NHS
Southport and Ormskirk Hospital
NHS Trust

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

To be held at 0930 on Wednesday 03 May 2023

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0930***
SO075/23 (P)	**Patient Story** *Purpose: To **receive** the patient story*	*No*	*L Barnes*	15 mins
SO076/23 (V)	**Chair's welcome and note of apologies** *Purpose: To **record** apologies for absence and confirm the meeting is quorate.*	*No*	*Chair*	
SO077/23 (D)	**Declaration of interests** *Purpose: To **record** any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
SO078/23 (D)	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 05 April 2023*	No	*Chair*	10 mins
SO079/23 (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**
SO080/23 (D)	**Audit Committee AAA Highlight Report** *Purpose: To **receive** the Audit Committee Highlight Report from the meeting held on 19 April 2023*	*No*	*I Clayton*	10 mins
INTEGRATED PERFORMANCE REPORT				**1005**
SO081/23 (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				**1025**
SO082/23 (D)	**Quality and Safety Reports** a) Committee AAA Highlight Report *Purpose: To **receive** the Quality and Safety Reports for information and assurance*	*No*	*G Brown*	10 mins
SO083/23 (D)	**Infection Prevention and Control (IPC) Board Assurance Framework (BAF)** *Purpose: To **receive** the Infection Prevention and Control (IPC) Board Assurance Framework (BAF)*	*No*	*K Clark*	10 mins
WORKFORCE				**1045**
SO084/23 (D)	**Workforce Reports** a) Committee AAA Highlight Report *Purpose: To **receive** the Workforce reports*	*No*	*L Knight*	10 Mins
SO085/23 (D)	**Freedom to Speak Up Report – Quarter 4** *Purpose: To **note** the Freedom to Speak Up Report (Quarter 4)*	*No*	*L Barnes*	15 mins
SO086/23 (D)	**Guardian of Safe Working Reports** a) Quarter 4 b) Annual Report *Purpose: To **receive** the Guardian of Safe Working Report*	*No*	*K Clark*	10 mins
FINANCE, OPERATIONS AND INVESTMENT				**1120**
SO087/23 (D)	**Finance, Performance, and Investment Reports** a) Committee AAA Highlight Report *Purpose: To **receive** the Finance, Performance, and Investment Reports*	*No*	*J Kozer*	10 mins
CORPORATE				**1130**
SO088/23 (D)	**Executive Committee AAA Highlight Report** *Purpose: To **receive** the Executive Committee AAA Highlight Report for meetings held in March 2023*	*No*	*AM Stretch*	10 Mins
CONCLUDING BUSINESS				**1140**
SO089/23 (V)	**Questions from Members of the Public**		*Chair*	*5 mins*

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

SO090/23 (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 07 June 2023		***12:00 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: Geoffrey Appleton

Approved Minutes of the Strategy and Operations Committee (Part 1)
Held on Microsoft Teams
Wednesday 05 April 2023
(Approved by the Strategy and Operations Committee on 03 May 2023)

Present

Name	Initials	Title
Geoffrey Appleton	GA	Non-Executive Director, STHK (Chair)
Ann Marr	AM	Chief Executive
Lynne Barnes	LB	Director of Nursing, Midwifery and Therapies
Gill Brown	GB	Non-Executive Director, STHK & S&O
Nicola Bunce	NB	Director of Corporate Services
Kate Clark	KC	Medical Director
Ian Clayton	IC	Non-Executive Director, STHK & S&O
Lisa Knight	LK	Non-Executive Director, STHK
Jeff Kozer	JK	Non-Executive Director, STHK
John McLuckie	JMcL	Director of Finance
Lesley Neary	LN	Chief Operating Officer
Sue Redfern	SR	Director of Nursing, Midwifery and Governance, STHK
Jane Royds	JR	Director of HR and OD
Rani Thind	RT	Associate Non-Executive Director, STHK
Christine Walters	CW	Director of Informatics, STHK
Peter Williams	PW	Medical Director, STHK

In Attendance

Name	Initials	Title
Matthew Burch	MB	Healthcare Partnership Manager, Pfizer Ltd *(observer)*
Elaine Deeming	ED	Assistant Director of Nursing and End of Life Lead *(Item SO050/23)*
Kate Edmondson	KE	Patient Experience Facilitator *(Item SO050/23)*
Lionel Johnson	LJ	Member of Public
Christine Griffith-Evans	CGE	Freedom to Speak Up Guardian *(Item SO063/23)*
Juanita Wallace	JW	Assistant to Director of Corporate Services (minute taker)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Rob Cooper	RC	Managing Director and Director of Operations and Performance, STHK
Richard Fraser	RF	Chair, STHK (Chair)
Paul Growney	PG	Associated Non-Executive Director, STHK
Gareth Lawrence	GL	Director of Finance, STHK
Nina Russell	NR	Director of Transformation
Anne-Marie Stretch	AMS	Managing Director

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
SO050/23	**Patient Story**	

	LB and ED presented the patient story video in which a member of Trust staff recalled her experiences of the care and support provided by the Intensive Care Unit (ICU) team, when her husband was receiving end of life care and died in July 2020, whilst Covid-19 restrictions were still in place. The story focused on how the staff had communicated with the family and supported them after the bereavement as well. ED commented that it had been very brave of the member of staff to share her experience and that several of the initiatives that the Trust had introduced to support the families of patients during Covid-19 had been maintained, including the memory boxes, which were funded from charitable funds and follow up contact after a patient had died at the Trust. This follow up contact had been extended beyond ICU, and in the last two years over 80% of relatives now received a follow up call to pass on the Trust's condolences and to offer any additional support and information about what needed to be done following a death. This was a way of alleviating the fears and worries of the relatives. Further change was the butterfly initiative where a sign was put up to indicate grieving relatives were in a room, so that staff were aware and could respect their privacy. The Oasis Room had also been created, with facilities for family members to remain close to end of life patients. Charitable Funds had also supported the refurbishment of this area to make it a suitable environment for relatives who wanted to remain on site. ED noted that, there had been an increase in the number of the end-of-life care complaints during Covid-19, but this had improved now that face-to-face discussions and visiting was allowed again. There had also been a number of compliments received from relatives about the high quality and compassionate care that had been provided as well as the kindness that they had experienced. ED highlighted the following initiatives which contributed to this care: • The introduction of 'The Pause' to end of life care in which staff and family members took a moment to pause around the bedside of a deceased patient without lots of medical interventions. This had been successful and was planned to be introduced to other wards who cared for end-of-life patients. • The introduction of the 'Honour Walk' in which staff took a moment to pause as a deceased patient left the ward on their last journey to the mortuary. • The mortuary corridor had been cleared to provide a more conducive environment for relatives going to the viewing room.	

	• The last National Audit of Care at the End of Life (NACEL) score for the Trust had been below the national average, however, this had been used as the basis of the improvement plan for End-of-Life Care. GA thanked the staff member for sharing her story and reflected on the impact of the butterfly initiative. JMcL commented that when he had started with the Trust in 2021 the refurbishment of the Oasis Room was being discussed and thanked ED for her tenacity to make this happen. GB reflected on the story and commented that the NACEL results were not what she had expected and asked if there were any reasons for this. ED advised that the NACEL audit related to the Trust's position in 2021/22 and that one of the areas of concern had been about communication. Improving communication with the patients and relatives had been an area of focus in the improvement plan and would hopefully be reflected in the results of the next audit. KC added that she was aware that quality discussions about end-of-life care were taking place with patients and their loved ones but sometimes these discussions were still taking place too late in the patients' journey. KC noted that this also continued to be an area of focus with clinicians. **RESOLVED** The Strategy and Operations Committee **received** the Patient Story	
SO051/23	**Chair's Welcome and Note of Apologies**	
	GA welcomed all to the meeting and noted that Matthew Burch, Healthcare Partnership Manager, Pfizer Ltd and Lionel Johnson, a member of the public were in attendance, LK advised that she had a conflicting commitment and would need to leave the meeting after presenting the Workforce Committee AAA Highlight Report (agenda item SO062/23). GA acknowledged the following Awards and Recognition that the Trust had received recently: • Jo Unsworth, a Bereavement Specialist Midwife at the Trust, received the Bereavement Midwife of the Year Special Recognition Award. • Lynne Barnes was shortlisted for LCR Pride Awards. • Robbie Graham received a National MyPorter Award • One Eyed Jack, (one of the Trust's Therapy dogs) received special mention at Crufts.	

	Apologies for absence were **noted** as detailed above.	
SO052/23	**Declaration of interests**	
	There were no declarations of interests in relation to the agenda items.	
SO053/23	**Minutes of the previous meetings**	
	The Committee reviewed the minutes of the previous meeting held on 01 March 2022 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Strategy and Operations Committee **approved** the minutes from the meeting held 01 March 2023	
SO054/23	**Matters Arising and Action Logs**	
	The meeting considered updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions and it was noted that the following actions had been completed: • SO034/23 – LN advised that an update on the impact of the Chase Heys beds and Ward 11a would be provided under Agenda Item SO057/23b. Action closed. • SO036/23 – JMcL advised that additional information regarding the allocation of the £234,00 received from the Integrated Care Board (ICB) had been forwarded to IC. Action closed. **RESOLVED:** The Strategy and Operations Committee **approved** the action log	
STRATEGIC AND GOVERNANCE		
SO055/23	**Charitable Funds Committee AAA Highlight Report**	
	GB presented the Charitable Funds Committee AAA Highlight Report and advised that no alerts had been raised. GB advised that: • The Committee had discussed the financial performance of the charitable funds to the end of February 2023 and had noted that whilst income levels remained good at £402,000, the rate of donations had slowed over the preceding three months. Additionally, it had been noted that legacies had been the main form of donation, during this period.	

	• There had been a discussion about the transfer of the Southport and Ormskirk Hospitals charitable funds, to the new trust when the Transaction was completed. The Committee had requested clarification on the future use of current unrestricted funds. JMcL advised that the unrestricted funds balance was £6,000 and that this was likely to be spent before the transfer. **RESOLVED:** The Strategy and Operations Committee **noted** the Charitable Funds Committee AAA Highlight Report of the meeting held on 28 March 2023	
SO056/23	**Board Assurance Framework (BAF)**	
	NB presented the Board Assurance Framework (BAF) quarterly update and advised that each lead director had reviewed their risks and that the document had been presented at the Executive Committee as well as the individual strategic objectives being reviewed by the relevant assurance committees. NB noted the progress that has been made against the actions. RT reflected on Strategic Objective 1 controls and felt that the Clinical Negligence Scheme for Trusts (CNST) and Ockenden action plan were different controls and should be listed separately. NB agreed to make this change at the next quarterly review. **Action** The controls section for maternity services (Strategic Objective 1) to be updated. RT noted that the diagnostic target of zero waits of more than six weeks had now been achieved and asked if this should be removed. NB agreed that now the SOC was assured the target was being achieved the action would be removed from the BAF. IC commented on the improvement in the presentation of Strategic Objective 2b BAF risk (condition of Trust estate) and noted that there was now clarity about the gaps in controls and he was assured. GB asked if the ongoing industrial action by the junior doctors should be included on the BAF and KC advised that this had been included on the Corporate Risk Register and was being reviewed regularly at the Risk and Compliance Group. **RESOLVED:**	**N Bunce**

	The Strategy and Operations Committee **approved** the Board Assurance Framework	
INTEGRATED PERFORMANCE REPORT		
SO057/23	The Committee received the Integrated Performance Report (IPR) Summary which provided an update on the Trust's performance against key national and local performance metrics during February 2023.	
	a) Quality and Safety Performance Report	
	LB and KC presented the report which provided an overview of performance against the quality and safety metrics and LB highlighted the following: • One never event, which involved the unintentional connection of a patient requiring oxygen to an air flowmeter, had been reported in February. It was noted that this had been swiftly identified and actions had been put in place to prevent a recurrence. • The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for February 2023 was 94.8%. A number of new HCAs had been recruited which would reduce the vacancy rate, when they took up post. • 64 falls had been recorded in February with two falls resulting in moderate harm. The main learning had been about supervision, completion of falls risk assessments and documentation. It was noted that falls had shown a reduction overall in the year to date. • One category 3 pressure ulcer had been reported in month, which was being investigated but may have been community acquired. • The percentage of complaints responded to within 40 days was 42.1% against a target of 80% and this was a deterioration from 50% in January. Work was ongoing with the Clinical Business Units (CBU) to reduce the backlog of outstanding complaints. Early intervention with patients and families had proved very successful in resolving issues informally. • Friends and Family Test – the % of patients rating the Trust as very good or good had reduced in month to 91.4% compared to 92.3% in January, however, the Trust continued to compare favourably with peers. The Accident and Emergency (A&E) service achieved 87.6% (86.7% Adults and 90% Children's) which was above the target of 77.8% and the national average of 83%. GB commented on the reduction in formal complaints as a result of the early intervention to resolve concerns and acknowledged the significant amount of work being undertaken to achieve this. GB also reflected on the HCA staffing improvement programme and asked if there was a specific action that had resulted in the increased recruitment and retention of HCAs. LB advised that the retention of	

	HCAs had been an area of focus with the Stay and Thrive programme and the HCA preceptorship programme which were both having a positive impact. GA commented that it was important to attract people to build a career in the NHS and many people were not aware of the range of roles and careers that the NHS offered. LB responded that there was work being undertaken with schools and local colleges, she also reflected that the NHS did offer lots of opportunities to train and progress as she had done. KC advised that: • Infection Prevention and Control metrics remained under the trajectory at the end of February. • There had been an increase in the number of Covid-19 cases in the organisation and the levels remained high compared to peers. The Trust's Covid19 testing policy had been aligned to the most recent national guidance that came into effect on 01 April. **RESOLVED** The Strategy and Operations Committee **received** the Quality and Safety Performance Report	
	b) Operational Performance Report	
	LN presented the report which provided a summary of operational activity and constitutional standards performance and highlighted the following: • A&E performance was 74.8% against the four-hour target compared to 71% across the Cheshire and Merseyside (C&M) region and 69.6% nationally. • Paediatric A&E performance had returned to pre-Streptococcus A (Strep A) levels; but attendances were higher than pre-pandemic levels (103% of 2019/20 levels) but the conversion rate to admissions remained the same. • Ambulance handover had improved to 38 minutes against the target of 15 minutes. The average handover time was 52 minutes in the C&M ICB. • Elective recovery performance for February was 97% of the same period in 2019/20 and had improved compared to December 2022 and January 2023. • The Trust remained on target to eliminate 78 week waits by the end of the financial year. There were a few patients who still needed a date, and one impacted by the orthodontics transfers to alternative providers. • Elective diagnostics was at 18.7% not seen in six weeks in February which was an improvement from 25.5% in January.	

- The Community Diagnostic Centre (CDC), which opened on 16 January 2023, had provided an additional 1,450 additional diagnostic tests, however, this was slightly lower than planned because the mobile Computerised Tomography (CT) scanner had not been available for two weeks.
- Cancer services
  - There had been a two-day reduction for CT scans for two-week waiters, a seven-day reduction for Magnetic Resonance Imaging (MRI) scans, and a one-day reduction for a Non-Obstetric Ultrasound (NOUS). There had also been a reduction in the radiology backlogs (47% reduction in patients waiting for a CT scan and a 15% reduction in patients waiting for an MRI).
  - 14-day urgent cancer referral performance was 91.7% in January, but LN advised that there had been continued improvement and there was confidence the 93% target would be achieved in February. LN advised that she had early sight of the data for February and the Trust had achieved over the target of 93%.
  - There had been a further improvement in the over 62-day performance from 92 to 80 during month.
  - 62-day cancer performance had improved from 272 patients to 70 in April.
  - 104-day performance had improved from 203 at the start of the year to 24 and it was noted that all patients were being actively managed.

It was noted that the junior doctors' industrial action in March had resulted in the cancellation of only a small amount of elective activity, but cancer and urgent activity had been maintained. The CBUs were in the process of planning for the next round of junior doctors' industrial action and would follow the same principles of prioritising elective capacity on the basis of clinical need.

LN provided an update on the impact of the Chase Heys beds and the performance of Ward 11a as a discharge facility:

- To date 28 patients had been discharged from Chase Heys of which 22 patients returned home, and eight of these returned home with a reduced package of care. Four patients had returned home with the level of care as anticipated and ten patients were discharged home instead of the anticipated discharge plan.
- There had been six admission avoidances from A&E directly to Chase Heys.

- Ward 11a had previously achieved 16% of patients discharged home before midday, this had improved to 50% in February. The Bartel score on admission to the ward was 53.5 (total dependency) and on discharge, this had improved to 64.7 (moderate dependency).

GB congratulated the teams on these achievements and asked if it was possible to capture the financial savings for the system, or patients being able to return home rather than need an intermediate care facility. LN

	and JMcL agreed to try and model this impact. LN advised that there were further beds available in Chase Heys and, that if funding was available the model could be expanded, and this could result in further savings. **Action** LN and JMcL to calculate the financial savings achieved with the introduction of the Chase Heys and Ward 11a model. GB asked for clarity on the Ears, Nose and Throat (ENT) service and LN explained that this was provided via a service level agreement (SLA) with Liverpool University Hospitals NHS Foundation Trust (LUHFT). LN noted that LUHFT had several vacancies within this service and were therefore finding it difficult to fulfil the SLA. LN advised that she had requested a meeting to discuss what could be done to address the gaps in cover. It was acknowledged that there was a national shortage of ENT specialists. **RESOLVED** The Strategy and Operations Committee **received** the Operational Performance Report	**L Neary / J McLuckie**
	c) Financial Performance Report	
	JMcL presented the report which detailed performance against key financial performance indicators and advised that the Trust had reported a £14.5m deficit at Month 11 in line with the agreed 2022/23 Plan. JMcL highlighted the following: • The cash balance at the end of February was £11.1m and JMcL was confident that the Trust would maintain the minimum required cash balances to the end of the financial year. • The Trust had achieved the Better Payment Practice Code (BPPC) target of 95%. • The Trust was on target to deliver the total Capital plan of £53.4m which included £5.4m of internally generated resources and JMcL thanked the Operational, Estates and Facilities and IT teams for delivering on this. **RESOLVED** The Strategy and Operations Committee **received** the Financial Performance Report	
	d) Workforce Performance Report	
	JR presented the Workforce Performance report and advised that: • The Personal Development Reviews (PDRs) compliance rate had decreased to 74.1% in February from 74.4% in January against the	

	target of 85%. It was noted that this was despite an improvement in the compliance rates for Corporate Services and Estates and Facilities. • Core mandatory training compliance had increased from 88.4% in January to 89% in February against the stretch target of 90%. It was noted that this was the highest compliance rate for the preceding 12 months. • The Trust's overall vacancy rate was7% in February compared to 7.7% in January, and this was the lowest rate in 24 months. • Time to Hire continued to improve and in February was 48 days against the target of 40 days. **RESOLVED** The Strategy and Operations Committee **received** the Workforce Performance Report	
QUALITY AND SAFETY		
SO058/23	**Quality and Safety Reports**	
	a) Quality and Safety Committee AAA Highlight Report	
	GB presented the AAA Highlight report and alerted the Committee to the following: • Work continued to improve the environment and IPC compliance in the Theatres. This included increasing the cleaning hours and aligning to the STHK cleaning schedules. A review of the fabric and condition of theatres on both the Southport and Ormskirk sites was also being undertaken. GB drew attention to the following advise items: • The Bereavement Midwife received special recognition from the Chief National Midwife at the Mariposa Awards. • The Assistant Director of Integrated Governance had presented the plans to implement the Patient Safety Incident Response Framework (PSIRF). • One never event had been recorded and this had emphasised the potential for shared learning as STHK had recorded a similar event earlier in the year. • An update on the radiology discrepancy incidents had been received. Assurance was provided that: • The Quality Priorities Update had demonstrated progress in all areas, and this would be noted in the Quality Account. • The Board Assurance Framework (BAF) Strategic Objective 1 had shown good progress.	

	JMcL advised that he should receive a copy of the theatre infrastructure review by the end of April, and this would be presented to the Executive Committee, and would then inform the 2023/24 capital programme priorities.	
SO059/23	**Quality Improvement Priorities Update**	
	LB and KC presented the Quality Improvement Priorities Update which provided an update on progress against the 2022/23 Quality Priorities and the draft 2023/24 Quality Priority proposals and LB advised that all Quality Priorities had made good progress. LB noted the following key areas: • There had been a 9% reduction in the number of falls against a target of 10% and significant work had been undertaken which included the appointment of a Falls Lead. • There had been a reduction in pressure ulcers as well as an improvement in the reporting and validation of pressure ulcers. The team was currently reviewing the S&O and STHK policies to create a single policy for the new organisation. • The Ockenden action plan has been broadened to encompass the recommendations from both the initial and the final reports and progress was on track. There had been several improvements in maternity services and a Maternity Improvement Group had been established. The Trust had met all the safety standards for the Clinical Negligence Scheme for Trusts (CNST). **RESOLVED:** The Strategy and Operations Committee **received** the Quality Improvement Priorities Update	
SO060/23	**Learning from Deaths Report** (Quarter 3)	
	KC presented the Learning from Deaths Quarter 3 report of 2022/23 and noted that the Medical Examiners office at S&O had been developed as a standalone entity and provided a stage one review of hospital deaths and if any potential learning or concerns were identified then a Structured Judgement Review (SJR) would be completed. It was noted that all Medical Examiners were fully trained to complete these reviews and the team was being expanded to include multi-disciplinary members. KC highlighted the following: • Following a review, no deaths had been identified as avoidable in the reporting period. • The following learning themes had been identified: o Delayed transfers of care - KC noted that the Trust had declared OPEL 4 at the end of December 2022 into the start of 2023 due to operational pressures and there had been an increased	

	length of stay in A&E as well as additional challenges managing the increased number of patients that required transfer to the wards. o Senior decision making / early diagnostics o Use of treatment pathways o Documentation, handover, and transfer o Initial response to deterioration of patients KC advised that work had already been completed to improve the use of Clinical Care pathways and work was ongoing to improve the quality of handovers and communication between departments. **RESOLVED:** The Strategy and Operations Committee **received** the Learning from Deaths Report (Quarter 3)	
SO061/23	**CQC Progress Update**	
	LB presented the CQC Progress Update report which provided a summary of the Trust's current position against the improvement themes from the 'Must and Should' do actions from the 2019 and 2021 Care Quality Commission (CQC) Inspections. The report also provided an overview of progress against the key themes at February 2023 and an outline of the plans of how to continue to monitor improvement and prepare for any future CQC inspections in the new organisation. LB advised that 95 (73%) of the Must and Should Do actions have been fully delivered and closed and the remaining 35 actions were divided into 11 Trust wide on-going themes which would continue to be monitored through the normal governance processes. The Trust was no longer classed as an outlier in any areas by the CQC and the number of enquiries received from the CQC had significantly reduced. IC commented that, whilst good progress had been made, there were still more than a quarter of the actions outstanding and asked if this was acceptable. IC also reflected on the possibility of the new organisation being assessed on Well-Led and receiving a rating of less than outstanding. LB advised that because of the nature of the outstanding issues they were continuously monitored at ward level via the SOCAAS ward accreditation scheme. NB advised that a planned comprehensive CQC inspection during the first year after the transaction would be unlikely because the CQC recognised that changes took time to embed. However, this would not apply to maternity services which were all being inspected following the	

	Ockenden report. NB commented that there was assurance that the CQC "must do" actions had all been completed at the time. GB reflected on the quality ward rounds that took place at STHK which allowed the NEDs to triangulate what was happening on the wards with the information being presented at the Board and committee meetings and hoped that this programme would be introduced across the new Trust. GA commented that there would be some challenges for the NEDs going forward as the quality ward rounds would take place across five different sites. **RESOLVED:** The Strategy and Operations Committee **received** an update on the CQC Progress, Actions, Engagement and Well Led Improvement Journey	
WORKFORCE		
SO062/23	**Workforce Report**	
	a) Workforce Committee AAA Highlight Report	
	LK presented the AAA Highlight report and advised that no alerts had been raised. LK advised that the Annual Staff Survey results had been presented and noted that the Trust had achieved its best score for 'We are compassionate and kind', however 'We are always learning' scored the lowest in the survey. The results for "staff engagement and morale" had declined from the preceding year. It was noted that staff in the Corporate Services and Capital and Facilities department had demonstrated a better experience than clinical areas and this had been discussed at the meeting. Assurance was provided that planning was underway for the proposed Junior Doctors' industrial action in April and the Corporate Risk Register had been updated to include this. *(LK left the meeting)*	
	b) Annual Staff Survey Results	
	JR presented the 2022 Annual Staff Survey Results and advised that the survey had been conducted between September and November 2022, and all full-time, part-time and bank staff were invited to participate. The survey questions were aligned with the NHS People Promise.	

	The results were published nationally on 09 March 2023 and the following was highlighted: • 636,348 staff across 264 NHS organisations responded. • The response rate nationally was 46% compared to 48% in 2021. The response rate for S&O was 34% in 2022 compared to 42% in 2021 and 47% in 2020. • The national survey results had reflected a less engaged and valued workforce, which was illustrated by the current levels of pay dispute and industrial action • The Trust had scored at or below the national average for the Trust peer group in all eight people promise themes. • Capital and Facilities (47.20 %) and Corporate Services (61.10 %) had the highest response rate whilst Medicine and Emergency Care had the lowest response rate (28.46 %). The survey results had been presented to the CBUs to develop plans to address any issues. RT reflected that the experience of many staff at work was often very dependent on their immediate manager and providing the right training and support for line managers could make a big difference. JR commented that a lot of work had been done with line managers in the past, however agreed that further investment was needed. RT commented that, during her recent maternity champion walkabout, she had spoken with a staff member who was due to retire due to the current pressures of the job and asked how the Trust was retaining the skills of staff who retired. JR responded that several staff members who retired did come back to reduced hours or on the bank, but this was an area where more focus was needed to make staff aware of their options. JK commented that people with specific skills were not always good managers and that leadership skills needed to be developed. Additionally, JK noted that the highest group of respondents at 42.20% was in the age group nearing retirement age (51-65). JR advised that work was ongoing to encourage more people into careers with the NHS and this included working with local universities to recruit students. JR advised that talent management was another area of focus and noted that whilst some work had taken place further improvements were needed. GA commented that leadership takes place at all levels, and it was important to identify leaders early in their careers and agreed with JK that the age profile of the workforce across the NHS was a cause for concern.	

	IC reflected on the presentation and the organisation going forward. He noted that there were several areas that both trusts had in common and asked if the Trust would retain the ability to drill down into the results by geographical location to monitor any areas of concern. JR advised that it was anticipated that going forward the drill down would provide a more forensic review of the hotspots and there would be improved information available. AM commented that it took time to build trust at all levels within an organisation and those in leadership positions needed to build this trust by action and it would take a while for the new organisation to achieve this. **RESOLVED:** The Strategy and Operations Committee **received** the Workforce reports	
SO063/23	**Freedom to Speak Up Annual Self-Assessment**	
	CGE presented the Freedom to Speak Up (FTSU) Annual Self-Assessment which provided assurance that the Trust was compliant with the National Speak Up Guardians office standard and noted actions that needed to be considered following the proposed transaction with STHK to further develop the FTSU culture. CGE noted that the results of the 2022 Staff Survey had shown a slight deterioration in the four questions relating to the freedom to speak up process, however, she noted that this deterioration was reflected nationally and that the organisation was currently undergoing a major change. AM reflected on the question about raising and addressing concerns and the importance of communication with staff members. GB agreed with AM and added that she often asked staff about safety concerns and felt there was a good level of awareness of the FTSU process. Additionally, the visibility of NEDs and Executive Directors in clinical areas helped with raising confidence in the FTSU process. CGE acknowledged that there was work to be done around communication and noted that, based on the low number of respondents in some of the hotspot areas identified, it was difficult to identify if there were any formal issues and undertook to investigate this further. **RESOLVED:** The Strategy and Operations Committee **approved** the Freedom to Speak Up Annual Self-Assessment	

FINANCE, OPERATIONS, AND INVESTMENT		
SO064/23	**Finance, Performance, and Investment Committee AAA Highlight Reports**	
	JK presented the AAA Highlight report and alerted that whilst performance against constitutional standards continued to compare well to peers there was still work to be done. JK advised that the 2023/24 final plan had been submitted to the ICB on 27 March and nationally on 30 March but there was a possibility that further amendments would be required to reduce the ICB deficit. Assurance was provided that: • The performance rate for the Better Payment Practice Code (BPPC) at Month 11 was 96% which was slightly above the target of 95% and JK recognised the achievement of this. • Three staff members were taking part in a national theatre initiative to improve theatre productivity. **RESOLVED:** The Strategy and Operations Committee **received** the AAA Report from the Finance, Performance, and Investment Committee	
SO065/23	**2023/24 Opening Budget and Activity Targets**	
	JMcL and LN presented the 2023/24 draft Financial Plan and JMcL advised that the plan had been approved for submission at the Finance, Performance, and Investment Committee. Planning had taken place with STHK to ensure the post transaction financial position would align to the transaction business case. JMcL highlighted the following: • The Trust was presenting a breakeven financial position after receipt of additional capital and revenue allocations which were consistent with the Transaction Business Case • The CIP target remained unchanged at £11.6m (4.5%) • There had been a slight amendment on the capital plan submission from £19.9m to £19.5m It was noted that the plan had not assumed any cash support, however, due to the delay in the transaction, this was a short-term issue and JMcL advised that the agreement with the ICB for advance payment was still in place and this would mitigate the short-term risk. JMcL confirmed that because of the national and ICB overall financial position further iterations of the plan were likely but the Trust had to set an opening operational budget. LN highlighted the following:	

	• The ICB had set each Trust a target for the elective restoration activity based on performance in 2022/23 and the target for S&O was 103% of 2019/20 levels. It was noted that the target for STHK was 109% of 2019/2020 levels. • The four-hour target for A&E performance had reduced from 95% to 76% and LN noted that this was similar to the current Trust performance. • The bed occupancy target of 92% was an area of concern and the feasibility of this target being achieved by each Place was being debated with the ICB. **RESOLVED:** The Strategy and Operations Committee **approved** the 2023/24 Opening Budget and Activity Targets	
CORPORATE GOVERNANCE		
SO066/23	**Executive Committee Report**	
	NB, on behalf of AMS, presented the AAA highlight report that detailed the activity and reports considered by the Executive Committee during March 2023 and advised that several items noted in the report had been addressed earlier in the meeting. NB highlighted the following: • The Trust was preparing for the Junior Doctors' Industrial Action (IA) from 13 to 16 March and lessons learnt from previous IA activity would be taken into account. • The review of radiology had been completed and following this review, no major concerns had been highlighted with the departmental processes. • Good progress had been noted as part of the Cost Improvement Programme (CIP). • The Committee approved the Electronic Prescribing and Medicines Administration (ePMA) Pilot Go live date for 19 April. • The Committee received an update on the progress with the fire safety works at the Southport site and it was noted that Merseyside Fire and Rescue were assured by the progress being made. • The Committee approved the proposal to go to tender for the installation and management of the Electric Vehicle (EV) charging points at both the Southport and Ormskirk sites and it was noted that this formed part of the Green Plan. • The Committee had agreed that HR policies currently under review should not be progressed given the period of TUPE consultation, and that this would be a matter for alignment in the new organisation. • The Committee had been made aware of the recent national communications regarding the use of gas and air in maternity wards and the potential risks of prolonged exposure. It was noted that this	

	was being reviewed by the Health and Safety Team and a risk assessment report and recommendations would be presented to the Executive Committee. GB asked if the CIP and the Quality Impact Assessments (QIA) were always presented at the Executive Committee. JMcL advised that the CIP update report, which was presented at Executive Committee, included a progress update on the QIAs, and the QIAs were signed off by KC and LB from a clinical perspective. All the 2022/23 CIP schemes had undergone the QIA process and NB added that CIP was only transacted if the QIA had been approved. **RESOLVED:** The Strategy and Operations Committee **received** the AAA Highlight Report from the Executive Committee	
CONCLUDING BUSINESS		
SO067/23	**Questions from Members of the Public**	
	GA advised that a question had been submitted by Matthew Burch, Healthcare Partnership Manager, Pfizer and requested that KC provide a response on behalf of the Trust. The question was as follows: '*Has SOHT adopted a proactive and systematic approach to contacting your Covid therapeutic eligible patients as suggested in the NHSE letter? I'd like to understand if anything systematic has been done across the Trust or at individual department level?'* KC provided the following response: S&O has been proactive in supporting a variety of projects to enhance clinical knowledge pertaining to Covid-19 therapies. The Trust actively recruited 252 patients, against a target of 20, to the RECOVERY trial which initially demonstrated the benefits of Neutralising monoclonal antibodies (nMABs). Additionally, the Trust also contributed to the pilot introduction of routine antibody testing for hospitalised Covid-19 positive patients which commenced in July 2021. As a follow-on from this, the Trust worked with system partners and community colleagues to support the identification of eligible patients in the initial rollout of this treatment in November 2021, which was led by the Cheshire & Mersey Delivery Unit (CMDU). At the time of receiving the letter referenced by Mr Burch, the Trust had already compiled and shared this information with CMDU who maintained the list of eligible patients to initiate treatment.	
SO068/23	**Any Other Business**	

	There being no other business, the Chair thanked all for attending and brought the meeting to a close at 12:08 The next meeting would be held on **Wednesday 03 May 2023 at 09.30**	

Strategy and Operations Committee Attendance 2023/24												
STHK Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser	A											
Ann Marr	✓											
Anne-Marie Stretch	A											
Geoffrey Appleton	✓											
Gill Brown	✓											
Nicola Bunce	✓											
Ian Clayton	✓											
Rob Cooper	A											
Paul Growney	A											
Lisa Knight	✓											
Jeff Kozer	✓											
Gareth Lawrence	A											
Sue Redfern	✓											
Rani Thind	✓											
Peter Williams	✓											
Christine Walters	✓											
S&O Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Lynne Barnes	✓											
Kate Clark	✓											
John McLuckie	✓											
Lesley Neary	✓											
Jane Royds	✓											
Nina Russell	A											
Richard Weeks	✓											
✓ = In attendance A = Apologies												

Strategy and Operations Committee (Part 1)

Matters Arising Action Log

Action Log updated 26 April 2023

Southport and Ormskirk Hospital NHS Trust

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

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
SO016/23	01/02/2023	**Guardian of Safe Working Report**	GB commented that one of the issues raised by the trainee doctors was delayed responses to annual leave requests and the cancellation of anticipated leave at short notice. KC advised that this was a historical issue as the Clinical Business Units (CBU) and the Roster Coordinators were managed separately with different Standard Operating Procedures (SOP), however, this was now managed through a centralised team with a consistent SOP and timescales were monitored via the CBU with medical oversight. As part of the work being undertaken by the TDF trainee doctors were more aware of the process to escalate any issues. KC assured that no further issues had been reported since there had been closer scrutiny of compliance. GB requested that the effectiveness of these measures be evaluated in the next GoSW report	KC		May-23	**01/02/2023** -The effectiveness of the revised centralised annual leave booking processes would be reviewed in the next GoSW report **May update:** An update will be provided under Agenda Item SO086/23a.	**Green**
SO056/23	05/04/2023	**Board Assurance Framework**	RT reflected on Strategic Objective 1 controls and felt that the Clinical Negligence Scheme for Trusts (CNST) and Ockenden action plan were different controls and should be listed separately. NB agreed to make this change at the next quarterly review	NB		Aug-23	**05/04/2023** - The controls section for maternity services (Strategic Objective 1) to be updated	**Green**
SO057/23	05/04/2023	**Integrated Performance Report** b) Operational Performance Report	GB commented on the investment that had been made into the Chase Heys and Ward 11a and asked if it was possible to capture what financial savings could be made as patients were being discharged home and not into intermediate care facilities. LN and JMcL would try to collate the evidence of the savings. Additionally, LN advised that there were additional beds available in Chase Heys and, that if it was possible to source the funding and a similar model was established, this could result in further savings.	LN / JMcL		~~01/05/2023~~ 01/07/2023	**05/04/2023** - LN and JMcL to collate evidence of the savings achieved with the introduction of the Chase Heys and Ward 11a model. **May update**: Additional data is required and the Trust was working with PLACE to collect this and an update would be provided in July 2023.	**Green**

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

COMPLETED ACTIONS

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	Status
SO034/23	01/03/2023	**Integrated Performance Report** b) Operational Performance Report	Two key Winter plan schemes (Chase Heys beds and a nurse led ready for discharge ward) had been delayed due to pressures across the system as well as a Covid-19 outbreak at Chase Heys, however these schemes were now in place and there had been improvement in discharges and LN would provide an update at the next meeting	LN		Apr-23	**01/03/2023 -** LN to provide an update at the meeting on 05 April 2023 on the impact of the Chase Heys beds and the Nurse/Therapy Led Ready for Discharge Ward **05/04/2023** - LN provided an update on the impact of the Chase Heys beds and Ward 11a under Agenda Item SO057/23b. **Action closed**	**Completed**
SO036/23	01/03/2023	**Quality Maternity Assurance Report**	IC commented on the £92.8m that NHS England and Improvement had invested into the ICB baselines on a recurrent basis and asked whether the £234,000 allocation that the Trust received was a one-off payment and if any of this had been allocated to overhead support for additional posts or was it direct spend. JMcL advised that this was focused on direct spend and JMcL agreed to provide additional information to IC offline.	JMcL		Apr-23	**01/03/2023** - JMcL to provide additional information to IC about the allocation of the £234,00 received from the ICB before the meeting on 05 April 2023. **05/04/2023** - JMcL advised that the additional information requested had been forwarded to IC. **Action closed**	**Completed**

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	AUDIT COMMITTEE
MEETINGS HELD:	19 April 2023
LEAD:	Ian Clayton

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

No alerts were raised.

ADVISE

- **Internal Audit Progress Report** – two reviews (IM&T: Backup and Resilience, Limited Assurance, and IM&T: Network Monitoring, Moderate Assurance) had been identified and it was advised that the action plan for these would be reviewed at the Executive Committee and a response would be presented by the lead director at the next Audit Committee meeting.
- **Anti-Fraud Annual Report** – it was noted that no new specific issues or risks had been identified. The key risks for fraud continued to be cyber-enabled fraud which included bank mandate fraud and phishing emails.
- **The Counter Fraud Function Standard Return (CFFSR) submission** – The Trust had received an overall rating of Green with two Amber ratings. The two areas rated as Amber related to the need to appoint a new Counter Fraud Champion due to current postholder leaving and the low rate of compliance for Conflict of Interest, although the work undertaken to address this by the Trust was acknowledged.
- **External Audit Strategy Memorandum** outlined the four areas of significant risk:
  - Management override of controls,
  - Risk of fraud in revenue recognition,
  - Valuation of property, plant, and equipment,
  - Risk of fraud in expenditure recognition

  It was noted that these risks were generic across the sector. One enhanced risk (IFRS16 Implementation) was noted as a new risk for the 2022/23 financial year, however as indicated in the accounting policies paper it was expected that the Trust would remain below the materiality threshold.
- **Corporate Register of Interests** – an issue had been identified with the recording of the corporate declaration forms by the medical staff as these had been historically completed as part of their appraisals but had not been passed on to Corporate Governance for inclusion on the Trust register of interests. This would have significantly improved Trust compliance. The medical appraisals system was now changing, and it would no longer be a requirement to complete these forms as part of the appraisal, so in future the medics would be asked to complete their yearly declarations on the Electronic Staff Records (ESR) in the same way as other affected staff and it was anticipated that this would result in an increase in compliance.
- **Accounting Policies** were approved and the impact of the implementation of the IFRS16 was discussed.
- **Effectiveness Review** - It was noted that the Audit Committee continued to perform its duties and no concerns had been raised despite the complexities of the (Agreement of Long Term Collaboration) ALTC governance arrangements.

ASSURE

- **Internal Audit Progress Report** noted that the following reviews from the 2022/23 audit plan had been finalised:
  - IM&T: Backup & Resilience – Limited Assurance
  - IM&T: Network Monitoring – Moderate Assurance
  - Clinical Assessment and Accreditation Scheme (SOCAAS) – Substantial Assurance
  - E-Rostering – Substantial Assurance
- **The Internal Audit Follow Up Report** had noted good progress on implementing the management actions with several actions being superseded as part of the transaction planning.
- **2023/24 Internal Audit Plan** had been drafted on the basis that the transaction would be completed and was reflective of the new organisation and included a combination of risk assessments from both trusts, and the transaction due diligence issues. However, there was also a sizeable contingency in case any issues arose during the merger of the two trusts. It was recognised that the audit plan was backloaded to allow time for the new processes to become embedded in the new Trust. The Committee approved the 2023/24 internal audit plan.
- **Head of Internal Opinion** – the Trust had received a substantial assurance audit opinion in relation to its internal governance and controls.
- **2023/24 Anti-Fraud Annual Workplan** – the workplan had been drafted in advance of the anticipated merger between St Helens and Knowsley NHS Teaching Hospitals (STHK) and Southport and Ormskirk Hospital NHS Trust (S&O) and it was noted that this would be subject to change as the transaction progressed.
- **Compliance with Fit and Proper Person's Test** – assurance was received that the relevant processes continued to be in place and annual checks were undertaken.
- **Board Assurance Framework (BAF)** – the Committee received the BAF which had improved substantially and reflected a greater focus on risk and consequences than previously. It was noted that work was underway to create a single BAF for the new organisation.
- **Aged Debt Analysis** – as part of the preparation work for the pending transaction with STHK a small portion of bad debts had been written off. It was noted that the Trust had also actively reduced debt with STHK which was now 85% less than reported at the end of December 2022.
- **Quotation Waivers** report was received.
- **Final Accounts Timetable** report was received, and it was noted that the meeting dates for the Audit Committee and Extraordinary Board in June had been aligned with STHK. It was noted that Mazaars had agreed in principle to undertake the S&O 2023/24 part year accounts, however this subject to Mazaars formally submitting a proposal and an agreement on fees.

New Risks identified at the meeting	None
Review of the Risk Register? No	

NHS
Southport and Ormskirk Hospital
NHS Trust

Title Of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**03 May 2023**
Agenda Item	**SO081/23**	**FOI Exempt**	**NO**
Report Title	**INTEGRATED PERFORMANCE REPORT (IPR)**		
Executive Lead	EXECUTIVE MANAGEMENT TEAM (EMT)		
Lead Officer	Michael Lightfoot, Head of Information Katharine Martin, Performance & Delivery Manager		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

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

Executive Summary

The performance report includes the Trust indicators relating to the NHS Constitutional standards, the 22/23 National Priorities and internal performance indicators which the Trust has identified as essential measures of operational delivery and assurance. The performance indicators are grouped according to the domains used by regulators in the Well Led Framework. Each indicator, with the exception of the Finance section, has a Statistical process Control (SPC) chart and commentary.

The Performance Summary highlights key changes in Trust performance and outlines specific actions linked to the Trust's improvement plan and key programmes of work.

Recommendation

The Committee is asked to receive the Integrated Performance Report detailing Trust performance in March, unless otherwise stated.

Previously Considered By:

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

Strategic Objectives

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

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

Strategy & Operations Committee - Integrated Performance Report

Performance Summary

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

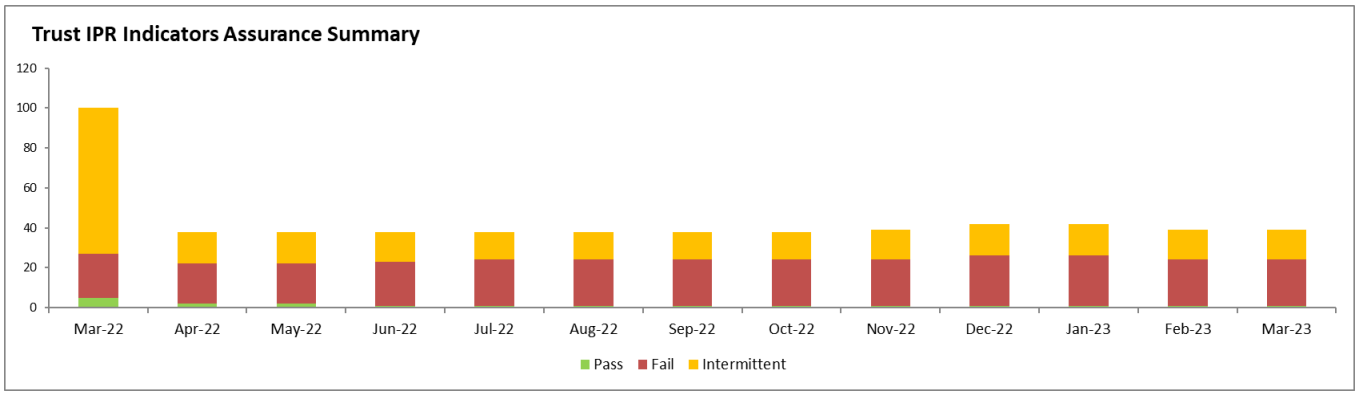
Quality - reflects those metrics aligned to Trust Objective – Care & Safety

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 March 2023 (2022/23 = 3).
There were no cases of MRSA in March. (2022/23 = 0).
There were three C. Difficile (CDI) positive cases reported in March (2022/23 = 48).
The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for March 2023 was 96.4% (2022/23 = 94.2%). This is based on 99.72% for Registered Nurses and 92.64% for Un-Registered Nurses.
There were three category 3 hospital acquired pressure ulcer reported in March, (1 DTI, 1 Unstageable & 1 Medical Device Related) (2022/23 = 24 – 16 DTIs, 7 Unstageable, 1 medical device related).
There were 56 patient falls in March of which one resulted in severe harm (2022/23 = 22 Falls with Harm). All pressure ulcers and falls with harm are managed through the Harm Free Care panel.
The Patient Friends & Family Test - % that rate the Trust as 'Very Good or Good' (Trust overall) achieved 90.4% in March, from 91.4% in February.
The % of complaints responded to within timescales has achieved 51.7% in March against the 80% target, this is an improvement on the previous month (42.1%). (2022/23 = 50.5%)
The Percentage of Patient Safety Incidents resulting in Moderate or above harm continues to perform lower than the target and has decreased from the spike seen in January. This has been impacted by lower incident reporting rates.

Operational Performance

Overall Accident and Emergency performance for March was 73.7% (Adults ED 49.2%, Paeds ED 88.8% in March). This compares favourably with peers, with an England average of 69.6%, North-West 69.2% and Cheshire & Mersey 71.6%. 36.2% of Ambulance Handovers occurred within 15mins, a decrease on February (43.6%) and behind the 65% target. 67.6% of Ambulance Handovers were within 30mins, compared to 74.3% in February against the 95% target. 58 Ambulance Handovers breached 60mins in March, an increase on the 34 reported in February.

Performance against the 14-day GP referral to Outpatients achieved the target in February 2023 (latest data month), at 93.6%, an increase from 91.7% January, this is higher than the average for England (86%), North-West (84.8%) and Cheshire & Mersey (80.4%). This is the highest since pre-Covid. 2ww referrals in 2022/23 were 39.7% higher than 2019/20.
The 62-day cancer standard increased to 50.5% in February, against the 85% target, from 44% in January. This is lower than the National (57.9%), North-West (59.2%) and Cheshire & Mersey (61.5%).
31-day performance has improved by 6.4% in February, to 92.6% against the 96% target. This is above National performance (92%), but marginally below North-West (92.8%) and Cheshire & Mersey (94.2%).

Operational Performance continued

The average daily number of stranded patients in March 2023 remained high at 234 (February 231). The number of super-stranded patients also remained high, at 100 in March, an increase of 3 on the previous month.

The Criteria to Reside metric increased in March, to 58, the highest since December. All these metrics were impacted by patient acuity, delays in care packages, availability of community beds and care home capacity.

The Trust continues to perform well on the Referral to Treatment indicator in comparison to both local and national performance, achieving 63.1% in March (62.9% in February). The average for NHS Trusts in England was 58%, Northwest 53% and Cheshire & Mersey 56.1% (Feb 23).

There were 206 52+ week waiters at the end of March, an increase on the 199 reported in February, with 3 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.

Performance against the Diagnostic target continues to improve, achieving 18.3% in March, (18.7% in February). The target in 2022/23 was to achieve 1%. The Trust is performing ahead of the National average (25.9%), North-West (24.5%) and Cheshire & Mersey (18.8%) (NHS Trusts – February 2023).

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

Financial Performance

£13.7m reported deficit reflects an improved position on the £14.2m planned deficit following the distribution of ICB Capital Charges support linked to CDC & TIF schemes as previously reported.

The Trust has achieved the CIP requirement of £7.8m, plus a further £3.0m Stretch Target agreed with the ICS at Planning (total CIP of 4.8%).

The Trust has achieved its statutory Capital Resource Limit following delivery of total capital investment of £53.4m.

The Trust has actively managed cash throughout 2022/23, maintaining a year-end balance of £1m which is in line with requirements of the revenue support that the Trust has received.

Delivery of the Better Payments Practice Code (BPPC) following a significant improvement in performance since 2021/22.

Agency cost control through establishment of the Trust Premium Rate Oversight Group (PROG) and CIP Council leading to a £2.2m / 24% reduction in expenditure.

Workforce

Personal Development Review compliance has increased significantly in March to 79.95%, against the 85% target. Performance in February was 74.1%. The 90% stretch target for Mandatory Training was implemented from June 2022 and the indicator has increased in March and is now only marginally behind the target at 89.6% for March (February 89%).

In month overall sickness fell below target in March, to 5.9% (6.3% in February). The rolling 12-month figure is reducing and is currently 6.7%. This is against sickness targets for 2022/23 of 6% (5% non-Covid, 1% Covid). Non-Covid Sickness was 5.2% in March, a reduction on the 5.6% reported in February.

The overall Trust vacancy rate continued the reducing trajectory, decreasing to 6.6% in March, from 7% in February, below the 7.4% target. In-month Staff turnover has increased in month to 1.1% in March from 0.5% in February (target 0.83%), impacted by a high number of retirements.

Integrated Performance Report

Strategy & Operations

Committee Report

March 2023

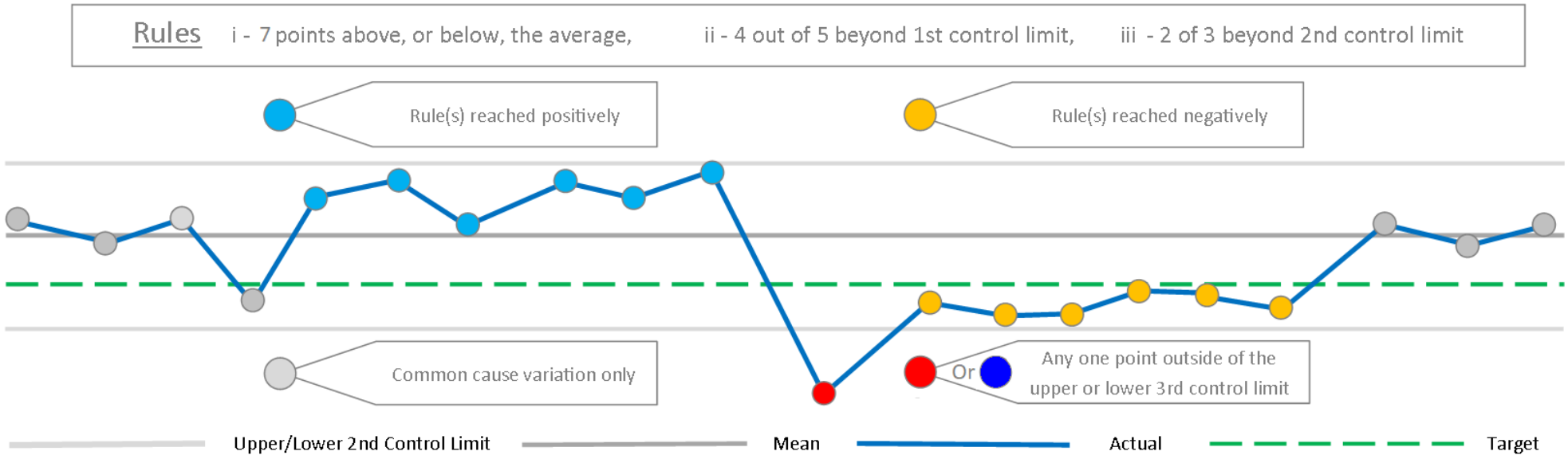
Guide to Statistical Process Control

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

Alert Indicators

Complaints - % closed within 40 working days

Accident & Emergency - 4 Hour compliance

62 day GP referral to treatment
Stranded Patients (>6 Days LOS)
Super Stranded Patients (>20 Days LOS)

Quality

Harm Free

Pressure Ulcers

Issues
• Hospital Acquired Category 3 Pressure Ulcer indicators is performing statistically as expected in March but is above target, with 3 reported in month; 1 deep tissue injury, 1 unstageable pressure ulcer and 1 medical device related pressure ulcer. None of these have been confirmed to be hospital acquired at this stage.
• The current 2022/23 total is 24, which relates to 16 deep tissue injuries, 7 unstageable pressure ulcers and 1 medical device related pressure ulcer.

Management Action
• Recent MASD awareness day on 16th March with educational information provided to all staff in relation to the skin protection pathway. Starting to see some improvement with reporting but work still ongoing.
• Bi-monthly training on pressure ulceration prevention. Education and training dates for the next 6 months are planned so that the dates can be accessed by ward managers to book ward staff on. Physiotherapists also encouraged to attend. The next sessions will introduce the new risk assessment score 'Maelor' with teaching. Further PMO initiatives will include recording 2-minute teaching sessions and ways to introduce patient stories into the teaching and training sessions.
• All suspected HAPU investigated for March by the TVN team and followed up with RCA and discussion at Harm Free Care if appropriate.

Patient Falls

Issues
• The overall number of falls reported remains statistically as expected, although for the second consecutive month, has decreased to 56 falls.
• 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 5.2 for the current financial year, with a March figure of 4.1.
• One fall resulting in moderate or above harm was reported in March.

Management Action
• Enhanced levels of care provision remain challenging and continues to be identified as a contributory factor to falls (including those with harm). Further deep dive completed and options appraisal being produced to agree actions to address this going forward.
• New enhanced care documentation to be piloted – to be rolled out week beginning 17/04/2023 with support and training from D&D Team and Falls Lead starting with 14b.
• Current eLearning package now updated to include additional elements to reflect the national package. Falls eLearning compliance is now at 89.2% trust wide (with a target of 85%) Expanding the falls training package to include face to face options.
• Simulation SOP now signed off and planning for falls simulations sessions in progress.
• Trust welcome pack being collated by the patient experience team, to include patient safety information (including falls prevention advice).
• Post falls management training/competency to be developed with guidance from new NAIF resources. Further dates for training for flojac (flat lifting device) released to increase compliance trustwide.
• NAIF audit shows S&O exceeding national average on all 4 KPIs.
• Thematic review from Quarter 3 reported that 96% of incidents included a medical review and completion of the post falls assessment documentation.
• 50% increase in the number of patients provided with written education regarding managing their falls risk.

Safe Staffing

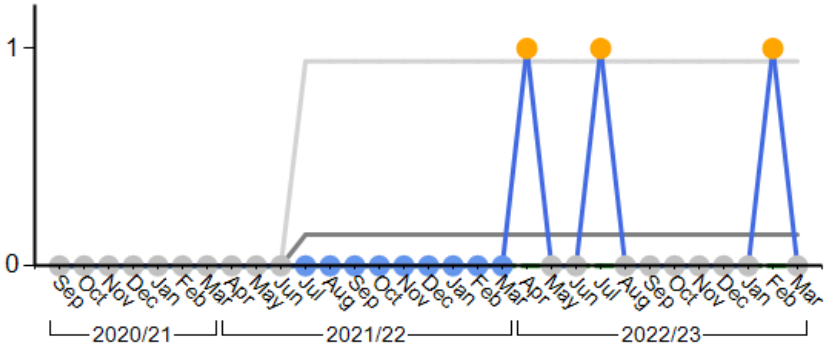
The improvement noted in Safe Staffing directly relates to the reduction in nursing vacancies' within month. Currently focused recruitment work is now starting to demonstrate a real time staffing improvement with all vacancies now recruited and awaiting start dates over coming months.

Patient Safety Incidents

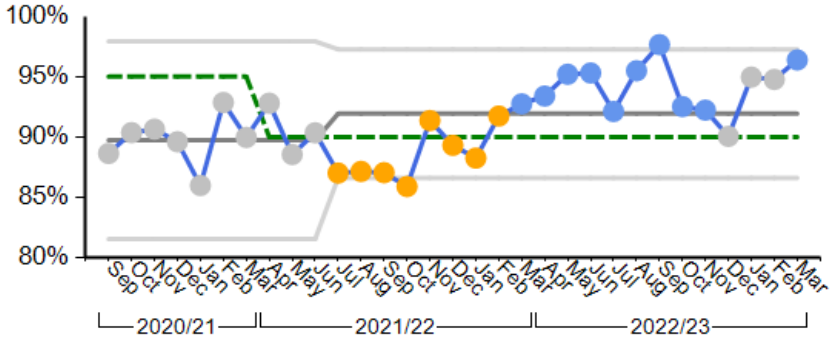
There has been a reduction in the number of incidents reported per 1000 days with an increase in the proportion resulting in harm. This may have been impacted by changes to the reporting of DOLS and staff being less likely to report near miss or no harm incidents.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Never Events	0	0	0	Mar 23		0	1	Feb 23	0	3	
	Safe Staffing	90%	96.4%	N/A	Mar 23		90%	94.8%	Feb 23	90%	94.2%	
	Hospital Acquired Pressure Ulcers - Categories 3 & 4	1	3	3	Mar 23		1	0	Feb 23	12	24	
	Patient Falls - Trust	63	56	56	Mar 23		63	63	Feb 23	756	812	
	Falls - Moderate/Severe/Death	1	1	1	Mar 23		1	2	Feb 23	17	22	
	Percentage of Patient Safety Incidents - Moderate/Major/Death (related)	2.1%	1%	7	Mar 23		2.1%	1%	Feb 23	2.1%	0.8%	

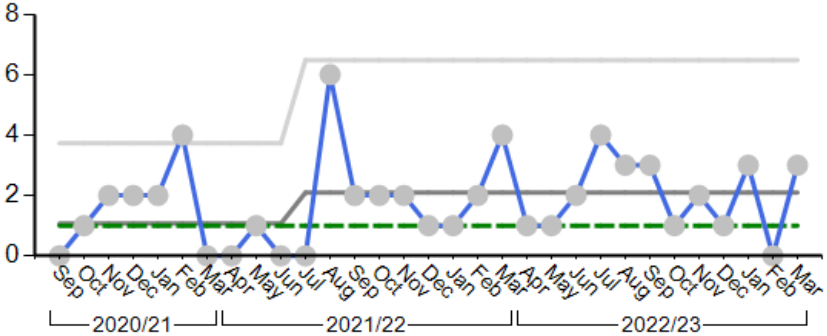
Never Events



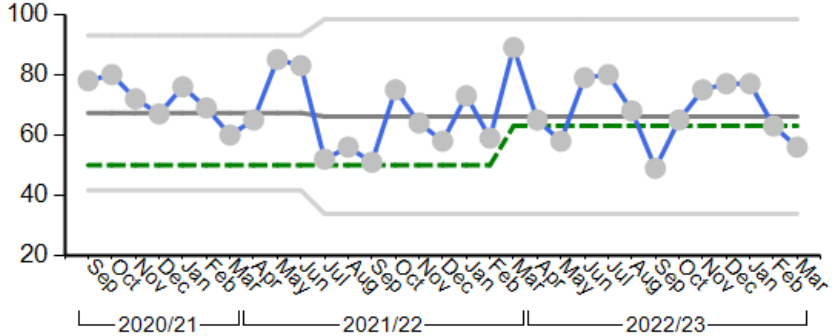
Safe Staffing



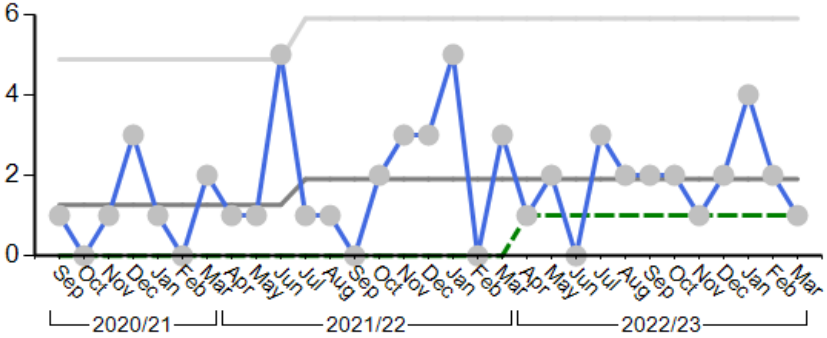
Hospital Acquired Pressure Ulcers - Categories 3 & 4



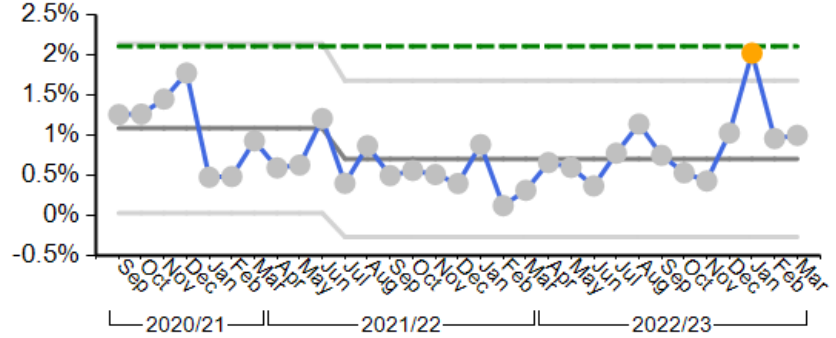
Patient Falls - Trust



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 with two Hospital Onset Hospital Acquired cases and one Community Onset Hospital Acquired reported in March.
• The Trust has finished the year with 48 reported cases, one below plan.

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.

E-Coli

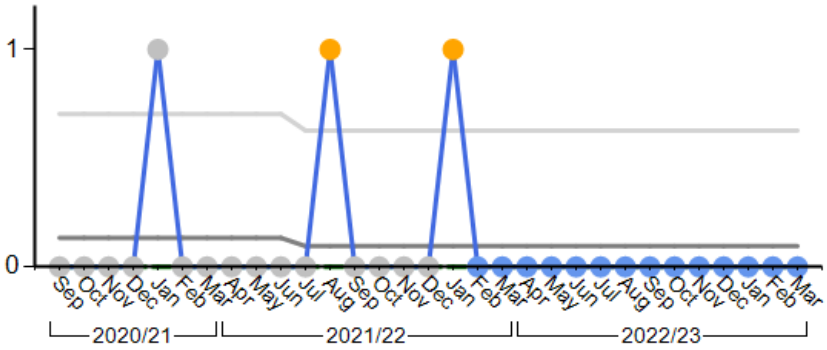
Issues
• Four E-Coli infections were reported in March, which is statistically as expected. All cases were Hospital Onset Hospital Acquired cases.

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

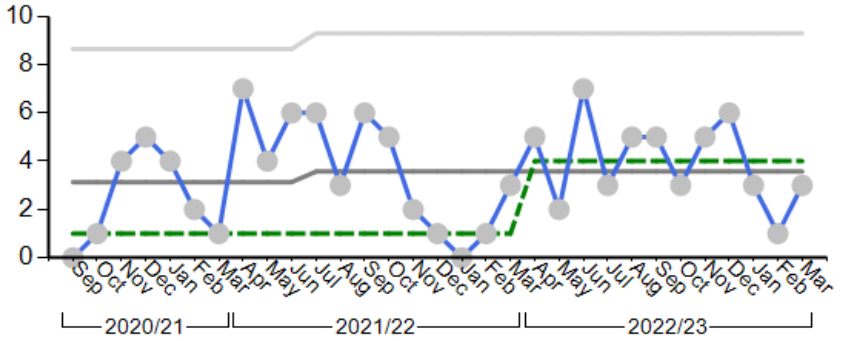
No MRSA cases were reported in March.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	MRSA	0	0	0	Mar 23		0	0	Feb 23	0	0	
	C-Diff	4	3	3	Mar 23		4	1	Feb 23	49	48	
	E. Coli	4	4	4	Mar 23		4	5	Feb 23	51	45	

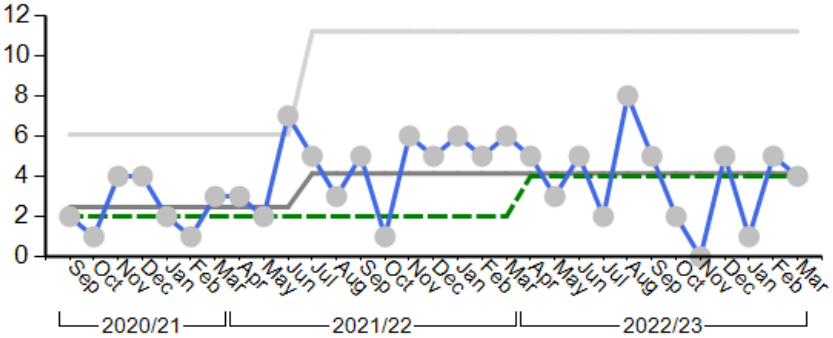
MRSA



C-Diff



E. Coli



Quality

Patient Experience

Complaints - % closed within 40 working days

• See accompanying action plan.

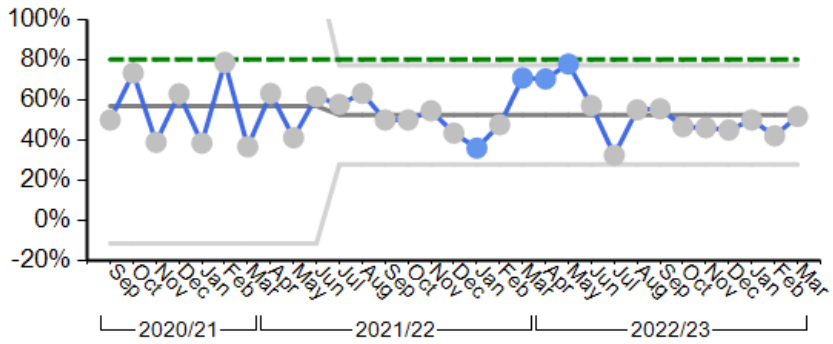
Friends and Family Test

Issues
• The Trust overall indicator continues to fail the assurance measure and has achieved 90.4% in March, a 1% decrease on the previous month.
• The overall indicator takes into account Acute Inpatients, A&E and Maternity. 47% of responses in March were from A&E, which has impacted the overall percentage. When each area is analysed individually, the Trust performs well in comparison to NHSE averages.
• The top themes attached to positive ratings are staff attitude, implementation of care and environment.
• The top themes attached to negative ratings are staff attitude, environment and waiting times.
• The score of 94.9% for Acute Inpatients is above the internal indicator of 94.3% but marginally below the February NHSE average of 95%.
• A&E achieved 85.3% (82.9% Adult's and 90.1% Children's). This is significantly above the Trust indicator of 77.8% and February NHSE average of 80%. This indicator remains assured.
• The experience of long waiting times in the adult A&E department continues to cause a higher number of negative responses and comments.
• Outpatients – achieved 94.6%. This is above the February NHSE average of 94% and above the internal target of 92.8%. This indicator remains assured.
• Labour Ward - achieved 100%, this is above the February NHSE average of 93% and internal indicator of 94%. This indicator has been showing positive variation for the last 7 months.
• Postnatal Ward – achieved 90.9% (based on only 22 responses). This is marginally below the February NHSE average of 93% and internal indicator of 92%. No comments were received in relation to the negative rating.

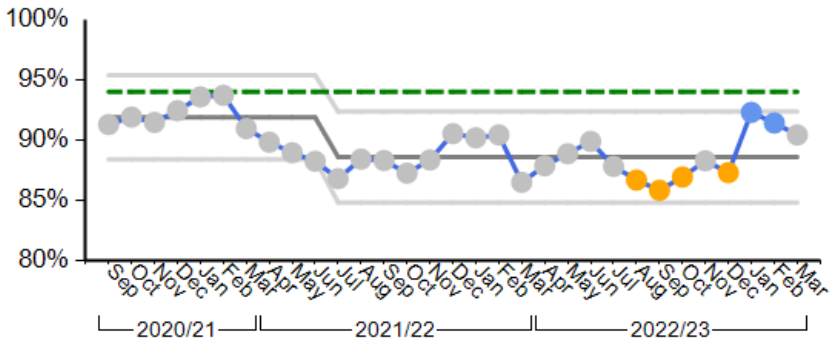
Management Action
• Monthly FFT summaries are shared with CBU's and are monitored through the Patient Experience and Community Engagement (PECE) group where CBU updates and actions to improve FFT are provided.
• Inpatient areas continue to review comments to identify any emerging themes or trends to 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 continues to provide opportunities to work collaboratively and gather further feedback from this patient group. The 2022 National Maternity Survey results have been received, action plan approved and monitored via PECE.

		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%	51.7%	N/A	Mar 23		80%	42.1%	Feb 23	80%	50.5%	F
	Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall	94%	90.4%	N/A	Mar 23	H	94%	91.4%	Feb 23	94%	88.7%	F

Complaints - % closed within 40 working days



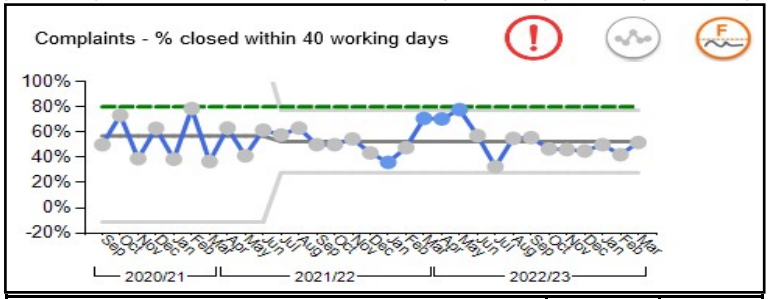
Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall



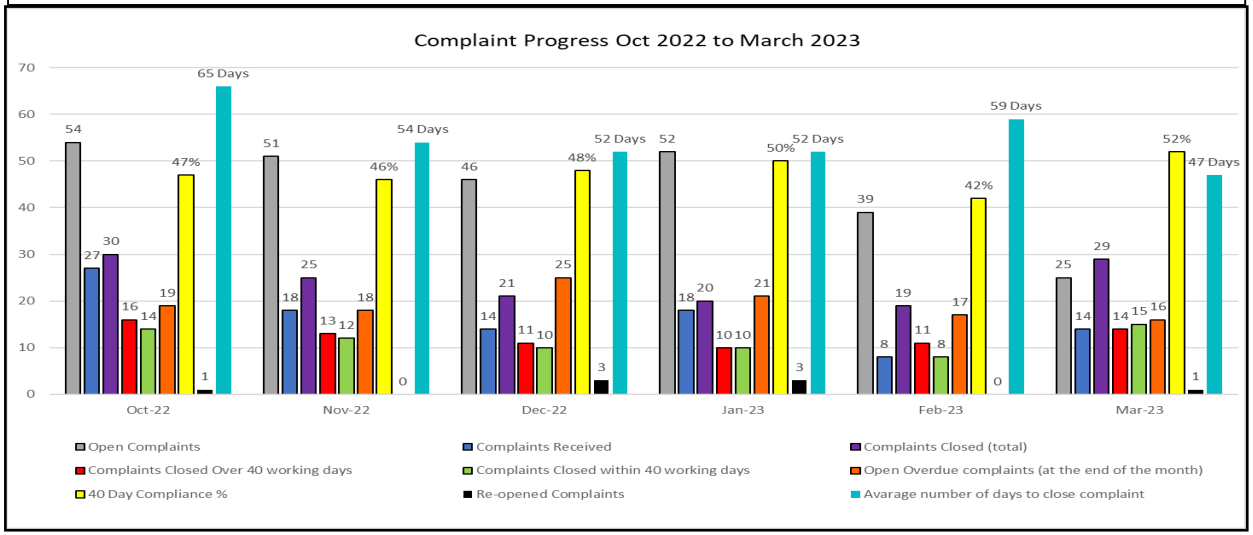
Complaints—% closed within 40 working days

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%	51.7%	N/A	Mar 23		80%	42.1%	Feb 23	80%	50.5%	F



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



	Jul-22	Mar-23
Overdue Complaints	32	16
Total Number of complaints closed	39	29
Overdue Complaints closed	26	14
Complaints closed within 40 working days	13	15
Average number of days to close	62 days	47 days
Compliance Percentage	33%	52%

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 is enhanced oversight and visibility of the complaints position within Medicine and Emergency Care CBU, supported by daily meetings.

As at the middle of April, continued to have no overdue complaints. They continue to review and progress all open complaints to ensure they are closed within timescales.

Women & Children's 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. As at 13th April, the Trust had 13 overdue complaints, of which 8 were in the final stage of sign-off. Whilst April is unlikely to achieve compliance with this indicator, it is anticipated that compliance will be achieved in May.

The Trust received 15 new complaints in March, compared to a monthly average for Apr—Feb 22/23 of 21. This is due to early intervention to prevent patient concerns escalating into formal complaints.

Operations

Access

A&E

Issues
• Whilst performance in March has declined by 1.1% on the previous month, it remains above 70%, achieving 73.7% in March.
• Local and national performance improved in March but the Trust remains in the top quartile nationally for ED performance, performing ahead of the National average (69.6%), Northwest (69.2%) and Cheshire & Mersey (71.6%) (NHS Trusts only). The Trust was the third highest performer in Cheshire & Mersey behind Liverpool Women's Hospital and Alder Hey.
• Conversion rate for the Trust has seen an improvement of 7.9% from March 2020 (28.9%) to March 2023 (21%).
• 12.5% of patients spent longer than 12 hours in the department (942 patients). This is comparable to previous months despite significantly more attendances.

Management Action
• Continuation of RATS (Rapid Assessment and Treatment model) to improve triage times and time to treatment.
• 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 as opposed

Ambulance Turnaround Times

Issues
• Performance against the 15minute handover slightly deteriorated in March, against an increase in ambulance arrivals.
• The average 15 minute handover time was 30:26, which was better than the North West average of 35:38 and the 3rd best in Cheshire & Mersey.
• Southport's average Turnaround time (35 mins) was an improvement of 3 minutes compared to February. This was 8 minutes better than the overall NWAS average (43 mins). Southport had the 3rd shortest time for average ambulance turnaround times in Cheshire and Mersey (Alder Hey again were 1st and Leighton were 2nd)
• For total time lost to handovers Southport was the 2nd best in the region - at 170 hours and behind only Alder Hey. The longest delay at Southport was 3 hours 36 mins - second best in the region behind Alder Hey.
• Patient flow was challenged in March, with high numbers of patients on RFD list, coupled with IPC outbreaks.

Management Action
• Increased focus of handover times by senior nursing staff and Rapid Assessment Triage (RATS) continues.

Referral to Treatment

Issues
• The Trust continues to perform well in comparison to both local and national performance, achieving 63.1% in March. The average for NHS Trusts in England was 58%, Northwest 53% and Cheshire & Mersey 56.1% (Feb 23).
• The Trust had the lowest number of 52 week waits based on Acute Trusts in Cheshire & Mersey (Feb data).
• There were 3 78-week waits at the end of March, the lowest of all Acute Trusts in Cheshire & Mersey (Feb data).
• There were 0 104 week waiters at the end of March.
• Overall ERF activity achieved 108% of 19/20 activity C&M latest data reported at 97.5%.
• Gynaecology – High number of theatre cancellations (33) in month as a result of sickness and industrial action.
• Oral Surgery – Reduced demand for minor op surgery resulting in reduced daycase activity.

Management Action
• Gynaecology – 2 consultant posts recruited to which will reduce impact of sickness. 1 starts in May, the second date is TBC (undergoing employment checks).
• Oral Surgery – Theatre sessions converted to new OP appts resulting in overperformance. Demand has started to slowly increase so expectation is that daycase

activity will normalise in next 3 months.

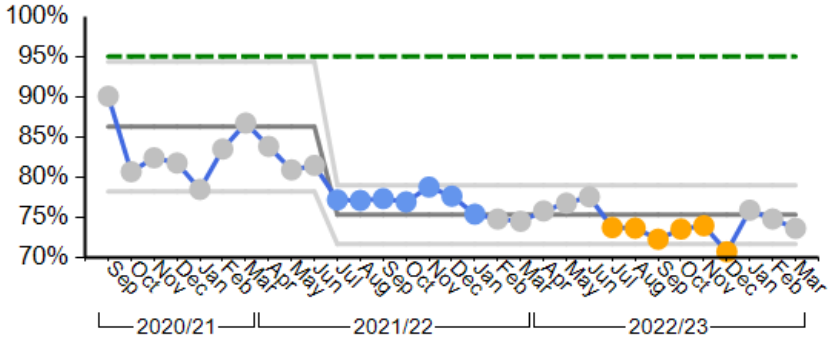
Diagnostics

Issues
• The Diagnostic Waits indicator continues to show special cause improvement and has improved further in March to 18.3%. This improvement is expected to continue.
• Trust performance is better than the average for NHS Trusts in England (25.9%), the North-West 24.5% and Cheshire & Mersey 18.8% (February data).
• Total diagnostics activity is 109.7% of 19/20 activity.
• Diagnostic scopes performance achieved 146.6% of 19/20 activity.
• Diagnostic scans performance is at 107% of 19/20.
• Endoscopy – The unit now offers all patients a date to attend within the six weeks timescale. We are also offering all target patients a date with 14 days. In addition, the Trust is supporting mutual aid.
• Radiology – Long waits for NOUS due to increased complexity of scans.

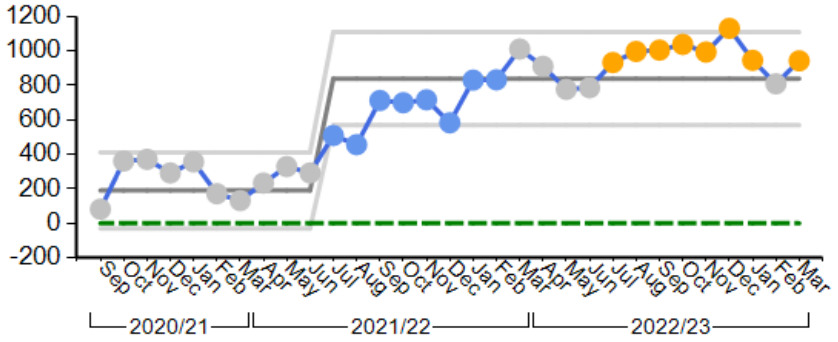
Management Action
• Endoscopy – A plan is being pulled together to cover nurse endoscopy sickness so the 14 days is not impacted.
• Radiology – Outsourcing company providing advanced sonographers to support lists which has been successful to date. More MSK injection lists planned using the company with 2 experienced consultants.
• Recruitment day took place April 2023.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
!	Accident & Emergency - 4 Hour compliance	95%	73.7%	2757	Mar 23		95%	74.8%	Feb 23	95%	74.4%	F
	Number of Patients spending 12+ Hours in ED - Trust	0	942	N/A	Mar 23	H	0	809	Feb 23	0	11261	F
	% of Patients spending 12+ Hours in ED - Trust	2%	12.5%	N/A	Mar 23	H	2%	12.3%	Feb 23	2%	12.5%	F
	Ambulance Handovers - % within 15 Mins	65%	36.2%	641	Mar 23	L	65%	43.6%	Feb 23	65%	39%	F
	Ambulance Handovers - % within 30 Mins	95%	67.6%	326	Mar 23	L	95%	74.3%	Feb 23		67.6%	F
	Ambulance Handover Over 60 Mins	0	58	58	Mar 23		0	34	Feb 23	0	881	F
	Diagnostic waits	1%	18.3%	897	Mar 23	L	1%	18.7%	Feb 23	1%	34.7%	F
	Referral to treatment: on-going	92%	63.1%	7143	Mar 23	L	92%	62.9%	Feb 23	92%	68%	F
	52 Week Waits	0	206	206	Mar 23		18	199	Feb 23	0	242	F
	Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month	1%	0.6%	15	Mar 23		1%	0.5%	Feb 23	1%	0.9%	?
	Stroke - 90% Stay on Stroke Ward	80%	74.1%	7	Jan 23	H	80%	76.7%	Dec 22	80%	60.6%	F
	TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	60%	81%	4	Mar 23	H	60%	64.7%	Feb 23	60%	80%	?
	Outpatient Letters to GP's within 7 Days	85%	70.8%	2954	Feb 23		85%	75.5%	Jan 23	85%	70.3%	F
	E-Discharges within 24hrs		83.6%	218	Mar 23	H		82.3%	Feb 23		79.9%	?

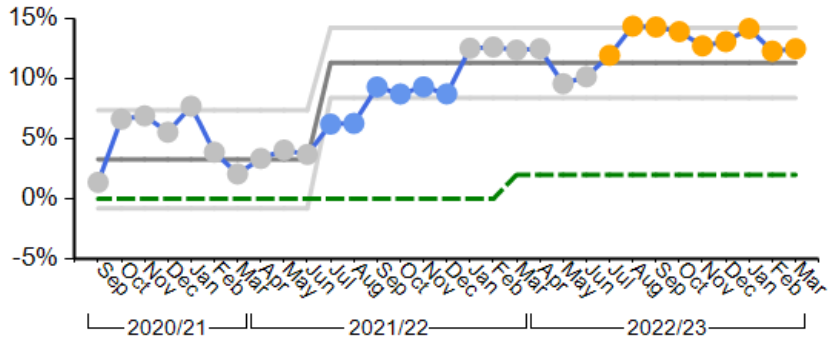
Accident & Emergency - 4 Hour compliance



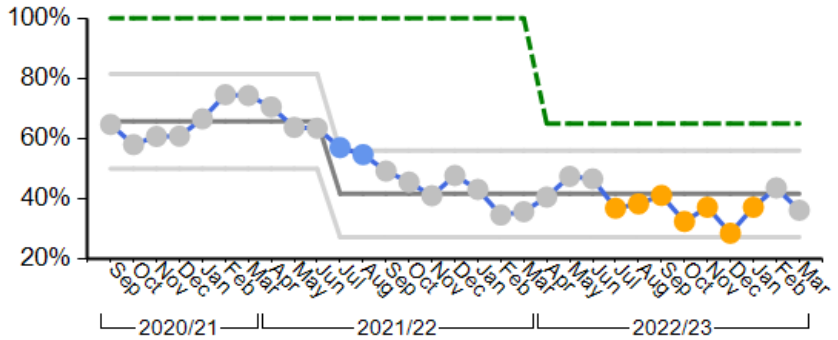
Number of Patients spending 12+ Hours in ED - Trust



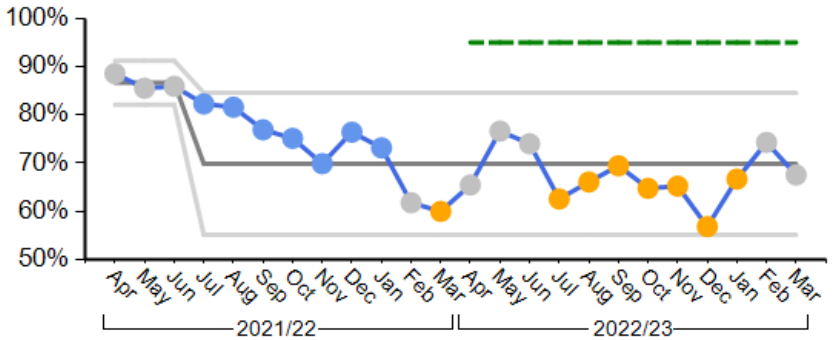
% of Patients spending 12+ Hours in ED - Trust



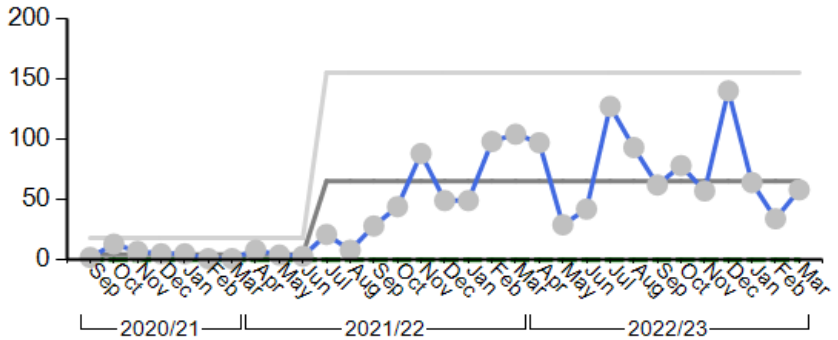
Ambulance Handovers - % within 15 Mins



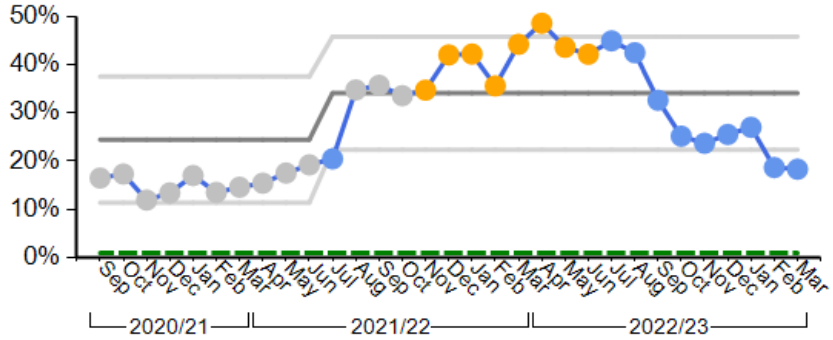
Ambulance Handovers - % within 30 Mins



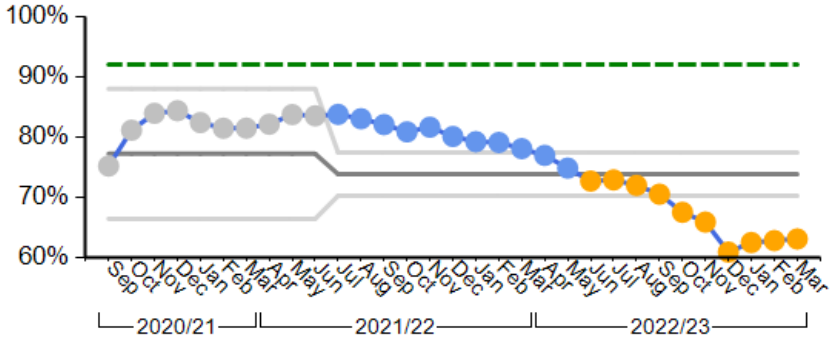
Ambulance Handover Over 60 Mins



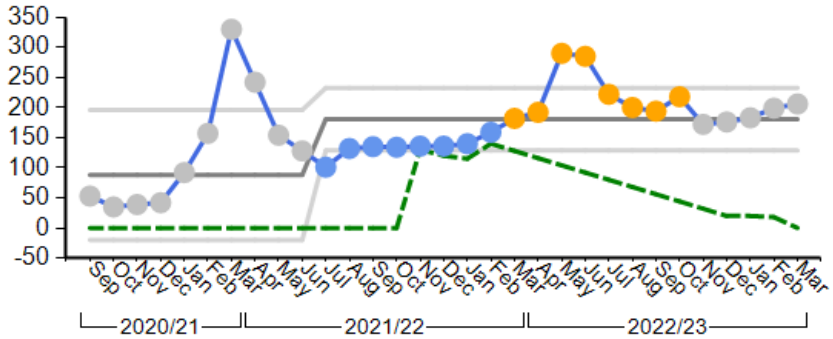
Diagnostic waits



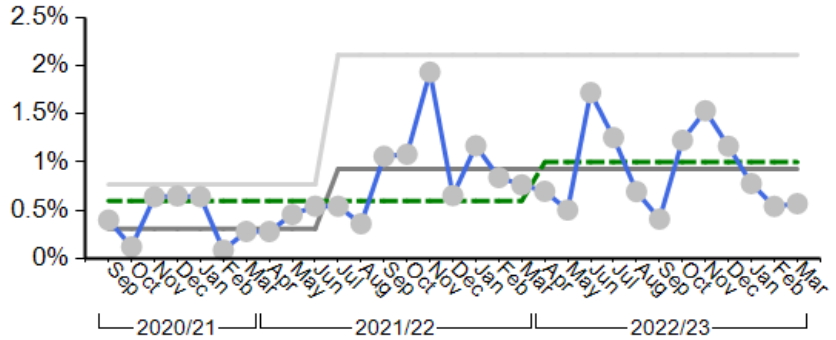
Referral to treatment: on-going



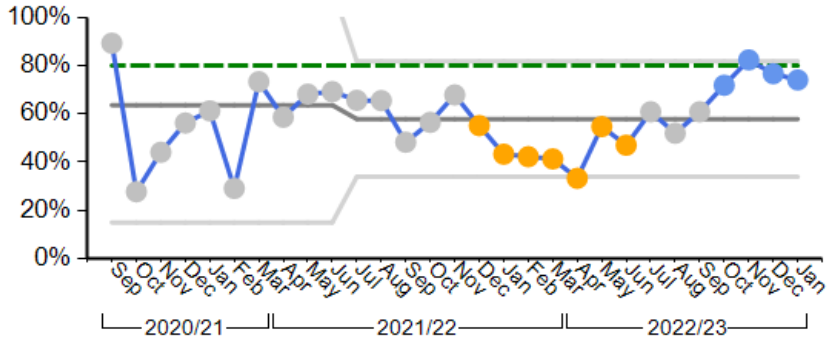
52 Week Waits



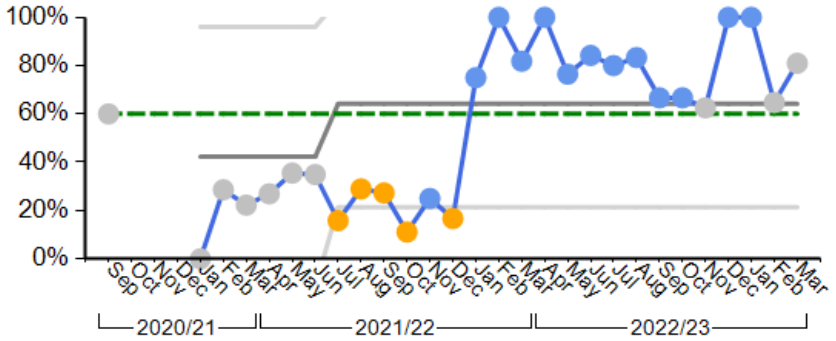
Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month



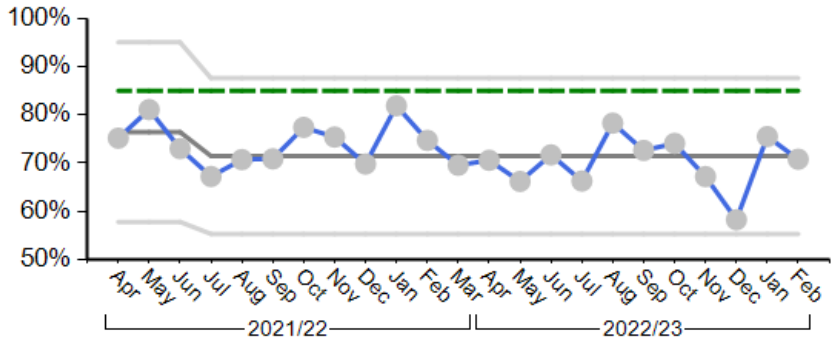
Stroke - 90% Stay on Stroke Ward



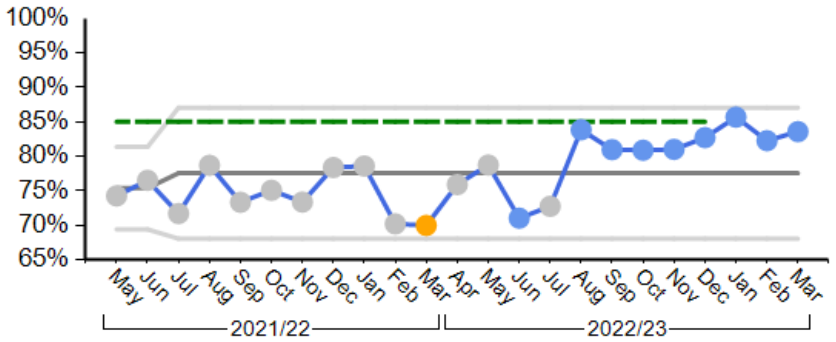
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care



Outpatient Letters to GP's within 7 Days



E-Discharges within 24hrs



Operations

Cancer

Issues

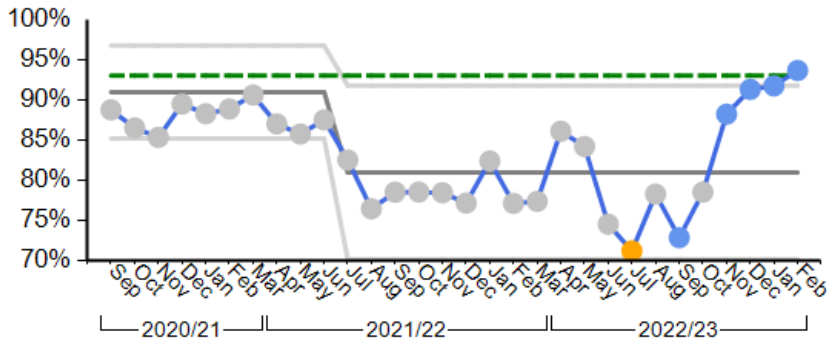
• The 14 day GP Referral to Outpatients continues to show special cause improvement and is at the highest level since pre-Covid, exceeding the target at 93.6% against the 93% target. This is higher than the National (86%), North-West (84.8%) and Cheshire & Mersey (80.4%) (NHS Trusts, Feb 23 data). This performance is against a significant increase in referrals (39.7% more referrals in 2022/23 than 2019/20).
• 31 day performance has improved by 6.4% in February, to 92.6% against the 96% target. This is above National performance (92%), but marginally below North-West (92.8%) and Cheshire & Mersey (94.2%).
• Performance against the 62 day standard was 50.5%, an increase on the previous month but lower than National (57.9%), North-West (59.2%) and Cheshire & Mersey (61.5%).
• New FIT Pathway 'go live' date has been brought forward to 15 May 2023 (from 30 June 2023)
• Histology challenges remain impacting on 7-day turnaround time, currently at 17 days for urgent due to significant increase in demand through February and March and unplanned Consultant leave.

Management Action

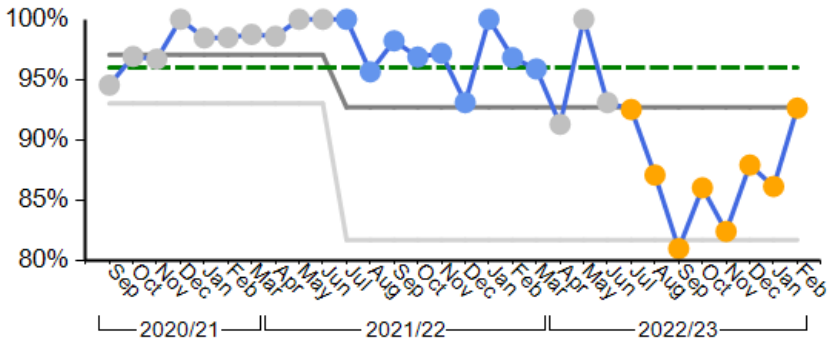
• Successful bid to Cancer Alliance for GP Fit Kit distribution. Kit distribution and Pathway go live both on track.
• STHK have advised that they have offered additional WLI's to substantive staff to decrease the reporting times.
• The Cancer Alliance have agreed funding for Band 7 and Band 5,to support the FD Programme JD's being sourced to enable recruitment throughout April and May 2023.

		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%	93.6%	76	Feb 23	H	93%	91.7%	Jan 23	93%	82.4%	F
	31 day treatment	96%	92.6%	5	Feb 23	L	96%	86.2%	Jan 23	96%	89%	?
!	62 day GP referral to treatment	85%	50.5%	26	Feb 23	L	85%	44%	Jan 23	85%	58.8%	F
	28 Day Faster Diagnosis Standard	75%	75%	252	Feb 23	H	75%	65.3%	Jan 23		66.1%	F

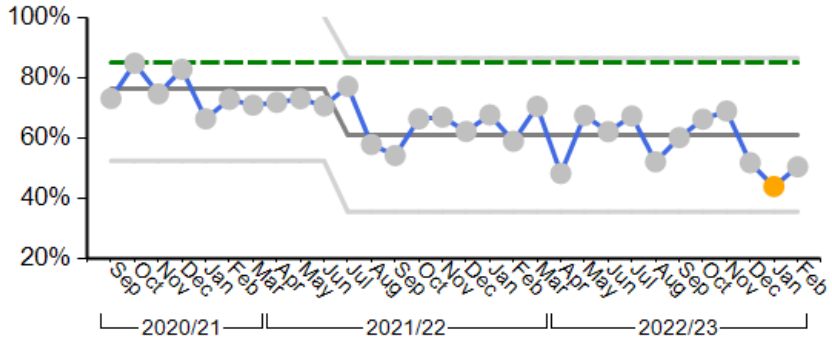
14 day GP referral to Outpatients



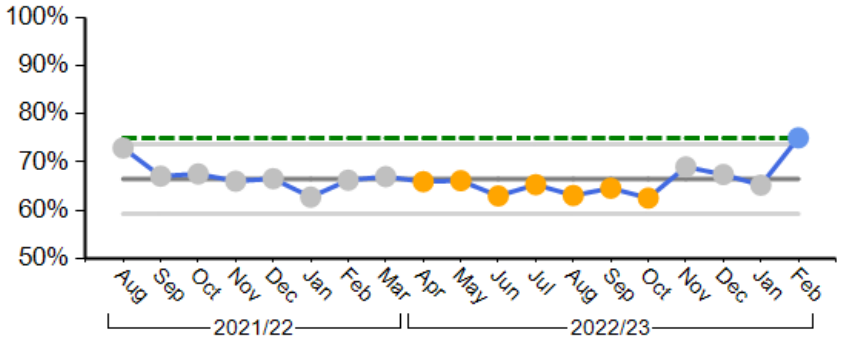
31 day treatment



62 day GP referral to treatment



28 Day Faster Diagnosis Standard



Operations

Productivity

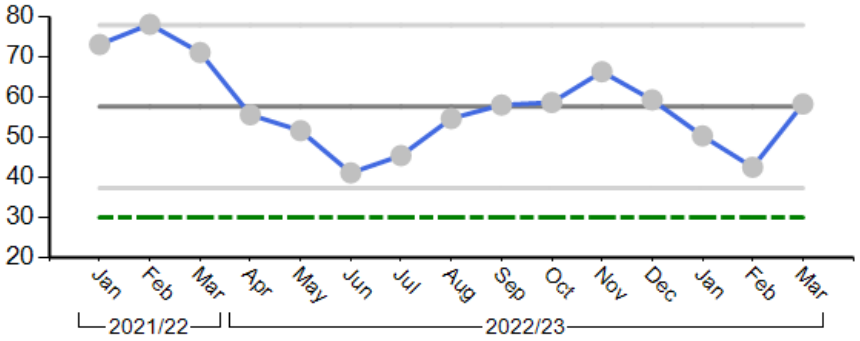
Stranded/ Super Stranded/ Criteria to Reside

Issues
• Both stranded patient metrics continue to fail assurance and show special cause concern and have increased in March.
• The increase in long stay patients can be attributed to patients acuity.
• RFD numbers continue to average around 60-70 per day which is the equivalent to two wards, which can be attributed to complex patients; with delays in for care packages and waiting for long term care home placements; community teams report high acuity and pressure to support the numbers of fast track patients at home; community beds exceeding 100% bed occupancy.

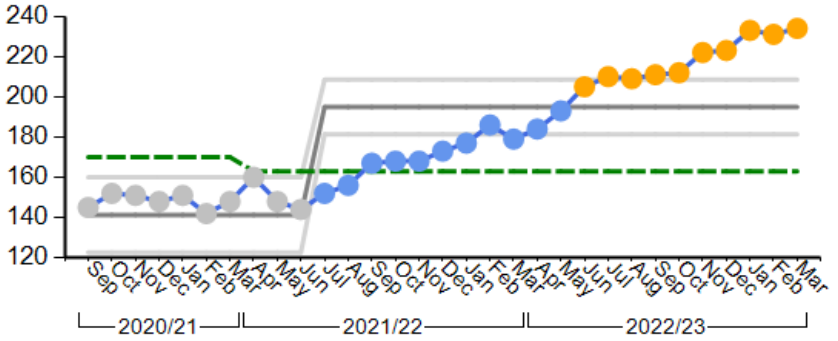
Management Action
• Clinical Point prevalence's taking place across wards to ensure progress of discharge plans which has evidenced appropriate pans are in place for patients with criteria to reside and non criteria to reside..
• Focus on improvement of patients discharged at 5pm to ensure meet trajectory.
• Increased escalation capacity, utilising Chase Heys and Ward 11A.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	No Criteria to Reside - Avg No of Patients	30	58	58.2	Mar 23		30	43	Feb 23			
!	Stranded Patients (>6 Days LOS)	163	234	234	Mar 23	H	163	231	Feb 23	163	2567	F
!	Super Stranded Patients (>20 Days LOS)	53	100	100	Mar 23	H	53	97	Feb 23	53	1024	F

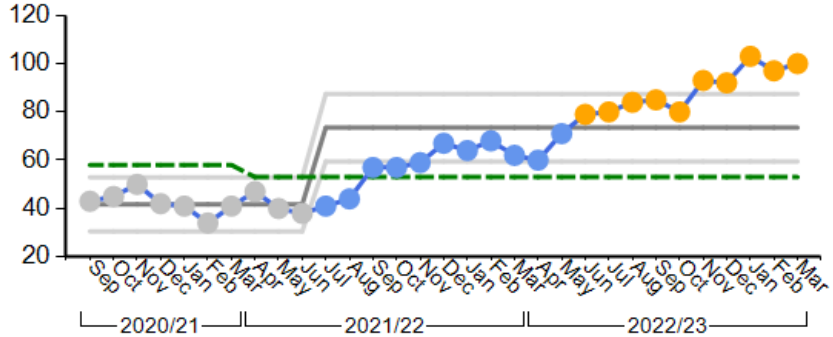
No Criteria to Reside - Avg No of Patients



Stranded Patients (>6 Days LOS)



Super Stranded Patients (>20 Days LOS)



Workforce

Organisational Development

Personal Development Reviews

Issues
• This indicator is showing special cause improvement with an increase of 5.9% in March, to 79.95%.

Management Action
• The intervention of the HRD with corporate teams has brought about the significant improvement in March.
• Continued focus on all CBU compliance will continue.
• PDR compliance raised at CBU monthly SLTs, Governance and budget meetings.
• Trust will be working with STHK for an electronic version of PDRs once the Trust completes the TUPE transfer processes

Mandatory Training

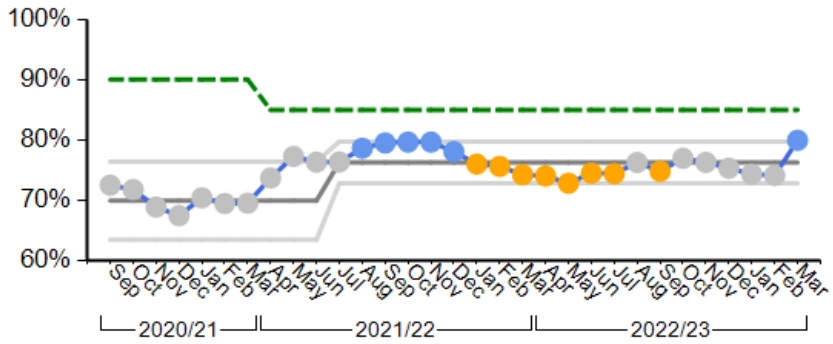
Issues
• The mandatory training indicator is failing its assurance measure since the stretch target of 90% was implemented.
• Core mandatory training compliance has been on an increasing trajectory for the last three months and is now just 0.45% behind the 90% target. This is a great achievement considering the ongoing demands in the clinical areas.
• Conflict resolution continues to see month on month improvements following the return to the recommended 3 yearly refresher period.
• Moving & handling training resumed face to face training in April, this may initially see an initial dip in compliance, as this will incur further release time from departments for clinical staff.
• Resuscitation training compliance has seen improvement across the last 12 months and showing in month fluctuations.

Management Action

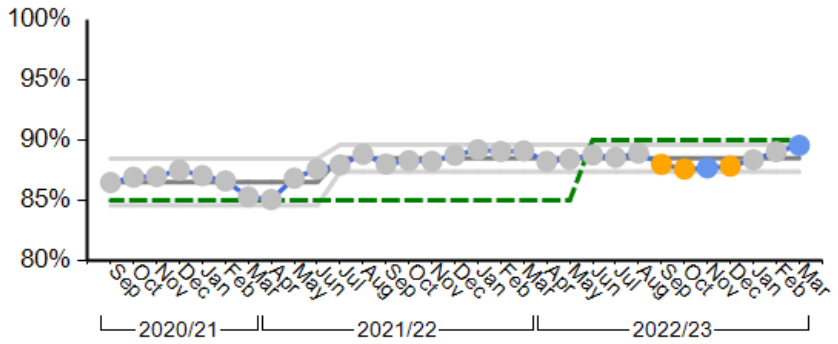
• A full review of role training allocations has been conducted to provide accurate data for resuscitation training within published reports. Many role allocations will remain unchanged. Any roles where a change to the training allocation has been identified are currently being modified. The training trajectory will be reviewed and updated once all changes have taken full effect.
• It is anticipated that compliance may plateau or decrease slightly due to several training cancellations due to the medical industrial action during March & April 2023. Additional dates have been scheduled to support and facilitate the training of those staff affected by these cancellations. Areas which have been most affected have been approached to provide one-off bespoke training sessions to further support and facilitate this training for those affected.
• By the end of April, the Training Department will update the ESR system to allow staff to update online modules up to 90 days in advance rather than the current 30 days in advance. This will improve flexibility for clinical staff groups to up to date training at a time that allows balanced against clinical priorities.
• Both core mandatory & essential skills training compliance continue to be monitored monthly by the Training Management Team and Clinical Competency Working Group.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Personal Development Review	85%	80%	N/A	Mar 23		85%	74.1%	Feb 23	85%	75.4%	
	Mandatory Training	90%	89.6%	N/A	Mar 23		90%	89%	Feb 23	90%	88.4%	

Personal Development Review



Mandatory Training



Workforce

Sickness, Vacancy and Turnover

Sickness

Issues
• The in-month sickness rate has decreased by 0.4% in March, and although remains statistically as expected, is below the target.
• Sickness rates have fallen in all CBUs across the Trust bar one, with the biggest reduction of 1.57% being seen in Corporate. Medicine and Emergency Care sickness absence rate rose by 0.91% in month.
• Seasonal infectious diseases continue to make up the majority of the absences in month with coughs / cold / flu, covid and gastrointestinal absences being very prevalent amongst many staff groups.
• The rolling 12-month sickness rate continues to fail the assurance measure but is reducing.

Management Action
• Focus by operational managers and HR remains on closing long term absence where there has been some significant progress in month as well as continued focus on repeated short-term absences in teams.

Vacancies

Issues
• The Trust overall vacancy rate is showing special cause improvement for the third consecutive month, and continues to be below target, at 6.6% against the 7.4% target.
• Medical vacancies remain below target, remaining static at 4.6% against the 5.8% target.
• Nursing vacancy rates continue improve, and have decreased to the lowest level reported in March at 6% against the 9% target.
• AHP/Therapy vacancy rates continue to maintain levels well below the target.

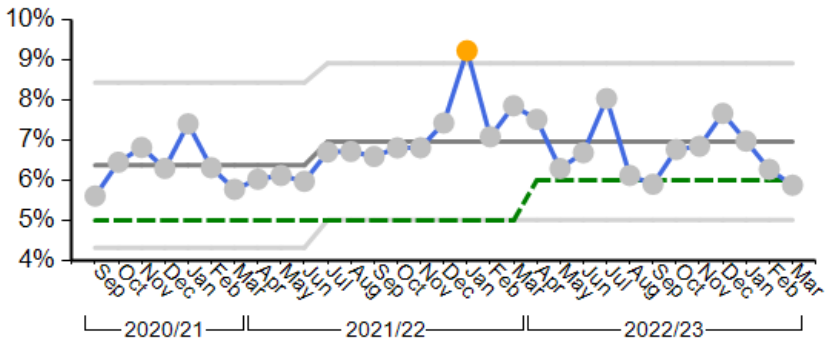
Management Action
• The Trust is continuing to see positive improvements across the vacancy rates, in particular within nursing and AHPS.
• Significant work in Q4 to reduce the number of HCA vacances which is having a positive impact.
• By the 17th April, a further 21.2 WTE HCAs had started which will further improve the position.
• For AHP vacancies the Trust is continuing to explore international recruitment options via the Cheshire and Mersey collaborative and to date have recruited 3 OTs and 2 Radiographers through this route, with further recruitment planned. During the summer last year we did slightly over recruit to our vacancies for some AHPs and this has ensured supply across the year.
• Medical vacancies have remained static, but we are continuing to see high volumes of applicants for more junior roles. We are also starting to receive the August rotations so are planning ahead to try to advertise and recruit quickly.

Staff Turnover

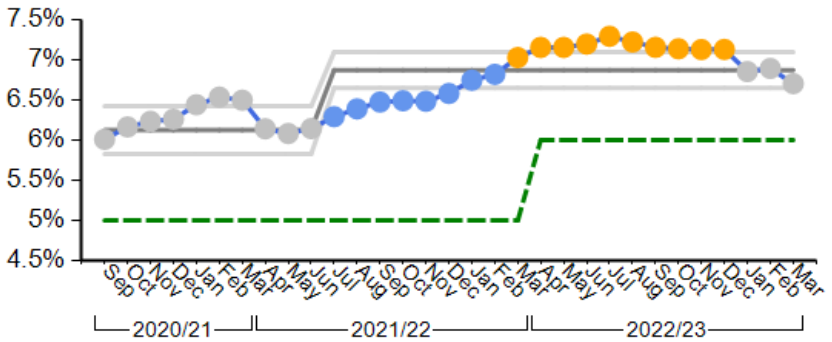
Whilst staff turnover is high this month 17 of the 40 leavers have been due to retirements. Work continues to ensure that those looking at retirement are offered the flexible return if this is appropriate, and changes in the pensions rules will ensure that this is a favourable option.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Sickness Rate	6%	5.9%	N/A	Mar 23		6%	6.3%	Feb 23	6%	6.7%	?
	Sickness Rate (Rolling 12 Month)	6%	6.7%	N/A	Mar 23		6%	6.9%	Feb 23	6%	7.1%	F
	Sickness Rate (not related to Covid 19) - Trust	5%	5.2%	N/A	Mar 23	H	5%	5.6%	Feb 23	5%	5.6%	F
	Trust Vacancy Rate – All Staff	7.4%	6.6%	N/A	Mar 23	L	7.4%	7%	Feb 23	7.4%	9.1%	F
	Staff Turnover	0.83%	1.1%	N/A	Mar 23	L	0.8%	0.5%	Feb 23	9%	6.8%	?

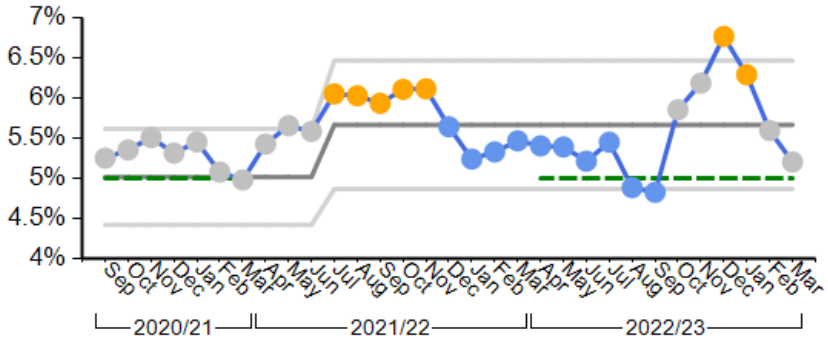
Sickness Rate



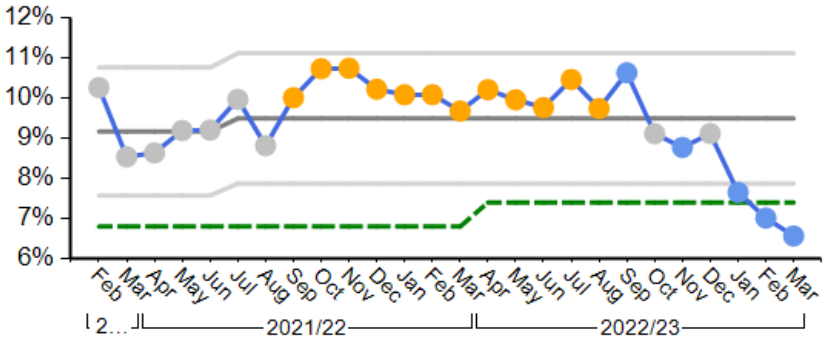
Sickness Rate (Rolling 12 Month)



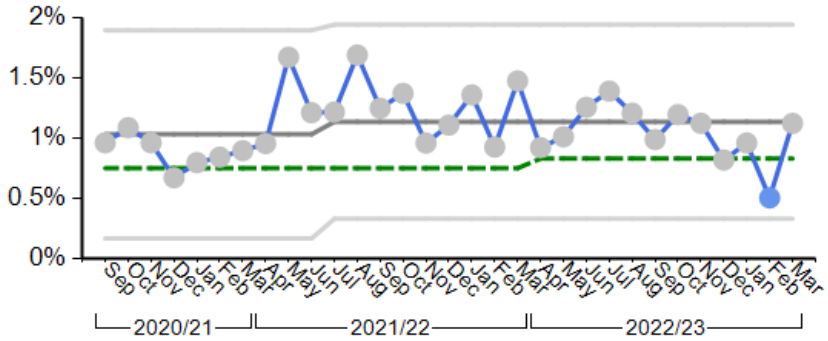
Sickness Rate (not related to Covid 19) - Trust



Trust Vacancy Rate – All Staff



Staff Turnover



Finance

Finance

• £13.7m reported deficit reflects an improved position on the £14.2m planned deficit following the distribution of ICB Capital Charges support linked to CDC & TIF schemes as previously reported.
• The Trust has achieved the CIP requirement of £7.8m, plus a further £3.0m Stretch Target agreed with the ICS at Planning (total CIP of 4.8%).
• The Trust has achieved its statutory Capital Resource Limit following delivery of total capital investment of £53.4m.
• The Trust has actively managed cash throughout 2022/23, maintaining a year end balance of £1m which is in line with requirements of the revenue support that the Trust has received.
• Delivery of the Better Payments Practice Code (BPPC) following a significant improvement in performance since 2021/22.

	Latest				Forecast			Year to Date	
Indicator	**Plan**	**Actual**	**Period**					**Plan**	**Actual**
I&E surplus or deficit/total revenue	2.1%	2%	Mar 23					5.68%	5.68%
Capital Spend	£14,800K	£17,000K	Mar 23					£53,400K	£53,400K
Cash Balance	£1,000K	£1,000K	Mar 23						

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY & SAFETY COMMITTEE (QSC)**
MEETING DATE:	**24 April 2023**
LEAD:	**Gill Brown**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Risk around estates standards and inability to decant wards to complete refurbishments. Estates issues have been acknowledged and identified by the Infection Prevention and Control (IPC) and Estates teams throughout all areas. Wards impacted will not be compliant with estates related IPC standards until this work is complete.
- On-line Consent training does not link with Electronic Staff Records (ESR) and therefore it is not possible to currently track compliance. This has been escalated for IT support to create an appropriate interface.

ADVISE

- Monthly Presentation: Neonatal – Family Integrated Care (FIC) and Baby Friendly Initiative (BFI)

Operational Performance

- Urgent and Emergency Care: 4hour performance 73.7%, while above C&M (72.0%) and national (71.5%) comparators still not achieving 95%

- Elective Recovery: Overall ERF activity is 108% of 19/20 activity. (C&M 97.5%). Day cases delivered 94% of 19/20 and elective activity delivered 117% of 19/20. Outpatient First activity delivered 105% of 19/20 activity. Total diagnostics activity is 109.7% of 19/20 activity.

- Cancer Performance: Slide set shared noting improvements in diagnostic performance and reduction in numbers of patients waiting 63-104 days and 104+ days.

Integrated Performance Report

- Complaints performance improving, although still not achieving 40 day target. Metrics under review.
- Noted positive feedback within Friends and Family Test.
- End of year position within trajectory for healthcare associated infections.
- Noted work ongoing related to falls and pressure area care.

Patient Safety Report

- Overview of themes from incident reporting and update on lost to follow up included.
- Increased number of transfusion incidents noted (see CEC notes).

Infection Prevention & Control Board Assurance Framework

- Content noted.
- Further detail requested regarding mitigations, controls, and reporting processes to Board.

Patient Safety Group (PSG)

- Work of temperature monitoring task and finish group continues.
- Medical devices ahead of schedule for new financial year following recommendations via extraordinary PSG.

Infection Prevention & Control Assurance Group AAA

- See Alert re. ward refurbishment.
- Issues with capacity within IPC team due to vacancies and absences. Recruitment underway.

Core Essential Skills Training

- Compliance with some mandatory and essential skills training modules below compliance targets. Resus training remains challenged with plans in place to achieve trajectory.
- See Alert re. consent training.

Cancer Annual Report 2021/22

- Content noted and delay in presenting to the Committee.

Clinical Effectiveness Committee

- Chemocare now single instance for Southport and Ormskirk (S&O) Hospital NHS Trust and St Helens and Knowsley NHS Teaching Hospitals (STHK). Electronic Prescribing and Medicines Administration (ePMA) launch on spinal progressing well with learning and positive feedback.
- Transfusion Administration Record compliance inconsistent across clinical areas – process reviewed with increased number of incidents reported.
- Work continues on collaboration across a number of areas: paediatric dietetics, aseptic services, care of transgender patients.
- Fully recruited to diabetes team vacancies
- Potential risk to Ears, Nose and Throat (ENT) service provided by Liverpool University Hospitals NHS Foundation Trust (LUHFT) due to resignations.

Quality Improvement Board Update

- Four of the five objectives on track. Reduction in hospital acquired Acute Kidney Injury (AKI) target not met.

Draft Quality Account

- Progress noted with improvements across multiple areas.

ASSURE

- Meeting effectiveness feedback: meeting well chaired and discussed items at an appropriate level of detail.

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

Review of the Risk Register
Not applicable

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONAL COMMITTEE**	**Date**	**03 May 2023**
Agenda Item	**SO083/23**	**FOI Exempt**	**NO**
Report Title	**INFECTION PREVENTION AND CONTROL (IPC) BOARD ASSURANCE FRAMEWORK (BAF)**		
Executive Lead	Dr Kate Clark, Medical Director and Director for Infection, Prevention and Control		
Lead Officer	Catherine Atkinson, Matron for Infection, Prevention and Control		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

The purpose of this report is to provide the Strategy and Operations Committee with an update in relation to the Trust's position against the measures within the Infection Prevention and Control (IPC) Board Assurance Framework (BAF).

Executive Summary

The IPC BAF was first reported to the Board in July 2020 and is presented to the Strategy and Operations Committee on a regular basis.

Since the publication of the update IPC BAF in September 2022, a full review has been undertaken of compliance against each Key Line of Enquiry. We are currently fully compliant (BLUE) with 94 actions, seven as GREEN (progressing on schedule) and 1 AMBER (slightly delayed).
Areas identified for further improvement relate to:

- Estate limitations / lack of side rooms – however Gamma Ready Rooms / Pods available for use in most clinical areas
- Staff Fit Testing records – currently being reviewed to ensure all records are held locally and on ESR
- Current capacity within the IPC Team - Consultant Nurse appointed on 12 month secondment (start date June 2023), Matron for IPC interviews scheduled and contingency plan in place to support until appointed. Trainee IPC nurse secondment – start day May 2023

To ensure these BLUE actions remain embedded and sustained the framework will be regularly revisited to monitor progress and mitigation regarding gaps and compliance against any new or amended guidance.

Recommendations

The Strategy and Operations is asked to receive the Infection Prevention and Control (IPC) Board Assurance Framework (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:**
Catherine Atkinson, Matron for Infection, Prevention and Control	Dr Kate Clark, Medical Director

Publications approval reference: 001559

Infection prevention and control board assurance framework

21 September 2022 V1.11

Updates from November 30th V1.8 highlighted

Foreword

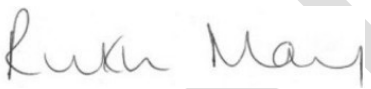
NHS staff should be proud of the care being provided to patients and the way in which services adapted and responded during the COVID-19 pandemic.

Effective infection prevention and control must continue and to support service recovery we have updated this board assurance framework (BAF) to support all healthcare providers to effectively self-assess their compliance with the National Infection Prevention and Control Manual (NIPCM) https://www.england.nhs.uk/publication/national-infection-prevention-and-control/

and other related infection prevention and control guidance to identify risks associated with infectious agents and provide an additional level of assurance to the Board. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors, and directors of nursing by assessing the measures taken in line with the NIPCM or existing local policies whilst the NIPCM is being implemented. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.



Ruth May

Chief Nursing Officer for England

1. Introduction

The application of Infection Prevention and Control (IPC) measures has been key in the response to the SARS-CoV-2 pandemic.

The UKHSA guidance was archived at the end of April 2022, the proposal is that NIPCM combined with this version of the Board Assurance Framework (BAF) will support this transition.

This will continue to ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users, and staff.

The update of the BAF helps providers to assess against the NIPCM as a source of internal assurance. It will also identify any areas of risk and the corrective actions required in response. The BAF provides assurance to trust boards that organisational compliance has been systematically reviewed.

The BAF is intended to support local organisations with decision making and be used by directors of infection prevention and control, medical directors, and directors of nursing if required unless alternative internal assurance mechanisms are in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. Local risk assessments should be based on the measures as prioritised in the hierarchy of controls https://www.england.nhs.uk/publication/national-infection-prevention-and-control/
. In the context of infectious agents, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed, and mitigated effectively.

4

Infection Prevention and Control board assurance framework

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (March 2023)
• **A respiratory plan incorporating respiratory seasonal viruses that includes:** ○ Point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services. ○ Segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g. clinically immunocompromised. ○ A surge/escalation plan to manage increasing patient/staff infections. ○ a multidisciplinary team approach is adopted with hospital leadership, operational teams, estates & facilities, IPC teams and clinical and non- clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan.	Yes, respiratory plan in place. PCR testing for symptomatic or suspected patients • We have Covid-19 pathway, also any suspected respiratory infections (including flu and RSV.) are tested for prior to admissions or if symptomatic on wards. We currently use PCR testing • We segregate or co-hort dependent on respiratory infection. • Individual patients are reviewed risk assessing immunocompromised to ensure they either need single isolation or if they can be co-horted as per National guidance COVID-19: information and advice for health and care professionals - GOV.UK (www.gov.uk) • Surge plan in place, identifying escalation areas in priority of usage. Circulated as part of weekend plans • As part of Winter Planning MDT meetings are held to discuss escalation and estate for isolation.	POCT SOP for Covid has been developed and is currently being rolled out Estate limitations – number of side rooms and decant areas	Cohort dependent on numbers identified and taking into account single sex guidance Gamma Ready Rooms in use	

• **Organisational /employers risk assessments in the context of managing infectious agents are:** ○ Based on the measures as prioritised in the hierarchy of controls. ○ Applied in order and include elimination; substitution, engineering, administration and PPE/RPE ○ Communicated to staff. ○ Applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ○ Communicated to staff. ○ Further reassessed where there is a change or new risk identified e.g. changes to local prevalence	As community prevalence and hospital prevalence increases risk is reviewed daily, we have clear chain of command to escalate concerns and advice / mitigation comes from this • All staff have had Risk Assessments, these are reviewed annually • PPE monitoring is undertaken via monthly audit, if a clinical area flags with low compliance, enhanced surveillance is undertaken and additional training and education provided • Continued Comms across the Trust and included in Trust Brief Live regarding IPC measures (social distancing, PPE, Ventilation) • Trust has now procured a total of 37 air purifiers and CO2 monitors (6/1/22).			
The completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	An organisational risk assessment is available via (H&WB for Staff) Living-with-COVID-V1-RA-SO.doc (live.com) Eligibility criteria also in place for patients available on intranet Covid documents and support			
Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents.	Risk assessments for staff are undertaken by line managers in collaboration with H&WB, Heath & safety and IPC colleagues.			
Ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons.	The Trust only moves patients following risk assessment to maintain IPC / patient / staff safety. Incidents by exception are monitored via Datix			
Resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors).	IPC use Tendable and the ICNET to review patients who admitted with known infections to risk assess and ensure NIPCM standards are met. Clinical staff utilise Care Flow to review patients with known infections and complete risk assessments			

	PPE and hand hygiene monitoring is undertaken via monthly audit in all clinical areas			
The application of IPC practices within the NIPCM is monitored e.g., 10 elements of SICPs	Regular IPC inspections in partnership with Domestics and facilities teams are undertaken as per schedule. Local clinical areas are monitored by local clinical leadership			
The IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level.	The IPC BAF is reviewed at IPG Assurance Group, approved at Quality & Safety Committee and then submitted to the Trust Board			
The Trust Board has oversight of incidents/outbreaks and associated action plans.	As outbreaks and incidents are identified the Trust establish an Outbreak Meeting, minutes are reported via IPC Operations Group to IPC Assurance group. This group reports to Quality & Safety Committee via a 'AAA' report (Alert, advise & assure) including a summary. Significant outbreaks will be reported directly to the weekly executive committee. Quality & Safety Committee and the Executive Committee report to Trust Board. Outbreaks/incidents are RIDDOR reported as appropriate. It is also highlighted in the monthly compliance report and certain outbreaks are reported to UKHSA / ICBs.			
The Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.	Several suppliers are available via procurement team. We aim were possible to fit staff with a minimum of two types of masks			

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**BRAG Rating (March 23)**
Systems and processes are in place to ensure that:				

The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	As Trust we are working to the National Standards of Healthcare Cleanliness. Additional business case is currently in development to recruit additional staff to ensure the service is robust. Monitoring is in place and reviewed through current governance structures. Information is reported to the IPC operational group and IPC assurance group then reporting by exception to Quality & safety committee (QSC) who reports to board. The charter was reported and approved through the executive committee (EC). Both QSC and EC report through to Trust Board.	Standard charters are currently in development, awaiting next steps in the Transaction to display for the new organisation	Additional staff currently booked through NHSP	
The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room.	Signage in place for infected Side Rooms (SR) and Bays where appropriate. IPC Team have developed a schedule for type of clean dependent on infection. The Trust has implemented a system - Red / Amber Green Zones – any changes are communicated via Comms Team			
Cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	We use a system called INVIDIA to monitor the 50 elements of the national cleaning standards			
Enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained.	Daily clinical reviews of all clinical areas – staff identify any patients with suspected infections The IPC Team utilise ICNET to identify infections and advise clinical staff and domestic teams of the type of cleans required. IPC Team and domestic teams maintain records to demonstrate the appropriate cleans are undertaken for the infections			

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	The Trust utilises UVC or HPV for enhanced cleans and an ongoing training programme is in place with manufacturers.			
Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	Domestics Audits completed by the Domestic Supervisors and Compliance Officer Domestics are trained and competency assessed to ensure safe application / contact time / usage of products to ensure environmental decontamination as per cleaning schedule.			
For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in: ○ Patient isolation rooms ○ Cohort areas ○ Donning & doffing areas – if applicable ○ 'Frequently touched' surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails. ○ Where there may be higher environmental contamination rates, including: Toilets/commodes particularly if patients have diarrhoea and/or vomiting.	Utilise the Trust Cleaning Policy incorporating HPV and UVC. Nursing staff complete elements of decontamination of equipment / environment within their local areas / remit.			
The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness	Responsibilities currently in place, being updated as per national standards of cleanliness plan. This will be updated on sign off the Cleaning Standard Charter.	Standard charters have been approved and are awaiting the Transaction to display new Trust logo & name.	Trust is currently working to the standards and appropriate monitoring in place	
A terminal clean of inpatient rooms is carried out: ○ When the patient is no longer considered infectious ○ When vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). ○ Following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is	Utilise the Trust Cleaning Policy incorporating HPV and UVC			

dependent on the ventilation and air change within the room).				
Reusable non-invasive care equipment is decontaminated: ○ Between each use ○ After blood and/or body fluid contamination ○ At regular predefined intervals as part of an equipment cleaning protocol ○ Before inspection, servicing, or repair equipment.	Utilise the Trust Cleaning Policy incorporating HPV and UVC. Included in cleaning schedules Refresher training for clinical staff completed in December 2022 and January 2023			
Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	Weekly and monthly ATP monitoring in place. Any exceptions identified at time of review are shared with user to resolve.			
Ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/	We have a specialist external authorising engineer to ensure compliance with HTM03-01. Assessment of ventilation and any mitigations are reviewed by the Engineering and Safety Group, Estates and Facilities group and Quality & Safety Committee			
Ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or The organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible.				
Where possible air is diluted by natural ventilation by opening windows and doors where appropriate				

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (March 23)
Systems and process are in place to ensure that:				
Arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated	There is a nominated AMS lead in Pharmacy Team. Quarterly antimicrobial management group (AMG) in place which reports into Drugs & therapeutic Committee. Monthly audits in place via Tendable. Quarterly point prevalence audit in place. From 23/24 requirement to report for CQUIN (03) Weekly data available from ICNET for MRSA patients – pharmacy review of appropriateness on prescribed antibiotics Daily checks of all prescriptions by ward Pharmacists to ensure appropriateness in line with formula. ARC is incorporated into drug chart. Daily pharmacist monitoring in place Process in place for pharmacists to highlight inappropriate antimicrobial prescribing .			
NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented – Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use				
The use of antimicrobials is managed and monitored:				
To optimise patient outcomes				
To minimise inappropriate prescribing				
To ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus are followed				
Contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including:				
Total antimicrobial prescribing;				
Broad-spectrum prescribing;				
Intravenous route prescribing;				

Adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources	CDI RCA completed and from 23/24 requirement to report for CQUIN (03)		
Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors.	Audit information available, reported via Antimicrobial Stewardship Group & IPC Operational Group		

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (March 2023)
Systems and processes are in place to ensure that:				
IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use	Information provided on trusts websites and social media. 'Catch it bin it kill it' signs are in place. Hand hygiene signage at entrance and inside ward areas. Patient information leaflets			
Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors	Visiting in place in line with national guidance which also supports Zoom calls for patients.			
National principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. national guidance on visiting patients in a care setting is implemented.				

Patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice.				
Restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives.	Visiting is reviewed as part of outbreak management guidance.			
There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene and cough etiquette. The use of facemasks/face coverings should be determined following a local risk assessment.	'Catch it bin it kill it' signs are in place. Hand hygiene signage at entrance and inside ward areas. There is an escalation plan for the use of facemasks, agreed at IPC Assurance Group or Executive Committee			
If visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE.	IPC advice is provided via posters, given verbally by ward staff and through social media and usual communications channels			
Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting.	Information provided on Trust websites, on outpatient letters, posters etc. Staff also verbally remind visitors regarding IPC requirements.			
Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian.	Ward staff undertake a local risk assessment completed for relatives/visitors visiting during AGPs			
Implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Elements of the toolkit used where appropriate			

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (March 2023)
Systems and processes are in place to ensure that:				
All patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients).	Patients are triaged and risk assessed for infection status at A&E. If patients become symptomatic as inpatients they are tested and isolated or co-horted as required in accordance to national guidance			
Signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM).	Information provided on trusts websites. Appropriate signage in place. If there is an outbreak – pop up signage is used.			
The infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement	Transfer and discharge documentation refers to infection status of patient. Process is in place to swab patients for Covid -19 prior to discharge to residential or care home facility.			
Triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious	Clinical proforma in place and utilised			

individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated.				
Patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated.	Face masks available for use and advised to be worn if tolerated.			
Patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite).	Not always able to due to capacity on ward areas . If patient is in A&E, we have red majors (individual cubicles) if identified as suspected respiratory infections.	Due to capacity issues and increasing patients with respiratory symptoms, including patients with cough and sputum production, it is not always possible to assess patients with a respiratory infection in a single room or separate area.	We utilise Gamma Ready room Pods	
Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available.				
Patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation	As per isolation guidance.			
If a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	Clinicians routinely undertake individual risk assessments regarding patients' appropriate care in line with current guidance			
The use of facemasks/face coverings should be determined following a local risk assessment.	There is an escalation plan for the use of surgical facemasks, agreed at IPC Assurance Group and Executive Committee			
patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy.	Patients managed appropriately eg reviewed clinically, isolation appropriate PPE provided as required.			

Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection	Staff vaccination programme available. Long stay (eg Spinal Unit and RFD list) patient vaccinations in progress			
Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.	Outbreaks managed according to policy			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection				
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**BRAG Rating (March 23)**
Systems and processes are in place to ensure that:				
IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties.	Mandatory Level 1 and Level 2 training in place. 85% minimum compliance. Compliance monitored in IPC Operational Group and Clinical effectiveness Committee			
Training in IPC measures is provided to all staff, including: the correct use of PPE	Training for clinical staff (Level 2) includes hand hygiene technique and PPE. Monthly hand hygiene and PPE audits in place			
All staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM);				

Adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk	Audits undertaken as per IPC audit schedule and includes monthly hand hygiene and PPE audits in place			
Gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	Information also provided in the TBPs guideline			
Hand hygiene is performed: Before touching a patient. Before clean or aseptic procedures. After body fluid exposure risk. After touching a patient; and After touching a patient's immediate surroundings	Included in the hand hygiene policy. monthly hand hygiene and PPE audits in place			
The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination (NIPCM)	Hand driers not in use in clinical areas			
Staff understand the requirements for uniform laundering where this is not provided for onsite.	As per uniform policy			

7. Provide or secure adequate isolation facilities

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (March 23)
Systems and processes are in place to ensure:				
that clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	Mask wearing for patients with respiratory infections is advised if it can be tolerated. Overall compliance with this is challenging to monitor as only applicable if able to be tolerated by patient. This is monitored locally			
patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM.	Clinicians routinely undertake individual risk assessments regarding patients' appropriate care			
patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent.	Patients with known infection are isolated or cohorted were possible. Utilisation of Gamma Ready Rooms in place			
standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings	As per TBPs (NIPCM and local IPC Operation manual)			
Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	Monitored locally and reviewed through the monthly hand hygiene and PPE audits			

8. Secure adequate access to laboratory support as appropriate

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (March 23)
There are systems and processes are in place to ensure that:				
Laboratory testing for infectious illnesses is undertaken by competent and trained individuals.	Service provided by Laboratory is appropriately accredited, and staff are appropriately trained			
Patient testing for infectious agents is undertaken promptly and in line with national guidance.	Patient testing is in line with national guidance			
Staff testing protocols are in place for the required health checks, immunisations and clearance	Health & Wellbeing checks are in place.			
There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.	Process in place, undertaken and reported by the lab			
Inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise.	As per clinical pathways and sepsis management			
COVID-19 Specific				
Patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk)	We currently test via PCR for discharge, currently implementing POCT LFD for asymptomatic discharges at 48 hrs as per guidance. POCT LFD testing is in place for asymptomatic discharges.			
For testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)				

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (March 2023)
Systems and processes are in place to ensure that:				
Resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors).	Adequate resources available, AMS leads and appropriate monitoring platforms in place	Current gaps / vacancy and Long Term sickness in IPC Team	Interim Consultant Nurse appointed (start date 12th June) Matron for IPC interviews scheduled and contingency plan in pace to support until appointed. Trainee IPC nurse secondment – start day May 23	
Staff are supported in adhering to all IPC and AMS policies.	Training is available , Policies are currently being reviewed as part of the Transaction	Some policies out of date, however under review	Working to utilised StHK policies if gaps	
Policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	As per outbreak policy			

All clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM	We meet the NIPCM guidance for both clinical waste and infectious linen / laundry. Waste Policy and Soiled Linen Bagging Procedure in place. Management of clinical waste is compliant with Waste HTM 07-01. We have all the separated in accordance with the NIPCM guidance and keep these separated from point of production to the waste leaving the site in locked cupboards/compounds/bins etc. All our containers, bags etc are correct as specified in the guidance and are purchased via Procurement or supplied by our specialist waste contractors.			
PPE stock is appropriately stored and accessible to staff when required as per NIPCM	Yes monitored via Procurement Team, daily top ups available to all clinical areas			

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions	BRAG Rating (March 2023)
Systems and processes are in place to ensure that:				
Staff seek advice when required from their occupational health department/IPCT/GP or employer as per their local policy.	Health & Wellbeing service in place. Process in place – supporting policies include: management of inoculation injuries, D&V,			

	immunisation/vaccination, health surveillance and stress risk assessment.			
Bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff.	The above process and policies apply to all staff			
Staff understand and are adequately trained in safe systems of working commensurate with their duties.	Safe systems of work would be part of our infection control guidance and our health and safety guidance			
A fit testing programme is in place for those who may need to wear respiratory protection.	Fit Testing is undertaken by CBUs, records held locally.			
Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:				
Lead on the implementation of systems to monitor for illness and absence.	Staff would be reviewed by OH and we would: • lead on the implementation to monitor for illness and in some circumstances absence. • Facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice, e.g. occupational vaccination and national vaccination programmes covid/flu vaccination programmes • Lead on implementation of system to monitor staff illness, absence and vaccination • H&WB actively encourage staff vaccination uptake			
Facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice.				
Lead on the implementation of systems to monitor staff illness, absence and vaccination.				
Encourage staff vaccine uptake.				
Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM.	Safe systems of work would be part of our infection control guidance and our health and safety guidance.			

A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19.	Living with covid-19 risk assessment to support this process. Risk assessments in place for all staff including BAME and pregnancy All staff have completed a self Risk assessment and line managers have risk assessed staff in their clinical area			
A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups.				
That advice is available to all health and social care staff, including specific advice to those at risk from complications.				
Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff.				
A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.				
Testing policies are in place locally as advised by occupational health/public health.	Testing policies in-line with government guidance			
NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)	Testing policies in-line with government guidance			
Staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance and a record of this training is maintained by the staff member and held centrally/ESR records.	Monitored centrally during the pandemic and is now delegated to the CBUs as part of training compliance monitoring	Currently reviewing records And developing Fit Testing SOP		
Staff who carry out fit test training are trained and competent to do so.	Fit Testing – CBUs have processes in place to ensure all patient facing staff have received fit test training to a currently available FFP3			
Fit testing is repeated each time a different FFP3 model is used.				
All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks				
those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood.	All records are held locally in the CBUs and records of fails and passes are recorded. Alternatives, such as a powered hood are provided as appropriate.			

That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions				
Members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	For those who are unable to be fit tested – a discussion is held regarding re-deployment opportunities.			
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	Process is in place records held locally			
Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	Reported by exception via AAA to CEC, QSC , EC and Board			
Staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.	As per Supporting Attendance Policy			
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.				

Completed
Progressing on schedule

Slightly delayed and/or of low risk
Significantly delayed and/or of high risk

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Workforce Committee
MEETING DATE:	25 April 2023
LEAD:	Lisa Knight

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Nil

ADVISE

- Risk Register – risks will be re-assessed post transaction.
- Lessons Learned sessions undertaken regarding the recent Junior Doctors industrial action.
- Planning underway to mark the International Day of the Midwife (05 May 2023) and International Nurses Day (12 May 2023).

ASSURE

- Presentation received from the Associate Director of Midwifery on her experience of joining the Trust which was very positive, and she was made to feel extremely welcome.
- Interviews for Guardian of Safe Working planned for mid-May 2023.
- PDRs – 80% which has been the highest level since October 2021. Estates & Facilities congratulated on their progress with 89.45%.
- Trust vacancies – reduction seen in month from 7% to 6.6% which has been the lowest rate for over two years and below 7.4% target.
- Core mandatory training – increase seen in month to 89.6% against a target of 90%. This is the highest level for two years.
- Sickness continues to reduce and has done so for the last five months – 5.9%.
- Rolling sickness – reduced in month to 6.7%. This is the lowest rolling absence since December 2021.
- Time to Hire – Hitting the stretch target of 40 days for first time.
- Posts currently under offer – 16 x medical, 12 x AHPs, 24 x Band 5s. There have been 23 HCAs new starters in month with a further 28 posts currently under offer.

New Risks identified at the meeting: Nil

Review of the Risk Register: Yes

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**03 May 2023**
Agenda Item	**SO085/23**	**FOI Exempt**	**NO**
Report Title	**FREEDOM TO SPEAK UP REPORT (QUARTER – 01 JANUARY TO 31 MARCH 2023)**		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Christine Griffiths-Evans, Freedom to Speak Up (FTSU) Guardian		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ☐ **To Receive**	

Purpose

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

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

Executive Summary

This report identifies the number of concerns raised through the Freedom to Speak Up service (FTSU) during Quarter 4 of 2023 (01 January – 31 March 2023). During the quarter, nine concerns have been raised through the FTSU process, please note this does not include concerns that have been raised and resolved informally through the management/FTSU Champion structure within the organisation. Of the nine concerns raised, one required input from Human Resources directly, via the Guardian or Line Manager.

To assist with setting the context and to support ongoing review, some statistics are included from the last twelve months.

During Quarter 4 there were no emerging/actual themes (categories)e identified from the concerns raised by staff. Some of the individual areas raised include:

- Concern about standards of care within ward areas.
- Concern that a doctor was potentially and inappropriately acting as a Power of Attorney for their patients.
- Lack of staff training relating to non-invasive ventilation (NIV) and tracheostomy patients.
- A member of staff within one ward area reporting dissatisfaction with a new management and leadership style.
- A member of staff was locked inside a room with their Team Leaders and was unable to leave when they became distressed.
- Comments from line manager added to a staff member timesheet regarding being off sick with Covid-19
- Concern over ventilation in the ward area and the multidisciplinary (MDT) room and staff not adhering to personal protective equipment (PPE) guidelines.
- A concern relating to periods of working as the lone and only doctor within ward/clinical area.

Recommendations

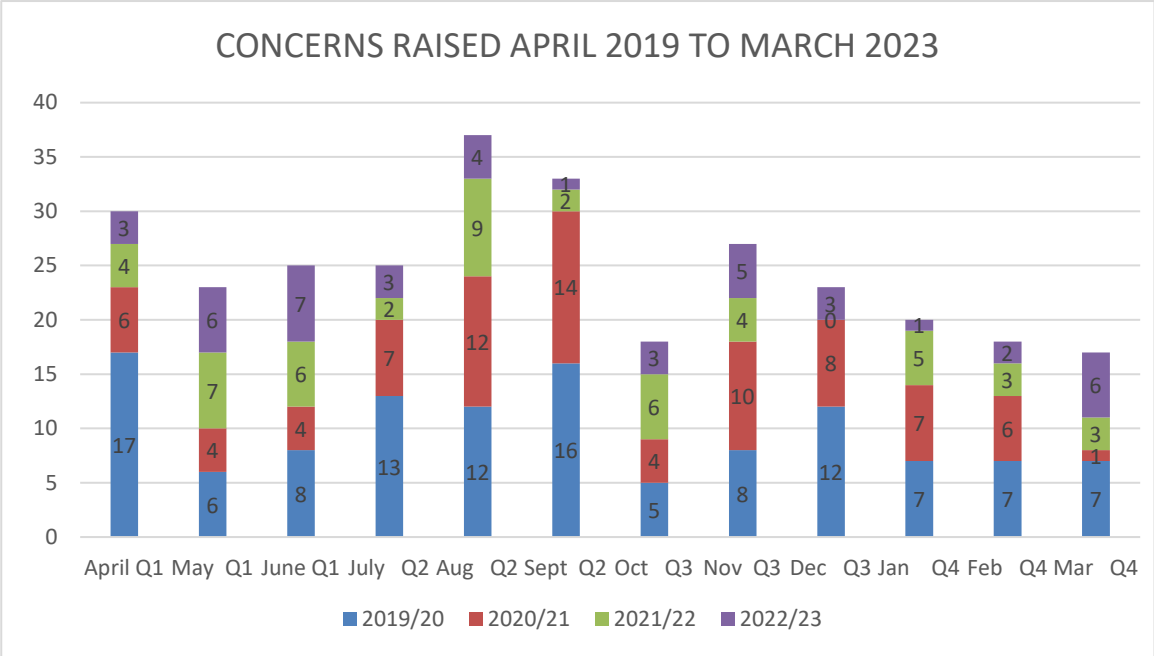
The Strategy and Operations Committee is asked to note the Freedom to Speak Up Report for Quarter (01 January to 31 March 2023) report and to suggest any further areas for future work and focus.

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

Report on Submission to National Guardian's Office

Quarter 4	1 January – 31 March 2023
Date submitted to NGO:	19 April 2023
Date National Data to be published:	To Be Confirmed
Number of Concerns Raised	**9** concerns (January 1, February 2, March 6) All of these were directly raised with the Freedom to Speak Up Guardian (FTSUG) apart from one which was raised through a FTSU Champion. When concerns are raised directly with FTSU Champions, the FTSUG is available to offer support and advice, which may include meeting those who have raised a concern and acting in a consultative role. This is a decrease of two in the total number of concerns received, when compared to Quarter 3. This report does not include those informal concerns/areas raised and resolved through the management/FTSU Champion structure

The graph below highlights the concerns raised, per month, over the past four years from April 2019 and up to and including March 2023:



1.1 Categories (Themes) Arising from Concerns Raised

There are no emerging or actual themes arising from concerns raised during Quarter 4.

The following areas have been raised by staff. Please note that for reasons of confidentiality, only general information is recorded within this report:

- Concern about standards of care within ward areas
- Concern that a doctor was potentially and inappropriately acting as a Power of Attorney for their patients.
- Lack of staff training relating to NIV and tracheostomy patients.
- A member of staff within one ward area reporting dissatisfaction with a new management and leadership style.

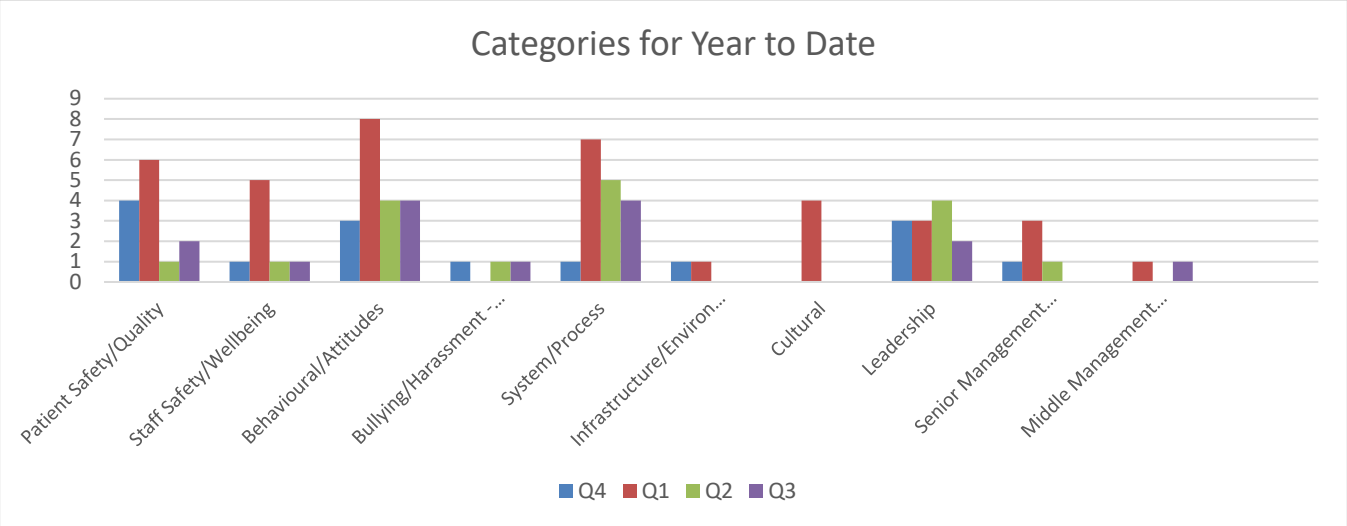
- A member of staff was locked inside a room with their Team Leaders and was unable to leave when they became distressed.
- Comments from line manager added to a staff member timesheet regarding being off sick with Covid-19
- Concern over ventilation in the ward area and the MDT room and staff not adhering to PPE guidelines.
- A concern relating to periods of working as the lone and only doctor within ward/clinical area.

The National Guardians Office, (NGO), requires all concerns to be categorsied, to a pre determined category list, to enable consistent national reporting. The table below highlights the categories of the concerns raised, during the quarter, as a percentage, please note each concern can fall into multiple categories, which is reflected in the tables below:

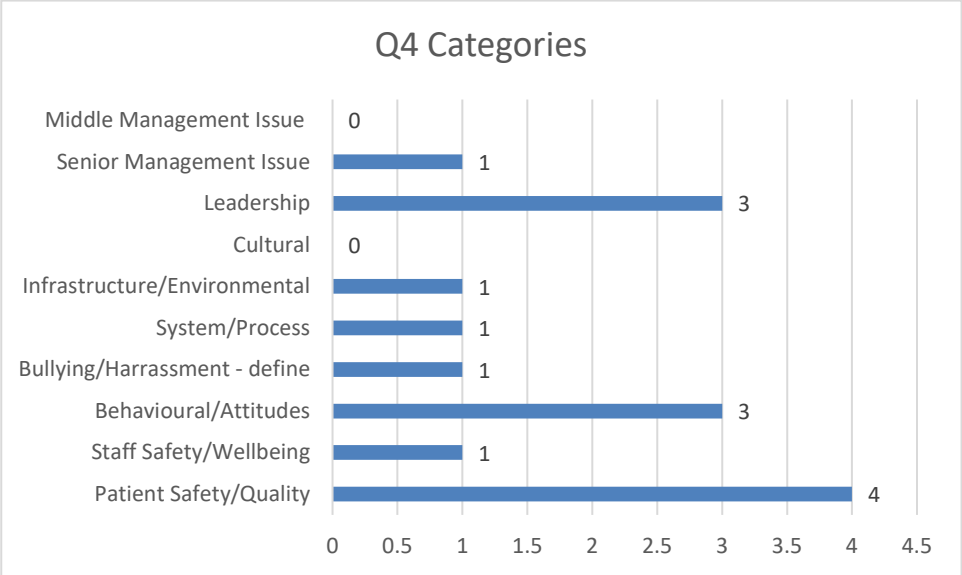
Issues this quarter: Q4 (All quarters shown for Comparison)

Categories (Themes)	Quarter 4 2022/23	Last Quarter (Q3) 2022/23	Q2	Q1
Behavioural / Relationship	20%	26.66%	23.52%	21.05%
System / Process	6.66^	26.66%	29.41%	18.42%
Cultural	0%	0%	0%	10.52%
Bullying/Harassment	6.66%	6.66%	5.88%	0%
Middle Management issue	0%	6.66%	0%	2.63%
Staff Safety	6.66%	6.66%	5.88%	13.15%
Infrastructure/Environment	6.66%	0%	0%	2.63%
Leadership	20%	13.33%	23.52%	7.89%
Senior Management Issue	6.66%	0%	5.88%	7.89%
Patient Safety/Quality	26.66%	13.33%	5.88%	15.78%

As the number of concerns per quarter remains low, further analysis across the year to date is helpful in identifying any themes. The graph below highlights the number of concerns per NGO category raised over the last four quarters, *(Please note Quarter 4, 2023 is the most recent):*



Graph below showing Categories for Quarter 4



1.2 Anonymous Concerns

During Quarter 4, there were two anonymous concerns. This is where the person raising the concern cannot be contacted as there are no contact details, e.g., anonymous letter / phone call/email.

During the quarter, out of the nine concerns raised, five staff members did not want to be identified and associated with the concern and therefore their details remain confidential, other than to the FTSU Guardian and administrator.

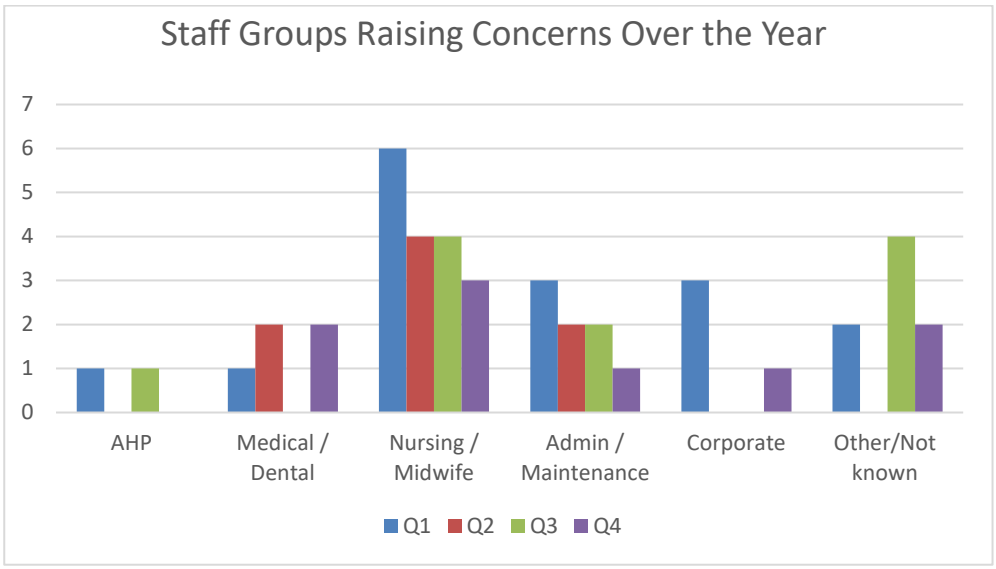
Out of the concerns raised this quarter, one member of staff was concerned about potential repercussions. For the other five staff members, known to the FTSU team, although they did not vocalise any concerns regarding repercussions, they made a choice for their name to remain confidential.

1.3 Staff Groups Raising Concerns

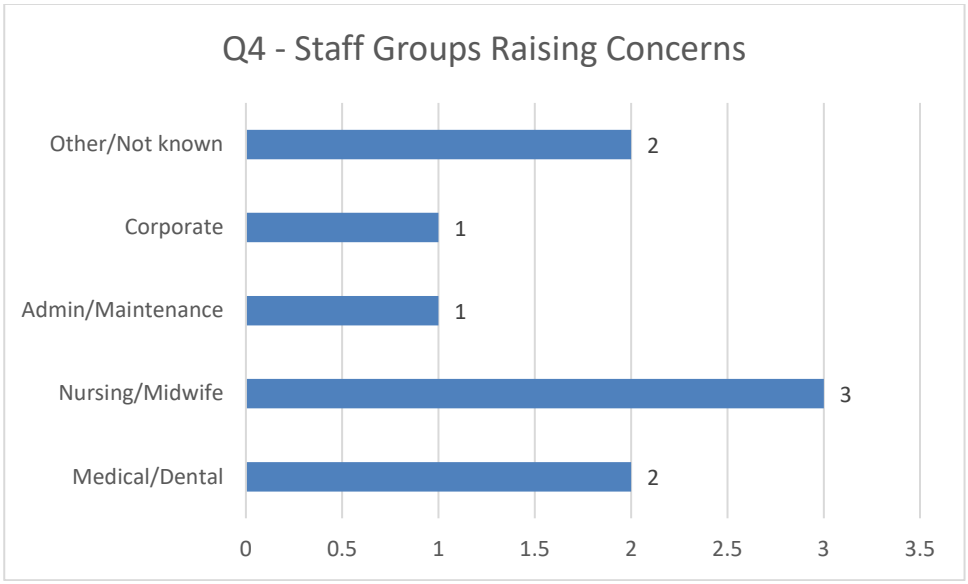
Concerns this quarter have been raised by a cross-section of staff, as shown in the table. These follow the definition of the National Guardian's Office. For comparison, all Quarter's results are also shown.

Staff Group	Current Quarter (Q4)	Last Quarter (Q3)	(Q2)	(Q1)
AHP	0%	9.09%	0%	6.25%
Medical and Dental	22.22%	0%	25%	6.25%
Nursing / Midwives	33.33%	36.36%	0%	37.5%
HCA	0%	0%	50%	0%
Admin/Maintenance	11.11%	18.18%	25%	18.75%
Corporate	11.11%	18.18%	0%	18.75%
Other/Not known	22.22%	18.18%	0%	12.50%

The Graph below shows the last 4 Quarters for comparison (Quarter 4 being our most recent)



This Graph below shows Q4 Staff Groups Raising Concerns



1.4 Situations where detriment was expressed because of speaking up

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

1.5 Feedback Post Raising Concerns

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

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

During this quarter feedback was received from three of the staff members, who raised concerns with the FTSU service.

All the feedback received this quarter was Positive, including the following:

- *Had a concern that I needed to inform someone about. I was listened too regardless of the outcome and felt supported.*

- *Thank you so much for chatting to me. Hopefully the Team Leaders will not do this again to any of the team.*

- *I felt better having somebody to speak to without worrying. I would encourage other staff members to speak to FTSU if they needed advice about a concern they have.*
  The meeting we had was very positive and it is a great service.

1.6 Changes as a Result of Speaking Up

The question is often asked '*What things have changed as a result of people speaking up?'* Each quarter we try to offer a brief overview of some of the changes, however further work is required to strengthen this area. Whilst feedback is requested from those who have spoken up, further work is required to gather feedback on "what has changed" after each case is closed.

Following a concern raised in Quarter 3, a process has been established to ensure that Carbon Monoxide Monitors used within Community Maternity Services are serviced annually and plan have been put in place to renew some of the equipment moving forward.

From the areas raised in Q4 the following actions have taken place:
- Discussions with Managers and Leaders within one area regarding civility at work and how some aspects of their current practice may exacerbate a conflict situation.
- Further training and support have been delivered to staff within ward area regarding the management of Non-Invasive Ventilation and deteriorating patients.
- Within one ward area, the need to adhere to IPC practices has been reenforced.
- Engagement sessions with staff being held by a Matron to understand concerns regarding leadership and management style to ascertain if any action is required.

1.7 How Concerns are Managed

Concerns are managed on a concern-by-concern basis, in line with the trust's FTSU policy. The Guardian has regular one to one's with the FTSU Executive Lead and Managing Director and has established links with the Human Resources Team.

1.8 Guardians Support

The FTSU guardian continues to be a member of the Regional and National network of Guardians. Although these are not meeting face to face, there is a monthly "teams" regional support meeting or workshop, with input from the national office. The guardian attended the NGO conference during the quarter and has attended a training day in relation to Supporting an Inclusive Speak up Culture in Black and Minority Ethnic People.

2. Freedom to Speak Up, Raising Concerns Policy (Corp 69)

The policy, which is in line with NGO/NHS England guidance is accessible on the intranet.

3.Concerns Taken Directly to CQC

During Quarter 4, one concern was reported anonymously, directly to CQC. This related to staff competency in undertaking and caring for patients undergoing Non-Invasive Ventilation (NIV) and those patients with tracheostomies, on ward 14b. In addition, concerns were raised regarding cleanliness and removal of filled urine bottles from patient bedsides. This has been reviewed and feedback has been forwarded to CQC, who have closed the concern. Actions taken include:
- Further training via simulation for staff within ward area regarding caring for patients with NIV or a tracheostomy and or are deteriorating.
- Observations of practice

4. Freedom to Speak Up Champions – new guidance from the NGO

We are currently undertaking a review of the champions in place across the trust, having recruited three new champions but lost one. A champion network meeting was held in March 2023.

We continue to recruit Champions under the National Guardian's office (NGO). We have a total of 25 Champions currently across the Trust. (2 stepping down for the moment).

An away morning for Champions is planned for 9th May 2023, to assist in informing a work plan for the next 12 months and a revised FTSU Strategy. One of the FTSU Guardians from St Helens and Knowsley NHS Trust has been invited to attend to assist in joined up working.

5.Staff Survey

The results of the 2022 Staff Survey show a slight deterioration, in the indicators, relating to speaking up:

Q19a I would feel secure raising concerns about unsafe clinical practice: Result for 2022 is 65.6% which is a reduction from 70.9% in 2021 and against an average of 70.8%

Q19b I am confident that my organisation would address my concern: Result for 2022 is 51.8% which is a reduction from 53.3% in 2021 and against an average of 55.7%

Q23e I feel safe to speak up about anything that concerns me in this organisation: Result for 2022 is 54.5% which is a reduction from 57.0% in 2021 and against an average of 60.3%

Q23f If I spoke up about something that concerned me, I am confident my organisation would address my concern: Result for 2022 is 42.6.2% which is a reduction from 44.7% in 2021 and against an average of 47.2%

The above results should be viewed within the context of a response rate to the survey of 34%, a period of sustained significant pressure within the health service, periods of industrial action and in view that the organisation is currently going through a major change. The deterioration in scores is reflected nationally, with the National Guardian, calling for all leaders to undertake further work to develop a positive FTSU culture.

The FTSU Guardian is undertaking some further analysis to identify any specific areas that may benefit from FTSU awareness sessions.

6.Awareness –

The FTSU Guardian has undertaken the following awareness raising activities during the quarter:

- one FTSU sessions with Student Nurses
- one FTSU session with Preceptees
- A meeting with team leader and supervisor within Medical Records (to discuss how to support FTSU within their department)

In addition, the trust website content relating to FTSU has been reviewed and updated and, posts have been placed on the Trust internal social media, (meeting place and twitter). The use of a QR code for staff to raise concerns is currently being explored.

The FTSU Guardian has also joined the staff networks to raise awareness of speaking up with and supporting staff, with protected characteristics.

7.The National Picture

National Guardians Office (NGO) Update

Listening to Workers: A Speak up Review of Ambulance Trusts in England

In February 2023, the NGO published the findings and recommendations from its review into FTSU arrangements within Ambulance Trusts in England, this was triggered by a perceived challenge in embedding a positive FTSU culture, which was supported by staff survey results from across ambulance trusts.

The report acts as a reminder to NHS Organisations, of the risks to organisational culture, when there is a sole focus on meeting targets, especially when organisations are under significant pressure and have reduced capacity. It reenforces the need to develop unity and shared ideas about what it takes to deliver excellent services and how this supports the ongoing safety and wellbeing of both staff and patients. FTSU is related to staff being given ownership of and acting as agents for change, within the organisations in which they work.

As with any published external review, it is both pertinent and appropriate to consider our FTSU culture and mechanisms within the context of the finding and recommendations contained within this report. The table below highlights the main findings from the review along with any associated recommendation and commentary regarding the current position within Southport and Ormskirk Hospital NHS Trust.

Review of Findings and Recommendations from Listening to Workers (NGO)

Finding	Recommendation	Current Trust Position	Action Required /Suggested	Rag Rating
Speaking Up Culture				
The Culture was having a negative impact on workers ability to speak up: • Fear of speaking up • No one will listen. • Staf Survey Results • Broader cultural issues such as command and control culture, bullying and harassment.	**1. Review broader cultural matters within Ambulance trusts:** Cultural review to consider management and leadership behaviours and focus on worker wellbeing as well as effectiveness of governance, leadership structures. Models of leadership, just culture, recruitment practices, operational and workforce pressures, bullying and harassment and discrimination.	Positive staff survey results published in 2023, with a number of areas identified for further focus. Changes will made to improve areas based on feedback from survey, including further staff engagement, just culture and FTSU. Survey results relating to FTSU have slightly deteriorated. Just and Learning Culture embedding, in progress, and evidenced through HR related investigations. Trust Strategic Objectives include specific objectives for Supporting Our Workforce and building an Open and Honest Culture, this involves a commitment to increase staff engagement and further develop an open management culture that enables staff to speak up. Staff Networks have been established to support listening and feedback from all staff. FTSU and staff engagement is raised as part of the staff induction sessions, received by all new starters. Managing Director video regarding staff engagement and speaking up is shown to all new starters. Executive Director of Nursing, Midwifery and Therapies or a Deputy	Develop and implement new FTSU Strategy, co-produced with FTSU Champions in 2023. Consider FTSU Cultural review end of 2023/beginning of 2024. Consider how FTSU is always tested at recruitment stage for leadership and management roles.	Compliant

		attend all clinical induction sessions to discuss staff engagement and speaking up		
Leadership and Management				
Significant Variation among senior leaders in understanding speaking up and the FTSU Guardian role. • Defensiveness • Lack of curiosity • Lack of training/awareness	**2. Make speaking up in ambulance trusts business as usual:** Mandate FTSU Training as per NGO guidance Trust leadership to engage with FTSU evidenced by Board development sessions. **And** Embed speaking up into all aspects of work. Annual evaluation of effectiveness of speaking up arrangements and include in annual report.	FTSU Training not currently mandatory Board is engaged with FTSU activities, as detailed above and via FTSU team and associated reports, Staff Voice Partnership events. Open and honesty part of the Trust Objectives FTSU is included in Quality Account Annual self-assessment completed with suggested actions to strengthen assurance.	Consider including in mandatory training for all staff going forward. . Consider how FTSU is always tested at recruitment stage for leadership and management roles. Consider mandatory FTSU training for all leaders and managers either in isolation or as part of leadership development. Consider FTSU Board Development Session post Transaction.	Compliant except for: • FTSU mandatory Training for all staff • FTSU mandatory Training for all Managers and Leaders • FTSU Board Development Session
Experience of People who Speak Up				
Many Examples of staff with poor experience of speaking up • Cases not handled according to policy and good practice • Lack of regard for confidentiality • Timeliness • Lack of feedback • Detriment	No Specific recommendations, covered by aspects of recommendations 1 & 2	All cases processed through the FTSU team handled in accordance with the Trust Policy, which is in line with national guidance. Staff are treated as per their wishes in relation to confidentiality and this is recorded by FTSU Team. Staff are offered feedback on progress when raising concerns and feedback is		Compliant

		sought from all staff members who raise concerns. Cases are monitored for detriment.		
Implementation of FTSU Guardian Role				
Breach of guidance from NGO in relation to Guardians role • Insufficient time and resources for FTSU Guardians	3. **Implement the FTSU Guardian role in accordance with national guidance to meet the need of workers**: Invest in FTSU Guardian Role FTSU Guardian recruitment should be fair, open and transparent. Regularly maintain and evaluate a network of FTSU Champions Provide emotional and psychological wellbeing support to FTSU Guardians	FTSU Guardian role in place 15 hours a week with additional support from chaplain. FTSU Guardian recruited through open and fair process and is an independent role. Current review of activity of existing champions ongoing FTSU Guardian has monthly one to one with Line manager, is a member of Northwest FTSU Forum and has made links with a FTSU Guardian in the southwest as part of their development and support network.	Will need to review once transaction with STHK NHS Trust complete.	Compliant
Role of System Partners and Regulators				
Lack of alignment between staff perceptions of speaking up culture and rating received from CQC. • Trust not compliant with guidance and lack of mechanisms to ensure compliance by regulators. • Partners in the healthcare system did not communicate effectively regarding speaking up culture in Trusts.	**4.Effectively regulate, inspect, and support improvement of speaking up culture in ambulance trusts.** Ensure workers voices are captured in regulators decisions. Training in relation to FTSU for those involved in regulation and inspection. Making assessment of speaking up culture and arrangement a cornerstone of their regulatory and oversight framework.	Recommendation is aimed at CQC and NHS England.	Trust will need to consider as part of ongoing work in demonstrating compliance with well led domain of CQC compliance	

	Improve their inspection methodology around FTSU culture and psychological safety.			

Freedom to Speak Up

NHS
Southport and Ormskirk Hospital
NHS Trust

Title Of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**03 May 2023**
Agenda Item	**SO086/23**	**FOI Exempt**	**NO**
Report Title	**GUARDIAN OF SAFE WORKING QUARTERLY REPORT (01 January to 31 March 2023)**		
Executive Lead	Dr Kate Clark, Executive Medical Director		
Lead Officer	Dr Kate Clark, Executive 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: 1) Fewer exceptions reported in this quarter, all except one were related to additional hours.
Recommendation
The Strategy and Operations Committee is asked to receive the Guardian of Safe Working Quarterly Report
Previously Considered By:

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

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

Prepared By:	**Presented By:**
Dr Kate Clark, Medical Director	Dr Kate Clark, Medical Director

Southport and Ormskirk Hospital NHS Trust

THE GUARDIAN OF SAFE WORKING
QUARTERLY TRUST REPORT

01 January – 31 March 2023

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

There were no immediate patient safety issues raised via exception reports during this period. The number of reports during this quarter has been significantly lower than other periods. One report referred to the ability to access senior advice from their registrar, this was escalated at the time and support was identified and provided by the consultant.

Reference period of report	
Total number of exception reports received	7
Number relating to immediate patient safety issues	0
Number relating to hours of working	6
Number relating to pattern of work	0
Number relating to educational opportunities	0
Number relating to service support available to the doctor	1

All reports for additional hours were paid as overtime payments.4 of the reports were from trainees in medicine, 2 in general surgery and 1 paediatric trainee.

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	0
Total number of overtime payments	6
Total number of work schedule reviews	0
Total number of reports resulting in no action	1
Total number of organisation changes	0
Compensation	0
Unresolved	0
Total number of resolutions	**7**
Total resolved exceptions	**7**

2. PAYMENT AND FINES

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

3. 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.

4. VACANCIES

SOHT continue to actively recruit and therefore vacancy rates are changing frequently – there are currently 9 vacancies spread across the specialties. The overall number of vacancies is reducing and this is helping to reduce episodes of excessive workload.

Sickness rates continue to be variable with a recent rise in sickness (mainly due to Covid) which led to short notice rota gaps requiring bank and agency support.

5. TRAINEE CONCERNS

Trainee Doctor forums have been held, although have been impacted by the recent industrial action.

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 4 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 continue to report a variable response to requests for annual leave. This is now monitored through a weekly oversight group and improvements have been seen.

6. FACILITIES

Facilities funding of over £60 000 has been made available for the Trust's Trainee doctors to improve rest and related facilities. It has been used to upgrade the mess in ODGH (indirectly funded) and to improve the Senior Trainee room at SDGH. The doctors mess at SDGH has had replacement furniture. Just over £10,000 remains with a plan to provide additional furniture for paediatric trainees at Ormskirk.

7. ADDITIONAL GOSW CONCERNS

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.

NHS
Southport and Ormskirk Hospital
NHS Trust

Title Of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**03 May 2023**
Agenda Item	**SO086_23**	**FOI Exempt**	**NO**
Report Title	**GUARDIAN OF SAFE WORKING ANNUAL REPORT 2022/2323**		
Executive Lead	Dr Kate Clark, Executive Medical Director		
Lead Officer			
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To provide an annual overview of issues pertaining to the role of the Guardian of Safe Working

Executive Summary

Key Messages of this Report & Recommendations:

1) Reports submitted related to levels of support available, this suggests trainees are more engaged with the process and recognise the value of reporting for reasons other than monetary compensation. Issues raised have been discussed in an extraordinary meeting supported by British Medical Association (BMA) and actions agreed are monitored through the Trainee Doctor Forum.
2) Supervisor meetings are not consistently taking place within the recommended timescale.
3) Trainees continuing to submit exception reports regarding late finishes in Medicine, an action plan has been developed to address issues identified.
4) Guardian of Safe Working post remains vacant.
5) Partial spend of the Health Education England (HEE) Facilities funding, updates provided to the Trainee Doctors Forum (TDF) and the Joint Medical Staff Negotiating Committee (JMSNC).

Recommendation

The Strategy and Operations Committee is asked to receive the Guardian of Safe Working Annual report for 2022/23.

Previously Considered By:

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

Strategic Objectives

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

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

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

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

☐ **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:**
Dr Kate Clark, Medical Director	Dr Kate Clark, Medical Director

NHS
Southport and Ormskirk Hospital
NHS Trust

THE GUARDIAN OF SAFE WORKING
ANNUAL REPORT TO TRUST BOARD

01 April 2022 – 31 March 2023

Introduction

Under the terms of the 2016 contracts all Trusts with trainees are obliged to have a Guardian of Safe Working (GoSW). The safeguards around working hours of doctors and dentists in training are outlined in the terms and conditions of service (TCS) and are designed to ensure that this risk is effectively mitigated and that this mitigation is assured.

The safety of patients is paramount to both the NHS and this organisation. The GoSW retired in Q4 2021/22 and the Trust had not appointed a replacement. The function of this role was supported by the Director of Medical Education (DME), the Executive Medical Director (EMD) and the Head of Resources to ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and /or employer, as appropriate; and provide assurance to the Trust board or equivalent body that doctors' working hours are safe.

Quarterly reports were presented to the Workforce Committee and include feedback from the Trainee Doctors Forum which occurs monthly.

1. EXCEPTION REPORT OVERVIEW (1ST APRIL 2022 – 31ST MARCH 2023)

Reference period of report 01.04.22 – 31.03.23	
Total number of exception reports received	99
Number relating to immediate patient safety issues	2
Number relating to hours of working	84
Number relating to pattern of work	
Number relating to educational opportunities	7
Number relating to service support available to the doctor	6

The number of reports submitted is slightly higher this year, 99 compared to 93 (2021-22). For the first time we have seen reports relating to service support available to the doctor. This was mainly within Medicine and was also associated with exception reports for finishing late. An extraordinary meeting was arranged between the relevant doctors, medical education, workforce, Medical Director and British Medical Association representatives to identify the issues and agree actions needed. The action plan was agreed to be monitored through the Trainee Doctor Forum.

Two reports relating to immediate patient safety issues were submitted during Quarter 3. One reported that due to short notice sickness a junior doctor 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 until an alternative was found. The second related to a gap in FY1 weekend cover which had not been filled by agency or bank. Further work regarding the transparency of roster management and requests to agency and bank to fill shifts was completed and shared with the Joint Medical Staff Negotiating Committee.

Reports related to workload were submitted from surgical trainees at the start of the year, this was also reflected in feedback through the GMC survey and HEENW resulting in HEE NW rating General Surgery NTS results as an ISF Level 2 (significant concerns). Plans were in place to address this, the numbers of exception reports have reduced and the most recent HEENW visit HEE NW has rated these issues as level 1 (minor concerns) as per HEE's Intensive Support Framework (ISF).

ER outcomes: resolutions	
Total number of exceptions where TOIL was granted	18
Total number of overtime payments	65
Total number of work schedule reviews	0
Total number of reports resulting in no action	12
Total number of organisation changes	0
Compensation	0
Unresolved	4
Total number of resolutions	**95**
Total resolved exceptions	**95**

The majority of exceptions are resolved with overtime payments, although TOIL is being requested more. Payments are being actioned more promptly with trainees reporting increased satisfaction with the Trust response.

There has been a shift in exception reporting this year from Foundation Year 1 trainees, 61% in 2021-22 to 47% in this reporting period, to the majority of reports now submitted by Foundation year 2 to CT/ST 1-2 increasing from 34% to 51% of the reports. Reports from higher trainees (ST3+) remain the smaller proportion (5% 2021-22; 2% 2022-23).

2. PAYMENT AND FINES

There have been no GOSW fines levied in the last year.

3. AREAS OF CONCERN

3a) Medicine Staffing

Plans continue to be developed to recruit staff and consider non-medical roles to provide additional support to the daily workloads.

3b) Non-compliant rotas

1 rota was non- compliant at the start of 2022 with plans in place to achieve compliance. This was successfully delivered by August 2022.

3c) Information Provided by Deanery and Lead Employer

This has been a focus of work to improve lines of communication so that gaps in workforce can be identified as early as possible and mitigated. There continue to be occasions where information is received late or changes are applied which impact on the Trust ability to fill vacancies robustly.

4. DOCTORS NOT ON THE NEW CONTRACT

All trainees are on the 2016 contract.

5. VACANCIES

This continues to fluctuate due to the rotational nature of posts, although an improving position has been noted.

6. TRAINEE CONCERNS

a) Ability to effectively utilise self-development time. Initially this was rostered in regular blocks of 1-2 hours. Following feedback this has been changed to less frequent blocks of 4-8hours in all rosters.

b) The Trust response to study and annual leave requests was inconsistent and at times lengthy. A standard operating procedure was agreed with the BMA to include timescales for response and rationale for declining leave. This has continued to highlight delays which are being monitored with escalation to the DME and EMD as needed.

7. FACILITIES

The majority of available funds have been spent to provide furniture for the doctors mess at the Southport site and most recently additional furniture for paediatrics at the Ormskirk site. Approval of spending is received through the trainee doctors forum.

8. ADDITIONAL GOSW CONCERNS

The vacancy within this role remains a concern although mitigated currently with an interview process in progress.

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Finance, Performance, and Investment Committee
MEETING DATE:	24 April 2023
LEAD:	Jeff Kozer

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Performance against constitutional standards continues to compare well to peers.
- The Trust has agreed to three adjustments to the financial plan that was submitted. The first is £1.6m additional Cost Improvement Programme (CIP) to bring the Trust up to the minimum level agreed across the Integrated Care Board (ICB) of 5%. The second relates to an agreement to categorise the energy inflation as a risk across the ICB, and this equates to £3.1m for S & O. There is then a £4.7m adjustment between S & O and STHK to enable the Trust to still plan for breakeven. The current ICB gap for 2023/24 is circa £135m and resubmissions are planned for 04 May.

ADVISE

- A&E performance reported at 73.7% in March 2023 at S&O compared with 72% across Cheshire & Merseyside and 71.5% nationally. Remain top quartile in the country.
- ERF activity achieved highest levels ever at 108% of 2019/20 levels, Cheshire & Merseyside at 97.5%

ASSURE

- The Trust is reporting a £13.7m deficit at month 12, which is in line with the financial forecast. All £10.8m of the Cost Improvement Target (CIP) is RAG rated as green and all QIAs have been completed.
- The cash balance at the end of March is £1m.
- The Better Payment Practice Code (BPPC) performance at month 12 is 96.8%.
- The capital spend at month 12 is £53.4m, which to note, includes an additional £26m to resolve backlog maintenance issues.
- Continued positive impact on performance metrics and patient outcomes for Chase Heys and Ward 11a.
- DM01 (routine diagnostic tests) performance at 18% vs c48% April 2022.
- Theatre productivity at Ormskirk at 78%, with highest number of cases per list delivered and highest % of cases starting on time.
- Zero 104+ week breaches.

New Risks identified at the meeting: None

Review of the Risk Register: No action taken

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Executive Committee
MEETINGS HELD:	April 2023
LEAD:	Anne-Marie Stretch, Managing Director

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Industrial Action (IA) Update (03 and 17 April 2023)
The Executive Committee was advised and assured on the operational and contingency plans in place ahead of the Junior Doctor's Industrial Action (IA) 10 – 15 April 2023. The impact of the IA was minimal and there had already been a planned lower level of elective activity during the period due to annual leave and the Easter period. The Trust was required to complete a Quality Impact Assessment (QIA). There would be a review of the effectiveness of the planning post the IA, to identify any lessons.

Radiology Incidents (03 April 2023)
The Medical Director reported that an external radiology review had been undertaken by an experienced, recently retired Radiology Manager from STHK. The review included an overview of the current governance processes for monitoring, managing, and learning from reporting discrepancies. The review had provided assurance that the teams are following appropriate processes aligned to Royal College of Radiology guidelines. The number of discrepancies being reported at the Trust were lower than expected (compared to the national average %) but that the discrepancies were found at equal rates for both internal and external (outsourced) reporting. The report contained suggestions for additional benchmarking and independent audits to strengthen the discrepancy reporting governance. The report had identified no concerns about the capability of individual clinicians, but issues about workload capacity and interruptions when reporting had been highlighted as areas for improvement.

ADVISE

Transaction Progress (every meeting)
The Executive Committee received weekly updates on the progress of the Transaction with STHK and discussed the implications of the delay and work that could continue to be progressed in preparation for the transaction, including policy alignment. The Committee also reviewed the TUPE communications following the end of the consultation period and the issue of the Measures to staff. It was noted that attendance at the continuing engagement sessions had dropped off. Therefore, alternative communications about the transaction date and promotion of the One Team One Trust website to respond to any further questions from staff were proposed.

2023/24 Financial Plan Update (every meeting)
The Director of Finance provided weekly updates on the discussions with the ICB and NHSE about the financial position of Cheshire and Merseyside following the final plan submission on 30 March, including the national escalation meetings and proposals for reducing the system financial gap.

Cost Improvement Programme (CIP) Update (03 April 2023)
The Director of Finance and the Chief Operating Officer continued to provide regular updates to the Executive Committee. The focus for the CBU teams had now moved to identifying the 2023/24 CIP schemes and 44% of the schemes were already rated as 'Green' or 'Amber' (as at 17.04.23).

MIAA Draft Internal Audit Plan 2023/24 (03 April 2023)
The Director of Finance presented the draft internal audit plan for the new Trust, that had been developed with STHK. It was agreed that due to the transaction delay the work scheduled for quarter 1 would need to be realigned. The plans were to be presented to the Audit Committee on 19 April 2023.

Orthodontics (03 April 2023)
The Chief Operating Officer provided an update on the transfer of the remaining orthodontic patients following the service closure at the Trust. Following assessment, the final transfer of patients to Alder Hey Children/s Hospital NHSFT had not yet been completed. These patients had been waiting a long time and the Chief Operating Officer had escalated concerns to NHSE.

78-Week Waiters (03 April 2023)
The Chief Operating Officer reported four 78-week outliers. one is an Orthodontic patient who should have been transferred to another provider (as above) and three are Vascular patients who have all been rebooked.

Decant Capacity Plans (17 April 2023)
To deliver the high-risk back log maintenance programme and refurbish the wards it had been recognised that due to operational pressures and high bed occupancy, additional decant capacity would be needed. The Estates team had completed a feasibility study on creating two wards on the current Corporate Management Offices (CMO) at Southport Hospital. The Executive Committee approved some initial design fees to explore this option further, recognising that office accommodation would need to be provided elsewhere, if this option was pursued.

Endoscopy Collaborative Bank Memorandum of Understanding (MOU) (17 April 2023)
Endoscopy Memorandum of Understanding was presented. STHK have been commissioned to set up and host a Cheshire and Mersey Collaborative Bank in order that diagnostic staff were able register to work sessions/shifts across trusts in the ICB to maximise the diagnostic capacity and reduce cancer waiting times. The MOU was approved.

Use of Entonox in Maternity (25 April 2023)
The Medical Director advised air monitoring tests have taken place with further monitoring tests to be carried out to include as many staff as possible in the review. Once the results of the samples have been tested, a report would be presented to the Executive Committee in May 2023. This had been identified as a risk and a health and safety assessment had been undertaken.

Monthly Staffing Report (25 April 2023)
The Monthly Staffing Report was presented that provided an update on nursing, midwifery and HCA staffing fill rate, costs agency spend and vacancies (March 2023 data). The report also included an update on recruitment actions moving forward. The Deputy Director of Nursing reported that the overall position is positive and highlighted the following:

- Fill rate 96.39% - (RN average 99.26% HCA average 93.99%)
- No wards fall below average 90% fill rate for month
- CHPPD 8.6
- Highest spend areas for variable pay - A&E, AMU (9B) and Maternity
- Healthcare Assistant vacancies had reduced

Policy Update (25 April 2023)
The Director of Corporate of Corporate Services presented an update on out-of-date policies and also discussed the process for reviewing and aligning policies for the new Trust. The Trust has 218 policies and 49% are in date (as of 12 April 2023). 3% of the policies are within six months of the scheduled review date. 92 policies are out of date and awaiting a review. The Executive

Team was asked to reinforce the need for the timely review of policies including requests for extensions where no changes were needed.

ASSURE

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

- CQC Relationship Meetings continue. Urgent care, RTT and an update on the Transaction, which they support, was discussed at the last meeting.
- The Director of HR & OD attended a C&M HRDs Meeting. Discussions took place about finances, collaborations and workforce challenges.
- The Director of Finance and the Medical Director attended the Strand Redevelopment Meeting arranged by Sefton Place who want to bring health care to the high street and are open to offers about how to do this. The Medical Director had identified that there may be opportunities for the new organisation to collaborate with other system partners to provide services on the high street for the population of Sefton.
- The Chief Operating Officer attended a national Integrated Care Service (ICS) and Integrated Care Board (ICB) Discharge Meeting on 24 April 2024 and provided feedback to Executive colleagues. One of the main issues of concern highlighted was the inconsistent offers of discharge services for patients from each Local Authority/Place.

MIAA Audit – Patient Safety Report (03 April 2023)
The Director of Nursing reported that the Patient Safety Audit Report from MIAA has given 'Substantial Assurance'. Recommendations were made for improving the psychology safety for staff and patients.

Core and Mandatory Essential Skills Training Update (17 April 2023)
The Committee received the report that provided an update on core mandatory and essential skills training for March the following key points were highlighted:

- Core mandatory training compliance was 89.55% against a target of 90%.
- Essential skills training compliance was at 80.89% against the target of 85%.
- 14 of 17 core mandatory training subjects had shown an improvement in month.
- 22 of 35 essential skills subjects had shown improvement in-month.
- Resus Training continued to improve, and the e-assessments remained above the 85% target.
- A new training needs analysis had been undertaken for the Neonatal unit and targeted training was being developed.
- The new Level 2 and Level 3 Fire Safety courses had been well attended.
- The Oliver McGown Mandatory Training Level 1 was now available as an online model and compliance would be monitored at the Executive Committee initially. The Director of Nursing advised that Sefton PLACE had requested a monthly update on compliance.

Green Year Plan 1 Update (17 April 203)
The Director of Finance asked the Committee to note that 20 of the Green Plan deliverables had been completed and highlighted the following deliverables:

- The review of staff benefits schemes including the cycle to work scheme.
- The creation of a Sustainable Procurement Policy.

The following deliverables were on track to be completed in the next six months:

- Expansion of electrical vehicles (EV) charging points.
- Printer reduction and the switch to purchasing and using 100% recycled paper within the printers.
- The development of green spaces/wildlife areas

The Director of Finance advised that next steps would be the reduction of carbon emissions and that 'green' standards are taken into account when leasing buildings and for new capital schemes.

NHS Prevention Annual Pledge (17 April 2023)
The Director of Transformation noted that this has been submitted.

Interactive Activity Tables (17 April 2023)
The Dementia & Delirium Specialist Nurse and the Learning Disability Specialist Nurse attended the Committee to present a bid to charitable funds for the Trust to purchase activity tables to support the care of patients with complex needs. These interactive tables were a form of cognitive therapy that could be used for all patient groups but particularly for those who have learning disabilities, age related diseases, mental health issues and physical health concerns. The Committee supported the proposal in principle but suggested an initial pilot on two wards to evaluate the quality of the product and impact on patient safety.

Staff Voice Partnership (SVP) Sessions -Feedback (25 April 2023)
SVPs sessions continued to take place and the Director of Transformation provided some feedback from a recent session.

- The Quiet Room in Maternity was not ideally located and there had been a request to look for an alternative venue.
- Clinical and other inappropriate Items being returned on the catering trollies. It had been suggested that an audit be completed to investigate what is left on the trays and if there are any issues with any particular wards. The Executive Committee agreed these occurrences should be reported as incidents
- Late requests for meals - the Director of Finance will pick the issues up relating to this as there is a piece of work ongoing looking at food wastage and ensuring that heated meals are delivered to the wards following a concern raised by the Patient Experience Group.

Risk and Compliance AAA Report (April 2023)
This was received for assurance at the Executive Committee on 25 April 2023.

New Risk identified at the meeting	Industrial action by different NHS staff groups remains and on-going risk.

Review of the Risk Register