	2	5	10

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

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If quality is not maintained in line with regulatory standards this will impede clinical outcomes and patient safety **CAUSE** Immature governance and risk management processes; poor understanding of minimum standards; shortage of appropriately trained clinical staff in certain specialties and professions; lack of robust processes and management systems to provide evidence and assurance to regulatory agencies. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; inability to demonstrate that risks are managed in a timely way; learning and improvements are delayed; poor clinical outcomes; difficulty in recruiting to clinical vacancies; high use of agency and locum staff leading to increased costs; reduced patient experience feedback; enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.	1. Trust Governance Structures. 2. Trust policies and procedures. 3. Quality priorities programme encompassing five priority areas: • Falls • Pressure Ulcers • AKI: hydration & nutrition • Communication with families • Ockenden Compliance 4. Risk Management Strategy and escalation framework. 5. Quality impact assessments (QIAs) for all service changes that are considered. 6. Single accountability framework for reviewing CBU areas for development/strengths. 7. Application of clinical pathways and guidelines. 8. Programmes in place for clinical standards and professional practice. 9. Work plans for medical staff. 10. Clinical revalidation. 11. Ward/departments staffing position is controlled through: • 3 x daily at staffing huddle; • 7 day staffing matron in place for oversight and management; • Weekly staffing review and sign off; • Roster sign off meeting. • Monthly nurse/midwifery staffing reports to Executive Committee 12. Training programme (mandatory and non-mandatory). 13. Regular resuscitation updates to Executive Committee 14. CQC actions from 2019 inspection complete. Continued oversight through Quality priorities, dashboards and SOCAAS. 15. Supervision and education of clinical staff across all professions. 16. Application of Patient Safety and other safety alerts. 17. Patient Safety Specialists appointed. 18. Cycles of business for governance meetings	1. Non-standardised Trust approach to quality improvement. 2. Clinical workforce strategy not fully developed. 3. Nursing, midwife, AHP and support staff recruitment and retention programme needs continued focus including HCAs ~~further development.~~	**LEVEL 1** (Operational Management) 1. Alert, Advise, Assure reports from Groups. • Harm free care panel • Serious Incident Review Group • Health and Safety Group • Risk and Compliance Group 2. Performance, Improvement, Delivery and Assurance (PIDA) with suite of measures. 3. Patient feedback (FFT/Patient Surveys) 4. Clinical audit reports 5. Mortality and SJR Process. 6. Review of documentation and quality indicators through use of tendable. 7. Health and Safety Inspection Programme 8. IPC Assurance Framework 9. Health and safety/fire risk assessment/audit programme. 10. Medical Examiners office/officers now set up and in practice. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Q&S Committee (monthly): ○ Mortality metrics ○ Never events ○ Incident data ○ Serious Incidents ○ CQUINS ○ Performance data ○ Complaints and compliments 2. HSMR/SHMI. 3. Quality Strategy metrics 4. Mandatory training 5. Monthly Safe Staffing Report 6. Nurse establishment reviews 7. SOCAAS ward accreditation programme 8. VitalPac deterioration measures 9. Freedom to speak up guardian 10. IPC BAF 11. Winter Staffing Assurance Framework Assessment **LEVEL 3** (Independent/Semi-Independent) 1. GMC / NMC Reports 2. Royal College Reports / Visits. 3. CQC inspection visits	1. CQC 'Must and should do' actions not addressed in full. 2. Gaps in evidencing that lessons are consistently learnt and changes in practice embedded following incidents, complaints, claims, inquests, and audit. 3. Guardian of safe working post vacant	1. Clinical workforce strategy to be completed by Nov 22. ~~Sept 22 Update: Approach to medical & clinical workforce strategy presented using HEE STAR methodology, supplemented by external review by Kendall Bluck consulting.~~ **Jan 23 Update** – Kendall Bluck recommendations for ED and medicine have been incorporated into. PTIPs developed for StHK/S&O transaction which will lead to a strategy for the new trust. 2. Enhance the sharing of lessons across the organisation and test that actions/changes are complete/ embedded into practice. Sept 22 Update: Actions progressing. Included in PSIRF implementation and updated incident management framework. **Jan 23 Update** – working with StHK for collaborative approach to PSIRF and organisational learning. 3. Risk Management training launched September 2021 and being regularly reviewed and rolled out to staff across the Trust. On-going – Dec 2022. **Jan 23 Update** – Training continues aligned to new RMF. MIAA gave significant assurance of implementation of risk management framework. 4. Quality Improvement program board established. TOR include definition of QI methodology, training needs and project delivery. (Dec 2022). **Jan 23 Update** – Monthly board in place reporting to QSC. Mid-year progress had been reported to SOC **Completed** 5. Nursing, midwifery & AHP recruitment and retention strategy (Dec 2022). **Jan 23 Update** – Nursing & Midwifery strategy complete and launched in Q3 ~~tabled for EC on 05/09/22~~. AHP strategy in draft, further work needed. Successful recruitment noted in nurse staffing reports. Actions in place to

	19. Use of temporary staffing arrangements to maintain Unify Fill-rates of above 90%. 20. Patient safety specialist roles 21. Medical examiners roles and fully established programme to review all deaths 22. Full roll-out/reporting of Tendable app measures 23. Nursing, midwife, AHP and support staff recruitment and retention programme in place. 24. 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. 25. Quality Improvement Plan goes through bi-monthly to QSC and is presented to the SOC 26. Incident reporting and investigation process 27. Ockenden 1 Action plan 28. Ockenden 2 gap analysis 29. Reporting of nosocomial infections and outbreaks 30. Corporate Objectives		4. CQC Insight Report, Outlier Alerts and engagement meetings 5. Healthwatch 6. Peer Reviews and accreditation. 7. Getting it right first time (GIRFT) programme. 8. NHSI/E oversight meetings 9. Quarterly and Annual Guardian of Safe Working Report. 10. Place ~~CCG~~ monthly quality and performance meetings. LMNS in attendance for maternity updates. 11. Internal/External Audit 12. Quality Account 13. Risk management deep dives and self-checks by the Integrated Governance team 14. Quality Improvement Plan goes through bi-monthly to QSC and is presented to the board.		support HCA recruitment and retention (May 2023) 6. Repeat MIAA audit of lessons learnt (Q1 2023/24) 7. Implementation of PSIRF and roll out of new Incident management framework (IMF) (April 2023) 8. GOSW -Exception reporting reviewed by HR, Director of Medical Education and Medical Director. No internal applicants & STHK unable to support. Further expression of interest request to go external (Oct 2022) **Jan 23 Update** – potential candidate, waiting for submission of Expression of Interest.
The Q&S Committee reviews key quality requirements, expectations and performance requesting remedial action plans where required using a systematic and robust methodology of review and challenge					

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

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

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

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

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

Inherent Risk			Risk as at January 2023			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
4	4	16	4	4	16	2	4	8

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK If the Trust cannot achieve its key performance targets it could lead to failure in delivering safe, high quality patient care and experience and failure to deliver contracts. **CAUSE** • COVID-19 causing delays in elective and diagnostic recovery, cancer pathways and patient discharge. • Continued rise in UEC demand and challenges with patient discharge due to insufficient/inconsistent alternative provisions across the system. • Reduction in the supply of suitably skilled and experienced staff across a number of services. • Ineffective use of resources to support improvements in productivity and improve clinical outcomes. • Failure in operational leadership **CONSEQUENCE** • Failure to deliver safe, high quality patient care • Reduced patient experience • Poor clinical outcomes • Over-reliance on temporary workforce due to current and	COVID-19 and Recovery • In line with national guidance Living with Covid, oversight and decision making has been assigned as part of BAU process to ETM. Systems and processes remain valid and can be stood back up dependent upon prevalence. • Part of C&M Acute Provider Collaborative 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 monthly basis and reported to Exec Committee & FP&I. • Non RTT trackers in place with planned programme of work • Directorate Manager role that is solely responsible for access - providing greater strengthen in governance and compliance. • Access policy for validation of all patients on waiting lists. • Clinical prioritisation of all patients. • Recruitment for dedicated DM, band 6 and band 5 for cancer services. UEC and Discharges • ED RCA process for breaches • Agreed in-hospital winter plan 2022/23 • Agreed out of hospital (system) winter plan for 2022/23 • 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 +14 beds at Chase Heys £840k for Sept 22-Mar 23	1. The expected outcomes and opportunities of partnership with STHK are still being explored across some services. 2. Need to identify other appropriate stakeholders for clinical services partnerships. 3. Shaping Care Together programme is yet to secure capital and define preferred option. 4. Lack of systematic capacity and demand modelling.	**LEVEL 1** (Operational Management) 1. Quarterly Performance, Improvement, Delivery and Assurance (PIDA) Boards – CBU assurance 2. Monthly CBU FPI's in place from April 2022 – CBU assurance. 3. Number of improvement boards in place reporting in via PIDA ○ Theatre Utilisation Board ○ Urgent and Emergency Care Improvement Board ○ Endoscopy Improvement Board ○ Cancer Improvement Board 4. Review of CBU Risk Registers at Risk and Compliance Group. 5. CBU review at Clinical Effectiveness Committee. 6. CBU Governance Meetings in place. 7. Local IPRs in place to monitor performance which are presented at monthly CBU FP&I and quarterly Performance, Improvement, Delivery and Assurance (PIDA). 8. Extraordinary PTL for long waiters (including cancer) in place from Aug 22 chaired by COO **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 9. CEO's reports to Board 10. Integrated Performance Report (IPR) to SOC, FP&I, Q&S and Workforce Committee (monthly) to monitor any impacts on patients as a result of the risk including: ○ Mortality ○ Incident data ○ CQUINS ○ Operational performance data ○ Complaints and compliments ○ Financial position 11. Monthly reports on ~~Covid-19,~~ elective restoration, UEC performance (including Covid) to FP&I. 12. Monthly reports on cancer improvement to QSC 13. Quarterly Joint Performance Meeting (NHSE, STHK and S&O) .	1. Constitutional standards are not routinely being met 2. Plans to deliver the 2022/23 operational plan in place, however impacted by covid. Awaiting NHSE requirement to develop plans for H2 2022/23 in light of current and potential impact of Covid-19 and further waves.	1. Elective recovery plans in place. ~~Sep 22 Update: Monthly progress reporting to EC & FP&I. Trust participates in C&M elective restoration cell that meet weekly. New extraordinary weekly PTL meeting established, chaired by COO to focus on long waiters and clinically urgent patients. Trust part of Tier 2 reporting to NHSE on long waiters, 2nd best performing Trust across C&M. CDC and 2nd CT scanner bids approved - c£5m, implementation plans in place.~~ **Jan 23 Update**: November 22 elective position was 107% 2019/20 levels which is the best it has been during 2022/23 and SOHT are best performing acute trust for 78+ and 52+ weeks. Extraordinary PTL meetings have remained in place. Tier 2 status stood down in November 2022 due to improved position. 2. Develop cancer improvement plan to address performance across all cancer metrics in line with plan for 2022/23. ~~Sep 22 Update: Continued focus on cancer. Weekly PTL meetings remain in place chaired by the ADO, weekly performance meeting in place, chaired by DCOO and extraordinary weekly PTL meetings in place chaired by COO with ADO attendance. Recently recruited to full capacity in tracker team, recruiting 2 x CNS colorectal and unsuccessful in recruitment for B5 and B6. STHK supporting. STHK review taken place, action plan developed to be reported via ETM in Sep 22.~~ **Jan 23 Update**: Continued focus on Trusts cancer position. Positive improvement seen in November 2022 with reduction in 62+ day backlog. New dedicated directorate manager (DM) and lead cancer matron started in post in November 2022 to support the team and improvement plans. 3. Develop Endoscopy Improvement Plan

	projected workforce gaps leading to increasing costs and potential impact upon quality of patient care and experience. • Failure in delivery of national performance targets/plans which could lead to intervention by regulator(s)/ and/or commissioner(s) • Reputational damage and loss of public confidence. • Financial penalties and loss of services. • Loss of market share. • Reliance on other acute providers to support the delivery of clinical services • Loss of ERF funds.	• System escalation system (OPEL) in place to trigger support from partners Workforce • Shaping care together programme. • Comprehensive trust service assessment completed to establish levels of fragility and core drivers Use of Resources • Use of Resources Programme established to support well led approach for clinical and corporate services. • Quality impact assessments (QIAs) for all service changes that are considered. • Use of Quality Improvement (QI) Methodology to ensure any service improvement becomes sustained and embedded. Operational leadership • Weekly Senior Operational Leadership (SOLT) Meetings • Monthly Senior Operational group (SOG) meetings with development plan in place • Essential skills and mandatory skills training programme		**LEVEL 3** (Independent/Semi-Independent) 14. NHSI Single Oversight framework and monitoring arrangements 15. CCG monthly quality and performance meetings. 16. NHS benchmarking data including Model Hospital Dashboard and Dr Foster reporting 17. Getting it right first time (GIRFT) programme. 18. Cancer Alliance oversee delivery and performance regarding cancer metrics. 19. NHS England / NHS Improvement 20. CQC 21. Internal Audit 22. External Audit.		~~Sep 22 Update: Endoscopy improvement group continues to meet monthly with COO & MD in attendance. Weekly and monthly data submissions to C&M. Best performer on points per list in C&M. TIF bid to support JAG accreditation national panel 3rd Oct 22.~~ **Jan 23 Update**: Endoscopy performance continues to improve. The Trust achieved 184.4% 2019/20 plans in November 2022. TIF bid approved and work has begun on £5.9m scheme to redevelop endoscopy at SDGH and ODGH. 4. Discharge planning: Improve the effectiveness of discharge processes to support 30% discharges before noon. ~~Sep 22 Update: Work in place with Sefton Place director to support discharges. Discharges workstream in place. Discharge campaign home before noon will be launched in Sep 22 with support from nursing and medical colleagues. DF and bed manager training planned Sep 22.~~ **Jan 23 Update**: Focus on discharge ahead of the Christmas Period with Home for Christmas Campaign. Ran daily MADE events during the 3-week period and executive chair (MD or COO) of the daily RFD meetings. Extension of opening hours for the discharge lounge for winter. 5. Capacity & Demand Modelling ~~Sep 22 Update: ECIST Capacity and Demand model presented to ETM in Aug 22, deficit of 30-40 beds. Mitigation actions in place to reduce. Funding c£900k awarded for 14 beds in community. Next steps are for BI to work with CBU's using NHSE IST capacity and demand tool for elective to determine capacity required to deliver latter part of 2022/23 and 2023/24.~~ **Jan 23 Update**: Focus is now on 2023/24 planning with CBU's developing specialty levels capacity and demand plans to support overall the overall planning. **Completed** 6. Theatre Improvement ~~Sep 22 Update: STHK review theatres presented to COO and MD, and then ETM. Theatre Recovery Plan under development which will be presented to ETM by end Sep 22. Redesigned theatre list planning meetings in line with STHK and COO in attendance on a weekly basis. Team visiting STHK for peer support. New theatre leadership team in place from 5th Sep 22.~~

						Jan 23 Update: Focus remains on theatre utilisation and productivity. ADO and AMD Planned Care attended regional event on theatre productivity and shared peer performance. Providing mutual aid to STHK for orthopaedics from January for 7 weeks. 7. Radiology Improvement Plan **Jan 23 Update**: To ensure the Trust maximises opportunities when the CDC opens, the COO has commissioned an external review of radiology. This will review current pathways and highlight areas where new pathways could be developed and areas of further improvement to ensure on day 1 the service is as productive as can be and responsive to patients' needs.
	The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

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

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

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

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

Inherent Risk			**Risk as at January 2023**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
5	5	**25**	4	5	**20**	1	5	5

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK There is a risk that essential hospital infrastructure could fail or not be fit for purpose to meet recognised H&S requirements or NHS HBN standards **CAUSE** Lack of capital investment to reduce CIR (Critical Infrastructure risk) backlog **Fire safety risk to life** as a result of lack of early warning (fire alarm) and ability to prevent spread of fire (compartmentation) **Failure of primary electrical systems (Southport)** which could result in loss of mains electricity to the site and loss of backup supply in the event of a power interruption **Failure of secondary electrical systems (Southport)** which result of loss on power through internal distribution network. Inability to effectively isolate areas **Inadequate ventilation (both sites)** resulting from insufficient air changes to meet HTM (Health Technical Memorandum) and infection control standards **Failure of nurse call system (both sites)** due to aging and obsolete parts causing rise to patient safety concerns and inability to care for patients safely **Failure of BMS (Building management System) (both sites)** resulting in inability to control critical systems that are linked to it such as heating, cooling, fire alarm systems **Failure CCTV and Access control systems (both sites)** resulting in lack of adequate security for both patients and staff **Failure lifts (both sites)** Impacting on the ability to transfer patients safely **Failure Mechanical/plumbing (water, oxygen, gas etc) (both sites)** due to ageing systems causing rise to patient safety concerns and inability to care for patients safely **Failure of autoclaves (Southport)** resulting in inability to deliver sterile services to the Trust, impacting on patient safety **SDGH (Southport District General Hospital)** Energy Centre plant and equipment.	1. Estate asset List & information in place 2. 6 Facet & Condition Surveys undertaken 3. Engineering Safety Systems Group has been established 4. Annual Capital Programme 5. Additional project management and construction capacity secured 6. Trust Green Plan 7. E&F Governance & performance management report 8. E&F Policies & SOP's	1. Gaps in asset information 2. Some assets awaiting surveys to be undertaken 3. Need for the development of an Estates Strategy that responds to the Shaping Care Together preferred service configuration option 4. Implementation of national standards of cleaning and new hospital food standards	**LEVEL 1** (Operational Management) 1. Planned Preventative Maintenance (PPM) Programme 2. Health & Safety Group 3. Water Safety Group 4. Estates Operational Statutory Compliance Group which monitors compliance with PPM's 5. Engineering safety Group 6. E&F Governance Group 7. Daily review of DATIX incidents to ensure timely response to mechanical & building related issues. 8. Weekly review of overdue reactive tasks relating to mechanical & building related issues. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Capital plan 2022/23 – identifies internal & external funding to address backlog maintenance projects listed adjacent 2. ERIC 21/22 Submission identifies how much backlog has reduced 3. Fire safety action plans for both sites which are monitored at the H&S Group. Progress meeting held with Merseyside Fire Service who are satisfied with progress made to date. 4. Progress monitored at Capital Investment Group	1. Current PPM Programme does not meet SFG20 - Standard maintenance specification for building engineering 2. Route to securing sufficient capital to address the serious backlog maintenance issues at the Trust 3. Fire enforcement notice from and Mersey fire and Rescue Service.	1. Current CAFM system does not have capabilities required for sufficient asset management or the ability to API link to SFG20 standards - Currently in Mobilisation phase site drawings are being uploaded and asset collection commenced in June. **Jan 23 Update:** Significant progress made – Workstream reviewed and revised target completion date April 2023 approved at E&F Governance Group due to the scale of the task 2. Trust has received £3.2m to tackle fire safety issues in 2022/23 which includes completion of fire alarm upgrade & fire compartmentation at SDGH and upgrade of fire alarm at ODGH. Merseyside Fire and Rescue are satisfied with the actions and progress. 3. A further £2.6m has been awarded which will be targeted against access control/CCTV at ODGH, electrical safety issues at SDGH & additional fire compartmentation works at ODGH to be completed in 2022/23. 4. Internally funded schemes to be completed in 2022/23 are SDGH water tank replacement, laundry decommissioning works, nurse call replacement for wards 7a,9a,9b,10a, 10b & ENT, lighting improvements to both sites and resurfacing of Ruff Lane car park entrance 5. Completed schemes to date include theatre fire safety storage works, replacement generator cables SDGH, Estates welfare workshop & replacement energy centre chimneys 6. Negotiations continue with C&M ICS to agree how the remaining gap will be addressed. **Jan 23 Update:** Trust has agreed with C&M ICB to have first call on any capital slippage in 2022/23 towards outstanding critical backlog maintenance

	CONSEQUENCE If our infrastructure fails or has issues there are several consequences which could potentially happen as a result, such as: • injury to patients, staff, visitors and contractors • Fines for non-compliant systems and support • Risk of fire • Death • Loss of trust assets • Public perception			**LEVEL 3** (Independent/Semi-Independent) 1. AE (Authorising Engineer) Appointments 2. AE (Authorising Engineer) Audits undertaken 3. Condition surveys		7. 3-year plan to eradicate backlog maintenance being updated in readiness for submission to ICB for additional funding in 2023/24 8. Work is ongoing to establish the resources which will fill the gaps in cleaning and hospital food standards.

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

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

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

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

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

Inherent Risk			Risk as at January 2023			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	5	4	20	4	2	8

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK There is a risk of a major and sustained failure of essential IT infrastructure **CAUSE** • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Inadequate investment in systems and infrastructure **CONSEQUENCE** • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	1. IM& T Committee Oversight & IT Management Governance 2. Procurement Frameworks 3. Trust Digital Strategy 4. Performance framework and KPI's 5. Cyber Security Response Plan 6. Benchmarking 7. Workforce Development 8. Risk Register 9. Major Incident Reviews 10. Disaster Recovery Policy 11. Disaster Recovery Plan and restore procedures 12. Backup System in place and operational 13. Engagement with C&M Cyber Security Group 14. Cyber Associates Network Membership 15. Business Continuity Plans 16. Care Cert Response Process 17. Project Management framework 18. Change Advisory Board 19. Digital Design Authority 20. Information asset owner / administrator register 21. Cyber Security Provision provided by Mid-Mersey Digital Alliance (MMDA) 22. Monthly Patching Strategy in place 23. Microsoft Defender Anti-Virus in place and actively monitoring for malware, viruses, and threats 24. All servers and PCs linked to Microsoft ATP\Defender 25. Regular Cyber Security Comms 26. Backup System with backup schedule in place 27. Care Cert Response Process in Place	1. Technical Development of Trust Staff	**LEVEL 1** (Operational Management) 1. IM&T Committee 2. Digital design Authority 3. IT On Call (including Network specific cover provided by MMDA) 4. Risk and Compliance Group 5. Information Governance Steering Group 6. Executive Management Committee 7. Information Asset Owner Framework 8. Benefits Realisation Framework monitoring 9. Cyber Security Action Plan 10. Monthly Cyber Security Assurance Group with MMDA **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Board and Committee Reports 2. Quarterly Digital Strategy Reviews 3. Monthly Cyber Security Reporting **LEVEL 3** (Independent/Semi-Independent) 1. Internal Audit reports 2. Annual Penetration Test and Report 3. Data Security Protection Toolkit Submission 4. Microsoft Unified Support Contract 5. Microsoft Server 2008 Extended Support 6. 24/7 Support Contracts in place for core systems such as EPR, Kainos, VMWare, Dell, etc. 7. Quarterly NHS Digital simulated phishing attack reports	1. Migration from end-of-life operating system ongoing and due to complete in 2022 2. Cyber Essential Certification / Accreditation - achieve by January 2026	1. Network Remediation Rollout underway (Ongoing with completion now scheduled for Q4 22/23) ~~**Sep Update:** This work has commenced with a current expected completion date of July 2023. A review is being undertaken to see whether with more resources the date can be brought forward.~~ **Jan 23 Update**: April 2023 for completion 2. Cisco Identity Services Engine Implementation (Now Scheduled for Q4 2022/23). 3. PC Network Segregation (to be complete Q3 2022/23) **Jan 23 Update:** Work fully complete at Ormskirk and ongoing at Southport. Due for completion Mar 2023 4. ~~Brocade Core Switch replacement (June 2022).~~ **Completed**. 5. ~~VPN Replacement (June 2022)~~ **Completed** 6. The AD for digital at S & O has now left the organisation and professional support is now being provided by the team from STHK while a proposal for the long-term arrangement is being developed. **Jan 23 Update:** Target date April 23 7. Full review of IT service and contracts, asset owners and system versions in-order to fully understand the risks across the IT service is underway. 14 risks identified to date – Ongoing 8. Digital Maturity/EPR replacement funding - £2.22m due to be received Jan/Feb 2022. Work is underway on the OBC for the remaining £19.4m.

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

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

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

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

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

Inherent Risk			Risk as at January 2023			Target Risk position		
Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score
5	4	20	5	4	20	2	4	8

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

Risks to objective	Controls	Gaps in Controls	Sources of Assurances	Gaps in Assurance	Mitigating Actions/Progress
RISK Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners **CAUSE:** • Failure to achieve the Trusts statutory breakeven duty • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders • Failure to develop and deliver strategic financial plans • Failure to control costs or deliver CIP • Failure to stabilise Fragile Services • Failure to secure sufficient capital support to address significant backlog, and transformational requirements • Failure to ensure alignment of essential co-dependant clinical services • Failure to implement transformational change at sufficient pace • Failure to respond to commissioner requirements • Failure to respond to emerging market conditions • Failure to respond to new models of care (FYFV / NHS LTP)	• Operational Plan and HCP/ICS financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances Processes • Monthly financial reporting • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSEI annual provider Licence Declarations • Signed Contracts with all Commissioners • Signed SLAs with all partners • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Declaration of interests • Benchmarking and reference cost group • Increased collaboration across C&M to deliver transformational CIP contribution	• Currently no financial recovery plan that delivers break-even/ addresses drivers of the underlying financial position • ~~National requirement for resubmission of 2022/23 Financial Plans~~ • Lack of medium & long-term financial plan, taking in to account current position and savings from any reconfiguration • Ability to mitigate inflationary pressures – specifically relating to Energy prices into 2023/24, other non-pay, plus 2022/23 pay award • Lack of strategic capital plan • E-rostering system not fully utilised across the Trust. • Demand and Capacity process to inform Operational Planning	**LEVEL 1** (Operational Management) • Monthly CBU FP&I meetings now established • Use of Resources Programme Board • ~~Corporate and CBU Efficiency Programme Group (EPG) meetings /~~ CIP Council meetings ~~to be established from June 2022~~ • Monthly budget holder meetings • Premium Rate Pay Control Panel across CBUs **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) • Finance & Performance Committee • Audit Committee • Annual Financial Plan • Monthly Finance Reporting • IPR • Annual Accounts • SLR/PLICs update reports • UoR Reports • Internal Audit Programme • National costing returns • Shaping care together programme **LEVEL 3** (Independent/Semi-Independent) • NHS England/Improvement monthly reporting • CQC Reports • CCG Contract Review Meetings • Head of Internal Audit Opinion • External Audit reports inc VfM Assessment	• Ability to monitor trajectory against financial recovery plan until developed • Demand and Capacity modelling to inform Operational Planning • ~~Premium Rate Pay Control Panel across the CBUs in process of being established~~ • ~~CIP Council in process of being established~~ • Trust PMO capacity to support delivery of CIP, UoR Action Plan, capital business cases, and service transformation	• Collaboration agreement in place with StHK with proposed transaction planned for April 2023 • ~~Develop scenario-based approach to Operational plan/budget setting for 2022/23 – Final Plan Re-submission June 2022~~ **Completed** • Development of Medium & Long-Term Financial Model & strategic capital plan – note absence of national medium & long term financial framework including payment mechanisms and economic modelling assumptions required in order to provide robust Medium & Long-Term plan **Jan 23 Update**: National Planning Guidance for 2023/24 – 2024/25 published in December 2022 • Development and implementation of monthly financial reporting suite and forecasting model to drive ownership and accountability for performance – in place from April 2022 – automation opportunities with BI ongoing • Establish processes for Capacity and Demand planning from October 2022 – 2023/24 Planning Round under way. • ~~Establish processes for identifying, implementing, and monitoring delivery of efficiency/productivity (CIP) – fortnightly CIP Council commencing June 2022~~ **Completed** • Management of rostering centralised from April 2022. E-rostering to be fully rolled out in all areas **Jan 23 Update**: final areas now under way with all users set up - anticipated completion during Q4 • Establish a Premium Rate Pay Control Panel across the CBUs **Jan 23 Update**: governance is completed and work on reducing premium pay is ongoing and reported via FP&I **COMPLETED** • Analysis of activity in relation to PbR to understand the drivers of changes, market share, and potential solutions

	EFFECTS: • Failure to meet statutory duties • External Cash Support Requirements • NHS Single Oversight Framework Segmentation Status increase **IMPACT:** • Unable to deliver viable services • Loss of market share • Regulatory intervention					**Jan 23 Update**: PLICS updates and next steps presented to September 2022 FP&I work continues for 2023/24 modelling - **COMPLETED** • Seek all possible sources of capital and revenue funding through national bids to support capacity and transformation, including opportunities re co-location of services - ongoing
	The FP&I Committee review the Integrated Performance Report and can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

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

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

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

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

Inherent Risk			**Risk as at January 2023**			**Target Risk position**		
Likelihood	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**	**Likelihood**	**Consequence**	**Score**
3	4	**12**	3	4	**12**	2	4	**8**

Risks to objective	**Controls**	**Gaps in Controls**	**Sources of Assurances**	**Gaps in Assurance**	**Mitigating Actions/Progress**
RISK If the Trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity there will be an impact on clinical outcomes and patient experience **CAUSE** Shortage of appropriately trained clinical staff in certain specialties and professions; Trust's geographic location; Trust's close proximity to other teaching hospitals with clearer USPs from a learning/ career development perspective; reputational damage over last 3 – 5 years has impacted on external perceptions of the Trust; Trust approach to recruitment and retention is underdeveloped across all areas. **CONSEQUENCE** Inability to deliver safe, high quality patient care and experience; high vacancy and attrition rates; over-reliance on temporary workforce leading to increasing prevalence of fragile services; higher costs associated with temporary staffing; enforcement action, prosecution, financial penalties, reputational damage, loss of commissioner and patient confidence in provision of services.	1. Our People Plan (Workforce and OD Strategy) aligned to NHS People Plan 2. Our Resourcing Plan (Strategy supported by clinical workforce plan). 3. Inclusive recruitment and selection processes in place 4. Overseas Recruitment Campaign for Nurses 5. Effective management of the junior doctor rotation programme and early indications of any shortages from the Lead Employer. 6. Job plans for medical staff. 7. Warm Welcome staff induction in place 8. Quality PDR process and career development discussion 9. Flexible working options in place including team rostering 10. Ward/departments non-medical staffing position is controlled through: 11. 3 x daily at staffing huddle 12. 7-day staffing matron in place for oversight and management 13. Weekly staffing review and sign off 14. Roster sign off meeting. 15. People Activity Group (PAG) with oversight of business cases for additional staffing 16. Leadership development programmes & 360 feedback available to all staff 17. Apprenticeship programmes available to all staff from Level 2-7 qualifications 18. Effective approach to supporting attendance to reduce sickness absence levels	1. Low number of applicants from BAME backgrounds successful at interview 2. Poor PDR compliance rate 3. Limited options for flexible working 4. Policy has too many stages/trigger points reducing effectiveness and limited manager informal interaction with staff in early stages of absence management 5. No easy ability for staff to move internally without full application process 6. Education structure requires integration	**LEVEL 1** (Operational Management) 1. Workforce Committee 2. Workforce Improvement Group (WIG) oversees work against the four operational priorities: ○ Agile working ○ Workforce systems ○ Clinical workforce plan ○ Change management 3. Quality and Safety Committee 4. Clinical Effectiveness Committee 5. Finance, Performance, and Investment Committee. 6. Risk and Compliance Group. 7. Clinical Effectiveness committee 8. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 9. CBU Governance Meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): 2. PDR completion 3. Sickness rates. 4. Absence Data 5. Turnover Data 6. Vacancy Rate 7. Time to Hire monitoring and reporting. 8. Apprenticeship Levy/Programmes 9. Staff Survey & Quarterly Staff FFT/Survey 10. GMC Medical Staff survey – annual 11. Nursing temporary staffing fill rate/ NHSP contract performance	1. Sickness absence not maintained below target 2. Low compliance rates for PDR completion 3. Medical vacancies that have been vacant for a long time	1. Clinical workforce plan to be developed. A work stream has been established as part of Workforce Improvement group (led by the Deputy Medical Director) to develop a framework for workforce planning and link to Fragile Services and Shaping Care Together. Implementation of establishment control is required before a robust workforce plan can be developed, the implementation of establishment control is progressing at pace and the majority of the preparation work is now complete. ~~**September 22 update:** Nursing and Midwifery workforce plan submitted to Workforce Committee for approval. Alignment to Medical and AHP workforce plan to follow (aiming for end of October)~~ **Jan 23 Update**: Medical Workforce Plan awaiting final comments from Medical Director prior to publication, this will then progress to Workforce Committee and progress will be regularly reported 2. Engagement planned with staff network colleagues to review Recruitment and Selection process to identify improvements & develop further inclusive approaches. **Jan 23 Update**: Staff Networks launched Oct 2022 – request staff network members to be part of R&S Review Group to inform future changes/improvements. To date: support for applicants with disabilities on application and at interview, guaranteed interview scheme, EDI charter marks e.g., Navajo, Disability Confident 3. Review of current rostering practice across each area and guidance and support is being offered to improve as phase 2 of the benefits realisation. 4 departments identified as pilots for team/self-rostering is now underway ~~**September 22 update:** Evaluation to be undertaken by end of October 2022.~~ **Jan 23 Update**: further guidance being prepared to support with the introduction of self-rostering 4. Review of supporting attendance policy with support from NHS England/Improvement to

		19. Updated Resourcing Plan required and no clinical workforce plan in place 20. Lead Employer progression 21. Internal transfer principles to be explored 22. Core mandatory & essential skills training programmes in place 23. Clinical Education Review undertaken 24. Bespoke and tailored support provided to newly recruited international colleagues 25. Essential skills training action plan in place to drive compliance and reviewed monthly 26. Early identification of junior doctor rota gaps and proactive block booking to address 27. Alignment of job planning rounds to business planning cycle 28. E-rostering system fully utilised across all clinical departments at the Trust		**LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement 2. CQC 3. CCG 4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education North West 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		address areas identified as outliers compared to Trust's with lower absences. ~~**August 22 update**: Following discussion with staff side agreement to leave policy with extension and to review fully alongside Supporting staff with long term conditions and disabilities by August 2023.~~ **Jan 23 Update**: action complete. Full review of policy paused due to potential introduction of C&M Wellbeing Policy. 5. Each CBU to have an improvement trajectory for planned reduction in sickness absence and progress to be monitored through monthly PIDA. ~~**September 22 update**: HRAs and BPs working closely with all CBUs on long term cases and to ensure that appropriate management action has taken place in respect of short term Absence. Monitored on quarterly basis and reported to Workforce Committee. Next report due October 2022.~~ **Jan 23 Update**: monitored on quarterly basis and CBUs are focussed on long term absence and repeated short term absence. Monitored by PROG and WFC. 6. Two joint Clinical Academic posts with Edge Hill University currently being advertised to increase attractiveness to medical posts at the Trust ~~**September 22 update:** Awaiting Royal College approval of job description for 2nd post prior to readvertisement~~. **Jan 23 Update**: Diabetes post has been filled and the 2nd job description for care of the older person has been re-approved and we are confirming possible interview dates with Edge Hill prior to advert 7. Internal transfer principles to be explored. There is no easy ability for staff to move without a full application process. T&F group established mid-October 2021 to assess need for transfer SOP with potential qualifying criteria to be determined. ~~**September 22 update:** Internal Policy to be finalised during Quarter 3 (22/23), following work through Valuing Our People through Inclusion Group. Progress being made through working group.~~ **Jan 23 Update**: working well and introduced Trust wide for nursing and HCA posts. It will be fully reviewed after two months. 12. Clinical Education Risk 2424 – Failure to meet the outcomes of the HEE Quality Framework & supporting governance structure & processes under review by Executive Team **Jan 23 Update**: Clinical Education review on hold in view of StHK/SOHT future collaboration. Clinical Education Risk 2424 rating reduced from High 12 to High 8 (Dec 2022) due to the improvements implemented by the Clinical Education Teams that meet

						the outcomes of the HEE Quality Framework Standards. 13. PDR action plan in place to drive improved compliance over the summer 2022 period (typical trend for reduced compliance) and progress monitored monthly. ~~**September 22 update**: All actions taken and the 55 non-compliant (excluding those staff on LTS) has reduced to 17. Each Exec Director scrutinising and challenging PDR rates for their areas of responsibility.~~ **Jan 23 Update:** actions all completed but no discernible improvement in compliance due to capacity issues for clinical managers and staff. There has been a reduction in compliance for corporate staff.
	The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

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

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

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

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

Inherent Risk			**Risk as at January 2023**			**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 SCOPE Values 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. Access to NHS Leadership Academy Programmes & 360 feedback, and internal leadership and management development programmes available 11. Mandatory and role specific training programme in place 12. Quality PDR discussions to promote positive behaviours 13. Apprenticeship programmes leadership & management offer Levels 3-7 14. Board role modelling and visibility through: a. Executive Back to the Floor sessions. b. Non-Executive Board to Ward visits c. Staff Voice Partnership quarterly activities including Exec Pop Ups and Team Talks. 15. Embedding Values and Behaviours in Induction and PDR processes. 16. 'Foundations of leadership programme 17. PDR Improvement Plan monitored though PIDA and the valuing our people inclusion. 18. A reciprocal arrangement in place through the Mediation Network	1. Limited alignment of values to key stages in employee life cycle 2. Low participation in staff networks 3. Team development interventions are on hold currently due to expensive and resource intensive 4. No talent management/succession planning frameworks in place 5. Low visibility of leadership team reported in recent Staff Survey 6. Pause of Board Development sessions due to COVID-19. 7. No Board Development programme in place for the year	**LEVEL 1** (Operational Management) 1. Workforce Committee 2. Workforce Improvement Group oversees the Transformational Leadership programme outlined in Our People Plan 3. Valuing Our People Inclusion Group oversees the culture and staff engagement programmes outlined in Our People Plan. 4. EDI Special Interest Group 5. Quality and Safety Committee 6. Clinical Effectiveness Committee 7. Finance, Performance, and Investment Committee. 8. Risk and Compliance Group. 9. Clinical Effectiveness committee. 10. Remunerations and Nominations Committee. 11. Performance, Improvement, Delivery and Assurance (PIDA) Boards. 12. CBU Governance Meetings. **LEVEL 2** (Reports and Metrics monitored at assurance committees and/or Board) 1. Integrated Performance Report to Board and Workforce Committee (monthly): ○ Mandatory training. ○ PDR completion. ○ Sickness rates. 2. Turnover. 3. Vacancies. 4. Performance Reports (monthly) 5. NHS staff Survey 6. Quarterly Staff Friends and family Test/Survey 7. GMC Medical Staff survey – annual	1. Staff Survey Engagement score remains below national average. 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.	1. EDI Board development programme agreed to promote and embed inclusive leadership practices at a senior level. **Jan 23 Update:** Programme paused in view of StHK/SOHT future collaboration so that activities can be aligned. EDI Training Programme in place for all staff until Q2 2023. 2. Talent management/succession planning framework, participation in the Workforce Improvement Group. **Jan 23 Update:** Nursing Career Pathway developed. Operations Career Pathway & Framework in development. MSW Career Framework in progress with HEE / place-based colleagues. Core Leadership Development Offer in place: - https://bit.ly/3YQVNkR Collaborative StHK/SOHT approach to apprenticeships to commence Q4 202/23. 3. The Trust is adopting the Leadership Academy system leadership competency framework and will undertake a self-assessment with leaders through a programme of work overseeing by the Workforce Improvement Group. **Jan 23 Update:** Place system leadership programme launched 28th September 2022 with 4 S&O delegates – 'Foundation in System Leadership' programme available to all staff via NHS Leadership Academy. **Completed**. 4. People Plan programmes monitored by the Valuing Our People Inclusion Group (VOPIG). **Jan 23 Update:** Staff Voice Partnership phase 3 commences Jan to June 2023 to increase Board visibility – work in progress to align to StHK model(s). EDI action plan in place to promote EDI agenda. 5. The Trust is reviewing its corporate induction messages to embed the Trust's SCOPE Values to engender compassionate & inclusive behaviours for new starters. **Jan 23 Update:** - A second revision to the Trust's Warm Welcome has been undertaken with a clear focus on the SCOPE values & the inclusive agenda. Launch of a new online induction programme due Q4 2022/23. An Executive attends each session in person.

		accessed by the Trust on a case-by-case basis where appropriate. 19. The Trust has 7 trained Schwartz Round facilitators as well as access to a further 3 as part of Sefton Place partnership. 20. EDI strategic objectives for 2022-24 established 21. Just and Learning principles established and aligned to employee relations and incident management processes		**LEVEL 3** (Independent/Semi-Independent) 1. NHS England / Improvement 2. CQC 3. CCG 4. NMC/GMC/HCPC and other professional regulators 5. Health Education England 6. Health Education Northwest 7. Internal/External Audit 8. Freedom To Speak Up Guardian (FTSUG) reports 9. Guardian of Safe Working Hours Report.		
	The Workforce Committee can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

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

Strategic Objective 6: Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	**Assurance Committee:** Trust Board **Executive Lead:** Director of Transformation (CEO)

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

Inherent Risk			**Risk as at January 2023**			**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 Integrated Care Board (ICB) wide acute provider partnership approach
• Complex health economy
• Lack of clarity about additional investment to address sustainability challenges
• Lack of public and staff engagement to ensure effective co-production of potential solutions to clinical and financial sustainability challenges.
 	
CONSEQUENCE
• Clinical unsustainability due to current and projected workforce gaps.
• Failure to deliver safe, high quality patient care and experience in the most appropriate environment
• Financial unsustainability due to increased costs
	1. Whole system engagement to address the required whole system change
	2. SCT Programme Plan including key milestones to enable public consultation
	3. Robust system governance structure in place to support the Shaping Care Together (SCT) programme
	  • Programme Board
	  • Operational delivery groups
	  • Clinical Leaders Group
	4. Strategic partnership (ALTC) established with StHK
	5. Comprehensive trust service assessment completed to establish levels of fragility and core drivers
	6. Member of Sefton Integrated Care Partnership (ICP)
	7. Member of the Cheshire & Merseyside Acute Provider Collaborative
	8. Patient and Public Engagement strategy for SCT programme
	9. Comprehensive due diligence completed, and documentation library created
	10. Quality and equality impact assessments completed and reviewed in advance of any changes to Trust service provision
	11. System Equality Impact Assessment process established
	12. Cheshire and Merseyside Integrated Care System governance structure
		1. Clear alignment between Shaping Care Together programme, System Management Board & Sefton Partnership
		2. Sefton Brough is still developing plans for the Place which are expected Autumn 2022.
		3. Lack of established Patient & Public Reference Group
		4. Expected outcomes and opportunities of partnership with StHK are still being explored for some service areas.
		5. Identification of other key stakeholders for clinical services partnerships where StHK is not appropriate and needs to link into Place and Provider Collaborative discussions which are still at early stages.
		6. Shaping Care Together programme is yet to secure capital and define preferred option
		7. Clinical workforce strategy not fully developed.
		8. Risks relating to current estates and infrastructure continues to be defined within the SCT Programme (this
			LEVEL 1
			(Operational Management)
			
			1. CBU FP&I (Monthly, Performance, Improvement, Delivery and Assurance (PIDA) Boards (Quarterly), with suite of measures
			2. Ongoing review and management of 'fragile services'
			3. Collaboration Senior Team Meetings (StHK & S&O Trust) reviewing immediate priorities and opportunities
			4. Shaping Care Together (SCT) programme plan – monitored for delivery at Programme Board and Trust Board
			5. Patient and public engagement strategy monitored at Programme Board
			6. Equality Impact Assessment outcomes monitored at SCT programme board.
			7. Ophthalmology Improvement Group – partnership meeting to develop and monitor system improvement plan
			8. North Mersey Stroke Board – partnership board to develop and implement case for change, engagement & operational plans
			9. Therapies Assurance Group – partnership meeting to monitor the improvement delivery
			10. Trust attending Cheshire and Merseyside Acute Provider clinical pathway collaboration meetings
			
			LEVEL 2
			(Reports and Metrics monitored at assurance committees and/or Board)
			1. Fragile Services reports to SOC and Board
			2. Integrated Performance Report (IPR) to SOC and Q&S Committee (monthly) to monitor any impacts on patients as a result of the risk including:
			  ○ Mortality
			  ○ Incident data
			  ○ CQUINS
			  ○ Operational performance data
			  ○ Complaints and compliments
			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
				Development of good working relationships with the new Primary Care Networks/Place Boards
				
				~~Understanding of the performance monitoring systems that will be established under the new NHS Bill that comes into effect on 1 July 2022~~
				
				New NHS operating framework published October 22
					1. SCT Programme to develop Models of Care and define preferred option.
					~~**September 22 Update:** Models of Care developed, and initial options assesses against hurdle criteria. Revised programme timetable has been approved by programme board. On-going discussions with the ICBs and Places regarding the future role of SCT Programme and system ownership~~
					Jan 23 Update: Discussions on going with Sefton Place and ICB about the future structure of the SCT programme and timetable
					2. Establish Finance and Capital Assurance Group
					~~**September Update:** Group has been supported by MIAA to formalise the deliverable projects for 2022/23 which are expected by Autumn 2022. Trust DOF is now the nominated chair of the group.~~
					Jan 23 Update: Capital projects group established to oversee delivery of CDC and TiF schemes. **Completed**.
					3. Continue to develop collaboration opportunities with StHK
					~~Establish Therapies Assurance group by February 2022~~ ~~**September 22 Update** – Work programme has now been developed with workstream leads in place, regular bi-monthly meeting booked in 2022~~
					Jan 23 Update: development of Patient Benefits Case and PTIP deep dives with all services now planning for integration post transaction
					4. Ophthalmology clinical working group established to support clinical workforce recruitment challenges. ~~September 2022 Update – Additional doctor recruitment has taken place which has significantly improved the position. Soft approach to opening to referrals commences in September starting with cataracts. Work continues between the STHK and S&O clinical teams.~~

	• 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		includes the wider system) 9. Places are still defining their commissioning and transformation priorities for 22/23	5. Quarterly Joint Performance Meeting (NHSE, StHK and S&O) 6. LUHFT & S&O Partnership Board **LEVEL 3** (Independent/Semi-Independent) 1. Participation in the C&M ICS leadership and programme boards 2. Active member of Sefton Partnership Attend the monthly Sefton Partnership Board 3. Active Member of the Cheshire & Merseyside Acute Provider Collaborative & supporting transformation/improvement work stream 4. Active member of the Cheshire and Merseyside Independent Sector working group 5. Collaborative working with Place to develop commissioning and transformation priorities for 22/23 – ~~draft priorities agreed and expected to be finalised Autumn 2022~~ 6. Northern Clinical Senate and Yorkshire and Humber Clinical Senate Report recommendations 7. NHS England / NHS Improvement 8. CQC 9. Internal Audit 10. External Audit		**Jan 23 Update:** cataract surgery repatriation planned from LUHFT and plans for integrated service with STHK developed and being implemented 5. Continue North Mersey Stroke Programme with implementation date of September 2022 ~~**September 22 Update** Full Business case formally approved by ICBs and implementation plans in place for 19/09/22~~ **Jan 23 Update:** Stroke pathway successfully implemented and embedded. No longer a fragile service. **Completed** 6. Continue to support Sefton Partnership Board with the development of priorities. High-level draft has now been produced by Seton Partnership Delivery Group and expected to finalised by Autumn 2022 – **Jan 23 Update:** Place Partnerships now working on plans for 2023/24 with S&O representation 7. Develop a North Mersey Ophthalmology Steering group supported by local CCGs – March 2022. ~~**September 22 Update** - Working Group established and being led by Sefton Place. Initial workstreams have been very proposed and scoping exercise now taking place.~~ **Jan 23 Update:** developed as a PBC proposal with STHK for the transaction FBC 8. Continue to develop Liverpool University Hospitals FT relationship with a particular focus on the SLAs already in place. ~~**September 22 Update** Next Partnership Board is booked for 30th September 2022 and regular diary invites set for next 12 months. Meetings have taken place to support Ophthalmology, Vascular and ENT~~ **Jan 23 Update:** regular meetings with LUHFT continue at CEO level
	.					
	The Hospital Management Board can request remedial action plans or conduct deep dives using a systematic and robust methodology of review and challenge					

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

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**01 February 2023**
Agenda Item	**SO010/23**	**FOI Exempt**	**NO**
Report Title	**INTEGRATED PERFORMANCE REPORT SUMMARY**		
Executive Lead	EXECUTIVE MANAGEMENT TEAM (EMT)		
Lead Officer	Katharine Martin, Performance & Delivery Manager		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To provide a summary on the Trust's performance against key national and local priorities.

Executive Summary

The Integrated Performance Report (IPR) Performance Summary Report highlights the performance against Trust indicators relating to the NHS Constitutional standards, the 2022/23 National Priorities and internal performance indicators which the Trust has identified as essential measures of operational delivery and assurance.

The IPR Performance Summary Report is grouped by Quality, Operations, Finance and Workforce. The detail for each domain is contained within the Integrated Performance Reports presented at the Assurance Committees, which includes Statistical Process Control (SPC) chart and commentary where required.

Recommendations

The Board is asked to receive the Integrated Performance Report Summary.

Previously Considered By:

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

Strategic Objectives

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

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

Southport and Ormskirk Hospital NHS Trust

Trust Board - Integrated Performance Report

Performance Summary

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

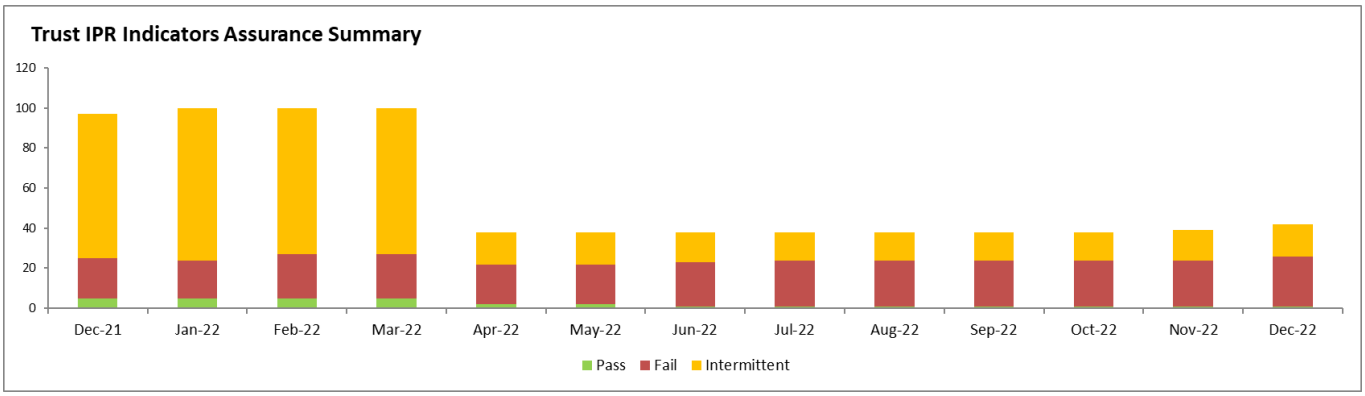
Quality - reflects those metrics aligned to Trust Objective – Care & Safety

Operations - Trust Objective – Service

Finance - Trust Objective – Financial performance and productivity.

Workforce - Trust Objectives – Supporting our workforce and Open and honest culture.

The indicator assured this month is Percentage of Patient Safety Incidents - Moderate/Major/Death(related). Finance indicators are not being reported using SPC.



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

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

There were no Never Events reported in December 2022, there are 2 to date this year.
There were no cases of MRSA in December. (2022/23 YTD = 0), last case January 2022.
There were five C. Difficile (CDI) positive cases reported in December 2022 (2022/23 YTD = 40).
Also five E.Coli cases in December, (2022/23 YTD = 35).
The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for December 2022 was 90.1%. This is based on 94.3% for Registered Nurses and 84.96% for Un-Registered Nurses. This indicator has been ahead of the 90% target for 10 consecutive months.
There was one category 3 hospital acquired pressure ulcer reported in December (2022/23 YTD = 19).
The Trust reports all Deep Tissue Injuries and Unstageable Pressure Ulcers as Category 3. Following validation, all category 3 pressure ulcers reported in 2022/23 are deep tissue injuries or unstageable pressure ulcers, with no avoidable category 3 pressure ulcers being reported in 2022/23 to date.
There were 77 patient falls in December of which two resulted in moderate harm (2022/23 16 Falls with Harm).
The Patient Friends & Family Test - % that rate the Trust as 'Very Good or Good' (Trust overall) increased to 87.3% in December, from 88.3% in November. ED improved by 0.1% to 81.8% with adults 79.2% and Paeds 85.6%.
The percentage of complaints responded to within timescales has achieved 45% in December against the 80% target and is 51.1% year to date. The Percentage of Patient Safety Incidents resulting in Moderate or above harm continues to be assured with performance lower than the target (target based on NHSE average NRLS published data).

Operational Performance

Overall Accident and Emergency performance for December 2022 was 70.7%. This compares favourably with peers, with an England average of 62.95%, Northwest 62.2% and Cheshire & Mersey 64.8% (NHS Trusts only).

Paediatric ED continued the surge in attendances which started in late November, seeing 27% more patients than last month and 83% more than December 2019.
Nine of the top 10 highest attendances on record occurred in December 2022 for Paeds.

28.6% of Ambulance Handovers occurred within 15mins, a decrease from November (37.2%) against the 65% target. 56.9% of Ambulance Handovers were within 30mins, compared to 65.2% in October, against the 95% target. 140 Ambulance Handovers breached 60mins in December, an increase on the 57 reported in November.

Performance against the 14-day GP referral to Outpatients was 88.2% in November 2022, (78.5% in October), this is against an average of 78.7% for England, 74.9% Northwest and 77.5% for Cheshire & Mersey. This is also against the third highest ever patient numbers seen with referrals for April – November 2022 53.8% higher than the same period 2019.

Operational Performance continued

The 62-day cancer standard improved but was below the target of 85% in month (November 2022) at 72.2% (65.2% in October). This is above the NHS Trust average for Cheshire & Mersey (68.8%), above England (60.9%) and Northwest (63.3%) (NHS Trusts only). This is against the highest activity recorded.

The Trust did not achieve the 96% target for the 31-day target in November 2022 with 82.4% performance in month (October 86%). The Trust is lower than the England average of 91.5%, Northwest 92.9% and Cheshire & Mersey 94%.

The average daily number of stranded patients in December 2022 increased to 223 (November 222).

The number of super-stranded patients was 92 in December, from 93 in November.

The Criteria to Reside metric is in excess of the 30 target, averaging 59 in December.

All these metrics were impacted by patient acuity, delays in care packages, availability of community beds and care home capacity.

The 18-week Referral to Treatment target (RTT) was not achieved in December 2022 with 61% compliance, (65.2% in November), against the 92% target. The Trust continues to perform well in comparison to peers, for example the average for NHS Trusts in England was 59.6%, Northwest 56.4% and Cheshire & Mersey 56.5%.

There were 176 52+ week waiters at the end of December, similar to the 172 reported in November, with 9 patients waiting longer than 78 weeks, the target is to achieve 0 by the end of April 2023. There remained no 104-week waiters. SOHT is the top performing acute trust across C&M for both 52 week and 78 week waits.

The Diagnostic target was not achieved in December 2022 with 25.5% patients waiting longer than 6 weeks, against a target of 1%. This compares to an NHS Trust average of England 27.5%, North-West 22.7% and Cheshire & Mersey 20% (November 2022 data).

Financial Performance

The Trust is reporting a £13.8m deficit at Month 9 in line with 2022/23 Plan

Continued escalation and operational pressures are currently being offset by allocations for elective restoration and executive contingency

The Trust has assumed 100% ERF funding to M9 on the basis of full allocations paid to Trust with ICB now advising no clawback for 2022/23

The 2022/23 financial plan sets out a CIP requirement of 3.5% (£7.8m), plus a further £3.0m Stretch Target in Q4. The Trust is reporting full delivery of CIP in 2022/23. QIAs now 95% complete.

Forecast Outturn - The Trust is forecasting a £14.2m deficit in line with plan for 2022/23.
Cash - The cash balance at the end of November was £7.4m. ICB have confirmed that cash support received during 2022/23 will need to be repaid in March 2023. In order to be able to access cash support funding by March 2023, the Committee is requested to recommend that the Strategic Overview Committee (SoC) approve a loan request of c£8.7m at their meeting on 01 February 2023 in time for loan application submission early February.

BPPC - 95% target achieved for NHS, non-NHS and in totality.

Debt over 90 days - This has increased by £9k since November. An action plan for the top 10 debt in this category was presented to Audit Committee on 18 January.

Capital - Whilst c£17m capital investment now scheduled for Q4, the Trust is on-track for the delivery of the 2022/23 capital programme. Orders are in place with Vinci for the TIF and CDC builds which comprises a major element of the spending. Remaining cash flows are being actively managed, and remaining TIF/CDC funding of c£9.5m will be drawn in February, with the £0.5m balance drawn in March to pay for remaining pieces of equipment and fees.

Workforce

Personal Development Review compliance has decreased in December to 75.3% against the 85% target. Performance in November was 76.3%. The 90% stretch target for Mandatory Training was implemented from June 2022 and the indicator is behind the target at 87.8% for December, a marginal increase on the previous month (87.7%).

In month overall sickness has increased by 0.9% in December and is 7.7%. The rolling 12-month figure remains 7.1%. This is against sickness targets for 2022/23 of 6% (5% non-Covid, 1% Covid). Covid absences on average account of in the region of 11.32% of all absences daily.

The overall Trust vacancy rate continues to fail its assurance measure and has increased in December to 10%, from 8.8% in November, against the 7.4% target. In-month Staff turnover has decreased to 0.8% in December from 1.1% in November (target 0.83%).

Southport and Ormskirk Hospital NHS Trust

Integrated Performance Report

Board Report

December 2022

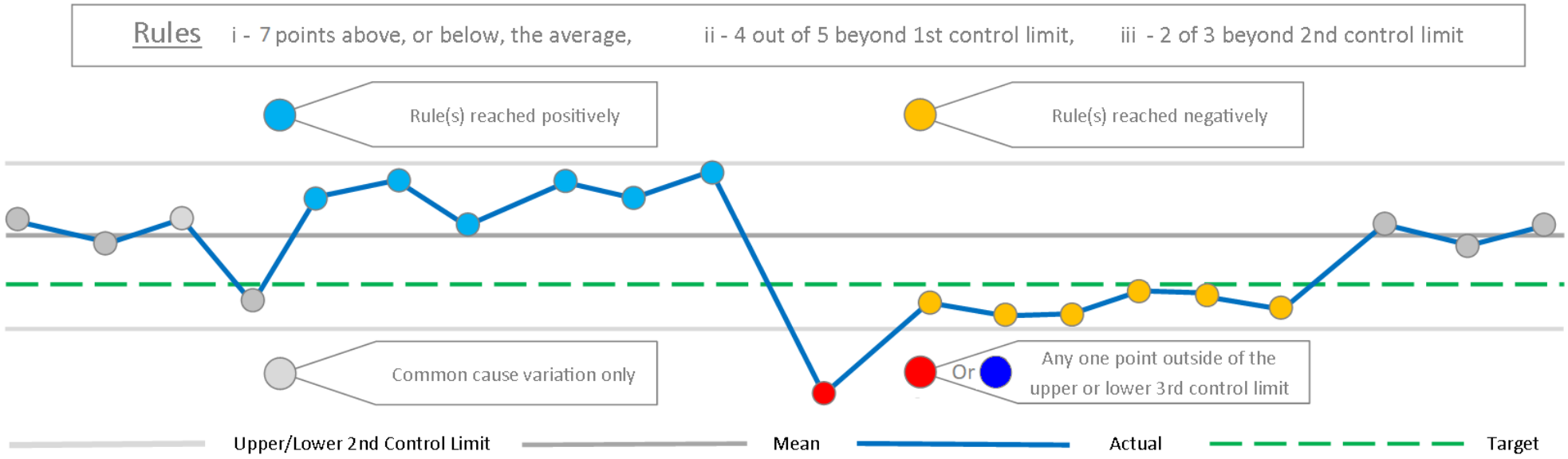
Guide to Statistical Process Control

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

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

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

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



Executive Summary

	Improvement	VariationCommon	Concern
Consistently Passing		Percentage of Patient Safety Incidents - Moderate/Major/Death (related)	
Inconsistent	I&E surplus or deficit/total revenue MRSA Safe Staffing TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month Capital Spend C-Diff E. Coli Falls - Moderate/Severe/Death Hospital Acquired Pressure Ulcers - Categories 3 & 4 Never Events No Criteria to Reside - Avg No of Patients Patient Falls - Trust Sickness Rate Staff Turnover	31 day treatment
Consistently Failing	Diagnostic waits E-Discharges within 24hrs Trust Vacancy Rate – All Staff	14 day GP referral to Outpatients 28 Day Faster Diagnosis Standard 62 day GP referral to treatment Ambulance Handover Over 60 Mins Cash Balance Complaints - % closed within 40 working days Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall Outpatient Letters to GP's within 7 Days Personal Development Review Stroke - 90% Stay on Stroke Ward	% of Patients spending 12+ Hours in ED - Trust 52 Week Waits Accident & Emergency - 4 Hour compliance Ambulance Handovers - % within 15 Mins Ambulance Handovers - % within 30 Mins Mandatory Training Number of Patients spending 12+ Hours in ED - Trust Referral to treatment: on-going Sickness Rate (not related to Covid 19) - Trust Sickness Rate (Rolling 12 Month) Stranded Patients (>6 Days LOS) Super Stranded Patients (>20 Days LOS)

Quality

Harm Free

Safe Staffing/Care Hours per Patient Day

Issues
• The Safe Staffing indicator has declined in December but remains just above target and statistically as expected.
• The decline in safe staffing fill rate is in line with the increase in sickness and annual leave provision in the weeks prior to Christmas. High sickness levels resulted in multiple requests for temporary staffing at short notice, which has been difficult to fill.
• Increased activity and opening of patient escalation areas, resulted in staffing spread thinner than usual and increased difficulties in filling all available clinical shifts.
• Performance of 90.1% in December relates to 94.34% for Registered Nurses and 84.96% for Un-Registered Nurses.
• Care Hours per Patient Day (CHPPD) has also declined, coupled with a spike in acuity and increased patient numbers. Whilst it remains above target, it is showing special cause concern for the last 2 months.

Management Action
• Ongoing recruitment to all trained posts ASAP and targeted HCA recruitment events.
• Additional use of NSHP to support low staffing areas.

Pressure Ulcers

Issues
• Both Hospital Acquired Pressure Ulcer indicators are performing statistically as expected but have reduced in December.
• The number of category 2 pressure ulcers is the lowest since January 2021.
• All Hospital Acquired Category 3's reported in 2022/23 to date are Deep Tissue Injuries or Unstageable Pressure Ulcers. There have been no confirmed Hospital Acquired Category 3 Pressure Ulcers this financial year to date.
• Trend of HAPU cat 2 to sacrum – impacted by long waits on seats in AED, also noted on walkabout that the patients nursed in the corridor on a bed are unable to have an air mattress unless a plug socket is in the area where the bed is placed.

Management Action
• All Hospital Acquired Pressure Ulcers are reviewed by the Tissue Viability Team.
• The use of the repose inflatable boots for continuous offloading of heels for patients with DTI's has seen a trend in the DTI reabsorbing whilst in hospital. Wards hold their own stock of repose boots. TVN team to work with ward managers to ensure they continue to maintain a stock for patients assessed as very high risk of pressure ulceration.
• Ongoing work is needed regarding pressure relieving equipment that can be used within AED. Options include inflate chair cushions and inflatable mattresses that can be used on a trolley or bed to initiate pressure relief to those patients' high risk and very risk on risk assessment.
• Pressure Ulcer Prevention (PUP) champions – lead by our wound care HCA with adhoc training for HCA's on the ward. Basics of PUP, react to red, management of moisture associated skin damage (MASD), category 1 pressure ulcers & barrier creams.
• Patient bedside seating project being undertaken with different specialities involved to identify which products would benefit a wider cohort of patients to prevent pressure damage, falls, patients with cognitive issues. Further meetings and costings due to take place in December.
• Working with the facilities matron and head of medical devices to look at what bed and mattress equipment can be available for patients with bariatric beds & chairs, pressure relieving air mattresses and hybrid mattresses.
• The Stop the Pressure event in November was a success with engagement from the medical wards at SDGH with ward boards highlighting to both staff and patients the various pressure ulcer prevention strategies available to reduce HAPU's.

• Education and training continues to be a focus with 4 members of staff spending a morning or afternoon session shadowing one of the TVN team. The TVN team have also delivered a session for the international nurse training programme. Bi-monthly PUP training has been arranged for 2023 with date available for all staff to book on through the Training and Education team. The dates have also been sent out for 2023 for link nurse training arranged every other month across both sites, with specialist sessions arranged on antimicrobial dressings, VAC therapy, PUP board game.
• The Lead TVN visited STHK TVN team to look at strategies they have implemented within their AED to prevent HAPU's.
• For 2023, there is a planned audit of the waterlow score on the acute wards to collect data on waterlow risk assessment in line with policy. This will identify gaps in knowledge and areas for further training and education needs of the trust.

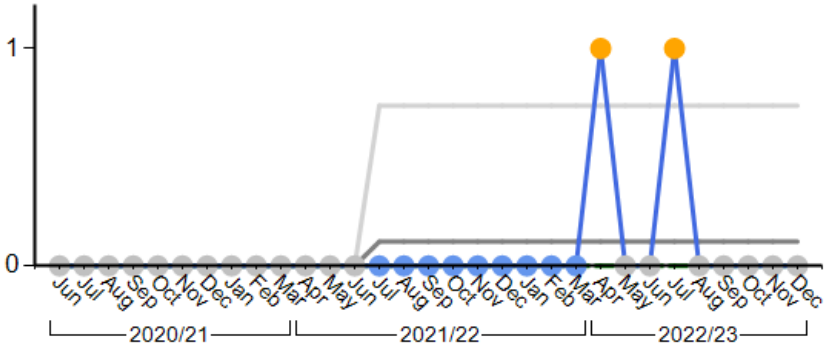
Patient Falls

Issues
• The overall number of falls reported remains statistically as expected, but there has been a marginal increase in December.
• Reporting by bed days shows an improvement, from 5.94 per 1,000 bed days in 2020/21, to 5.58 in 2021/22 and 5.3 for the current financial year, with an December figure of 6.1.
• Two falls resulting in moderate or above harm were reported in December.

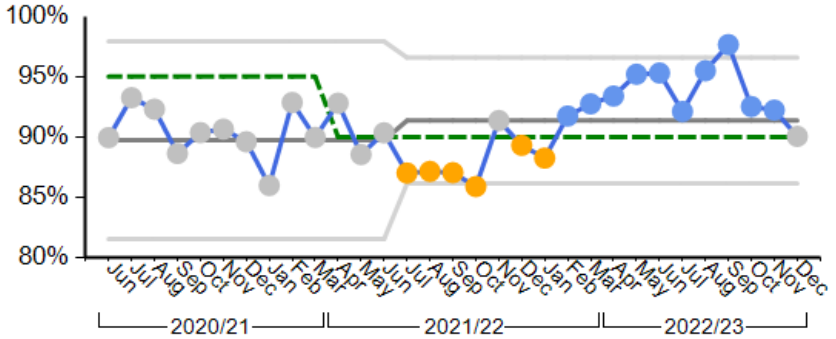
Management Action
• Deep dive completed into wards with high falls numbers and actions implemented with a resulting decrease in the number of falls on one of the targeted wards.
• Continuing work to increase knowledge and understanding of the requirements for enhanced levels of care (ELOC) being given at a ward level. Provided read and sign document for all staff to complete detailing key points and responsibilities. Information stand outside hospital restaurant held in November providing detailed information on ELOC.
• Enhanced level of care assessment being reviewed to make it more user friendly and fit for purpose.
• Application made to charitable funding for additional mobility equipment for each ward to use for assessment, e.g. red walking sticks – delivery received and sticks delivered to wards.
• Staff focus groups completed and issues raised to be fed back through falls group to add into trust wide action plan.
• Deconditioning project ongoing on 7b (pilot).
• Guidance for when and how to implement a low bed being written to support staff with the decision-making process.
• D&D team have produced a short-term sedation guideline (in draft form at present).
• Documentation (falls care plan and post falls assessment) reviewed to add additional prompts to support staff in following policy and post-fall guidance flowchart.
• Reviewing what aspects of falls prevention are considered in SOCAAS and adding to this as appropriate.
• Continuing to roll out flojac training to clinical staff as time allows.
• Process of medication falls review to be reviewed with pharmacy to ensure a robust system for falls medication reviews is in place.
• Inpatient welcome pack being produced to include general falls prevention advice.
• Staff training on falls prevention ongoing at organised education days/ward meetings/therapy inservice training sessions.
• Meeting with community falls leads to consolidate relationship between acute and community services to share learning where able.
• Met with STHK falls lead to compare and contrast services to identify areas for improvement/areas we need to align.
• Attendance at the Cheshire and Merseyside Falls Prevention Steering Group commenced
• Review completed of patients who have fallen following sedation which will support the work the D&D team are completing on their guideline.
• The Ramblegard equipment has now been serviced (completed Sept) and we are back up to original level across the trust.
• Use of regular additional streams of information through trust news (including monthly falls newsletter) and social media to inform of lessons learnt and key messages.
• A project to review the seating available to our AED and inpatients is ongoing to work towards the reduction of deconditioning (and pressure areas), including promoting the deconditioning games, and relaunch of the pyjama paralysis work and exploring the use of volunteers to encourage patients to complete a 'gentle movement' programme to reduce deconditioning.
• Ongoing review of bed rails/assessments/use of low beds and guidance to support decision making for the use of low rise beds.
• Use of Tendable to audit following falls on wards, to immediately identify areas for improvement.
• Falls Prevention resources/information – new patient information booklet to be reviewed at Falls Group and exploring the use of a patient safety video that NHSE have released incorporating falls prevention.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Never Events	0	0	0	Dec 22		0	0	Nov 22	0	2	
	Safe Staffing	90%	90.1%	N/A	Dec 22		90%	92.2%	Nov 22	90%	93.8%	
	Hospital Acquired Pressure Ulcers - Categories 3 & 4	1	1	1	Dec 22		1	2	Nov 22	12	19	
	Patient Falls - Trust	63	77	77	Dec 22		63	75	Nov 22	756	614	
	Falls - Moderate/Severe/Death	1	2	2	Dec 22		1	1	Nov 22	17	16	
	Percentage of Patient Safety Incidents - Moderate/Major/Death (related)	2.1%	0.9%	7	Dec 22		2.1%	0.4%	Nov 22	2.1%	0.7%	

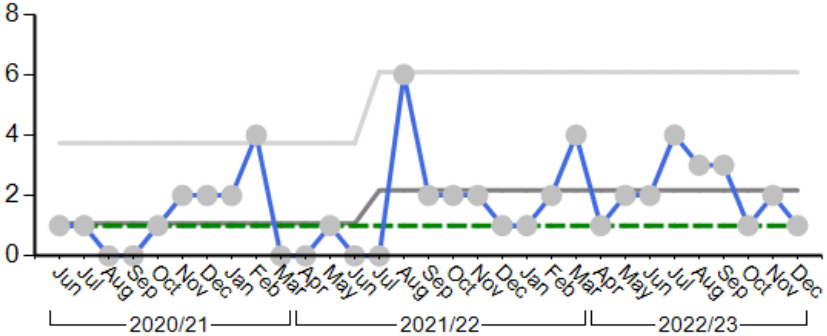
Never Events



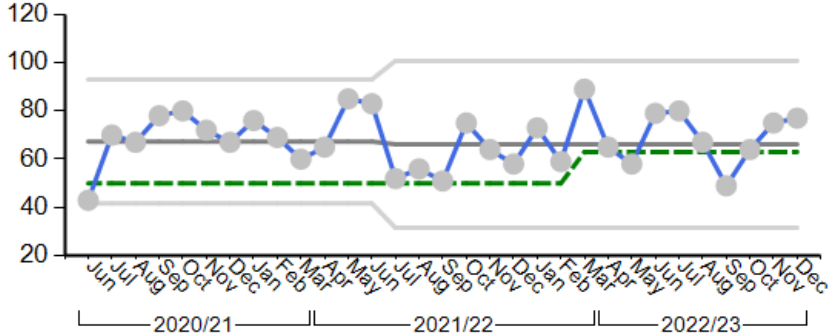
Safe Staffing



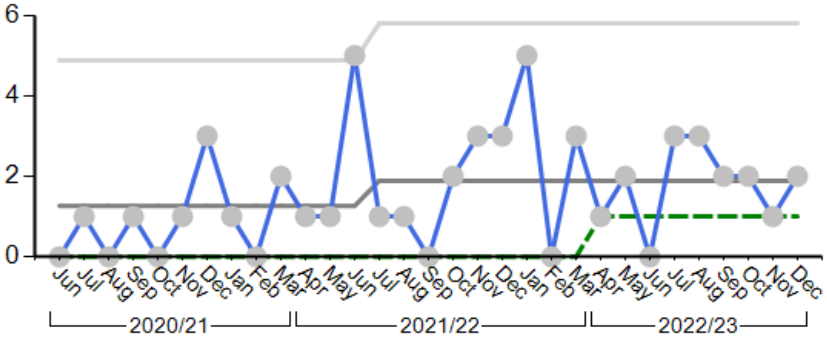
Hospital Acquired Pressure Ulcers - Categories 3 & 4



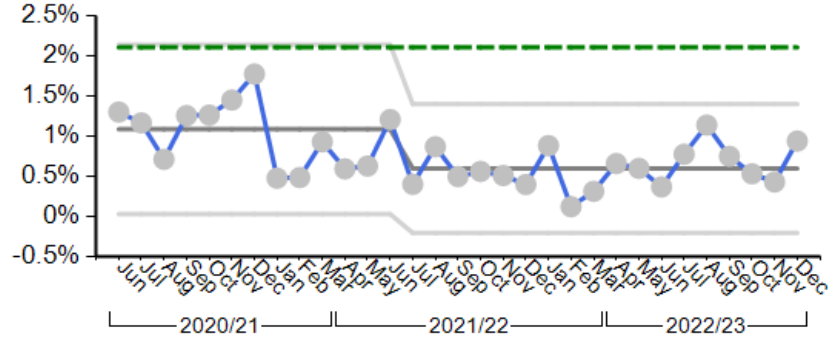
Patient Falls - Trust



Falls - Moderate/Severe/Death



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



Quality

Infection Prevention and Control

C.Diff

Issues
• The indicator is performing statistically as expected.
• 5 reported cases in December, 2 Hospital Onset Hospital Acquired (HOHA) and 3 Community Onset Hospital Acquired (COHA). This is the same as the previous month and above target.
• Themes relate to elderly patients with multiple co-morbidities including infections that required treatment with antibiotics.

Management Action
• Each of the patients have been reviewed by the Microbiologist and the clinical team, with Antimicrobial pharmacist also supporting and providing teaching to medics.
• Patients identified with C.diff are isolated and treated for C Diff infection and vacated bed spaces and equipment are cleaned with chlorine dioxide infection.

E-Coli/Klebsiella/MSSA

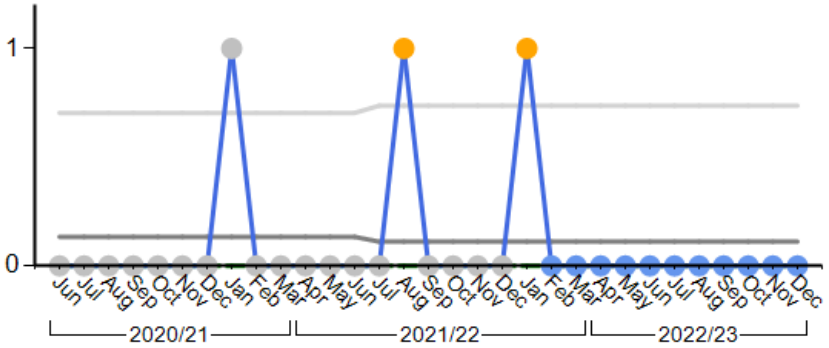
Issues
• Five E-Coli infections were reported in December, which is statistically as expected. All cases were Hospital Onset Hospital Acquired cases.
• One klebsiella case was reported in December, this is statistically as expected.
• One MSSA case was reported in December, this is statistically as expected.

Management Action
• Each of the cases were reviewed by the Microbiologist and the patients doctor, and treatment was prescribed based on microbiological and diagnostic evidence.

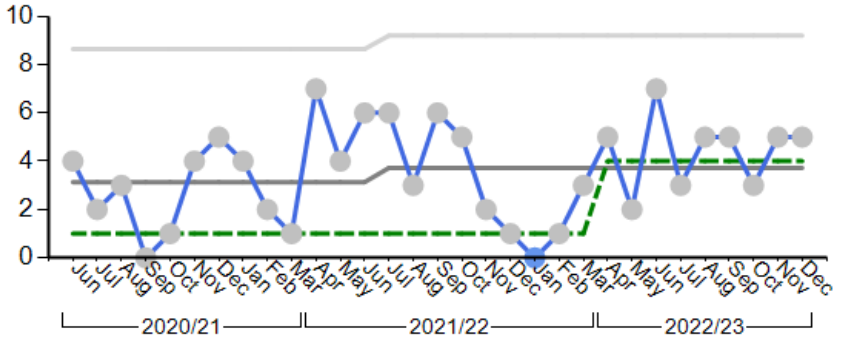
No MRSA or pseudomonas cases were reported in December.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	MRSA	0	0	0	Dec 22		0	0	Nov 22	0	0	
	C-Diff	4	5	5	Dec 22		4	5	Nov 22	49	40	
	E. Coli	4	5	5	Dec 22		4	0	Nov 22	51	35	

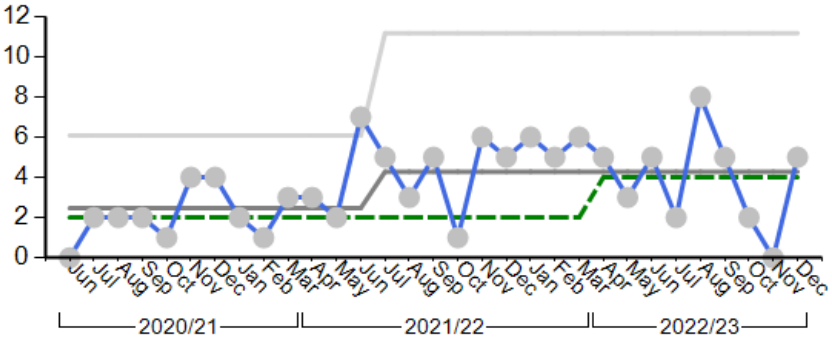
MRSA



C-Diff



E. Coli



Quality

Patient Experience

Complaints - % closed within 40 working days

• See accompanying action plan.

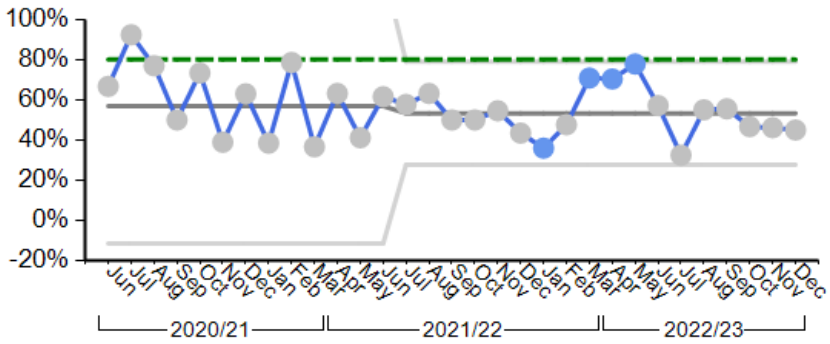
Friends and Family Test

Issues
• The Trust overall indicator continues to fail the assurance measure and shows special cause concern and has decreased to 87.3% in December.
• There have been marginal declines in scores for all areas, except for A&E which has improved by 0.1%.
• The score for Acute Inpatients has decreased slightly to 93.1% from 93.8%. This remains below the internal indicator of 94% and November NHSE average of 94%. Themes alongside negative ratings are environment, staff attitude and clinical treatment.
• An increased score from 81.7% to 81.8% in A+E overall. This relates to 79.17% from Adults A&E and 85.62% from Children's. The overall percentage remains above the Trust indicator of 77.8% and above November NHSE average of 75%.
• The experience of long waiting times in the adult A&E department continues to cause a higher number of negative responses and comments.
• Outpatients - A slight decrease in score from 94.6% to 94.4% when compared to previous month. This is above the November NHSE average of 93% and internal target of 92.8%.
• Labour Ward - Decrease in overall score from 100% to 98.1%, this is above the November NHSE average of 93% and internal indicator of 94%.
• Postnatal Ward - A decrease in performance from 94.7% to 90.9%, this is below the November NHSE average of 93% and internal indicator of 92%. Themes alongside negative ratings are communication, environment and implementation of care

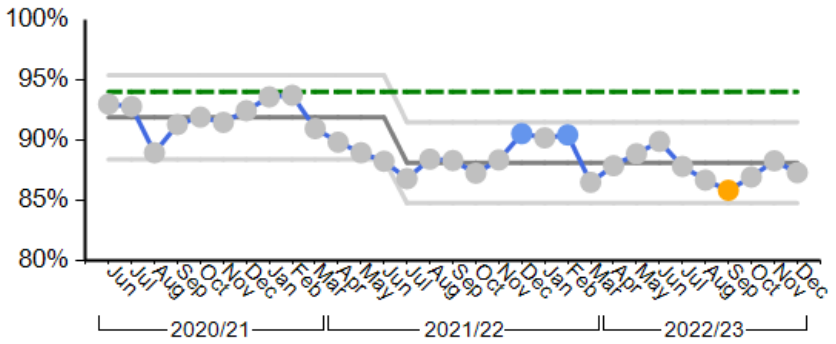
Management Action
• Monthly FFT summaries are shared with CBU's and are monitored through the Patient Experience and Community Engagement group where CBU updates and actions to improve FFT are provided.
• Inpatient areas continue to review comments to identify any emerging themes or trends to inform a 'You said, we did' approach to improvement. FFT results are reviewed at ward/department level through a performance review process.
• Progress on the 2021 National Inpatient Survey action plan continues to be monitored via the Trust Patient Experience and Community Engagement group.
• The local Maternity Voices Partnership meeting is now reinstated and will provide opportunities to work collaboratively and gather further feedback from this patient group.
• The 2022 National Maternity Survey results have been received, action plan to be developed and presented to PECE for approval.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
!	Complaints - % closed within 40 working days	80%	45%	N/A	Dec 22		80%	46.2%	Nov 22	80%	51.1%	F
	Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall	94%	87.3%	N/A	Dec 22		94%	88.3%	Nov 22	94%	87.8%	F

Complaints - % closed within 40 working days



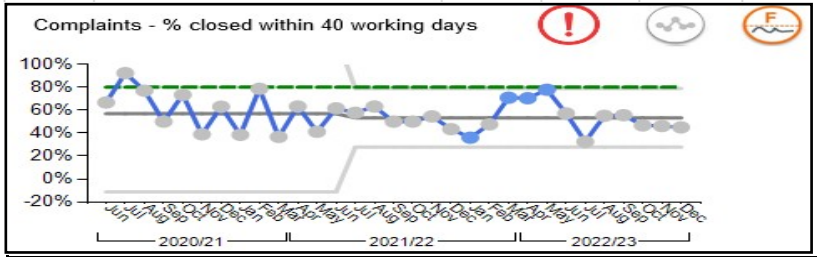
Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall



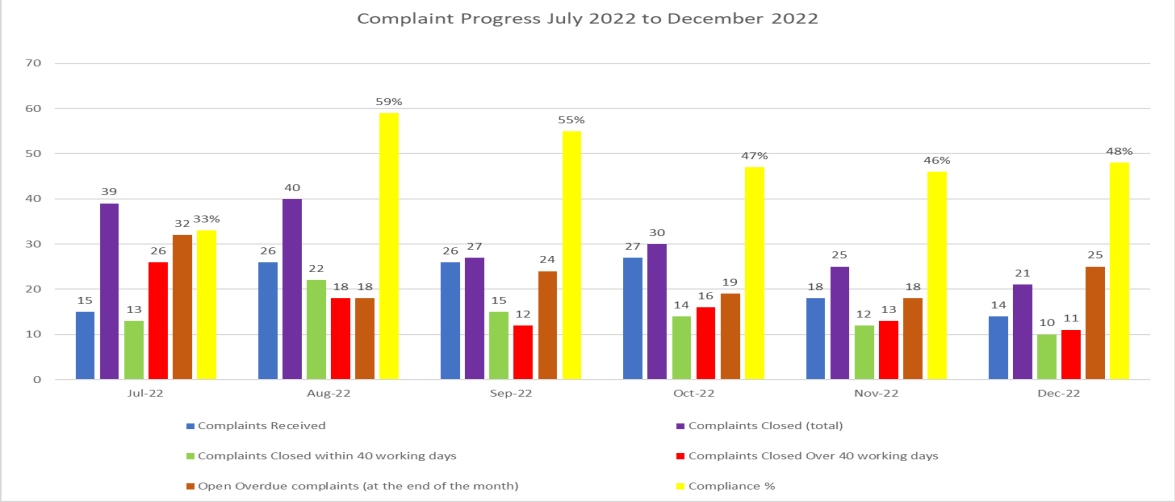
Complaints—% closed within 40 working days

Southport and Ormskirk Hospital NHS Trust

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
!	Complaints - % closed within 40 working days	80%	45%	N/A	Dec 22		80%	46.2%	Nov 22	80%	51.1%	F



Situation: This indicator has historically struggled to achieve the 80% target. Performance in December continues to be challenged.



	July 2022	Dec 2022
Overdue Complaints	32	25
Total Number of complaints closed	39	21
Overdue Complaints closed	26	11
Complaints closed within 40 working days	13	10
Average number of days to close	62 days	52 days
Compliance Percentage	33%	48%

Issues:

Backlog of overdue complaints.

Resource in CBU Governance Teams.

Delays with Quality Assurance processes.

Competing priorities of Clinicians to complete statements and responses.

Actions:

There has been one vacant post within Urgent Care for a patient safety manager for part of December and January however this post has now been filled and the business unit are hoping to welcome their new team member at the end of January beginning February subject to clearance. In the interim Urgent Care have a member of NHS P to support the division with their open/overdue complaints.

Planned care have also been in a similar position with a vacant patient safety manager post since November and vacant governance officer post since September. However, both posts have now been filled with the replacement safety manager(s) and governance officer are now in post.

Women & Children's complaint responses, have been impacted by Long term Consultant sickness, high levels of short term sickness and the unprecedented activity and acuity across Paediatrics. The plan is to continue to escalate and follow up weekly to ensure , the responses are collated within the timeframes going forward , with the support from the Governance team.

A Datix incident is reported for all complaints that breach the 40 working day timeframe so that an investigation can be carried out to identify any lessons learnt within the complaint investigation process. Lessons are identified by the completion and review of a chronology.

Mitigations: Although the trust is not reaching the 80% compliance target. Positive progress is still being made to reduce the number of overdue complaints and maintain timely responses for all new complaints. With the filled vacancies above it is anticipated that the trust will become compliant by March 2023.

The number of complaints being re-opened is showing an improving trend. In Jan—Mar 2022, an average of 3.7 complaints re—opened every month, in comparison, no complaints have been re-opened between Oct-Dec 2022.

Operations

Access

A&E

Issues
• All metrics relating to A&E performance are failing their assurance measures and showing special cause concern.
• The Trust remains challenged against the 4hour standard and performance in December has declined by 3.3% on the previous month. This is against attendances comparable to the previous month.
• The Trust remains in the top quartile nationally for ED performance, achieving 70.7% in December for the 4-hour standard. Significant pressures in relation to staff sickness, skill mix, patient acuity and limited discharges continues to affect performance in December 22
• The Trust performed ahead of the National average (62.95%), Northwest (62.2%) and Cheshire & Mersey (64.8%) (NHS Trusts only) and the was the second highest performer in Cheshire & Mersey behind Liverpool Women's Hospital.
• 13.1% of patients spent longer than 12 hours in the department (1130 patients), this is the highest number so far this year.
• Paediatric A&E saw a surge in attendances in December, with attendances 27% higher than the previous month and 83% higher than December 2019.
• A&E performance impacted by high bed occupancy levels, contributed to by IPC measures, surges in attendances and a requirement for all specialty reviews to be undertaken in A&E.
• Bed pressures lead to an increased LOS in ED with increased treatments and reviews undertaken in the department for patients who would previously have been admitted.

Management Action
• Full capacity trust meetings chaired by COO and relevant actions undertaken within Trust and system in line with escalation plan.
• Continuation of RATS (Rapid Assessment and Treatment model) to improve triage times and time to treatment, stability in clinical model from January due to change of shift patterns.
• 3 times daily huddles with flow and ED teams to maximise communication.
• Use of discharge lounge to expedite discharges.
• Development of clear clinical pathways for SDEC and CDU to maximise patient experience and avoid admission as clinical appropriate.
• Ensure patients are safe and receive quality of care in appropriate area.

Ambulance Turnaround Times

Issues
• All metrics failing their assurance measure and have deteriorated in December.
• The Ambulance Handovers - % within 15 Mins and % within 30 Mins are showing special cause concern with the lowest reported for more than two years. This is against arrivals comparable to the previous month.
• 33.5% decrease in ambulance arrivals against same month 2019/20.
• Challenges continue with timely release of cubicles to enable crews to handover promptly, high numbers of patients awaiting admission who remain in ED until an inpatient bed becomes available, CDU continues to be used as an escalation area which reduces capacity and the impact of IPC cleaning requirements also remains.

Management Action
• Use of NWAS checklist to assist with timely handover of patients from crews to the department where clinically appropriate.
• Standardised NWAS clinical criteria for SDEC Medical used by crews across LUFT, STHK and S&O to enable clinical consistency in patients appropriate for direct streaming.
• ALO support to nursing staff to mitigate clinical risk.
• Use of additional ED Clinical Co-ordinator to ensure handover times adhered to by monitoring incoming ambulances, liaising with bed manager and undertaking early transfers from ED to wards.
• Senior clinician based in triage during periods of surge.
• Ensure appropriate patients are fit to sit to release cubicles and trolleys for those who clinically require them.
• Commencement of Rapid Access Treatment pathways to release capacity from department.

Referral to Treatment

Issues
• The Referral to treatment: on-going indicator continues to fail assurance and shows special cause concern with a 4.9% deterioration in December.
• The number of 52-week waits is above the trajectory and has deteriorated in December.
• The Trust continues to perform well in comparison to peers, for example the average for NHS Trusts in England was 59.6%, Northwest 56.4% and Cheshire & Mersey 56.5%.
• There were 9 78-week waits at the end of December.
• There were 0 104 week waiters at the end of December.
• SOHT continues to be top performing acute trust across C&M for both 52 week and 78 week waits.
• Overall elective admitted activity achieved 81% of plan in December.
• Significant impact to delivery of admitted activity in December 22 due to increased covid and flu patients utilising bed base (approx. 20% of bed base).
• Oral – reduction in activity due to conversion of minor oral surgery to Outpatient.
• Gynaecology - all elective activity in theatres cancelled during festive period to ensure adequate cover for c-section lists.
• Pain – continued impact of supporting anaesthetic cover for cancer/urgent theatre sessions resulting in cancellation of routine pain lists to support. Only 1 consultant to cover pain service.

Management Action
• Continued risk stratification of the waiting list.
• Trust is part of the Cheshire & Mersey wider elective restoration group.
• Oral – Capacity converted to OP to support throughput in numbers and therefore conversion rate to WL in the future.
• Gynaecology – Interviews to be held on 12th January 2023 for consultant obstetrician. This position will provide cover for more c-section lists ensuring that elective activity is protected.
• Pain – consultant post recently advertised but no applicants. Linking with STHK to see if any opportunity to offer support through the partnership.

Diagnostics

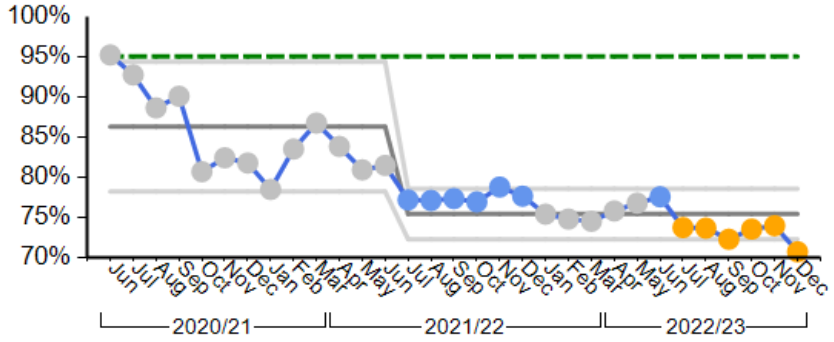
Issues
• The Diagnostic Waits indicator is failing assurance but is showing special cause improvement for the last 3 months.
• Performance against the 1% target has reduced by 1.8% in December to 25.5%.
• Trust performance is better than the average for NHS Trusts in England (27.5%) but slightly worse than the North-West 22.7% and Cheshire & Mersey 20% (November data).
• Total diagnostics activity is 75.7% of plan for December and 106.7% of 19/20 activity.
• Diagnostic scopes over-performed in December, delivering 120.2% against the plan.
• Scans underperformed in December, delivering 72.1% of the plan.
• Endoscopy - Total of 4 patients waiting longer than 13 weeks for procedure. This is an improvement of 15 patients compared to November 2022.
• Endoscopy - Building work for TIF to commence January 2023 with potential to impact on activity.
• Radiology – CT scanner out of service for 3 days in December impacting activity.
• Radiology – MRI scanner upgrade resulted in loss of activity in December.
• Radiology – Private provider reduced NOUS capacity in December.

Management Action

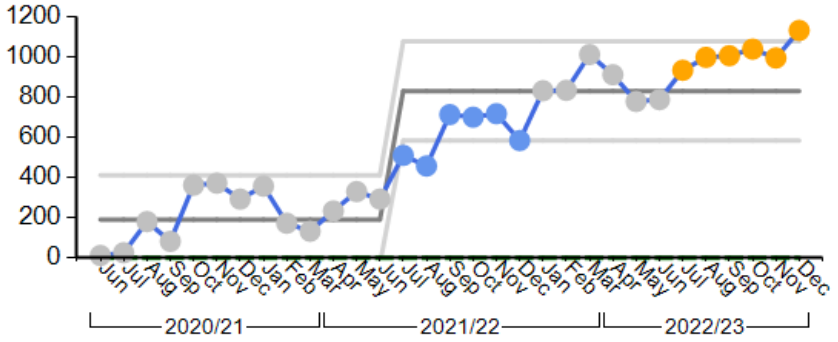
• Endoscopy – On track to deliver plan of 0% for DM01 across Flexi-Sigmoidoscopy and Gastroscopy.
• Endoscopy – Awaiting approval for request for 4 additional weeks insourcing to support loss of activity.
• Radiology – mobile CT scanner being delivered in January.
• Radiology – MRI upgrade now complete. Procurement of mobile MRI scanner has commenced to negate against future issues.
• Radiology – Consultants providing additional capacity for NOUS in January.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
!	Accident & Emergency - 4 Hour compliance	95%	70.7%	3408	Dec 22	L	95%	74%	Nov 22	95%	74.2%	F
	Number of Patients spending 12+ Hours in ED - Trust	0	1130	N/A	Dec 22	H	0	993	Nov 22	0	8565	F
	% of Patients spending 12+ Hours in ED - Trust	2%	13.1%	N/A	Dec 22	H	2%	12.7%	Nov 22	2%	12.4%	F
	Ambulance Handovers - % within 15 Mins	65%	28.6%	727	Dec 22	L	65%	37.2%	Nov 22	65%	39%	F
	Ambulance Handovers - % within 30 Mins	95%	56.9%	439	Dec 22	L	95%	65.2%	Nov 22		67%	F
	Ambulance Handover Over 60 Mins	0	140	140	Dec 22		0	57	Nov 22	0	725	F
	Diagnostic waits	1%	25.5%	1135	Dec 22	L	1%	23.7%	Nov 22	1%	38.1%	F
	Referral to treatment: on-going	92%	61%	6249	Dec 22	L	92%	65.9%	Nov 22	92%	70.1%	F
	52 Week Waits	20	176	176	Dec 22	H	32	172	Nov 22	0	242	F
	Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month	1%	1.2%	25	Dec 22		1%	1.5%	Nov 22	1%	1%	?
	Stroke - 90% Stay on Stroke Ward	80%	63.2%	7	Oct 22		80%	57.1%	Sep 22	80%	51.7%	F
	TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	60%	62.5%	6	Nov 22	H	60%	66.7%	Oct 22	60%	76.6%	?
	Outpatient Letters to GP's within 7 Days	85%	67.3%	3913	Nov 22		85%	74.1%	Oct 22	85%	70.9%	F
	E-Discharges within 24hrs	85%	82.7%	248	Dec 22	H	85%	81%	Nov 22		78.6%	F

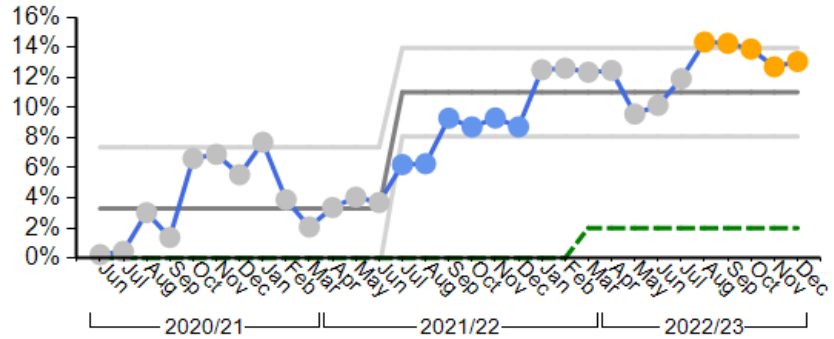
Accident & Emergency - 4 Hour compliance



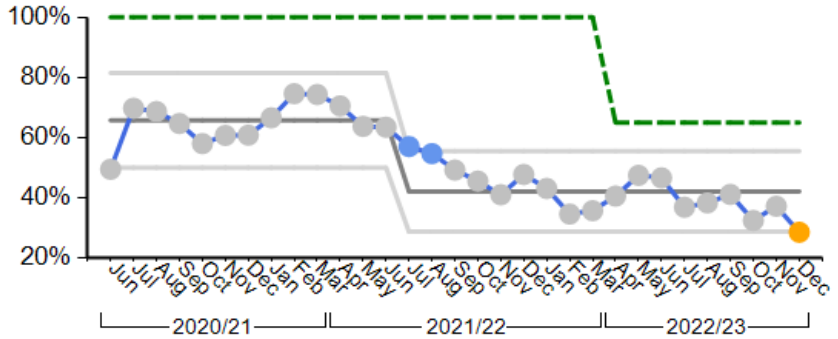
Number of Patients spending 12+ Hours in ED - Trust



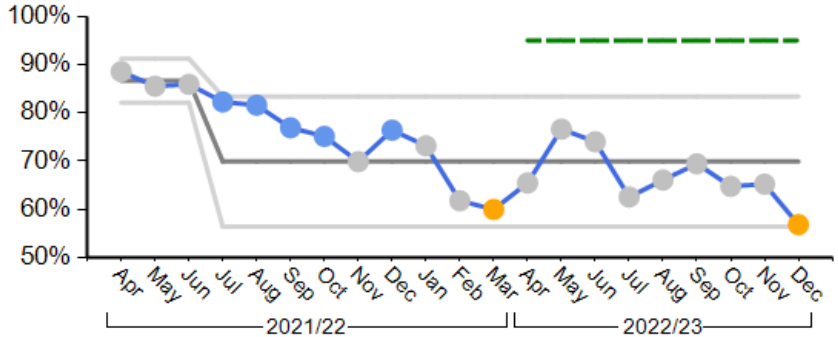
% of Patients spending 12+ Hours in ED - Trust



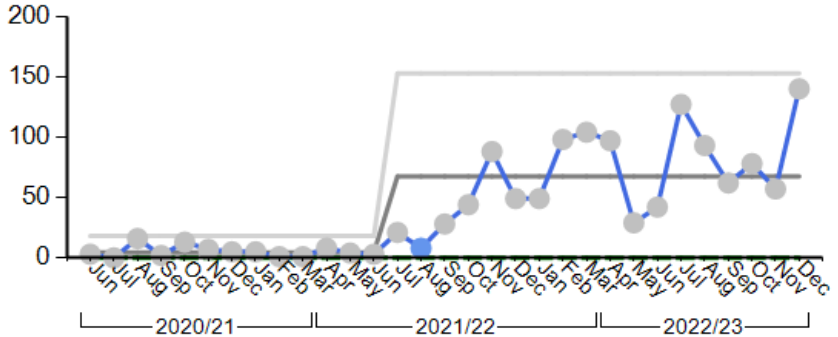
Ambulance Handovers - % within 15 Mins



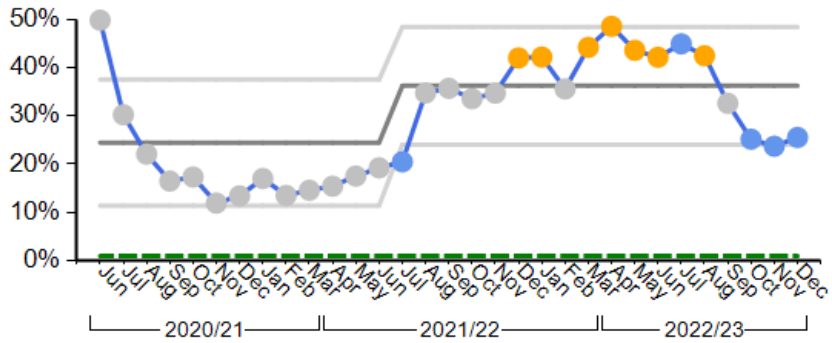
Ambulance Handovers - % within 30 Mins



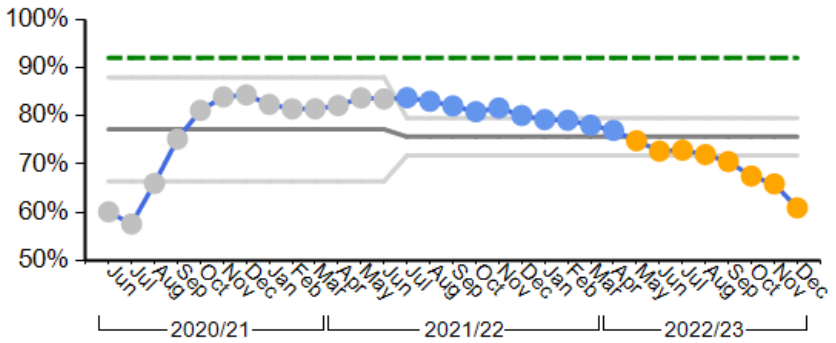
Ambulance Handover Over 60 Mins



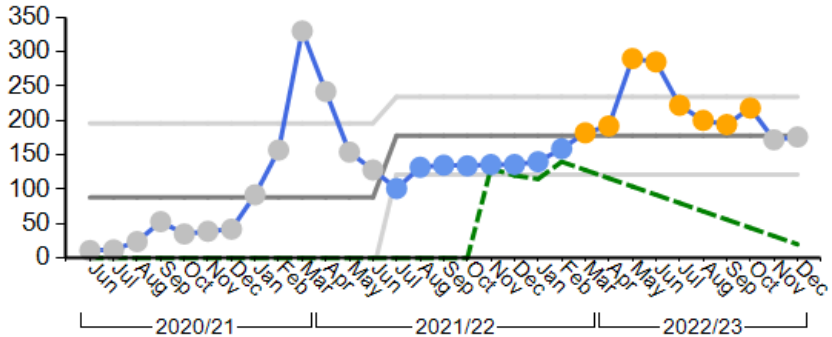
Diagnostic waits



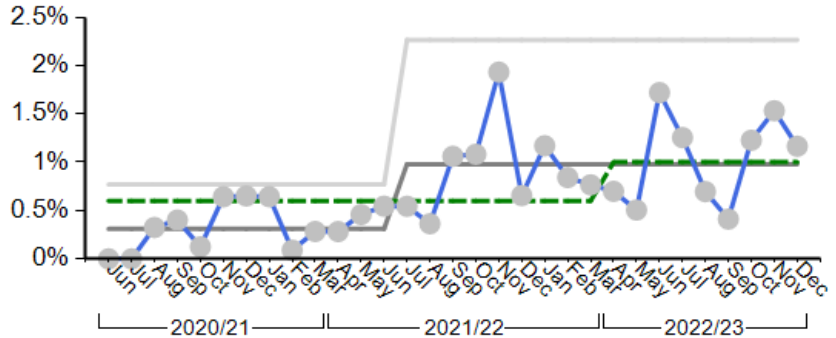
Referral to treatment: on-going



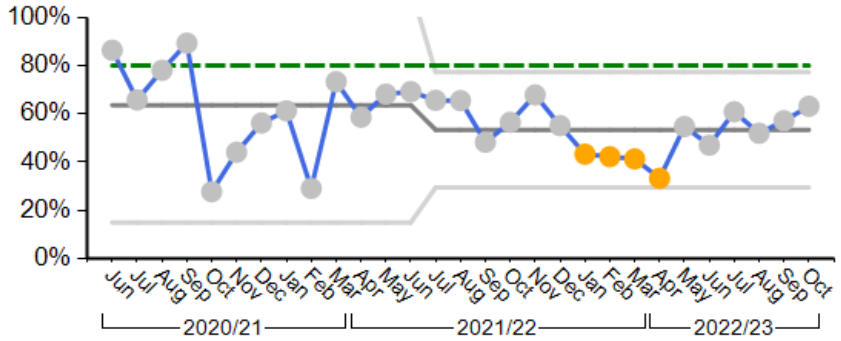
52 Week Waits



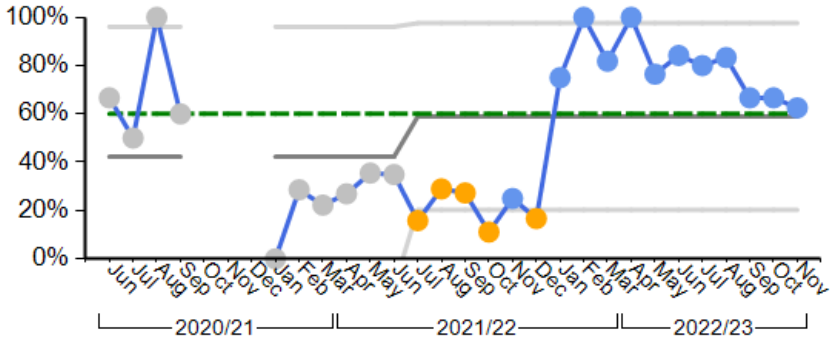
Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month



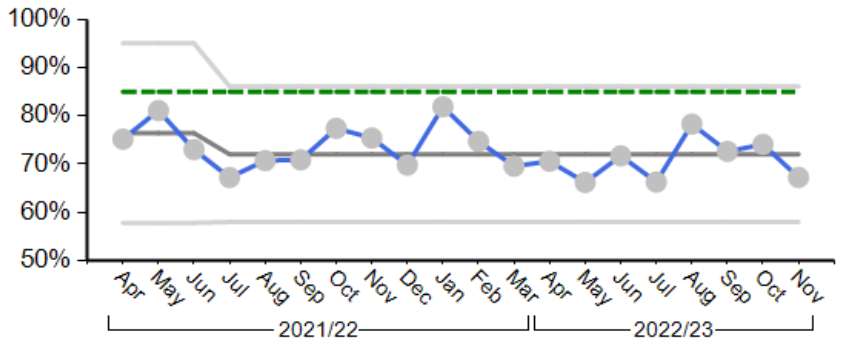
Stroke - 90% Stay on Stroke Ward



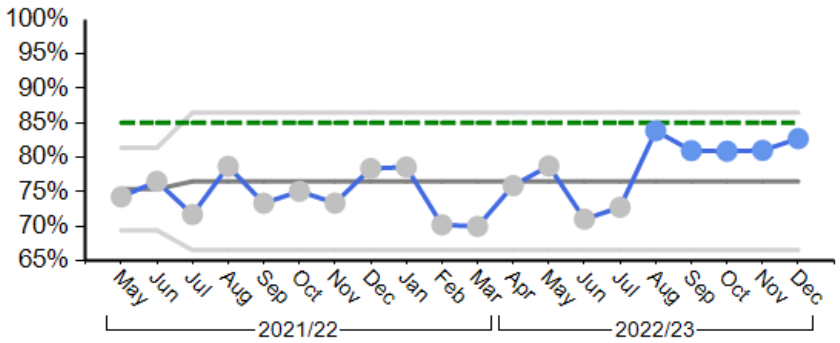
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care



Outpatient Letters to GP's within 7 Days



E-Discharges within 24hrs



Operations

Cancer

Issues

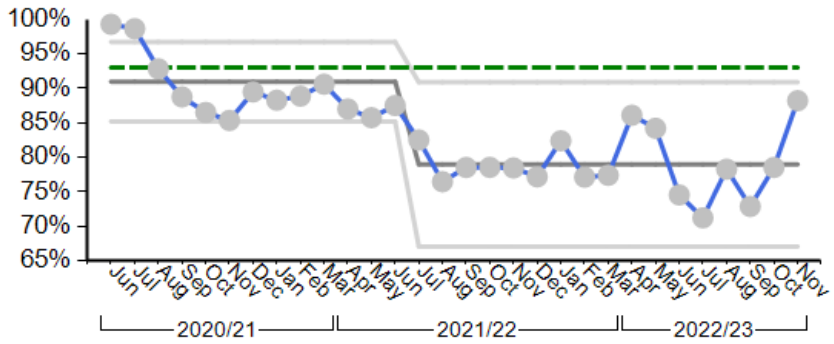
• The 14 Day GP referral to Outpatients is failing the assurance measure but there has been a 9.7% increase in November, to 88.2% against the 93% target. The Trust is performing well in comparison to 78.7% for England, 74.9% North West and 77.5% for Cheshire & Mersey (NHS Trusts only). This is also against the third highest patient numbers seen with referrals for April – November 2022 already 53.8% higher than the same period 2019.
• The 31-day target is showing special cause concern, and has deteriorated in November, reporting the second lowest level for more than 2 years, at 82.4% against the 96% target. The Trust is an outlier, with an England average of 91.5%, Northwest 92.9% and Cheshire & Mersey 94%. Activity levels are high, the number of patients reported this month is the fourth highest this financial year and at 74 patients is well above average activity levels seen in 2019/20 (58.7 patients per month).
• The 62-day GP referral to treatment continues to fail the assurance measure although has been on an improving trajectory for the last 3 months, achieving 72.2%% against the 85% target in November. This is above the NHS Trust average for Cheshire & Mersey (68.8%), England (60.9%) and Northwest (63.1%). This is against the highest number of patients ever seen.
• There are currently 8 104+ day breaches, this is a decrease of 0.5 patient compared to the previous month.
• RCA process needs reinforcing and completed weekly rather than month end.
• Management of back log for all tumour groups, impact of longest waiting patients over 104 days.
• Issues with the High Risk FIT programme that went live in April, relating to delays in endoscopy, capacity of CNS team for triage and delays to 1st appointments.
• Histology challenges impacting on 7-day turnaround time. Vacancies in the lab and national shortages of pathologists has impacted turnaround times of reports.
• Diagnostic capacity, particularly in MRI due to increase in inpatient requests and an increase in the urgency of requests for cancer and urgent.

Management Action

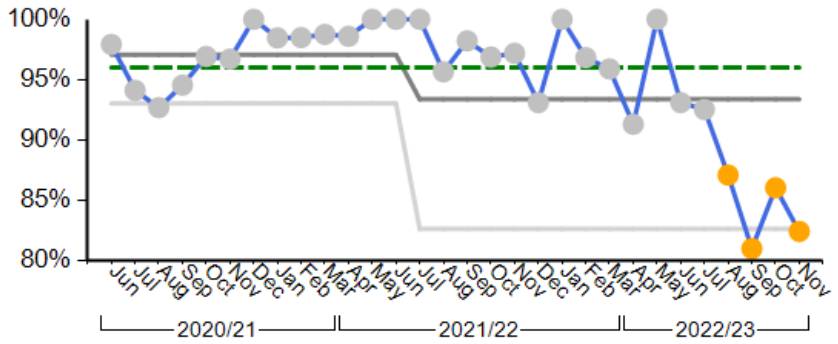
• New streamlined RCA process being rolled out across the Cancer Services Team. RCA backlog to be cleared by end of January 2023.
• Weekly PTL reporting with COO oversight. The backlog continues to decrease below the planned trajectory.
• Fortnightly steering group to escalate High Risk FIT issues and update on wait times.
• Cellular Pathology Manager attends the cancer performance meeting on a weekly basis to provide latest turnaround times, currently 14 days for escalation. STHK have doubled the number of trainees and are currently recruiting those who are due to qualify early 2023.
• Improvement plan submitted for Radiology. Significant improvements have been made with CT. Mobile scanner due onsite 17.01.23 should help with flexibility in capacity of CT's.
• Processes to be implemented in Radiology to support BPTP.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	14 day GP referral to Outpatients	93%	88.2%	159	Nov 22		93%	78.5%	Oct 22	93%	79.2%	F
!	31 day treatment	96%	82.4%	13	Nov 22	L	96%	86%	Oct 22	96%	89%	?
	62 day GP referral to treatment	85%	72.2%	26	Nov 22		85%	65.2%	Oct 22	85%	63%	F
	28 Day Faster Diagnosis Standard	75%	69%	410	Nov 22		75%	62.6%	Oct 22		65%	F

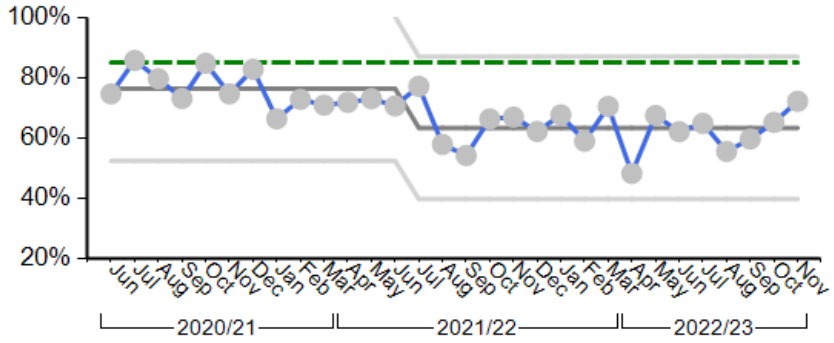
14 day GP referral to Outpatients



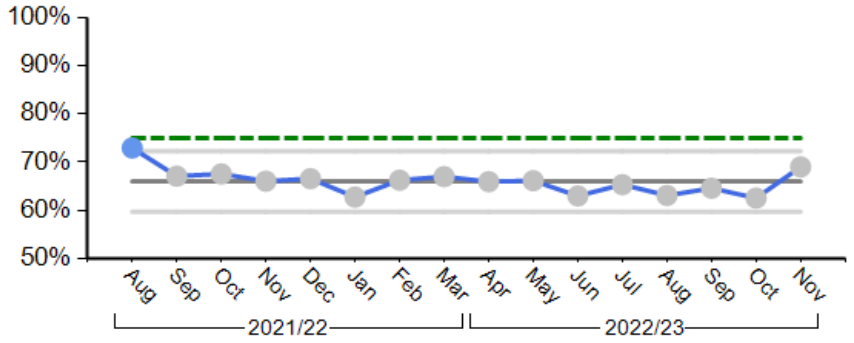
31 day treatment



62 day GP referral to treatment



28 Day Faster Diagnosis Standard



Operations

Productivity

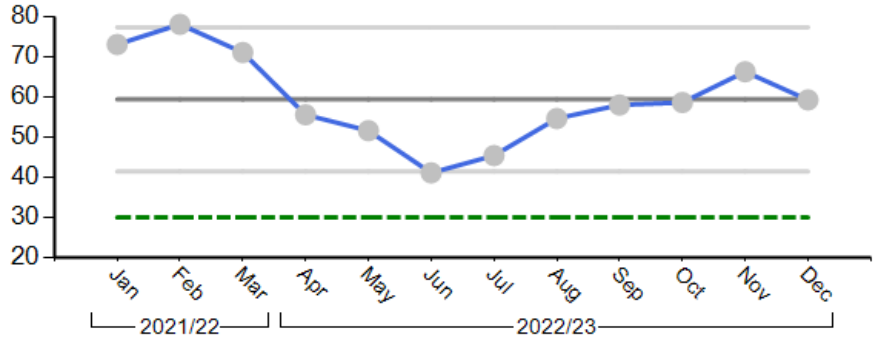
Stranded/Super Stranded Patients/Criteria to Reside

Issues
• Both indicators are failing their assurance measures and showing special cause concern.
• The number of Stranded patients is the highest since this indicator has been recorded.
• The number of Super-Stranded patients indicators has remains consistent with the previous month at the highest levels recorded.
• The number of 'No Criteria to Reside' patients has reduced to 59 but remains well above the target of 30.
• The increased number of stranded and super-stranded patients attributable to patients requiring to remain in hospital following covid, availability of packages of care, care homes accepting new patients and patients who are recovering from covid.
• Bed occupancy remained high throughout December.
• Increase in acuity of patients.
• RFD numbers continue to increase at around 60 per day which is the equivalate to two wards, which can be attributed to acutely unwell patients; with significant delays in for care packages; community teams report high acuity and pressure to support the numbers of fast track patients at home; community beds exceeding 100% bed occupancy.

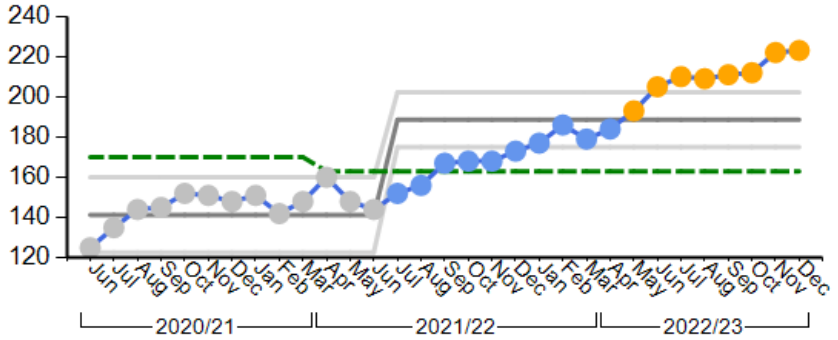
Management Action
• There is focus on improvement of patients discharged at 5pm to ensure meet trajectory. There was significant improvement of 6.7% compared to previous month and 4.7% variance to plan following a successful home for Christmas campaign. The ethos and principle for the campaign will continue to meet target.
• A new model of rehabilitation and nursing care was partially commenced to move medically optimised patients who are ready for discharge to avoid de-conditioning to an acute ward from December, to improve patient outcomes and reduce level of ongoing support when leaving hospital.

Alert	Indicator	Latest Plan	Latest Actual	Latest Patients	Latest Period	Latest Variation	Previous Plan	Previous Actual	Previous Period	Year to Date Plan	Year to Date Actual	Assurance
	No Criteria to Reside - Avg No of Patients	30	59	59.22	Dec 22		30	66	Nov 22			
!	Stranded Patients (>6 Days LOS)	163	223	223	Dec 22	H	163	222	Nov 22	163	1869	F
!	Super Stranded Patients (>20 Days LOS)	53	92	92	Dec 22	H	53	93	Nov 22	53	724	F

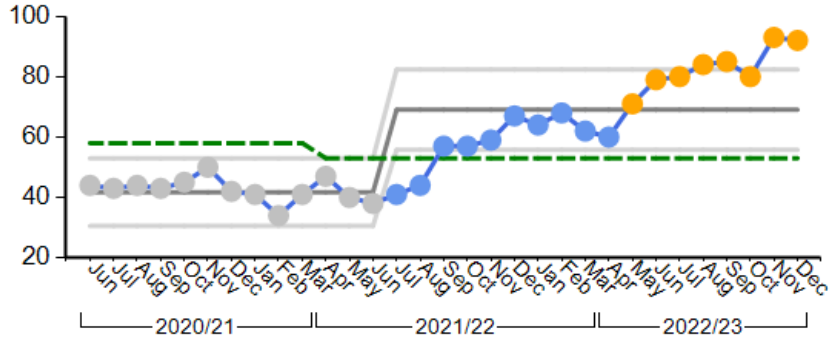
No Criteria to Reside - Avg No of Patients



Stranded Patients (>6 Days LOS)



Super Stranded Patients (>20 Days LOS)



Workforce

Organisational Development

Personal Development Reviews

• See accompanying action plan.

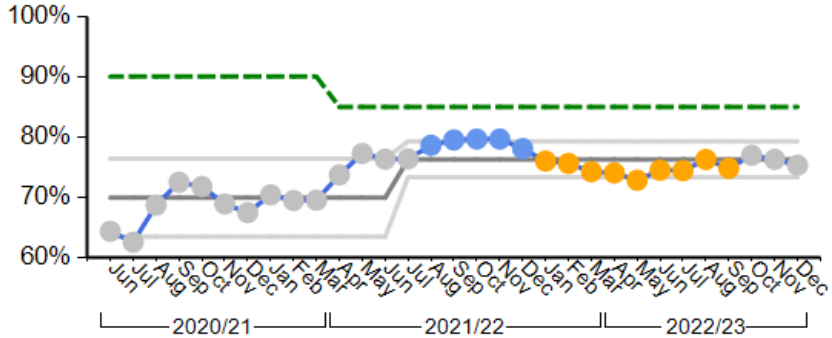
Mandatory/Essential Skills Training

Issues
• The mandatory training indicator is failing its assurance measure since the stretch target of 90% was implemented.
• Core mandatory training compliance has seen a decline in recent months, but has increased marginally in December to 87.8%, remaining 2.2% under the 90% target implemented in June 2022.
• Essential Skills training is failing the assurance measure and has decreased slightly in December to 79.8% against the 85% target.

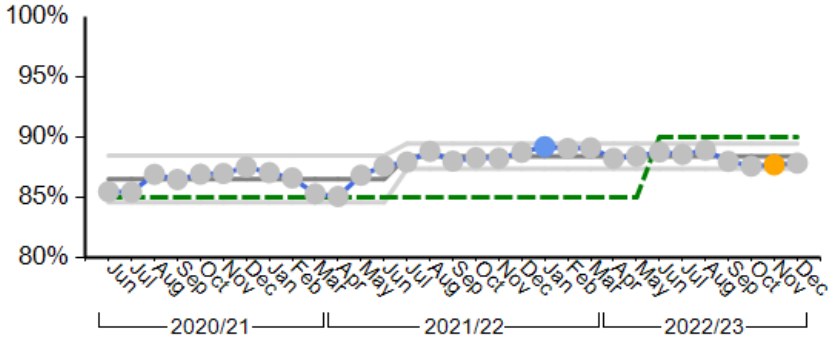
Management Action
• Access to all online training is readily available via ESR and face to face training programmes are in place to support staff to achieve compliance.
• It is positive to note that all resuscitation training competencies have seen improvement over the last 12 months with only minor fluctuations in month, ensuring our patients always have trained staff on duty.
• The Trust continues to compete with the overall escalation state and increased patient demands with a focus on safe staffing levels and patient safety over the completion of some essential training elements.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
!	Personal Development Review	85%	75.3%	N/A	Dec 22		85%	76.3%	Nov 22	85%	75.1%	F
	Mandatory Training	90%	87.8%	N/A	Dec 22	L	90%	87.7%	Nov 22	90%	88.2%	F

Personal Development Review



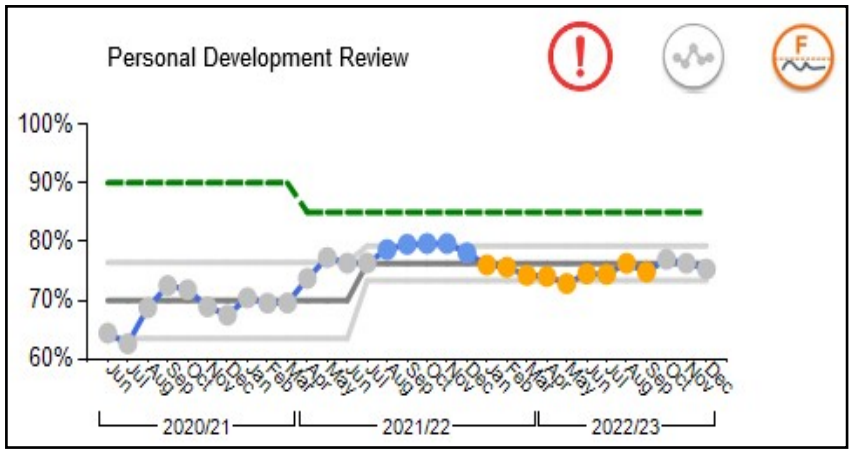
Mandatory Training



Non Medical Appraisal/Personal Development Reviews

Southport and Ormskirk Hospital NHS Trust

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
!	Personal Development Review	85%	75.3%	N/A	Dec 22		85%	76.3%	Nov 22	85%	75.1%	F



Background: The annual appraisal/PDR is an AfC requirement for all non medical staff at the Trust and from April 2021 will be linked to pay progression. The Trust has an 85% compliance target and they form part of the Trust's performance framework and are monitored at PIDA. Appraisals are an indicator of overall staff engagement and form a crucial activity in the management of human resources.

Situation: PDR compliance down by 1.00% overall with only Corporate and Capital and Estates seeing an increase in month, but all areas in the Trust are below target. The biggest drop in compliance sat in Medicine and Emergency Care for the second consecutive month with a reduction of 2.93% during December. Medicine and Emergency care have dropped by over 5.00% in the last two months. However, of greatest concern are Corporate Teams overall who have a compliance totalling only 55.76% - a substantial level of 29.24 off target.

Issues: Poor definition of the purpose of appraisals at the Trust

Poor management appraisal skills

Poor documentation and process

Lack of consistent recording impacting on the quality of data

Actions:

Whilst targeted intervention has taken place for those staff with no PDR in last three years, we have seen a repeat of drop off in compliance for Corporate teams. A focus by the HRD last year saw an immediate increase in compliance but this has not been sustained into 2022 from 2021. All Corporate managers will be advised separately of their compliance rates with an expectation by the end of February 2023 that these levels will increase to at least 85% in each team.

PDR compliance raised at CBU monthly SLTs, Governance and budget meetings

How to guides have been provided to managers in respect of recording of completed activity

Escalation to SOLT has brought about no discernible sustained improvements

Trust will be working with STHK for an electronic version of PDRs once the Trust completes the TUPE transfer processes

Mitigations:

A further reduction in compliance in December of 1.00% which is disappointing after a reduction last month too. Hospitals have remained extremely busy in December, being indirectly affected by staff industrial action in neighbouring Trusts and NWAS. Sickness levels rose by 1.00% overall compared to November which put further strain on manager time to complete even those which would have fallen out of compliance in month.

Managers have reported the inability to further increase compliance rates due to the lack of staff to safely staff the wards and other clinical areas, the absence rate within the Trust due to burn out following the regular covid rises in this time and the lack of time as they, themselves, find themselves having to work in the safer staffing numbers so that patient care has not been affected.

Workforce

Sickness, Vacancy and Turnover

Sickness

Issues

• The in-month sickness rate has increased by 0.9% in December, although remains statistically as expected.
• Whilst there have been increases in sickness absence due to Covid, the increase in sickness rates in December is predominantly attributable to non-Covid sickness, which is showing special cause concern having reached the highest level since this measure was reported.
• Daily numbers of absence are rising from November through December with an average of 235 non covid absences daily (up by 26 per day on average from 209) compared with covid average of 32 (also up from November which was 25 on average). Covid absences on average account of in the region of 11.32% of all absences daily which is a reduction of 0.68% from November.
• The rolling 12 month sickness rate continues to fail the assurance measure but remains static at 7.1%.
• Registered Nurse sickness rates are failing their assurance measure and have increased to 9.4% in December.
• Unregistered Nurse sickness is failing the assurance measure but following three consecutive months on an increasing trend, have decreased by 0.4% in December to 9.6%.
• Medical Staff sickness continues to be assured although has increased to 4.1% in December.
• Seasonal infectious diseases make up the majority of the increase with coughs / cold / flu, covid and gastrointestinal absences being very prevalent amongst many staff groups.

Management Action

• Focus by operational managers and HR remains on closing long term absence as well as repeated short-term absence in teams.

Vacancies

Issues

• The Trust overall vacancy rate continues to fail its assurance measure and has increased in December to 10% against the 7.4% target.
• Medical vacancies continue to show special cause improvement, and have continued the downward trend in December, with a rate of 4.2% against the 5.8% target.
• Nursing vacancy rates continue to show special cause improvement but have increased in December to 10% against the 9% target.
• The main area of concern within Nursing is the HCA vacancy rate.
• AHP/Therapy vacancy rates, while failing assurance, have exceeded the target and are showing special cause improvement with a further 0.3% reduction in December. This is the lowest level reported.

Management Action

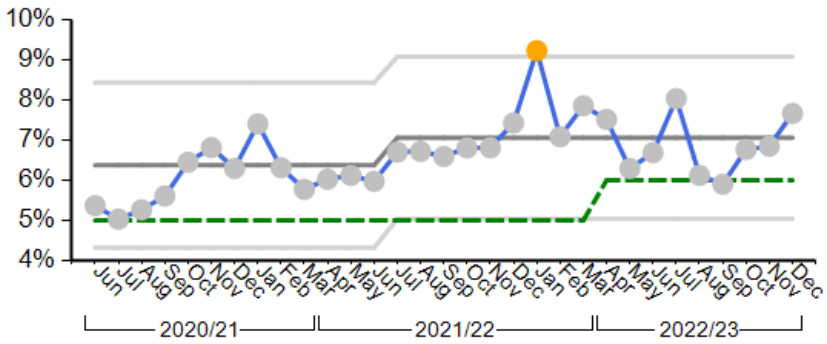
• There are currently 170 posts currently under offer to improve the overall Trust vacancy rate quickly.
• There are currently have 80 new starters with a booked start date in January, which will see the overall vacancy rate move back in the right direction.
• Nursing vacancy rate – this is remaining stubbornly high despite the recent recruitment activity; however the Trust has a WTE of 23.81 with a booked start date in January and have 3 further recruitment events taking place in January and February. NHSP also have 12 Care support workers on programme, all of which will be offered posts once they complete the required hours, if they are suitable.
• The AHP vacancy rate is also below target, however we are aware that we do have some difficult to fill posts and we are continuing to support any efforts to fill these posts. The Trust is also utilising international recruitment and have already recruited in both radiology and occupation therapy and this will continue as NHSE further their offer of support for international recruitment.
• The medical vacancy rate is continuing to move in the correct direction and the Trust has recently made 2 offers at consultant level and have a further AAC arranged during January. There are a further 15 medical posts under offer.

Staff Turnover

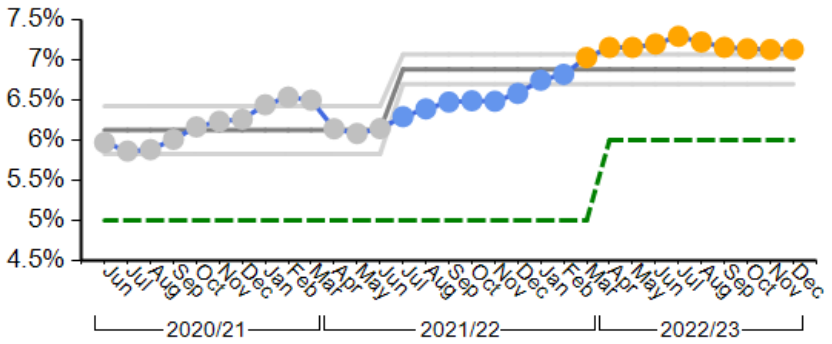
Staff turnover is also moving positively and is under target. The main area of concern is that of medics, however after investigation it is noted that the majority are either retiring or moving back into training and this is always a positive move, and indeed they may well return as a trainee if we can ensure they have a positive experience whilst working at the Trust.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Sickness Rate	6%	7.7%	N/A	Dec 22		6%	6.8%	Nov 22	6%	6.9%	?
	Sickness Rate (Rolling 12 Month)	6%	7.1%	N/A	Dec 22	H	6%	7.1%	Nov 22	6%	7.2%	F
	Sickness Rate (not related to Covid 19) - Trust	5%	6.8%	N/A	Dec 22	H	5%	6.2%	Nov 22	5%	5.6%	F
	Trust Vacancy Rate – All Staff	7.4%	10%	N/A	Dec 22	L	7.4%	8.8%	Nov 22	7.4%	9.8%	F
	Staff Turnover	0.83%	0.8%	N/A	Dec 22		0.8%	1.1%	Nov 22	9%	6.8%	?

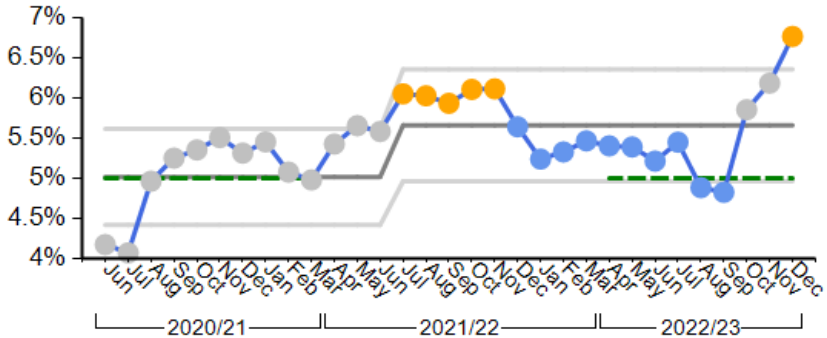
Sickness Rate



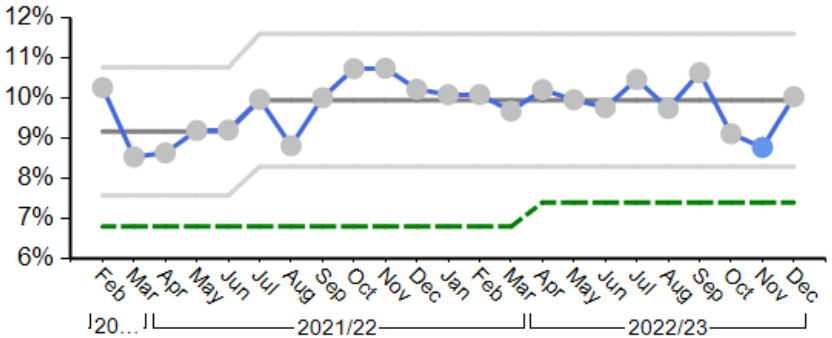
Sickness Rate (Rolling 12 Month)



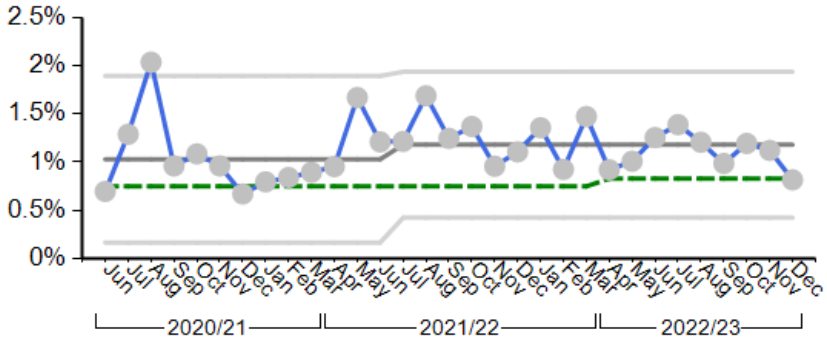
Sickness Rate (not related to Covid 19) - Trust



Trust Vacancy Rate – All Staff



Staff Turnover



Finance

Finance

The Trust is reporting a £13.8m deficit at Month 9 in line with 2022/23 Plan
Continued escalation and operational pressures are currently being offset by allocations for elective restoration and executive contingency
The Trust has assumed 100% ERF funding to M9 on the basis of full allocations paid to Trust with ICB now advising no clawback for 2022/23
The 2022/23 financial plan sets out a CIP requirement of 3.5% (£7.8m), plus a further £3.0m Stretch Target in Q4.
The Trust is reporting full delivery of CIP in 2022/23. QIAs now 95% complete.
Forecast Outturn - The Trust is forecasting a £14.2m deficit in line with plan for 2022/23.
Cash - The cash balance at the end of November was £7.4m.
ICB have confirmed that cash support received during 2022/23 will need to be repaid in March 2023.
In order to be able to access cash support funding by March 2023, the Committee is requested to recommend that the Strategic Overview Committee (SoC) approve a loan request of c£8.7m at their meeting on 1st February 2023 in time for loan application submission early February.
BPPC - 95% target achieved for NHS, non NHS and in totality.
Debt over 90 days - This has increased by £9k since November. An action plan for the top 10 debt in this category was presented to Audit Committee on 18 January.
Capital - Whilst c£17m capital investment now scheduled for Q4, the Trust is on-track for the delivery of the 2022/23 capital programme.
Orders are in place with Vinci for the TIF and CDC builds which comprises a major element of the spending.
Remaining cash flows are being actively managed, and remaining TIF/CDC funding of c£9.5m will be drawn in February, with the £0.5m balance drawn in March to pay for remaining pieces of equipment and fees.

	Latest				Forecast			Year to Date		
Indicator	**Plan**	**Actual**	**Period**	**Variation**				**Plan**	**Actual**	**Assurance**
I&E surplus or deficit/total revenue	7.4%	6.8%	Dec 22					0%	-2%	
Capital Spend	£2,200K	£1200K	Dec 22					£8,800K	£11,200K	
Cash Balance	£7,400K	£7400K	Dec 22						£75,000K	

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	QUALITY & SAFETY COMMITTEE (QSC)
MEETING DATE:	23 January 2023
LEAD:	Gill Brown

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Nil to alert at SOC
-

ADVISE

- No **Alerts** raised at previous meetings

AKI presentation - Dr Hasnain Raza, Consultant Nephrologist delivered update, reporting:

- Progress made against quality metrics noted. Currently fifth best performing Trust in the Northwest.
- Urine dipstix analysers now procured.
- Also, gradual progress being made with recruitment, workforce plan and access to ultrasound within 24hrs.
- Education and Training – a priority for the team.
- Further update requested to a future QSC

Operational Performance

- Urgent and Emergency Care: - The Trust experienced extreme pressures over Christmas and New Year with peak of Covid and 'flu towards the end of December. Performance remains challenged, but the Trust's performance benchmarks well against peers in Cheshire and Mersey (C&M) region and national performance.
- Paediatric Emergency Department increased demand during December - impacted by increased attendances relating to Strep A infections / concerns.

- Elective Recovery: - Reduced performance in December compared to November due to impact of pressures. Endoscopy continues to perform well. The Community Diagnostic Centre (CDC) went live on 16 January 2023, with gradual increase in diagnostics on offer. Groundworks commenced for Endoscopy unit at Ormskirk Hospital site and mobile CT scanner now on site at Southport Hospital site.
- Update highlighted *#investinginourfuture* to track progression of CDC/TIF work.

- Silver Industrial Action Group continues to prepare for ongoing strikes with some anticipated impact on activity from physiotherapy industrial action scheduled for 26 Jan and inter-trust patient transport.

CQC Improvement Plan Update Report

- Overview of progress of CQC Improvement Plan and current reporting structures to monitor performance of outstanding actions into 11 themes.
- Two Amber rated themes – Medical Staffing / 7day services and Policies. Both themes being addressed by Long Term Collaboration / Transaction workstreams with STHK and monitored by appropriate S&O Committees

Patient Safety Report

- Increased number of StEIS reports due to changes in reporting cooled babies, following feedback from the Local Maternity and Neonatal System (LMNS), and identification of some historic events. Information regarding actions, themes and learning to be revised for next report to QSC

Clinical Negligence Scheme for Trusts (CNST) Maternity Services Incentive Scheme Compliance Declaration

- CNST actions reviewed at biweekly Maternity Improvement Meeting, with support from the Project Management Office (PMO) and Audit teams.
- Compliance against all ten safety actions declared

Patient Safety Group AAA

- Noted transcription risk as part of the Electronic Prescribing and Medicines Administration (EPMA) rollout. Risk managed by Program Board with learning and mitigation from STHK, who also hold this risk.
- Risk will remain until Pharmacy module is implemented.
- Business case for funding for both organisations is being led by STHK.

Integrated Performance Report (IPR)

- IPR Reviewed.
- Additional update presented regarding compliance with response times for complaints: Issues, actions, mitigations, and progress noted

Core Mandatory & Essential Skills Training Report

- Core Mandatory Training:
  Overall Compliance 87.85% (December 2022). Target 90%.
  Actions to improve compliance of modules below target noted.

- Essential Skills Training:
  Slight decrease in overall compliance to 79.76% in December 2022 (Target 85%).
  Current improvements and actions to further improve compliance discussed and noted.
  Targeted improvement in Fire Safety Training (Level 2 and Level 3) compliance requested. Director of Finance to report back progress at next QSC.

Patient Experience & Community Engagement Group.

- Issues relating to availability of heated meal trolleys at Southport Hospital and deployment of ward-based Catering Assistants discussed. Review of systems at both sites to be undertaken

ASSURE

- AAA reports received from:
  - Patient Safety Group
  - Clinical Effectiveness Committee
  - Safeguarding Assurance Group
  - Patient Experience & Community Engagement Group.

- 'Lost to Follow Up' - verbal update received. Process being monitored by CBUs and reported to CEC. Formal written report requested for next QSC.

- Quality Improvement (Quality Priorities) Update received. Overall positive progress against the Trust's 2022/23 Quality Priorities noted.

- Board Assurance Framework (BAF) Strategic Objective 1 – Report approved. For presentation to Strategy and Operational Committee (01/02/23).

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

Review of the Risk Register

NA

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGIC & OPERATIONS COMMITTEE (SOC)**	**Date**	**01 February 2023**
Agenda Item	**SO012/23**	**FOI Exempt**	**NO**
Report Title	**CQC ACTION PLAN PROGRESS REPORT**		
Executive Lead	Lynne Barnes – Director of Nursing, Midwifery and Therapies		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ✓ **To Receive**	

Purpose

This report provides a summary of our current position against the improvement themes from the 'Must and Should' do actions from the 2019 and 2021 CQC Inspections.

Executive Summary

Following our 2019 comprehensive and well led inspection, the current overarching CQC rating for the Trust is Requires Improvement (RI). Safe, Effective, Responsive, and Well-Led have a current rating of RI; Caring is Good.

An unannounced CQC inspection of the Medicine Core Service was undertaken in March 2021, the Trust was inspected but not rated at this time. Inspectors reported 'significant improvements' across all the reviewed areas with no regulatory breaches or 'must do' actions noted.

In March 2022, following review of the status and progress of the remaining open actions from the improvement plan, it was recommended at the Quality and Safety Committee (QSC) to close the CQC Improvement Plan and incorporate or monitor through usual governance processes.

It should be noted that out of the 130 Must and Should Do actions, 73% (95) have been fully delivered and closed, the remaining 35 are split into 11 Trust wide themes and included in section 4. Whilst progress has been made, there is a need to focus on specific key themes, which will be familiar to the Committees, as progress continues to be monitored through usual governance processes such as IPR, risk registers, ward dashboards, SOCAAS, assurance reports and quality priorities.

The report also provides a brief overview of the progress in relation to CQC Well Led self-assessment, regulation and on-going CQC engagement.

Recommendations

The Strategy and Operations Committee is asked to receive the update in relation to the review of the 2019 and 2021 CQC actions and note the progress of the key themes monitored through usual governance processes, CQC engagement / regulation and well-led improvement journey.

Previously Considered By:

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

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

Southport and Ormskirk Hospital NHS Trust

Care Quality Commission (CQC) Improvement Plan Review

1. PURPOSE OF THE REPORT

This main purpose of the report is to provide a summary of our current position against the improvement themes from the 'Must and Should' do actions from the 2019 and 2021 CQC Inspections.

2. BACKGROUND

Following our 2019 comprehensive and well led inspection, the current overarching CQC rating for the Trust is Requires Improvement (RI). Safe, Effective, Responsive, and Well-Led have a current rating of RI; Caring is Good. An unannounced CQC inspection of the Medicine Core Service was undertaken in March 2021, during this inspection, the Trust was inspected but not rated. Inspectors reported 'significant improvements' across all the reviewed areas with no regulatory breaches or 'must do' actions noted.

By way of assurance and in preparation for any future CQC Inspections, the Quality & Safety Committee (QSC) have asked for a review of the key themes by core service of the 'must and should' do actions from the 2019 and 2021 CQC Inspections to ensure all improvements made are embedded and sustained.

In March 2022, following review of the status and progress of the remaining open actions from the improvement plan, it was recommended at QSC to close the CQC Improvement Plan and incorporate or monitor through usual governance processes.

A 'Check and Challenge' process is in place to ensure that closed actions and subsequent improvements remain embedded and sustained, this includes Quality and Safety Walkabouts, SOCAAS (Southport & Ormskirk Clinical Assessment and Accreditation Scheme), Ward Dashboards and use of the Tendable audit programme. This was approved at QSC in March 2022 and a paper was received By SOC in March 2022.

3. UPDATE

Governance - It should be noted that out of the 130 Must and Should Do actions 73% (95) have been fully delivered and closed, the remaining 35 are split into 11 Trust wide themes and included in section 4. Whilst progress has been made, there is a need to focus on specific key themes, which will be familiar to the committee, as progress continues to be monitored through usual governance processes such as IPR, risk registers, ward dashboards, SOCAAS, assurance reports and quality priorities. The proposed transaction with StHK will further enhance our ongoing improvement journey.

CQC Engagement - We continue to meet regularly with CQC colleagues, the last meeting being in December 2022, specific focus included closing three existing enquiries in relation to a patient complaint from an inpatient ward on Southport site, a staffing concern on a ward at Ormskirk site

and updated NHSE/I fire guidance for any new escalation areas during winter; all three have been closed.

The CQC RO (Relationship Owner) also commented on the 'positive improvement journey the Trust has been on since he first inspected the Trust in 2014, areas particularly highlighted were the development of the IPR and risk registers. It was also noted that as a Trust we were

- not currently flagging as an outlier for any areas from a CQC perspective
- We have seen a reduced (currently zero) backlog in relation to the completion of investigations on StEIS reportable incidents within the national framework reporting timelines
- The number of CQC enquires received has also significantly reduced. In 2019, there was an average of 6 per month this has fallen to an average of less than 2 per month in 2022 and in June and October 2022 there were zero enquiries.

Joint engagement meetings with StHK are expected to commence in February 2023.

Regulation - From a regulatory perspective, a report was presented to SOC (Strategy & Operations Committee) in May 2022 – *'CQC Compliance and Registration', this provided a* summary of policies, processes and practices within the Trust to demonstrate how ongoing compliance is maintained with the CQC's fundamental standards. This is provided at **Appendix A** for reference. We continue to work with StHK colleagues in relation to any required changes to our CQC registration as a result of the planned transaction.

4. KEY THEMES

From the 2019 inspection the Trust received 123 'must & should' do actions and a further 7 'should dos' from March 2021. Although there were a number of 'standalone' core service specific actions identified there were several actions which are 'duplicated themes' and appear in several core services and Trust Wide. In March 2022, following review through governance processes the original CQC Improvement plan was closed, however as discussed in Section 3, 11 themes were identified which continue to be monitored through usual governance processes.

Key Theme	BRAG	Overview & Progress	Governance
DNACPR		• Monitoring of Complaints in relation to communications regarding End of Life, Discharge and DNACPR • Relaunch of the Treatment Escalation Plan and incorporation into medical clerking documentation • Completion of DNACPR documentation monitored monthly as part of the Tendable Clinical Standards Audit • Bi-annual Trust wide DNACPR audit	• Quality Priorities Board • Patient Experience and Community Engagement Group • Resuscitation Committee • Mortality Operational Group • Quality & Safety Committee
Safeguarding(MCA/ DOLS)		• MCA Training in place and monitored. Trajectory in place.	• Safeguarding Assurance Group • Quality & Safety Committee

Key Theme	BRAG	Overview & Progress	Governance
		• Delivery of bespoke training delivered at several opportunities. These include the Foundation Years (FY) medics training, international nurse training, Intensive care development day, ambassador awareness days. Further to this one of the practice educators is delivering training in the completion of 2-stage capacity assessments. • The revised medical clerking document now includes decision making regarding treatment escalation and the required 2-stage capacity assessment; this is due to launched over the forthcoming month. • Since November 2022 the 2-stage capacity assessment prior to completing a DOLS authorisation is completed electronically through Careflow. All fields are now mandated and must be completed	
Mandatory Training & Resuscitation Training		• Essential skills training including resuscitation and life support reported quarterly to QSC. • Monthly progress report presented to Executive Committee. • Trajectory in place for Resus training. • All non complaint staff are flagged back to respective managers within CBUs and staff will be booked on to relevant training. • Adult and paediatric advanced life support training is now provided in house and is receiving excellent feedback. • NLS capacity secured at neighbouring Trust.	• Workforce Committee • Resuscitation Committee • Executive Committee • Quality & Safety Committee
Fridge & Room Temperature / Medicines Management		• My Kit Check - electronic alerting system in place to send and record alerts to when fridges go out of temperature range. • Estates are aware if room temperature issues, this is included on the risk register, a capital plan is being developed. • A fridge & room temperature task & finish group established focusing on: ○ Regulating temperatures subject to IPC compliance ○ Escalation for advise and guidance when cold chain has broken	• Medicines Safety Committee.

Key Theme	BRAG	Overview & Progress	Governance
Nurse Staffing		• Nursing & Midwifery Strategy in place • Nurse/HCA recruitment and retention programme in place • International Nurse recruitment successful • Registered Nurse fill rate above the 90% since October 2021 • Reported on IPR	• Workforce Committee • Executive Committee • Quality & Safety Committee • Strategy & Operations Committee
Medical Staffing & 7 Day Services		• Progressing through Fragile Services work • Long Term Collaboration with StHK • Kendall Bluck review completed. Actions currently being delivered.	• Workforce Committee • Executive Committee • Strategy & Operations Committee
Policies		• New policy approval system introduced to provide a more efficient process of approval • Alignment to StHK policies and procedures to be undertaken as part of the transaction. • Monthly progress report presented at Executive Committee	• Executive Committee • Clinical Effectiveness Committee • Workforce Committee • Joint Negotiating Committee

Key Theme	BRAG	Overview & Progress	Governance
Flow & Discharges		• Delayed discharges and potential mixed sex breeches in critical care are highlighted at 3 x daily bed meeting • Nurse Director Urgent Care & System Flow role in place and based within Trust • Number of Section 42's received fallen since 2019 • Audit review of all September 2022 AED readmissions 24 hours after discharge with majority either intra hospital transfers from SDGH to ODGH and long waiters reattending due to time of wait. • Discharge Improvement Group is in place led by MEC. • A single point of contact e-mail address in in place and monitored daily for any discharge concerns. • The Volunteer service also continue to provide follow up calls to all patients on discharge • Communication in relation to discharges is monitored through Quality Priorities - reduction in complaints since 2021/22 • Discharge checklist and patient information reviewed and updated in 2022 • Results of Discharge Checklist Audit have been published and are in the process of being shared with ADONs and at CBU Governance meetings	• Executive Committee • Quality & Safety Committee • Finance Performance & Investment Committee • Strategy & Operations Committee
Privacy & Dignity		• Reconfiguration and refurbishment since last inspection. • SOCAAs, Clinical Standards audits, and senior quality and safety walkabouts are in place. • Dementia and Delirium Team / Admiral Nurses are now in post to support care of patients with Dementia. • Any concerns in relation to privacy and dignity received via PALs, Complaints or Incidents are immediately investigated and lessons learned shared. • Risk assessments completed in relation to escalation areas for A&E in line with national guidance. • Monthly patient experience reports to PECEG with AAA presented to Quality & Safety Committee.	• Clinical Effectiveness Committee • Quality & Safety Committee • Strategy & Operations Committee • Patient Experience & Community Engagement Group • Quality & Safety Committee • Strategy & Operations Committee

<table>
<tr><th>Key Theme</th><th>BRAG</th><th>Overview & Progress</th><th>Governance</th></tr>
<tr><td></td><td></td><td>• Improvement in all national patient surveys.
• Initiatives introduced such as
○ Sleep packs
○ John’s Campaign
○ Opening of new Discharge lounge
○ Refurbishment of Oasis Room
○ Launch of Carers Passport for carers who want to support loved ones whilst in hospital</td><td></td></tr>
<tr><td>Complaints</td><td></td><td>• Positive progress that has been made over the past six months, with reducing the backlog of overdue complaints whilst trying to maintain and improve compliance with providing a response within 40 working days.
• Reported monthly through IPR
• Significant improvement between July 2022 – Dec 2022.

<table><tr><th></th><th>July 22</th><th>Dec 22</th></tr><tr><td>Overdue Complaints</td><td>32</td><td>25</td></tr><tr><td>No Complaints Closed</td><td>39</td><td>21</td></tr><tr><td>Overdue complaints closed</td><td>26</td><td>11</td></tr><tr><td>Closed within 40 Days</td><td>13</td><td>10</td></tr><tr><td>Ave No Days to close</td><td>62</td><td>52</td></tr></table>
• Monthly complaints report presented at Committee meeting</td><td>• Patient Experience & Community Engagement Group
• Quality & Safety Committee
• Strategy & Operations Committee</td></tr>
<tr><td>Documentation (Risk Assessments)</td><td></td><td>• Several risk assessments are now electronic on VitalPac including 4AT and MUST, both have seen significant improvement for completing since they moved to electronic.
• The generic Risk Assessment document / booklet completed on admission has been build electronically this includes mandatory fields, a date for roll out has yet too be agreed.
• Documentation audits in place.</td><td>• Patient Experience & Community Engagement Group.
• Clinical Effectiveness Committee
• Quality & Safety Committee</td></tr>
</table>

BRAG Key
Delivered and sustained
Action Completed
On Track to Deliver
No Progress / Not Progressing to Plan

5. WELL LED

To support our Well Led improvement journey, we have undertaken a comprehensive Well-Led self-assessment across all 8 well led domains using the CQC key characteristics. This was presented to Executive Committee in November 2022 and was well received. Any current gaps identified will be incorporated into an improvement plan with a focus on actions that can be progressed at Trust Level jointly with StHK in order to facilitate the transcaction.

6. CONCLUSION & NEXT STEPS

Under the CQC's new monitoring framework there is a move away from the reliance on comprehensive onsite inspections as the trigger for assessing quality and issuing ratings. Instead, there is more reliance on a risk assessment and good quality data from a variety of sources, including service users' feedback, combined with focused onsite inspections where necessary, to assess quality and change a rating.

We continue to monitor compliance against the CQC Key Lines of Enquiry (KLOEs) which are also a significant proportion of our Must & Should do actions through SOCAAS assessments, Tendable monthly clinical standards audits and weekly Quality & Safety Walkabouts. We are also in the process of developing a template to use with wards and clinical areas which will include

- Key areas of focus from CQC KLOEs
- Check list of themes highlighted from recent CQC inspections
- Any concerns identified from SOCAAS, Clinical Standards audits, Ward Dashboards, incidents and complaints and concerns.
- Further develop CQC Well Led improvement plan in conjunction with StHK colleagues.

We continue to work with StHK colleagues to develop a CQC preparation programme including Well Led to be rolled out in 2022/23.

7. RECOMMENDATIONS

The Committee is asked to receive the update in relation to the review of the 2019 and 2021 CQC actions and note the progress of the key themes monitored through usual governance processes, CQC engagement / regulation and well-led improvement journey.

Southport and Ormskirk Hospital NHS Trust

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Compliance with CQC Regulations and Fundamental Standards

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

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

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

Southport and Ormskirk Hospital NHS Trust

Appendix A

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

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

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

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Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
4	12 - Safe care and treatment	Assessing risks against health and safety standards, mitigating risks, staff providing care have relevant qualifications, competence, skills and experience, ensure premises and equipment used are safe for intended purpose. Ensure sufficient quantities of medicines/equipment to remain safe. Proper oversight of safe management of medicines. Infection prevention and control (IPC).	**Safe**	WSC; Workforce, Executive	DoHR, DoN, DoF		• H&S risk assessments in place and outlined in H&S Policy & supporting documents. • Workplace inspections reported to Health and Safety Committee which reports to Quality & Safety Committee and programme of environmental checks in place, with actions taken to address any issues identified. • H&S Teamwork with Quality Matrons to review areas highlighted for improvement in 2019 CQC Inspections (COSH Cupboards locked and hazardous substances locked away & placement of Oxygen cylinders) • Relevant checks against job description/person specification undertaken as part of recruitment process for all staff. Annual appraisals confirm staff have maintained knowledge and expertise to undertake roles and responsibilities. • Missed doses of medication are recorded, audits undertaken by the pharmacy team and reviewed on senior nurse walk around (this was included as a measure for Improving Medicines Safety Quality Priority in 2021/22 • Programme of medical device maintenance in place. Medical Devices Group reports into CEC via AAA • Compliance with infection prevention control (IPC) is regularly audited and assessed through SOCAAS, Clinical Standards and separate IPC audit • RCAs undertaken on any serious IPC incidents including C.Diff/MRSA bacteraemia cases to identify lessons learned. IPC panels in place. Two MRSA bacteraemia reported year to date in 2021-22 and C.Diff cases remain below trajectory set in 2021-22. • Mandatory skills compliance monitored at Workforce Committee and reported regularly to Quality and Safety Committee.

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Funda-mental Standard (FS) number	Regulation	Summary	Domain	Committee	Exec Lead	RAG status	Current position
5	13 - Safeguarding service users from abuse and improper treatment	Zero tolerance approach to abuse and unlawful discrimination and restraint, including neglect, degrading treatment, unnecessary restraint, deprivation of liberty. All staff to be aware of local safeguarding policy and procedure and actions needed if suspicion of abuse.	**Safe**	QSC, Workforce	DoN, DoHR		• The Trust has a zero-tolerance approach to abuse, discrimination and unlawful restraint (policies also in place) The Trust has a Freedom to Speak Up - Raising Concerns Policy and also Disciplinary Policy and Procedure in place for any staff who fail to meet the Trust's SCOPE values and behavioural standards. • Each clinical area has a Safeguarding resource file with key information to ensure all areas for safeguarding are reported appropriately. • Safeguarding Ambassadors inn place to act as a point of contact for safeguarding for wards and clinical areas • Safeguarding level 1 is the minimum mandatory requirement for all staff, with level 2&3 targeted at those who require it, i.e. those working with children and young people and those in decision-making roles respectively. Compliance with training is reported to the Safeguarding Assurance Group and Quality & Safety Committee. Awareness of Deprivation of Liberty Safeguards (DoLS) is included in induction and mandatory training. All training thresholds met in March 2022. • The Trust provides training in conflict resolution. • Security is on site 24 / 7 at both Southport and Ormskirk sites

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6	14 - Meeting nutritional and hydration needs	People who use services have adequate nutrition and hydration to maintain life and good health.	**Effective**	QSC	DoN		• Trust utilises the Malnutrition Universal Screening Tool (MUST) for adults to ensure compliance with NICE guidance, this is now included in the patient's admission documentation and risk assessments. • Patients identified as at risk of malnutrition have nutritional care plans in place, information is also monitored through fluid balance charts. • There is a red tray and red jug system in place for patients who require additional support with eating and drinking. • All general wards are required to operate protected mealtimes. • Patients are regularly assessed to note any changes in nutrition and hydration status. Fluid balance is reviewed at the end of each shift and MUST assessments completed within 24 hours of admission, then weekly. • Regular audits are conducted to maintain focus on high standards of hydration and nutrition throughout the Trust. A specific fluid balance audit has been developed on Tendable • In addition, Trust is exploring the future use of VitalPac for recording of fluid balance going forward. • Nutrition & Hydration was a Quality Priority for the Trust in 2021/22 and will be rolled over into 2022/23 with AKI incorporated, this will be monitored through Quality Improvement Board. Quality Matrons are leading a piece of QI work in relation to timely completion of MUST assessments, this includes reviewing weighing devices on wards and clinical areas. • The volunteer service prior to the pandemic provided dining companions to further support patients feeding during meal times. This is planned to be reinstated in 2022/23. • Recommendations in relation to nutrition and hydration were highlighted in the 2019 CQC Inspection and focused Medical Core Services inspection in 2021. All recommendations are addressed through the actions described above and monitoring continues through the Quality Priority and Nutrition Hydration & Mouth Care Group which provide assurance to the Quality and Safety Committee • Achieved Breastfeeding Friendly status.
7	15 - Premises and equipment	Premises and equipment are clean, secure,	**Safe**	QSC	DoCS		• Workplace inspections and COSHH risk assessments in place. • Waste Management Policy in place with regular awareness raising and training provided for staff. Recent investment to provide adequate storage for clinical

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

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

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Appendix A

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

Southport and Ormskirk Hospital NHS Trust

Appendix A

10	18 - Staffing	**Sufficient numbers** of suitably qualified, competent, skilled and experienced persons deployed to meet CQC requirements.	**Safe, Effective**	Workforce	DoHR		• Workforce priorities are referenced withing the Board Assurance Framework (BAF) (Strategic Objectives 4 & 5) with clear actions to mitigate. • The Trust's workforce strategy 'Our People Plan' has been developed in line with the ambitions of the national NHS People Plan that we need more people, working differently, in a compassionate and inclusive culture. It is designed to be flexible enough to respond to the lived experience of our staff and our shared hopes for the Trust over the coming years. Our People Plan describes how we will support our staff to recover from our response to the pandemic, reset to a post-Covid 19 world and cope with changes in demand and delivery of services to patients across Southport and Ormskirk. At the same time, ensuring that staff feel empowered, valued, developed, trusted and motivated to move towards the future, embracing change and the introduction of technology and new ways of working and endeavouring to improve the quality of care they provide. • Whilst significant national recruitment challenges remain within specific specialties and for specific roles, in particular, nursing and medical staff. It is, however, notable that in the last 12 months we have managed to recruit 100 international nurses, and this has had a significant positive impact. We will continue with overseas nursing recruitment as part of the Pan Mersey International Collaboration, and as part of the collaboration, we are exploring the possibility of extending this to fill some of our Allied Health Professional vacancies, as well as exploring further international recruitment activity for the medical workforce. • The Trust has also been proactively working towards filling Healthcare Assistant vacancies through regular recruitment events. Further retention initiatives include the development of a bespoke induction and preceptorship programme, recognising the need to ensure this group of staff are properly supported within the Trust. In addition, the Trust has collaborated with local Universities, formalising a partnership agreement with Edge Hill University and securing its first jointly appointed Consultant Clinical Academic position. The Trust will build on these relationships further to strengthen the pipeline of students choosing the Trust as their preferred employer, as well as further opportunities to attract nursing and medical applicants. • Medical vacancies are now at the lowest level the Trust has seen for at least 4 years, with the vacancy rate current at 5.8% bringing it in line with the national average.

Southport and Ormskirk Hospital NHS Trust

Appendix A

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

Southport and Ormskirk Hospital NHS Trust

Appendix A

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

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

Southport and Ormskirk Hospital NHS Trust

Appendix A

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

NHS
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NHS Trust

Title of Meeting	**STRATEGIC & OPERATIONS COMMITTEE (SOC)**	**Date**	**01 February 2023**
Agenda Item	**SO013/23**	**FOI Exempt**	**NO**
Report Title	**QUALITY PRIORITIES UPDATE - 2022/23**		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Jo Simpson, Assistant Director of Quality		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ✓ **To Receive**	

Purpose

This paper provides the Committee with an update on progress against the 2022/23 Quality Priorities

Executive Summary

Overall progress against the Trust Quality Priorities is positive, with all Quality Priorities making progress towards trajectory by 31 March 2023.

Key areas to note include:

- Falls - Despite a marginal increase in crude number of falls reported in December 2022, reporting by bed days shows an improvement, from 5.94 per 1,000 bed days in 2020/21, to 5.58 in 2021/22 and 5.3 for the current financial year in line with the 10% reduction target.
- Pressure Ulcers - The number of category 2 pressure ulcers is the lowest since January 2021.
- AKI - Quarter 2 and 3 monthly data demonstrated the Trust is on track to meet the 20% reduction trajectory for Hospital Acquired AKI.
- Communication with families - Zero complaints received in December for 2022 for End-of-Life Care and DNACPR and four complaints received in relation to discharge communications in December 2022. This is reflective of the increase in capacity and flow within the Trust and system solutions have been discussed with both primary and community colleagues. There is also a proposal of a system wide Discharge Transformation Support Group which Trust colleagues will participate in.
- The Ockenden action plan has been broadened to encompass the recommendations from both the initial and the final reports. Progress is on track and is being monitored in a multi-disciplinary bi-weekly scrutiny meeting led by the new Associate Director of Midwifery and Nursing.

Recommendations

The Strategy and Operations Committee is recommended to note the progress of the 2022/23 Quality Priorities

Previously Considered By:

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

Strategic Objectives

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

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

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

✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Jo Simpson - Assistant Director of Quality Liz Carr – Programme Manager	Lynne Barnes – Director of Nursing, Midwifery and Therapies

Southport and Ormskirk Hospital NHS Trust

Southport and Ormskirk Hospital NHST – Quality Priorities update January 2023

<table>
<tr><th>Quality Priority</th><th>Outcomes Measures</th><th>Update</th><th>BRAG</th></tr>
<tr>
<td>1. Reduce number of falls</td>
<td>Reduce all falls by at least 10% and falls resulting in harm by at least 20% compared to 2021/22</td>
<td>
Position
<table>
<tr><th></th><th colspan="5">Latest</th><th colspan="3">Previous</th><th colspan="2">Year to Date</th><th></th></tr>
<tr><th>Indicator</th><th>Plan</th><th>Actual</th><th>Patients</th><th>Period</th><th>Variation</th><th>Plan</th><th>Actual</th><th>Period</th><th>Plan</th><th>Actual</th><th>Assurance</th></tr>
<tr><td>Patient Falls - Trust</td><td>63</td><td>77</td><td>77</td><td>Dec 22</td><td></td><td>63</td><td>75</td><td>Nov 22</td><td>756</td><td>614</td><td></td></tr>
<tr><td>Falls - Moderate/Severe/Death</td><td>1</td><td>2</td><td>2</td><td>Dec 22</td><td></td><td>1</td><td>1</td><td>Nov 22</td><td>17</td><td>16</td><td></td></tr>
</table>

The overall number of falls reported remains statistically as expected, but there has been a marginal increase in December 2022.
Reporting by bed days shows an improvement, from 5.94 per 1,000 bed days in 2020/21, to 5.58 in 2021/22 and 5.3 for the current financial year in line with the 10% reduction target.
Two falls resulting in moderate or above harm were reported in December and are currently being investigated.

Ongoing Improvement Workstreams

Deep dive completed into wards with high falls numbers and actions implemented with a resulting decrease in the number of falls on one of the targeted wards.
Continuing work to increase knowledge and understanding of the requirements for enhanced levels of care (ELOC) being given at a ward level. Provided read and sign document for all staff to complete detailing key points and responsibilities. Information stand outside hospital restaurant held in November providing detailed information on ELOC.
Enhanced level of care assessment being reviewed to make it more user friendly and fit for purpose.
Staff focus groups completed and issues raised to be fed back through falls group to add into trust wide action plan.
Documentation (falls care plan and post falls assessment) reviewed to add additional prompts to support staff in following policy and post-fall guidance flowchart.

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<table>
<tr><th>Quality Priority</th><th>Outcomes Measures</th><th>Update</th><th>BRAG</th></tr>
<tr><td></td><td></td><td>
• Continuing to roll out flojac training to clinical staff as time allows.
• Process of medication falls review to be reviewed with pharmacy to ensure a robust system for falls medication reviews is in place.
• Met with STHK falls lead to compare and contrast services to identify areas for improvement/areas we need to align.
• Attendance at the Cheshire and Merseyside Falls Prevention Steering Group commenced
• Use of regular additional streams of information through trust news (including monthly falls newsletter) and social media to inform of lessons learnt and key messages.
</td><td></td></tr>
<tr><td>2. Reduce number of hospital acquired pressure ulcers</td><td>
• Reduce number hospital acquired pressure ulcers with lapses in care by 10% compared to 2021/22
• Ensure all patient harm incidents are reported and investigated
</td><td>
Position

<table>
<tr><th></th><th colspan="5">Latest</th><th colspan="3">Previous</th><th colspan="2">Year to Date</th><th></th></tr>
<tr><th>Indicator</th><th>Plan</th><th>Actual</th><th>Patients</th><th>Period</th><th>Variation</th><th>Plan</th><th>Actual</th><th>Period</th><th>Plan</th><th>Actual</th><th>Assurance</th></tr>
<tr><td>Hospital Acquired Pressure Ulcers - Category 2</td><td>4</td><td>1</td><td>1</td><td>Dec 22</td><td></td><td>4</td><td>2</td><td>Nov 22</td><td>48</td><td>38</td><td></td></tr>
<tr><td>Hospital Acquired Pressure Ulcers - Categories 3 & 4</td><td>1</td><td>1</td><td>1</td><td>Dec 22</td><td></td><td>1</td><td>2</td><td>Nov 22</td><td>12</td><td>19</td><td></td></tr>
</table>

• Hospital Acquired Pressure Ulcer indicators are performing statistically as expected but have reduced in December.
• The number of category 2 pressure ulcers is the lowest since January 2021.
• All Hospital Acquired Category 3’s reported in 2022/23 to date are Deep Tissue Injuries or Unstageable Pressure Ulcers. There have been no confirmed Hospital Acquired Category 3 Pressure Ulcers this financial year to date.
• Review of any potential HAPUs to sacrum – impacted by long waits on seats in AED, also noted on walkabout that the patients nursed in the corridor on a bed are unable to have an air mattress unless a plug socket is in the area where the bed is placed.

Ongoing Improvement Workstreams

• All Hospital Acquired Pressure Ulcers are reviewed by the Tissue Viability Team.
• The use of the repose inflatable boots for continuous offloading of heels for patients with DTI’s has seen a trend in the DTI reabsorbing whilst in hospital. Wards hold their own stock of repose
</td><td></td></tr>
</table>

Quality Priority	Outcomes Measures	Update	BRAG
		boots. TVN team to work with ward managers to ensure they continue to maintain a stock for patients assessed as very high risk of pressure ulceration. • Ongoing work is needed regarding pressure relieving equipment that can be used within AED. Options include inflate chair cushions and inflatable mattresses that can be used on a trolley or bed to initiate pressure relief to those patients' high risk and very risk on risk assessment. Extra electrical trunk cabling now installed along AED corridor to provide extra electrical power points. • Pressure Ulcer Prevention (PUP) champions – lead by the TVN HCA with targeted wound training for HCAs on the ward. Basics of PUP, react to red, management of moisture associated skin damage (MASD), category 1 pressure ulcers & barrier creams. • Patient bedside seating project being undertaken with different specialities involved to identify which products would benefit a wider cohort of patients to prevent pressure damage, falls, patients with cognitive issues. Further meetings and costings due to take place in December. • Working with the facilities matron and head of medical devices to look at what bed and mattress equipment can be available for patients with bariatric beds & chairs, pressure relieving air mattresses and hybrid mattresses. • The Stop the Pressure event in November was a success with engagement from the medical wards at SDGH with ward boards highlighting to both staff and patients the various pressure ulcer prevention strategies available to reduce HAPU's.	
3. **Acute Kidney Injury: Nutrition and Hydration**	• **Reduce Hospital Acquired AKI by 20% compared to the 2021/22 baseline** ○ *Urine dipstick test within 24 hours of 1st AKI alert* ○ *Ultrasound scan of urinary tract within 24 hours of 1st AKI alert* ○ *Completion of a MUST assessment during an inpatient stay* ○ *Number of patients with MUST score of 2+ referred to dietetics* ○ *Undertake NEWS2 observations at the correct intervals -% on time*	**Position** • Quarter 2 and 3 monthly data demonstrated the Trust is on track to meet the 20% reduction trajectory for Hospital Acquired AKI. • Trust continues to participate in AQUA AKI pathway and we are currently on trajectory for achieving the cumulative target set by AQ	

Quality Priority	Outcomes Measures	Update	BRAG
	○ *Unplanned CC admissions (T0) and (T1) recorded.*	 **Ongoing Improvement Workstreams** • A deep dive was agreed to better understand the reasons for current number of hospital acquired AKIs and a clinical audit is planned (led by Fy1 / Fy2) in Quarter 4 • Additional urinalysis machines ordered for all ward templates and clinical areas such as A&E, Maternity and Paediatrics. The package includes training and equipment maintenance. • Ultrasound scans – Critical Care Outreach Team (CCOT) to remind Doctors at medical handover the importance of documenting and booking scans within 24 hrs of 1st AKI alert. AKI Clinical Lead is working with Radiology to develop a SOP and improve booking process • QI Project work is going on AMU to embed a new practice to ensure that every patient has a MUST assessment completed with their first set of observations on admission to the ward. • Data from October 2022 (when project started) was 67.5% to December 2022 we have reached 100%. Ideally patient flow would be from AED to AMU and then to the required speciality, therefore if all patients go through AMU all MUST assessments would be completed within 24hrs, this is reflected in AMUs figures which will then have a significant positive impact on all medical wards. Up to December numbers of direct admissions to the wards are low however due to capacity issues direct admissions increased in December and beginning of January. • In December 2022 Trust achieved 84.74% NEWS 2 Observations on time for all patients against 80% trajectory. Training remains in place; the Critical Care Outreach Team (CCOT) are currently reviewing Track & Trigger training package and are developing an in house AIMS course.	

Quality Priority	Outcomes Measures	Update	BRAG
4.To improve communications with families prior to discharge/End of Life /DNACPR	• Number of complaints received relating to EoL communication • Number of complaints received relating to discharge communication • Number of complaints received in relation to Communication regarding DNACPR • % where evidence of discussion with patient for DNACPR decision	**Position** • Review of visiting guidance extremely positive for families and loved ones • Family Integrated Care accreditation achieved for the Neonatal Unit • No complaints received in December 2022, relating to communications at end of life • Four complaints received in relation to discharge communications in December 2022, reflecting the increased in capacity and flow within the Trust. Sefton ICB have invited Trust staff to join the Care Home Network meeting and a Sefton System Discharge Transformation group is being established with Trust participation • No complaints received in December 2022, relating to communications in relation to DNACPR, this is supported by the monthly DNACPR question monitored through Clinical Standards audit - *% where evidence of discussion with patient for DNACPR decision* achieved 96%. **Ongoing Improvement Workstreams** • The relaunch of the Treatment Escalation Plan (TEP) will support improving discussion with patient and families regarding escalation of care and DNACPR decisions, this is being incorporated into the medical clerking document • A training package has been developed and introduced for all clinicians and senior clinical decision makers to improve confidence in conversations and decisions relating to treatment escalation planning, decisions about DNACPR and anticipatory clinical management planning. • In collaboration with Queens Court Hospice, an audit is being undertaken reviewing the data from the individual plans for care of those thought likely to be dying and the documentation of the recognition of dying. Trend analysis is expected in Quarter 4.	
5. Compliance with the Immediate and Essential actions of the Ockenden 2 enquiry	• Compliance with the 92 elements of the Ockenden 2 Standards	**Position** • The Ockenden action plan has been broadened to encompass the recommendations from both the initial and Ockenden 2 Report. • Progress is on track and is being monitored in a bi-weekly scrutiny meeting led by the Associate Director of Midwifery. • Patient Safety Manager now in place • Bereavement service enhanced	

Quality Priority	Outcomes Measures	Update	BRAG
		• Investments seen in theatres, leadership, governance, Neonatal AHPs, O&G Consultant and junior medical rotas for neonatal. • Declaring compliance with 10 safety standards for Maternity Incentive Scheme (MIS) • Human Factors Training in place • Workforce planning in line with RCOG guidance • Significant learning and improvement from incidents • MVP in place • Maternity and Neonatal Champions in place, including Healthwatch and MVP representative. • Plan in place for centralised CTG monitoring. • New structure proposed for new organisation. • MIAA audit in relation to compliance against Ockenden 1 recommendations concluded 'Substantial Assurance'. **Ongoing Improvement Workstreams** • Joint working between S&O and StHK • Review of Ockenden 2 compliance against each recommendation and RAG rate to be presented in Q4 Maternity report to Q&S • Continue to engage with the LMNS for regional and national actions • The Executive Medical Director is working with Obstetrics and Gynaecology Consultant body to ensure appropriate input and oversight in relation to Ockenden plan for all medical actions. • The Maternity Improvement Group continues to meet bi-weekly to review progress.	

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGIC & OPERATIONS COMMITTEE (SOC)**	**Date**	**01t February 2023**
Agenda Item	**SO014/23**	**FOI Exempt**	**NO**
Report Title	**CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) MATERNITY SERVICES INCENTIVE SCHEME COMPLIANCE DECLARATION**		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery & Therapies		
Lead Officer	Brendan Prescott, Deputy Director of Quality, Risk and Assurance		
Action Required	✓ **To Approve** ✓ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

To update the Committee on the progress against the Clinical Negligence Scheme for Trusts (CNST) Maternity Services Incentive Scheme 10 safety actions and the Trust's plan to declare compliance against the scheme.

Executive Summary

This paper provides an update on compliance with the fourth year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Services Incentive Scheme. This scheme offers up to 10% rebate of the Maternity premium for trusts that are able to demonstrate compliance against 10 safety actions.

This scheme supports the Safer Maternity Care Ambition by supporting the delivery of safer maternity care by rewarding trusts that meet ten safety actions which have been designed to improve the delivery of best practice in maternity and neonatal services.

CNST actions have been reviewed at the biweekly Maternity Improvement Meeting with support from Audit and PMO colleagues. On review of the evidence for the CNST Safety Actions up to the extended data capture date of 05 January 2023, **the Trust will declare compliance against all 10 actions.**

The Trust declaration form will be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) for Sefton's Integrated Care System.

The Trust will submit the completed Board declaration form to NHS Resolution by Thursday 02 February 2023.

Recommendations

The Strategy and Operations Committee is asked to approve the Clinical Negligence Scheme for Trusts (CNST) compliance declaration.

Previously Considered By:

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

Strategic Objectives

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

1. INTRODUCTION

This paper provides an update on compliance with the fourth year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Services Incentive Scheme. This scheme offers up to 10% rebate of the Maternity premium for Trusts that are able to demonstrate compliance against 10 safety actions.

This scheme supports the Safer Maternity Care Ambition by supporting the delivery of safer maternity care by rewarding Trusts that meet ten safety actions which have been designed to improve the delivery of best practice in maternity and neonatal services.

CNST actions have been reviewed at the biweekly Maternity Improvement Meeting with support from Audit and PMO colleagues. On review of the evidence for the CNST Safety Actions up to the extended data capture date of 5th January 2023, the Trust will declare compliance against all 10 actions.

The Trust declaration form will be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) for Sefton's Integrated Care System.

The Trust will submit the completed Board declaration form to NHS Resolution by Thursday 2nd February 2023.

2. CNST SAFETY ACTIONS

2.1 The detail of the 10 safety actions are presented below :

Maternity Incentive Scheme – Year 4 (Relaunched May 2022) Ten Safety Actions	
Safety Action 1	Are you using the National Perinatal Mortality Review tool to review perinatal deaths to the required standard
Safety Action 2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
Safety Action 3	Can you demonstrate that you have transitional care services to minimise separation of mothers and their babies and support the recommendations made in the Avoiding Term Admissions into Neonatal Units Programme?
Safety Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?

Safety Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?
Safety Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?
Safety Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?
Safety Action 8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years starting from the launch of the MIS year 4?
Safety Action 9	Can you demonstrate that the trust safety champions (obstetrician, midwife and neonatologist) are meeting bimonthly with Board level champions to escalate locally identified issues ?
Safety Action 10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification scheme from 1st April 2021 to 5th December 2022 ?

3. DECLARATION

3.1 The Trust has populated and evidence log for reference against each safety action and their respective elements to demonstrate compliance, supported by Women and Children's, Audit and Programme Management Office colleagues . Evidence review has been undertaken at the Maternity Improvement meetings in held in Q3 and at the start of Q4 2022 -23.

3.2 Regular updates to executive committee to demonstrate compliance and to progress actions have also been undertaken during Q3 2022-23.

3.3 The review of evidence has provided the assessment of compliance as below :

Safety Action 1 – COMPLIANT

The Trust is able to declare compliance against the 4 sections of this Action relating to the use of the tool and notification to MBRRACEUK as well as board notification on reporting. There is a managed risk of panel availability of appropriate health professionals to ensure all cases are reviewed within agreed timeframes.

Safety Action 2– COMPLIANT
The Trust is now working collaboratively with St Helens and Knowsley IT colleagues on a digital strategy and a paper has been presented to Strategy and Operations on the procurement of a new clinical system which will ensure longer term compliance of production of data sets. A paper setting out the plan has been presented to both Executive Committee and Strategy and Operations Committee. This work is being led by the Head of IT on behalf of 6 organisations in total who have been challenged in meeting the criteria submission. The Trust was able to provide assurance that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) passed the associated data quality criteria for the allocated timeframe in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file.

Safety Action 3– COMPLIANT
The Trust is able to demonstrate its compliance with transitional care for the 8 sections of this action, including audit plans and data capture for regional review.

Safety Action 4– COMPLIANT

The Trust can demonstrate compliance on obstetric and anaesthetic workforce attendance as per RCOG principles as well as progress on the neonatal medical and nursing workforce plan with a business case approved and recruitment underway to support the outcomes of the workforce review.

Safety Action 5– COMPLIANT

The Trust is able to demonstrate compliance of workforce planning and the 4 sections of this safety action and planned reporting is ongoing in line with the annual cycle for maternity board reporting.

Safety Action 6– COMPLIANT

The Trust is able to demonstrate compliance against the 3 elements of this safety action including a gap analysis of Saving Babies' Lives care bundle version two and subsequent action plan. This is now planned as part of the regular audit cycle.

Safety Action 7– COMPLIANT

There is strong evidence of compliance against this safety action with the MVP chair also being a Safety Champion and invited to safety walkabouts. We can confirm that the MVP is prioritising the experiences of Black, Asian and Minority Ethnic families in order to inform the shaping of services.

Safety Action 8– COMPLIANT

As of 5th January 2023 the Trust was compliant both with core competency training plan in place over a 3 year period as well as compliance with the 90% target of multidisciplinary training for

maternity emergencies; foetal monitoring and surveillance and resuscitation/ management of the deteriorating newborn infant.

Safety Action 9– COMPLIANT

The Trust is able to show compliance against the 4 sections of this safety action with a pathway of escalation in place and circulated to Neonatal and maternity teams. The TOR and agenda for the Safety Champions meetings has been reviewed with staffing, training and incidents all included on the agenda. There are regular Champion's walkabouts undertaken to inform as well to allow escalation of identified issues.

Safety Action 10– COMPLIANT

The Trust is compliant with the 3 sections of this action with a monthly ongoing cross-check audit to ensure that all eligible cases have been reported by the audit team.

4. CONCLUSION

The Trust is compliant on the 10 CNST Safety Actions.

The Trust will complete the declaration of compliance by Thursday 2nd February subject to LMNS and commissioner agreement. Commissioners agreed to complete sign off at the Quality Contract Meeting on 18th January 2022.

5. RECOMMENDATION

The committee is recommended to approve the compliance declaration for Southport and Ormskirk Hospital NHS Trust.

The MIS compliance declaration form is now live to access for submission.

Please note the requirement from the LMNS and ICB for action.

6. APPENDIX

1. Email from D Gould (LMNS) received 11th Jan 2023

Southport and Ormskirk Hospital NHS Trust

Dear Colleagues

As you are aware the process for sign off for Trust MIS year 4 CNST Compliance has changed for this year.

Following the formation of the ICS/ICB and the enhanced role of the LMNS there is an additional requirement that the LMNS will provide assurance to the ICB Accountable Officer, Graham Irwin, that each trust has followed a robust assurance and sign off process and apprised the ICB Accountable officer of the following:

- Assurance process
- Trust Board Sign Off
- Declaration of compliance against all 10 safety actions
- Where there is a declaration of non-compliance with any of the safety actions plans to address those to be fully compliant for MIS Year 5

The LMNS team will be required to collate this for all providers for sign off by Graham Irwin on 27th January 2023.

He will then countersign each trusts submission which must have Trust CEO sign off.

This will then enable all Trusts to submit by the deadline of 2nd February 2023.

In view of this please can you send by 12.00 Noon on Thursday 26th January 2023 to debbygould@nhs.net and copied to Siobhan.kinsella@nhs.net:

1. A summary of the assurance process followed within your organisation including :
    - Date your MIS presentation was taken to your Quality Committee or equivalent
    - Name of the Committee that the MIS was presented to (they vary between organisations)
    - Confirmation of date the MIS submission presented to Board for sign off

2. A copy of your final presentation demonstrating level of compliance against all the 10 safety actions (Including those not compliant and reasons for non compliance)

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Workforce Committee
MEETING DATE:	24 January 2023
LEAD:	Lisa Knight

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Nil

ADVISE

- Employee Relations Quarterly update presented and noted by Committee.
- Slight decrease in PDRs in month. Ongoing plan for improvement in place.
- There are a number of HCA vacancies. Plans in place to address including events set up over the next six weeks.
- Equality Delivery System 2022 (EDS2022). A self-assessment is currently being undertaken. There are three Domains with each Domain having their own action plan. Domain 3 Inclusive Leadership remains outstanding. The team are working closely with S&O Executives and STHK on this.
- Sickness absence presentation delivered to the Committee with ongoing plans to improve sickness absence in the next quarter.
- Time to Hire 3-day decline in month. Review undertaken and improvement expected in the next few months.

ASSURE

- Board Assurance Framework SO4 and SO5 – both have been reviewed and updated in January 2023 with mitigations and actions.
- Our People Plan Quarterly report was presented, and good progress noted.
- Flu vaccinations are at 78% and Covid at 56%. The Trust is in the highest quartile in the North West for take up.
- Vacancies:
    - Medical vacancies continue to show improvements currently at 4.2% against a target of 5.8% which is great news. It was noted that there are 15 posts under offer.
    - Nursing vacancies are at 10% against a target of 9%. It was noted that there are 24 new starters in January 2023.
    - AHPs are noted to be at their lowest number of vacancies at 5.6% against a target of 9% with 13 posts also under offer.
- Patients Equality Monitoring report noted and approved by the Committee. This will be shared the Trust website.
- The following HR policies were approved:
    - *CORP 68 Equality Analysis Guidance*
    - *PERS 43 Induction, Core Mandatory & Essential Skills Training Policy*
    - *PERS 44 Transitioning in the Workplace Policy*
    - *PERS 08 New and Expectant Parents Policy (Maternity Paternity Shared Adoption leave)*

New Risks identified at the meeting: risk of industrial action which has been added to corporate risk register

Review of the Risk Register: Yes

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**01 February 2023**
Agenda Item	**SO015/23**	**FOI Exempt**	**NO**
Report Title	**OUR PEOPLE PLAN – QUARTERLY UPDATE**		
Executive Lead	Jane Royds, Director of Human Resources and Organisation Design		
Lead Officer	Tracy Gunn, Head of Education, Training and Organisation Design		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

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

Executive Summary

Progress against the 19 key deliverables is as follows - 17 are in progress (green) and two have identified issues to be resolved (amber).

The People Plan Integrated Performance Report (IPR) measures the impact of *Our People Plan* programmes of work against the aspirational targets to be achieved by 2023.

The People Plan IPR data for January 2023 remains static for the Belonging to the NHS and Staff Engagement sections as this data is drawn once a year.

Recommendations

Strategy & Operations Committee to note the progress being made to provide assurance on delivery of the Trust's '*Our People Plan'*.

Previously Considered By:

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

Strategic Objectives

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

Prepared By:	Presented By:
Jane Royds, Director of Human Resources and Organisation Design	Tracy Gunn, Head of Education, Training and Organisation Design

'People Plan' – Quarterly Progress Update Jan 2023

1. Purpose

This report provides the quarterly update on the progress against the key programmes of work identified in the Trust's *People Plan* and the key deliverables informed by the Staff Survey 2021.

2. Background

The results from the Annual Staff Survey are used to inform the annual key deliverables that support the Trust's *Our People Plan* and ensure action was taken from the feedback received from staff.

Based on the 2021 Staff Survey results released in March 2022, the key deliverables for 2022/23 were reviewed and refreshed by Valuing Our People & Inclusion group (VOPIG) - see Appendix 1. The Trust's Workforce & OD Strategy has a 2-year timescale and is ready for review in 2023. This timing perfectly aligns with the strengthening ties with our StHK partners.

3. Our People Plan – Key Deliverables 2022/23

Progress against the 19 key deliverables is as follows, 17 are in progress (green), 2 have identified issues to be resolved (amber).

Since the last report, the following activity has taken place:

- Along with Sefton Place partners, the Trust held its sixth Schwartz Round in November 2022 and smaller 'Team Time' rounds have taken place in CCU.
- More than 30 staff have been referred to the individual restoration programme; evaluation of the programme is currently being undertaken.
- A nursing and midwifery workforce plan was approved in September 2022, and an aligned medical workforce plan is under development.
- A nursing career pathway with associated leadership development offer was presented to WIG in October receiving support to align to the overall leadership offer for staff. An Operations Career Framework is under development and work is underway to embed the Maternity Support Worker competency framework with HEE.
- The Trust has been awarded the Navajo Charter Mark signifying good practice, commitment and knowledge of the specific needs, issues and barriers facing LGBT+ people. The Trust is a Disability Confident Employer and is in the process of applying for the Fair Employment Charter at aspiring level.
- Staff networks were launched in November 2022, and a second phase of networks is scheduled for January 2023. There has been limited attendance to date but increased communications for this month's networks has taken place.
- Delivery of a suite of Equality, Diversity and Inclusion training commenced in October and will run until Spring 2023.

- A review of recruitment and selection processes at the Trust has commenced, resulting so far in the development of a statement for inclusion on all recruitment adverts (offering support to individuals to access and complete online applications via NHS Jobs), as well as the inclusion of Navajo & Disability Confident charter marks on recruitment materials. Next steps are to process map the full recruitment process with a view to identifying the hot spots for action.
- The third programme of events under the Trust's Staff Voice Partnership engagement strategy will commence in January 2023. There is a move to align the Staff Voice Partnership programme and processes in sync with StHK moving forwards.
- Civility & respect training was launched late 2022 with limited attendance due to capacity issues. Further dates will be released for Spring 2023. Civility & respect forms an integral part of our new starter induction programme. In the interim, there is a focus on teams where issues have been identified.
- The Trust has embedded the new AfC I.T. system with positive results
- There has been an extensive focus on health & wellbeing e.g. flu & covid vaccination programme, financial & psychological wellbeing by signposting to support systems, individual support by the H&W department.
- The Trust has launched its revised leadership development offer to include apprenticeships, NHS Leadership Academy and AQuA programmes & courses
- Just & Learning – a management guidance document has been completed and work continues to develop employee and witness guidelines.
- The HR policy review schedule is making good progress to ensure compliance

The deliverables with identified issues/making slow progress are – roll out of reverse mentoring and management essentials training which will be reviewed with StHK as we form one organisation.

4. Our People Plan – Measures of Success

In the last quarter, the number of live ER cases has risen compared to the target of 10 per month but some of these are appeals. The majority are relating to grievances which remain ongoing. It is worth noting that whilst grievances have risen, it can be seen as a positive indicator that staff feel safe to raise their concerns. Sickness absence had some green shoots in the early part of the last quarter but has increased in November and December as the seasonal rise in absence rates starts to be seen. Data for Q3 for staff engagement will be available once confirmed from the national staff survey results 2022.

5. Recommendations

Strategy & Operations Committee to note the progress being made to provide assurance on delivery of the Trust's *Our People Plan*.

Appendix 1 ***Our People Plan*** **– Key Deliverables 2022/23**

Key Areas of Focus	Key deliverables 2022/23	Mar'22 progress rating (where applicable)	Jul 2022	Oct 2022	Jan 2023
Looking after our people	6 weekly Schwartz Rounds and introduce Team Talks (CCU)		Green	Green	Green
	Develop an annual HR Policy Development framework (2021/22)	Amber	Amber	Green	Green
	Launch Just and Learning / Civility and Respect training		Green	Amber	Green
	Develop Management Essentials training inc. flexible working requests		Amber	Amber	Amber
	Winter vaccination programme – flu & covid		Green	Green	Green
	>20 staff completed Individual Restoration programme		Green	Green	Green
	Revised Health and Wellbeing strategy		Green	Green	Green
Belonging to the NHS	Deliver suite of EDI training (2021/22)	Amber	Amber	Green	Green
	Establish Staff Networks (2021/22)	Amber	Amber	Green	Green
	Revise and align leadership development offer (2021/22)	Green	Amber	Green	Green
	Introduce reverse mentoring (2021/22)	Amber	Amber	Green	Amber
	Launch Staff Voice Partnership		Green	Green	Green
	Review of R&S Process		Amber	Green	Green
New ways of working	Increased oversight of flexible working requests		Amber	Green	Green
	Review HR systems (2022/23)	Green	Green	Green	Green
	Develop Trust Clinical Workforce Plan (2022/23)	Green	Green	Green	Green
	Further roll out of STAR workforce planning methodology		Green	Green	Green
Growing for the future	Development of Advanced Clinical Practitioner roles		Green	Green	Green
	Maximise opportunities for SAS and Trust Grade doctors		Green	Green	Green

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Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**01 February 2023**
Agenda Item	**SO016/23**	**FOI Exempt**	**NO**
Report Title	**GUARDIAN OF SAFE WORKING QUARTERLY REPORTS (01 JULY TO 30 SEPTEMBER 2022 AND 01 OCTOBER TO 31 DECEMBER 2022)**		
Executive Lead	Kate Clark, Medical Director		
Lead Officer	Kate Clark, Medical Director		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To update on issues related to Guardian of Safe Working.

Executive Summary

Key Messages of this Report & Recommendations:

- Trainees are much more engaged with the exception report process.
- Supervisor meetings are not consistently taking place within the recommended timescale
- Trainees continuing to stay late in Medicine, an extraordinary meeting took place with DME, MD, BMA representative & trainees to identify and resolve issues. Actions are monitored through the trainee doctor's forum (TDF)
- Trainees are at times struggling to comply with the required Self-development time; this will be resolved by changes to rosters to allow a half or full day.
- Issues around phlebotomy services not providing adequate ward service.
- Guardian of Safe Working post remains vacant.
- Partial spend of the HEE Facilities funding, updates provided to TDF and JMSNC)

Recommendations

The Strategy and Operations Committee is asked to receive the Guardian of Safe Working Quarterly Reports.

Previously Considered By:

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

Strategic Objectives

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

☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Kate Clark, Medical Director	Kate Clark, Medical Director

Southport and Ormskirk Hospital NHS Trust

THE GUARDIAN OF SAFE WORKING
QUARTERLY TRUST REPORT

01 July 2022 – 30 September 2022

And

01 October – 31 December 2022

INTRODUCTION

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

1. EXCEPTION REPORT OVERVIEW

July - September 2022 (Q2)

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

Trainees are much more engaged with the Exception Report system overall. There is still a tendency for juniors to report for compensation rather than improvement of working conditions, although this is being discussed within the Trainee Doctor Forum (TDF). This has led to recent submissions of exception reports regarding levels of senior support during a shift which was addressed promptly by the clinical director. It is therefore encouraging to see that the system is being used to report more than just additional hours. There has also been improvement in the reporting from non-foundation doctors, which again is encouraging as the system is in place for all junior doctors.

Meetings with Education Supervisors are not consistently being recorded on the system, and not always within the recommended timescales. The importance of these meetings and ensuring that the doctors concerns are addressed is being reiterated to the Supervisors; the Resourcing team are issuing reminders to the Supervisors with outstanding exceptions each week.

It has also again been stated that consultants are discouraging exception reporting in some areas and again clear messaging is going to consultants to advise against this.

Some Consultants continue to expect new trainees to be up to speed immediately in new role (balance between being new and performing at expected level for a new trainee). This is being addressed through CBU meetings.

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

Reference period of report	01/07/2022 – 30/09/22
Total number of exception reports received	50
Number relating to immediate patient safety issues	0
Number relating to hours of working	40
Number relating to pattern of work	7
Number relating to educational opportunities	2
Number relating to service support available to the doctor	2

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	9
Total number of overtime payments	34
Total number of work schedule reviews	0
Total number of reports resulting in no action	2
Total number of organisation changes	0
Compensation	0
Unresolved	5
Total number of resolutions	**45**
Total resolved exceptions	**45**

1.1. MEDICINE

Workload across the organisation remains high and this is reflected in the 36 exceptions raised. 32 of the exceptions related to foundation doctors and due to the volume of exceptions raised a meeting was arranged to allow conversations to take place to attempt to resolve some of the issues identified.

1.2. SURGERY

13 Exception Reports this quarter generally for additional hours due to excessive workload. These are predominantly on the Junior rota, and work is ongoing to try to improve this.

The remaining exception was in Ophthalmology due to a lack of senior support as a result of sickness

2. EXCEPTION REPORT OVERVIEW

October - December 2022 (Q3)

Again during the period we have seen a spike in COVID related absence, particularly in December, and this coupled with the demands on the services has meant unprecedented levels of patients within the Trust.

There continues to be a strong level of engagement with the system, with 30 exceptions being raised during this period. It is disappointing that we still are not making progress in getting exception meetings recorded on the system and exceptions closed, however we will continue to work to ensure that this becomes standard practice.

Reference period of report	01/10/2022 – 31/12/22
Total number of exception reports received	30
Number relating to immediate patient safety issues	2
Number relating to hours of working	20
Number relating to pattern of work	0
Number relating to educational opportunities	4
Number relating to service support available to the doctor	4

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	2
Total number of overtime payments	5
Total number of work schedule reviews	0
Total number of reports resulting in no action	2
Total number of organisation changes	0
Compensation	0
Unresolved	
Total number of resolutions	**7**
Total resolved exceptions	**23**

Due annual leave the resolution payments have not yet been actioned, the instructions will be given to payroll during January.

2.1. MEDICINE

Workload across the organisation remains high and this is reflected in the 18 exceptions raised. The general feeling of the exceptions was that they are working regular additional hours due to the volume of work. This was referenced within the 2 reports relating to immediate patient safety issues. Due to short notice sickness a junior was asked to stay additional hours following a night shift until cover was identified; this was escalated at the time and the Associate Medical Director for Medicine & Emergency Care held the bleep and released the doctor. The second related to a gap in FY1 weekend cover which had not been filled by agency or bank.

2.2. SURGERY

12 Exception Reports this quarter generally for additional hours due to excessive workload. These are predominantly relating to foundation doctors and work is ongoing to try to improve this.

3. PAYMENT AND FINES

There have been no GoSW fines levied in the last 12 months.

4. ROTA COMPLIANCE AND IN-HOUSE LOCUM ARRANGEMENTS

There were no Work schedule reviews during this period.

All rotas are now compliant with the 2016 Junior Doctor Contract rule.

DOCTORS NOT ON THE NEW CONTRACT

All trainees are on the 2016 contract.

The issues reported as immediate patient safety concerns were also escalated to the MD and DME. No patients came to harm as a result.

5. VACANCIES (as of 30 September 2022)

SOHT continue to actively recruit and therefore vacancy rates are changing frequently – there are currently 9 vacancies spread across the specialties.

A number of offers have very recently been made and this has been partly due to HR pushing hard to advertise. The overall number of vacancies is reducing, and this is helping to reduce episodes of excessive workload.

However there has been a rise in sickness (mainly due to Covid) and this has led to short notice rota gaps and has had an impact on staffing levels particularly overnight. It is also noted that the amount of doctors required to provide safe care in MEC does not match the current establishment and the team are reliant on bank and agency workers to support this.

6. TRAINEE CONCERNS

Trainee Doctor forums have been held, alongside separate meetings with the foundation doctors to try to look for solutions to reduce the number of exceptions reports received

a) Attendance at the TDF continues to be variable with agreement that the year representatives will collate feedback from colleagues prior to the meetings.

b) Self-Development Time is now included in all relevant rotas. This is mostly in blocks of four or more hours which is popular and said to work well. As a result of feedback this has been extended on to the medicine rotas and as a result there are fewer exceptions raised around inability to take this time.

c) Trainees report delayed responses to annual leave requests and cancellation of expected leave at very short notice. An SOP has been agreed to provide a response and sign off within seven days of submission. This is being monitored through the CBUs and the TDF.

One trainee escalated a concern to the MD who was able to resolve it with the support of the CBU.

7. FACILITIES

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

There remains an outstanding proposal to change the kitchen/bar/toilets area in the CEC to a bigger sleep area with non-gendered bathrooms. Estate's capacity to do this remains an issue.

8. ADDITIONAL GOSW CONCERNS

1) The post remains vacant following multiple advertisements. An individual has made enquiries and has sought counsel from the previous post-holder and the GoSW at STHK and is likely to submit an expression of interest. There is support from BMA, junior doctors, and the Trust to expedite the recruitment process as soon as this has been submitted.

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Finance, Performance, and Investment Committee
MEETING DATE:	23 January 2023
LEAD:	Jeff Kozer

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- The Trust is reporting a £13.8m deficit at month 9, which is in line with the financial plan. £10.6m of the Cost Improvement Target (CIP) target is RAG rated as green and at month 9 the Trust is delivering to plan. With regards to Elective Recovery Fund (ERF) the Trust has assumed payment in full up to month 9. There were significant non-elective pressures in December with one of the results being that the plan for 11a to be a nurse lead unit has had to be delayed until the end of January. The pressure relating to the pay award and non-pay inflation as well as non-elective pressures is being monitored closely to ensure the yearend forecast of a £14.2m deficit is achieved.
- The cash balance at the end of December is £7.4m. The ICB finance team have facilitated the Trust being advanced £9m but as previously reported this will be repayable by the end of March. The Committee agreed to recommend to SOC a loan request to be made in February of circa £8.7m, which will enable the Trust to draw down the cash in March.
- There have been issues with the pharmacy robots on both sites, and therefore this will be taken into consideration in capital planning for 2023/24 and beyond.
- Overall A&E performance in December 2022 compares positively to peers (second best across NW and 22nd/111 nationally) but significantly below the national standard.
- Increase in covid, flu, staff sickness absence and industrial action led to high levels of bed occupancy and challenges with patient flow.

ADVISE

- Cheshire and Merseyside ICB have confirmed that there will be no clawback for ERF under performance for the remainder of 2022/23.
- As at month 9 Cheshire and Merseyside ICB has a circa £30m gap to achieve the 2022/23 plan. There are several measures being proposed, and of those Southport and Ormskirk are likely to receive further funding of circa £400k. As a consequence, the ICB will expect the Trust to improve its plan accordingly, resulting in a forecast of £13.8m deficit
- The draft plan for 2023/24 is due the week commencing 20th February with the final plan being due week commencing 27 March.
- ERF Activity for December 2022 fell from 107% in November 2022, highest level ever on record to 95% in December 2022.

ASSURE

- The Better Payment Practice Code (BPPC) performance at month 9 is 96%, which is slightly above the 95% target.
- The capital programme spend at month 9 is slightly below the plan of £12.3m at £10.7m, and all schemes including important backlog schemes such as fire safety and primary electrical infrastructure are on track to fully utilise the £27.8m allocated in 2022/23.
- The Trust is 1 of only 2 trusts in the Cheshire and Merseyside ICB to see a reduction in agency spend in year compared to 2021/22, with a 25% reduction.
- CDC went live 16 January 2023 at SDGH offering 12 hours per day/7 days per week across a number of modalities.

• Second CT Scanner (mobile) in place from late January 2023 to support reducing backlog and increase resilience for the sole CT scanner. • Endoscopy modular build at ODGH started 16 January 2023.
New Risks identified at the meeting: None
Review of the Risk Register: No action taken

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Executive Committee
MEETINGS HELD:	December 2022 and January 2023
LEAD:	Anne-Marie Stretch, Managing Director

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Preparation for Industrial Action (standing item)
The Committee received weekly updates on the potential for industrial action from several unions representing NHS staff. The outcome of the RCN and Unison ballots for the Trust was that there was not a mandate to take strike action. It was noted that members of the Chartered Society of Physiotherapists would be taking strike action on 26 January and plans had been put in place to mitigate the effect of this action. The Committee also planned for the indirect impact of industrial action at other Trusts.

Ascom /Pager Network Issues (05/12/2022)
The Committee received an update on the ongoing issues being experienced with the Ascom phone/pager issues. Remediation work was undertaken by the supplier on the RF pagers in December, which has had a positive impact on the reliability of the solution. Datix issues in relation to the Ascom RF Pagers failures have significantly reduced following the changes that have been made and monitoring is ongoing. However, the Wireless Ascom handsets are still proving to be problematic. An ongoing piece of work to redesign the wireless network to resolve this issue is underway, with a pilot of the new configuration to take place

Theatre Cleanliness (19/12/2022)
The Committee received a report on issues that had been identified in relation to the standards of cleaning and IPC risks in some of the theatres and that different operating models for cleaning were used on the two different sites. Remedial action had been taken and proposals for a standardised approach were being developed.

ADVISE

Maternity Action Plan Update (bi-weekly standing item)
The Executive Committee received updates on the progress of implementing and embedding the plan and it was noted that all actions were now complete.

Policy Management Update (05/12/2022)
The Committee receive an update on the management of Trust policies. Capacity was identified as a risk to maintaining the policy review administrative process and temporary additional resources had been sought to assist. The Committee had approved an extension to review dates for several policies that were legally compliant but only needed to be updated to reflect the Trust's just and learning culture. The Committee had also approved the archiving of several policies that were no longer required.

Clinical Negligence Scheme for Trusts (CNST) Business Case (05/12/2022)
The Committee had approved the business case for the development of the Neonatal workforce and the investment would support delivery of the Ockenden recommendations and Clinical Negligence Scheme for Trusts (CNST) maternity safety standards, for the medical workforce.

Spinal Integrated Community Care Service Contract (05/12/2022)
The Committee approved the awarding of the two-year Spinal Integrated Community Care Service Contract to Revitalise.

Essential Skills Training Update (12/12/2022 and 23/01/2023)
The Essential Skills Training update was discussed, and it was noted that low compliance with the newly introduced Fire Safety Models had impacted on the Trust's overall compliance. The national Tier 1 online module for learning disabilities and autism training was now available via the Electronic Staff Records (ESR) system. This training had previously been provided by the Trust's Safeguarding team. Essential skills compliance would continue to receive Eexecutive committee oversight.

Resuscitation Training Update (12/12/2022)
The Committee received an update on the Resuscitation Training, and it was noted that there had been an improvement in compliance. Executive committee oversight would continue.

Monthly Nurse Staffing Report (19/12/2022 and 16/01/2023)
The Committee received an update on the monthly nurse staffing, vacancy rates, recruitment, and establishment reviews and assurance provided that measures were in place to maintain and deliver minimum safe nurse staffing levels. It was noted that the Nursing Establishment Review had been completed and was currently undergoing triangulation with the clinical priorities and current available resources.

Clinical Negligence Scheme for Trusts (CNST) Compliance Update (19/12/2022)
The Committee was advised that the Trust had achieved compliance against nine of the ten safety actions and noted that the final safety action would be completed by mid-January 2023.

Future Clinical Photography Provision at S&O (19/12/2022)
The Committee reviewed a proposal to develop a dedicated service at S&O and agreed to put this on the list of cost pressures for 2023/24.

Mutual Aid Support for StHK T&O (19/12/2022)
The Committee reviewed the plan that had been developed to enable STHK to utilise a theatre at Ormskirk to continue delivery of orthopaedic activity while essential maintenance work was undertaken on the StHK suite of theatres, to commence on 09 January 2023. Any impact on S&O elective recovery capacity had been mitigated.

Incident Investigation Resource (23/01/2023)
The Committee discussed the business case for additional resources to support the new national Patient Safety Incident Response Framework (PSIRF) which all Trusts would be required to implement by October 2023. It was agreed that further consideration was required to the Trust approach..

Robotic Process Automation (RPA) (24/01/2023)
The Committee received a progress report on the project for RPA to support routine administrative process to support several operational processes e.g., Appointment slot allocations and the download of data from clinical systems.

Medical Education External Quality Review Feedback (University of Liverpool & HEENW) (24/01/2023)
The Committee received an update on the feedback following the recent external quality review visits. An action plan will be developed and evidence provided to both the University and HEENW.

Frontline Digitisation Funding 2022-2024 Investment Agreement

The Committee reviewed and approved the investment agreement and Memorandum o Understanding to enable the draw down of the 2022/23 funds from the frontline Digitisation Funding allocation.

ASSURE

System Meetings (standing item)
Directors provided feedback from several external meetings and events with system partners where they had represented the Trust.

Capital Planning Assurance Group Weekly Update (standing item)
The Committee received the Capital Planning Assurance Group weekly progress report and remain assured of the progress being made to deliver the Targeted Investment Fund (TiF) and Community Diagnostic Centre (CDC) developments, including the recruitment of staff.

MIAA Risk Management – Core Controls (Final Report) (19/12/2023)
The Committee received assurance that, following a review of the risk management core controls, there was a high level of assurance. It was noted that the agreed actions in respect of the two low risk recommendations had been completed.

MIAA Southport and Ormskirk Clinical Assessment and Accreditation Scheme (SOCAAS) Review (16/01/2023)
The Committee noted that the Trust had received 'substantial assurance' following a review of the ward accreditation scheme.

Clinical Negligence Scheme for Trusts (CNST) Declaration (fully compliant) (16/01/2023)
The Committee received confirmation that the Trust had achieved full compliance against all ten safety actions and noted that the Trust declaration would be presented to the Strategy and Operations Committee on 1st February for approval.

Equality Delivery System (EDS) 2022 (24/01/2023)
The Committee received the Equality Delivery System (EDS) 2022 report which provided an overview of the activity to date to meet the EDS programme. This included an update on the Trust's approach to the delivery of the CORE25PLUS5, a national NHSE approach to support the reduction of health inequalities at both system and national level

Cost Improvement Programme (CIP) Update (24/01/2023)
CIP had been delivered to plan to month 9 and schemes were progressing through the weekly Quality Impact Assessments (QIA) Panels. The Committee was assured of the focus on the delivery of 2022/23 plans as well as the development of the 2023/24 plans.

New Risk identified at the meeting	None

Review of the Risk Register
The following risks referenced in the Alerts section and included on the Trust's Risk Register have been discussed by the Executive Committee:

- Risk 2237 Ascom - Poor Ascom signal
- Risk 2549 Risk Industrial Action – Potential impact of industrial action to Southport and Ormskirk Hospitals Mental Health (in reach) and walk in centres