NHS
Southport and Ormskirk Hospital
NHS Trust

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

To be held at 0930 on Wednesday 07 June 2023

V = Verbal D = Document P = Presentation

Ref No.	Agenda Item	FOI exempt	Lead	Time
PRELIMINARY BUSINESS				***0930***
SO098/23 (V)	**Employee of the Month Film** *Purpose: To **receive** the Employee of the Month Film*	*No*	*Chair*	10 mins
SO099/23 (P)	**Patient Story** *Purpose: To **receive** the patient story*	*No*	*L Barnes*	15 mins
SO100/23 (V)	**Chair's welcome and note of apologies** *Purpose: To **record** apologies for absence and confirm the meeting is quorate.*	*No*	*Chair*	
SO101/23 (D)	**Declaration of interests** *Purpose: To **record** any Declarations of Interest relating to items on the agenda.*	*No*	*Chair*	
SO102/23 (D)	**Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meeting held on 03 May 2023*	No	*Chair*	10 mins
SO103/23 (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				**1005**
SO104/23 (D)	**Trust Objectives** a) Trust Objectives 2022/23 Year End Review b) Approval of the 2023/24 Joint Trust Objectives *Purpose: To **review** the 2022/23 Objectives and to **approve** the 2023/24 Joint Trust Objectives*	*No*	*AM Stretch*	15 mins
INTEGRATED PERFORMANCE REPORT				**1020**
SO105/23 (D)	**Integrated Performance Report (IPR)** a) Quality and Safety b) Operations	*No*	*L Barnes* *K Clark* *L Barnes* *L Neary*	15 Mins

	c) Finance d) Workforce		*J McLuckie* *J Royds*	
	*Purpose: To **receive and note** the IPR for assurance.*			
QUALITY & SAFETY				**1035**
SO106/23 (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*	5 mins
SO107/23 (D)	**Quarterly Maternity Assurance Report** *Purpose: To **note** the Maternity Assurance Report*	*No*	*L Barnes*	10 mins
WORKFORCE				**1050**
SO108/23 (D)	**Workforce Reports** a) Committee AAA Highlight Report b) Workforce Race Equality Standard Report (WRES) (including action plan) c) Workforce Disability Equality Standard Report (WDES) (including action plan) *Purpose: To **receive** the Workforce reports*	*No*	*L Knight* *J Royds*	5 Mins 15 mins
FINANCE, OPERATIONS AND INVESTMENT				**1110**
SO109/23 (D)	**Finance, Performance, and Investment Reports** a) Committee AAA Highlight Report *Purpose: To **receive** the Finance, Performance, and Investment Reports*	*No*	*J Kozer*	5 mins
CORPORATE				**1115**
SO110/23 (D)	**Executive Committee AAA Highlight Report** *Purpose: To **receive** the Executive Committee AAA Highlight Report for meetings held in May 2023*	*No*	*AM Stretch*	5 mins
CONCLUDING BUSINESS				**1120**
SO111/23 (V)	**Questions from Members of the Public** *Purpose: To **respond** to questions from members of the public received in advance of the meeting.*		*Chair*	*5 mins*
SO112/23	**Any Other Business**		*Chair*	*5 mins*

(V)

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

Date and time of next meeting: ***1130***
0930 Wednesday 05 July 2023 ***close***

RESOLUTION TO EXCLUDE MEMBERS OF THE PUBLIC

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

Chair: Richard Fraser

Approved Minutes of the Strategy and Operations Committee (Part 1)
Held on Microsoft Teams
Wednesday 03 May 2023
(Approved by the Strategy and Operations Committee on 07 June 2023)

Present

Name	Initials	Title
Geoffrey Appleton	GA	Non-Executive Director, STHK (Chair)
Ann Marr	AM	Chief Executive
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
Rob Cooper	RC	Managing Director and Director of Operations and Performance, STHK
Lisa Knight	LK	Non-Executive Director, STHK
Jeff Kozer	JK	Non-Executive Director, STHK
Gareth Lawrence	GL	Director of Finance, 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
Sarah Coppell	SC	Lead Nurse, Medicine, and Emergency Care *(Item SO075/23)*
Christine Griffith-Evans	CGE	Freedom to Speak Up Guardian *(Item SO085/23)*
Michelle Kitson	MK	Matron, Patient Experience (*SO075/23)*
Brendan Prescott	BP	Deputy Director of Quality, Risk and Assurance (Part 1)
Juanita Wallace	JW	Assistant to Director of Corporate Services (minute taker)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Lynne Barnes	LB	Director of Nursing, Midwifery and Therapies
Richard Fraser	RF	Chair, STHK (Chair)
Paul Growney	PG	Associated Non-Executive Director, STHK
Anne-Marie Stretch	AMS	Managing Director

AGENDA ITEM	DESCRIPTION	Action Lead
PRELIMINARY BUSINESS		
SO075/23	**Patient Story** MK presented the patient story video in which a physiotherapist on Ward 11a spoke on behalf of the patient about the positive impact of the multi-disciplinary rehabilitation setting and how this enabled a patient to	

achieve what was important to him and return home after a long hospital stay. As a result of the various interventions by staff on Ward 11a, such as visits to the hospital's wellbeing garden, which supported both physical and emotional wellbeing, the patient was able to be discharged home and could move around unaided in his own home.

GB reflected on the patient being able to climb two flights of stairs and asked if the patient lived in a block of flats. MK confirmed that this was the case and noted that the therapist had been extremely proud that the patient could now walk up the stairs unaided. GB commented that this was a significant achievement and meant that a patient who was originally going to be discharged to intermediate care was now able to live at home with his partner independently. This was an excellent example of the difference this intensive discharge support could have on the outcomes and quality of life for patients.

GA reflected on the compassion shown in the video and how it was often the little things that matter most to the patient that made the biggest difference to achieving their goals. On behalf of the committee GA expressed thanks to the team for all they do and to the patient for agreeing to share his experience.

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

SO076/23 Chair's Welcome and Note of Apologies

GA welcomed all to the meeting.

GA acknowledged the following Awards and Recognition that the Trust had recently received:

- Professor May Ng OBE, Diabetes expert, had been chosen to deliver a prestigious national lecture in recognition of improvements she has delivered in patient care nationally and globally. The Arnold Bloom Lecture was awarded to a healthcare professional who has contributed significantly to improving the quality of clinical care for people with diabetes.
- Adelle McNamara, one of the Trust's Physiotherapists, had completed London Marathon.

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

SO077/23 Declaration of interests

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

SO078/23 **Minutes of the previous meetings**

The Committee reviewed the minutes of the previous meeting held on 05 April 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 05 April 2023

SO079/23 **Matters Arising and Action Logs**

The meeting considered updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions the following actions was updated:

- SO057/23 – LN and JMcL planned to complete a full evaluation of the Chase Hayes and 11a schemes in July 2023. This would reflect the system savings for both schemes and the Trust would be working with Sefton PLACE to assess the benefits of the schemes.

RESOLVED:
The Strategy and Operations Committee **approved** the action log

STRATEGIC AND GOVERNANCE

SO0080/23 **Audit Committee AAA Highlight Report**

IC presented the Audit Committee AAA Highlight Report and advised that no alerts had been raised.

IC drew attention to the following advise items:

- **Internal Audit Progress Report** – two new reviews had been completed. IM&T: Backup and Resilience (limited assurance), and IM&T: Network Monitoring (moderate assurance) had been reported and it was advised that the management actions would be reviewed at the Executive Committee and a progress report would be presented by the lead director at a future Audit Committee meeting.
- **External Audit Strategy Memorandum** had outlined the four areas of significant risk for 2023/24 and 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 accounts, however, the accounting policies paper indicated that it was expected the Trust would remain below the materiality threshold.

CW confirmed that the management actions in respect of the two MIAA Audit reports were being progressed and there were no concerns that they could not be completed within the agreed timescales. A progress

report would be presented to the Executive Committee later in the month.

IC commented on the functioning of the Audit Committee under the Agreement for Long Term Collaboration (ALTC) governance arrangements and reflected that even though the S&O Board had been nervous about delegating control whilst still retaining oversight of assurance, the processes had worked well. IC added that the focus of the Committee had shifted to one where it aimed to assist the Executive rather then find fault and there had been open, honest, and efficient responses to issues that had arisen during the financial year. As a result of this was that there were no substantial issues or concerns about systems and controls to be carried forward into the new post transaction organisation.

RESOLVED:
The Strategy and Operations Committee **noted** the Audit Committee AAA Highlight Report of the meeting held on 19 April 2023

INTEGRATED PERFORMANCE REPORT

SO081/23

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 March 2023.

a) Quality and Safety Performance Report

BP and KC presented the report which provided an overview of performance against the quality and safety metrics and BP highlighted the following:

- The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for March 2023 was 96.4%. Several Health Care Assistants (HCA) recruitment events had taken place and posts had been offered to fill the existing vacancies.
- Three pressure ulcers had been reported in Month, (one deep tissue injury, one unstageable pressure ulcer and one medical device related pressure ulcer). It was noted that none of these had yet been confirmed as hospital acquired pressure ulcers.
- The number of recorded falls had reduced in March (4.1 falls per 1,000 bed days) and this was a reduction of 22% when compared to March 2022. BP noted that this reduction was a result of the hard work on patient safety which had been part of the Quality Priorities for 2022/23.
- The Family and Friends Test - the percentage of patients rating the Trust as very good or good had reduced in March to 90.4% compared to 91.4% in February and it was noted that this had been impacted by the long waits in the Accident and Emergency (A&E) Department (47% of respondents were from the A&E). BP advised that the labour ward in Maternity had achieved a 100%

recommendation rate, and this was attributed to the ongoing hard work over the preceding 12 months.

- The percentage of complaints attended to within 40 days was 51.7% against a target of 80% and this was an improvement from 42.1% in February, and several of the Clinical Business Units now had no outstanding complaints.

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 and highlighted the following:

- The overall A&E four-hour performance for March 2023 was 73.7%, compared to 72% across Cheshire and Mersey (C&M) region and 71.5% nationally. LN noted that whilst performance was significantly short of the 95% target for 2022/23, it was not far off the new 2023/24 target of 76%.
- Paediatric A&E attendance numbers had reduced back to pre-Streptococcus A (Strep A) levels, however, levels remained higher than pre-pandemic with forecasted activity for 2023/24 at 115% of the 2019/20 baseline. It was noted however that conversion rates (to admissions) remained lower than 2019/20.
- The Trust's average turnaround time on ambulance handovers was 35 minutes which was an improvement of three minutes compared to February. This was eight minutes better than the overall North West average of 43 minutes.
- Bed occupancy remained challenged at over 100% (average 108%) with continued escalation into several of the assessment areas.
- The Chase Hey and Ward 11a schemes continued to deliver positive benefits for patients and staff as well as across the system. There had been an 80% reduction in the level of prescriptions of domiciliary care upon discharge from the Chase Hey and it was noted that the Trust was one of the better performing trusts in terms of the NHSE metric which focused on no criteria to reside (NC2R) who were patients who no longer needed to be in an acute bed. LN advised that she attended a National Discharge Event the previous week where NC2R was an area of focus.
- Elective recovery performance for March was 108% against 2019/20 levels and this was the highest level of elective activity achieved during the year.
- The Trust ended the year with four 78-week breaches. Of these patients, one was an orthodontic patient who was waiting for transfer to Alder Hey Children's NHS Foundation Trust and this transfer had since been completed. The others were vascular patients who all breached through patient choice and had subsequently had their procedures in April, so that all 78-week waits had now been eliminated.

- Elective diagnostic access times continued to improve and was at 18% against the national average of 25.9%. The new target for 2023/24 was 5% taking longer than 6 weeks, so a continued focus was required, and it was noted that there were improvement plans in place.
- Cancer Services – the performance for two-week referrals was 93.6% which was the highest since pre-Covid-19 levels. It was noted that the 62-day performance remained a challenge. There has been an increased focus on the front and back end of the waiting list over the preceding months and this would remain a priority for 2023/24.

GB reflected on the improvement in stroke services over the preceding 12 months and noted that this had been an area of concern at the start of the ALTC. Additionally, GB commended the staff and wider system for their hard work in making the new stroke pathway a success. GA commented that he and RT had visited the Stroke Unit and had been impressed by the multi-disciplinary team approach.

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

c) Financial Performance Report

JMcL presented the report which detailed performance against key financial performance indicators and advised that the Trust had reported a £13.7m deficit at Month 12. It was noted that this reflected an improved position on the2022/23 £14.2m planned deficit following the distribution of the Integrated Care Board (ICB) capital charges support linked to the Community Diagnostic Centre (CDC) and Targeted Investment Fund (TIF) schemes.

JMcL highlighted the following:

- The Trust achieved its statutory Capital Resource Limit following the delivery of a total capital investment of £53.4m which included £26m backlog maintenance funding.
- The Trust had actively managed the cash position throughout 2022/23, maintaining a year-end balance of £1m which was in line with the requirements of the revenue support that the Trust had received.
- The Trust achieved the Cost Improvement Programme (CIP) requirement of £7.8m, plus a further £3.0m Stretch Target agreed with the Integrated Care Service (ISC) (a total CIP of 4.8%).

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 Review (PDR) compliance had increased from 74.1% in February to 79.95% in March, against a target of 85%. Estates and Facilities had shown a big improvement. It was noted that work was ongoing to ensure that all staff members had a meaningful PDR discussion.
- Core Mandatory Training had increased from 89% in February to 89.6% in March against the stretch target of 90%.
- There had been an improvement in overall sickness from 6.3% in February to 5.9% in March.
- Time to Hire was at 40 days and it was noted that there were currently 16 medical, 12 Allied Health Professionals (AHPs) and 25 Band 5 nursing posts out to offer. Additionally, there were 23 new HCA starters in month and a further 28 posts under offer.

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

QUALITY AND SAFETY

SO082/23 **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:

- The risk to being able to improve the estates standards because of the inability to decant wards to complete refurbishments, as a result of the high bed occupancy. This meant that areas where important Infection Prevention and Control (IPC) improvements were needed could not always be accessed. The Committee had noted that the Executive were exploring the feasibility of converting the Corporate Management Offices to decant wards, and this was also noted in the Executive Committee AAA Highlight Report.
- The online Consent training link with Electronic Staff Records (ESR) had not been working, which meant that compliance could not be tracked until the fault was resolved.

GB drew attention to the following advise items:

- The meeting received the Neonatal Family Integrated Care (FIC) and Baby Friendly Initiative (BFI) presentation which highlighted the

excellent work being done and GB noted that the progress made was exceptional.

- The Infection, Prevention and Control Board Assurance Framework had been received, and the committee had requested additional information regarding mitigations and controls for some elements, and the processes for escalating any concerns.
- The limitations of the current IPC provision as a result of vacancies and sickness levels within the team had been discussed and assurances received that recruitment was underway. There were several mandatory and essential skills training modules that were below compliance targets, and this was mainly due to the impact of the ongoing operational challenges and the recent industrial action. This was discussed regularly at the Executive Committee meetings.
- The potential risk to the Ears, Nose and Throat (ENT) service provided via an SLA with Liverpool University Hospitals NHS Foundation Trust (LUHFT), as a result of workforce shortages, was noted.
- The Quality Improvement Board had provided an update and noted that four of the five Quality Improvement objectives for 2022/23 were on track. The reduction in hospital acquired Acute Kidney Injury (AKI) target had not been met and this would remain an area of focus for 2023/24.
- The Draft Quality Account was presented, and progress had been noted with improvements across many areas.

CW advised that the issue with the online consent training had now been resolved. KC reported that work had started to roll out the training and increase compliance.

GA reflected on the progress that could be seen from the Draft Quality Account and thanked the staff involved for their hard work.

SR advised that a new IPC nurse consultant had now been recruited and BP noted that the employment checks were being completed for the employment of the IPC matron and added that mitigations were in place to provide additional matron support for the team until these individuals took up post.

SO083/23 **Infection Prevention and Control (IPC) Board Assurance Framework (BAF)**

KC presented the Infection Prevention and Control (IPC) Board Assurance Framework (BAF) which provided an update in relation to the changes to the NHSE Infection Prevention and Control (IPC) Board Assurance Framework that had been introduced during the pandemic and noted that the Trust was currently fully compliant (BLUE) with 94 actions, there were seven GREEN criteria which were in the process of being addressed and one AMBER criteria where the Trust remained partially compliant.

KC advised that to ensure that the IPC principles remained embedded and sustained, the framework was regularly revisited to monitor progress and mitigation regarding gaps and compliance against any new or amended national guidance.

The following areas had been identified for further improvement:

- Policies and processes for IPC being up to date - there were now plans in place for the team to work with St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) to ensure that IPC standards and policies were aligned to the national IPC handbook.
- Isolation facilities – this formed part of the new assessment of working to live with Covid-19 and the Trust would need to be more proactive in identifying and isolating more vulnerable patients, however, this would be a challenge with the current estate because of the limited availability of side rooms. The Emergency Department had the capacity for this, and pods could be erected around bed spaces to create isolation areas on the wards, however, this impacted bed capacity. It was noted that this was managed daily via the bed meetings and supported by the IPC team.
- Work continued on the national standard of health care cleanliness and compliance with the Cleaning Charter had been approved by the Executive Committee. It was noted that the Charters should have been displayed in all areas from 01 April 2023, however, it had been agreed to pause this until the transaction had been completed and the Charter could be displayed with the new Trust logo.
- Compliance with national standards was monitored via the IPC Group using an electronic system to demonstrate compliance with these standards and updates were provided to the Quality and Safety Committee as part of the AAA Highlight Report.

KC advised that the management of outbreaks was reported through operational areas and to assurance committees as part of the AAA Highlight Reports. Any outbreaks were also reported to the Executive Committee.

IC reflected that when he read the report, he looked at the gaps in assurance and then the areas of concern. IC noted that there were a number of out-of-date policies and asked if the STHK policies would be used going forward. KC advised that the policies for both trusts would be aligned to the national IPC handbook and that there would be local implications to the estate components that would be specific to each site.

RESOLVED:

The Strategy and Operations Committee **received** the Infection Prevention and Control (IPC) Board Assurance Framework (BAF)

WORKFORCE

SO084/23 **Workforce Report**

a) Workforce Committee AAA Highlight Report

LK presented the AAA Highlight report and advised that no alerts had been raised.

Assurance was provided that:

- There had been a reduction in vacancies from 7% to 6.6% which was the lowest rate for over two years and was below the target of 7.4%.
- Core mandatory training had increased to 89.6% against a target of 90% and this was the highest compliance level for two years.
- Sickness absence had reduced to 5.9%. Rolling sickness had reduced to 6.7% and this was the lowest since December 2021.
- Interviews for Guardian of Safe Working were planned for mid-May 2023.

SO085/23 **Freedom to Speak Up Quarter 4 Report**

BP introduced the Freedom to Speak Up Report Quarter 4 and CGE presented the report which provided assurance that Trust staff felt able to raise their concerns and that systems and processes were in place for staff to do this safely and confidently, knowing that appropriate action would be taken. It was noted that nine concerns had been raised during the period and there were no specific themes identified, the concerns raised included:

- 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 reported dissatisfaction with a new management and leadership style.
- A member of staff reported that they had been locked in a room with their Team Leader during an appraisal discussion and unable to leave when they became distressed.
- Comments from a line manager added to a staff members 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 the ward/clinical area.

CGE advised that:

- There were two less concerns raised in the quarter when compared to Q3.
- One concern had been raised directly with the Care Quality Commission (CQC) and this related to staff training and competency to care for patients undergoing non-invasive ventilation (NIV) and with tracheostomies. Additionally, concerns had been raised directly to the CQC regarding the cleanliness and removal of filled urine bottles from patient bedsides. These concerns were reviewed, and a report provided to the CQC, who closed the concerns.
- Five staff members, known to the Freedom to Speak Up (FTSU) team, had chosen for their concerns to remain confidential, however, they did not vocalise any concerns regarding repercussions. It was noted that one other staff member had raised a concern about potential repercussions.
- Two concerns had been raised anonymously.

CGE advised that as a result of staff members raising their concerns the following actions were taken:

- 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 had been delivered to staff within the ward area regarding the management of NIV and deteriorating patients.
- Within one ward area, the need to adhere to IPC practices has been reinforced.
- Engagement sessions with staff were held by a Matron to understand concerns regarding leadership and management style to ascertain if any action was required.
- A review of the champions in the Trust was being undertaken and it was noted that three new champions had been recruited and one champion had stepped down. A Champion Network meeting was held in March 2023.
- A FTSU Champions Away morning was scheduled for 09 May and one of the FTSU Guardians from STHK would also be attending.
- The Staff survey results relating to the FTSU indicators had shown a slight reduction in scores and it was noted that this was reflected nationally.

CGE advised that the National Guardians Office (NGO) had recently published its findings and recommendations from its review into FTSU arrangements within Ambulance Trusts in England (Listening to Workers: A Speak up Review of Ambulance Trusts in England) and following a review it was noted that S&O was compliant except for the following areas:

- FTSU mandatory training for all staff
- FTSU mandatory training for all Managers and Leaders

- FTSU Board Development Session

CGE advised that all staff members received information about FTSU which included a video message from AMS. Additionally, CGE had started to run induction sessions with new staff and preceptors.

JR advised that the issue about a staff member being locked in a room with the team leader had been addressed and CGE advised that the door had been locked for privacy reasons and there had been a lack of understanding that this could lead to a problem and assured the Committee that the practice had been stopped.

GB reflected on the importance of the report as well as the update from the NGO regarding the review of the ambulance trusts and asked if the FTSU training was a mandatory part of the induction programme. CGE advised that the training referenced were the national programmes that were mandated for new staff members, however, the modules for the managers were currently not mandated by the Trust. GB asked if this would be mandated in the future given the important role FTSU played in the culture of an organisation and future improvements and suggested that refresher training be considered for all staff. GA requested that JR review this.

J Royds

Action
JR to review the possibility of mandated training for managers as well as a refresher course for all staff members.

IC commented that the main purpose of the report was to provide assurance that the system was working and embedded in the Trust and that staff felt empowered to speak up if necessary. IC commented on the concern raised about the power of attorney and asked if the staff member had gone beyond their duties. CGE advised that this had been investigated and there were no legitimate concerns found. KC assured that all the appropriate steps had been taken, which included police involvement and the doctor had also been engaged with the process. NB suggested that the outcome of this investigation be noted in the next FTSU report for governance purposes and to protect the individual concerned.

J Royds

Action
An update on the outcome of the concern raised that a doctor was potentially and inappropriately acting as a Power of Attorney for their patients be included in the next quarterly FTSU report.

RT reflected on the training elements for the senior leaders and commented that it was important for leaders to lead by example and suggested that training was implemented for all senior staff members.

Additionally, RT asked how the Trust tested for the values of FTSU in applicants for senior leadership roles. CGE advised that there were not any specific tools available, but the organisation had mandated questions. JR added that values-based recruitment questions were the best way to explore candidates' values, and this was something to be considered once the trusts moved forward as one organisation. AM noted the importance of senior leadership setting an example of the values expected within an organisation.

AM reflected on the staff survey results and commented that Board members were committed to the FTSU process. Once the transaction had been completed it would be important to get the culture right and communication would play a big role in this to promote the values and culture of the new organisation, of which FTSU would be an important part.

GB reflected on recent board to ward visits that she had undertaken and advised that when interacting with ward managers and staff she would ask if staff knew how to raise concerns and if they would be comfortable to do so. GB advised that, in her experience, staff were aware of the FTSU Guardian and Champions, however, more could always be done to improve this. CGE advised that a spot check audit was currently been carried out on both sites to assess staff awareness of the FTSU team and the outcome would be included in the next quarterly report.

RESOLVED:
The Strategy and Operations Committee **noted** the Freedom to Speak Up Report (Quarter 4)

SO086/23 **Guardian of Safe Working Reports**

a) Guardian of Safe Working Quarter 4 Report

b) Guardian of Safe Working Annual Report 2022/23

KC presented the Guardian of Safe Working Report for the period 01 January to 31 March 2023 which provided an update on issues related to the Guardian of Safe Working (GoSW) as well as the Guardian of Safe Working Annual Report for 2022/23 which provided an annual overview of issues pertaining to the role. KC highlighted the following:

- The post of the GoSW role remained vacant, however, interviews were scheduled to take place during May.
- There had been an improvement in the exception report process, and it was noted that there had been a significant reduction in the number of reports submitted in the last quarter. Several late reports had been received during the quarter and this was attributed to the internal hospital pressures during the period.

- There had been an increase in the number of reports received at F1 and F2 levels and these related to the level of support available for the trainees.
- Two reports relating to patient safety issues. 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 staff. 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.
- There had been one non-compliant rota at the start of 2022 which had been successfully mitigated by August 2022.

KC advised that concerns about the timely approval of annual leave had been raised. There was now an agreed Standard Operating Process (SOP) in place and the approval of annual leave requests was monitored weekly and, whilst the target of a two-week turnaround time (TAT) had not been met, progress had been made. It was noted that there were currently ten outstanding leave requests, and these were waiting on feedback from the relevant doctor before they could be finalised.

GA reflected on the ongoing national pay dispute and commented that, whilst the Trust could not change things nationally, it could create the right culture locally. KC agreed with GA's comment and added that reports related to workload had been submitted from the surgical trainees at the start of the year and this had also been reflected in feedback through the General Medical Council (GMC) survey and Health Education England (HEE) North West rating General Surgery NTS results as an Intensive Support Framework (ISF) Level 2 (significant concerns). KC assured that plans were in place to address this and noted that the number of exception reports had reduced and, following the most recent HEENW visit, these issues had been rated as level 1 (minor concerns) as per HEE's ISF.

GB reflected on the variable response to the approval of annual leave and asked if there were any trends. KC advised that this was mainly across medicine and noted that work had been done around the rota coordination. It was noted that historically there were separate rota coordinator teams for each division, however, these teams had been amalgamated and there had been an improvement in turnaround times, with the current TAT at four weeks. Additionally, it was noted that medicine was the area with the highest number of trainees. GB

requested that an update on the TAT for annual leave requests be included in the next quarterly report.

K Clark

Action
An update on annual leave request turnaround times was to be included in the next quarterly report.

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

FINANCE, OPERATIONS, AND INVESTMENT

SO087/23 **Finance, Performance, and Investment Committee AAA Highlight Report**

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

- The Trust has agreed to three adjustments to the 2023/24 financial plan that was submitted. The first was £1.6m additional CIP to bring the Trust up to the minimum level agreed across the ICB of 5%. The second related to an agreement to categorise the energy inflation as a risk across the ICB, and this equated to £3.1m for S&O. There was an additional £4.7m adjustment between S&O and STHK to enable the Trust to still plan for breakeven. The current ICB gap for 2023/24 was circa £135m and the next round of resubmissions were due on 04 May.

JK advised that the Trust had achieved the highest levels of elective recovery activity ever at 108% of March 2019/20 levels.

Assurance was provided that:

- All £10.8m of the CIP was RAG rated as 'green' and all Quality Impact Assessments (QIAs) had been completed.
- The Better Payment Practice Code (BPPC) performance at month 12 was 96.8%.
- The capital spend at month 12 was £53.4m and included an additional £26m to resolve backlog maintenance issues.
- DM01 (routine diagnostic tests) performance was at 18% not seen within six weeks compared to 48% in April 2022.
- There were zero 104+ week breaches.

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

CORPORATE GOVERNANCE

SO088/23 **Executive Committee Report**

RC, on behalf of AMS, presented the AAA highlight report that detailed the issues considered by the Executive Committee during April 2023 and advised that several items noted in the report had already been addressed earlier in the meeting. RC highlighted the following:

- 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 Transfer of Undertakings (Protection of Employment) (TUPE) communications following the end of the consultation period and the issue of the final Measures to staff. It was noted that attendance at the engagement sessions had declined therefore, alternative communications about the transaction date and promotion of the One Team One Trust website to respond to any further questions from staff had been proposed.
- Decant capacity plans had been discussed and it had been agreed that these would need to be reviewed as part of the wider Estate and site development strategy and capacity plan going forward.
- A policy update had been received and there had been a discussion about the reviewing and alignment of policies for the new Trust. It was noted that the Executive Team would ensure the timely review of policies.

RC advised that the Ward 11a and Chase Heys projects had been put forward for an MJ award and this was recognition of the impact these projects had made.

IC reflected on the policy update and asked if it was possible for a report which provided an update on policies to be presented in six months to ensure visibility in the new organisation. RC agreed with IC and advised that regular updates were provided to the Executive Committee. NB noted that during Covid-19 all organisations had suspended work on policies as part of the EPRR escalation status and this, combined with current operational pressures, had resulted in an increased number of policies being out of date. NB assured that both organisations were working to clear the backlog of out-of-date policies and that this would be monitored post transaction. Additionally, it was a condition of the transaction that the key clinical and patient safety policies would be aligned as soon as possible following the transaction. JR advised that work on several of the HR policies had been put on hold as a result of the TUPE Measures where a decision had been taken to adopt the STHK policy for the new organisation.

RC advised that the Director of Transformation had started a secondment with Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) as the Programme Director for Efficiency at Scale Programme on 01 May and thanked her for her commitment to S&O.

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

CONCLUDING BUSINESS

SO089/23 **Questions from Members of the Public**

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

SO090/23 **Any Other Business**

GA noted that the STHK Start of the Year Conference had taken place on 28 April, and it had been a great launch pad for the new organisation.

There being no other business, the Chair thanked all for attending and brought the meeting to a close at 1105.

The next meeting would be held on **Wednesday 07 June 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	A										
Ann Marr	✓	✓										
Anne-Marie Stretch	A	A										
Geoffrey Appleton	✓	✓										
Gill Brown	✓	✓										
Nicola Bunce	✓	✓										
Ian Clayton	✓	✓										
Rob Cooper	A	✓										
Paul Growney	A	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	✓	A										
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 02 June 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. **02/06/2023** - This was discussed under Agenda Item SO086/23a on 03 May. Action closed	**Completed**
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**: LN and JMcL would provide an update in July 2023. This would reflect the system savings for both schemes and the Trust would be working with Sefton PLACE to assess the benefits of the schemes.	**Green**
SO085/23	03/05/2023	**Freedom to Speak Up Quarter 4 Report**	GB asked if this would be mandated in the future given the important role FTSU played in the culture of an organisation and future improvements and suggested that refresher training be considered for all staff. GA requested that JR review this	JR		Sep-23	**03/05/2023** - JR to review the possibility of mandated training for managers as well as a refresher course for all staff members	**Green**

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Original Deadline	Forecast Completion	Status Outcomes	BRAG Status
SO085/23	03/05/2023	**Freedom to Speak Up Quarter 4 Report**	IC commented on the concern raised about the power of attorney and asked if the staff member had gone beyond their duties. CGE advised that this had been investigated and there were no legitimate concerns found. KC assured that all the appropriate steps had been taken, which included police involvement and the doctor had also been engaged with the process. NB suggested that the outcome of this investigation be noted in the next FTSU report for governance purposes and to protect the individual concerned.	JR		Sep-23	**03/05/2023** - An update on the outcome of the concern raised that a doctor was potentially and inappropriately acting as a Power of Attorney for their patients be included in the next quarterly FTSU report	**Green**
SO086/23	03/05/2023	**Guardian of Safe Working Report**	GB reflected on the variable response to the approval of annual leave and asked if there were any trends. KC advised that this was mainly across medicine and noted that work had been done around the rota coordination. It was noted that historically there were separate rota coordinator teams for each division, however, these teams had been amalgamated and there had been an improvement in turnaround times, with the current TAT at four weeks. Additionally, it was noted that medicine was the area with the highest number of trainees	KC		Sep-23	An update on annual leave request turnaround times was to be included in the next quarterly report	**Green**

COMPLETED ACTIONS

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

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS COMMITTEE**	**Date**	**07 June 2023**
Agenda Item	**SO104/23**	**FOI Exempt**	**No**
Report Title	**TRUST OBJECTIVES YEAR END REVIEW**		
Executive Lead	Nicola Bunce, Director of Corporate Governance		
Lead Officer	Richard Weeks, Corporate Governance Manager		
Action Required	☐ **To Approve** ✓ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To summarise progress in achieving the Trust objectives for 2022/23.

Executive Summary

At the start of 2022/23 the Strategy and Operations Committee (SOC) agreed 26 objectives supporting the 6 strategic aims of the organisation.

Each of the objectives had agreed measures of success. At the end of the financial year a review has been undertaken of the success in delivering these objectives.

The below table summarises the progress in delivering the 2022/23 Trust Objectives, as assessed by the Executive leads for each of the objectives.

Progress	RAG	Count	Percentage
Fully achieved	Green	14	54%
Progress made but not be fully delivered by 31st March 2023	Amber	12	46%
Not delivered	Red	0	0%

Recommendations

The Strategy and Operations Committee is asked to receive the Year End review which provides assurance of the progress made during the year.

Previously Considered By:

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

Strategic Objectives

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

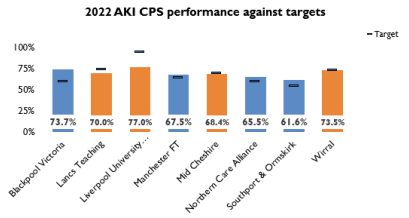
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire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

Southport and Ormskirk Hospital NHS Trust

Southport and Ormskirk Hospital NHST - Trust Objectives 2022/23

Year End Progress

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
1. Strategic Objective 1 – Improve clinical outcomes and patient safety to ensure we deliver high quality services					
1.1 Reduce number of falls and hospital acquired pressure ulcers	DoN	• Reduce all falls by at least 10% and falls resulting in harm by at least 20% compared to 2021/22 • Reduce number hospital acquired pressure ulcers with lapses in care by 10% compared to 2021/22 • Ensure all patient harm incidents are reported and investigated	Quality and Safety Committee	**Patient Falls** 2021/22: 810 falls; 5.79 per 1,000 bed days 2022/23: 812 falls; 5.21 per 1,000 bed days -0.2%; 10.0% **Patient Falls - Moderate/Severe/Death** 2021/22: 25 falls; 0.18 per 1,000 bed days 2022/23: 22 falls; 0.14 per 1,000 bed days 12.0%; 22.2% **Hospital Acquired Pressure Ulcers** 2021/22: 68 HAPU's; 0.49 HAPUs per 1,000 bed days 2022/23: 66 HAPU's; 0.42 HAPUs per 1,000 bed days 2.9%; 12.9% • All patient harm incidents are reported and investigated.	
1.2 Improve the early detection of deteriorating patients.	DoN/MD	• Achieve compliance with AQUA Acquired Kidney Injury (AKI) standard for US within 24hrs and urinalysis. • Reduce Hospital Acquired AKI compared to the 2021/22 baseline	Quality and Safety Committee	Due to an increase in numbers in Quarter 4, we have not met the reduction of Hospital Acquired AKI by 20%. However, the Trust continues to participate in the AQUA AKI pathway, and we are currently on trajectory for achieving the cumulative target set by Advancing Quality (AQ).	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
					
		• Implement and report hydration and nutrition performance metrics		• Completion of a MUST Assessment during an inpatient stay remains above target (90%) – March 2023 92.53% and the number of patients with MUST 2+ referred to Dietetics has significantly improved following the implementation of an electronic referral system. Dietitians are now able to respond to referrals much quicker and the dietetic team have also introduced a new proforma for recording their contact with patients which is filed in the medical notes for everyone to read while the patient is on the ward	
		• Undertake NEWS2 observations at the correct intervals 95% of the time		• In March 2023 we achieved 88% NEWS 2 observations on time for all patients. Training remains in place. The Critical Care Outreach Team (CCOT) are currently reviewing Track & Trigger training package and	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
				are developing an in house AIMS course.	
		• Audit compliance with the sepsis bundle and reduce incidents related to late detection		We continue to participate in the advancing quality benchmarking programme for sepsis. Areas of compliance: • Documentation of NEWS score with 1 hour of hospital arrival = 99% • Administration of antibiotics within 1 hour of diagnosis = 70% • IV fluids commenced within 1 hour of sepsis diagnosis = 81% Areas still requiring improvement: • Blood cultures taken with 1 hour of sepsis diagnosis. • Serum lactate taken with 1 hour of sepsis diagnosis.	
		• Achieve CQUIN standard for unexpected admissions to critical care		• The Critical Care Team continue to follow excellent practice in relation to patient's needing to be escalated to Critical Care. Documentation has been improved and the Team continue to achieve 100% compliance with the CQUIN.	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
1.3 Improve the quality of end of life care	DoN/MD	• Improve DNACPR documentation with additional training, awareness raising and regular audits • Improve documentation pertaining to communication of diagnosis and end of life planning (documentation audit) • Recognition of patients approaching end of life with application of advanced management and treatment plans with clear levels of escalation (NACEL audit)	Quality and Safety Committee	• Compliance with DNACPR questions within monthly Clinical Standard has improved since March 22 with an average of 92% over the year. • The relaunch of the Treatment Escalation Plan (TEP) will support improving discussion with patient and families regarding escalation of care and DNACPR decisions, this is being incorporated into the medical clerking document (currently being re-printed) • A training package has been developed and introduced for all clinicians and senior clinical decision makers to improve confidence in conversations and decisions relating to treatment escalation planning, decisions about DNACPR and anticipatory clinical management planning. • A Clinical Audit & Quality Improvement project - Improving the clinical relationship and collaborative working between palliative care and hepatology services won the first joint 'A Clinical Audit & Quality Improvement' competition. Since then, it has been confirmed that it will also be published nationally.	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
				• Two posters demonstrating collaborative working between the Trust and Queenscourt Hospice were presented at the Palliative Care Congress in March 23. The posters will also be published in the BMJ supportive and palliative care. This is a fantastic example of the collaborative working between the Trust and Queenscourt. Passing the baton of care is based on the training around TEPS/DNAPCPR/ACMPs.	
		• Improve feedback from patients and relatives evaluated via PALs/Complaints/patient survey results		• Continued reduction in the number of complaints regarding communication and End of Life care received per month, mainly attributable to early resolution when concerns have been initially raised.	
1.4 Continue roll out and development of the S&O hospitals Clinical Assessment & Accreditation Scheme (SOCAAS) to demonstrate a cycle of continuous quality improvement	DoN/MD	• Complete SOCAAS evaluation for every ward • Results of SOCAAS and delivery of the improvement plans to be reported as part of the CBU performance metrics	Quality and Safety Committee	All wards evaluated. Improvement plans are developed and monitored following assessments through the relevant CBUs. From April 2022 – March 2023 the following ratings have been awarded: • 14 Golds • 17 Silvers • 5 Bronze	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
				MIAA audit demonstrates sound processes for assurance purposes regarding standards of clinical care.	
1.5 Improve Patient Experience and reduce complaints	DoN/MD	• Learning from complaints and focussing on improving communication between staff, patients and their relatives • Reporting and learning from incidents with SMART actions • Increase in FFT response rates in areas that aren't meeting the expected number • Increase in FFT scores for patients having a positive experience • Reduction in patient complaints • Increase in complaint case resolution.	Quality and Safety Committee	• FFT comparable or above peer for all reporting groups • Increase in response rate 25.6% in Mar 22 to 31% Mar 23 • Increase in FFT Very Good or Good scores 86.5% Mar 22 to 90.4% Mar 23. • Number of open complaints reduced by from 70 in May 22 to 20 in Apr 23 • New complaints per month reduced from 23 per month May-Oct 22 to 13.6 per month Nov 22-Apr 23 • Improvements noted for all national patient surveys.	
1.6 Implement the recommendations of the Ockenden report into the safety of maternity services	DoN	• Delivery of the recommendations of the second Ockenden Report • Achievement of the CNST maternity safety bundle for 2022/23	Quality and Safety Committee	• The Ockenden action plan has been broadened to encompass the recommendations from both the initial and Ockenden 2 Report. • Continuous progression reported and scrutiny in place with the establishment of a weekly monitoring meeting for Ockenden evidence. • Bereavement service enhanced.	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
				• Investments seen in theatres, leadership, governance, Neonatal AHPs, O&G Consultant and junior medical rotas for neonatal. • Declaring compliance with 10 safety standards for Maternity Incentive Scheme (MIS) • Human Factors Training in place. • Workforce planning in line with RCOG (Royal College of Obstetrics & Gynaecology) guidance. • Significant learning and improvement from incidents • Maternity Voice Partnership (MVP) in place • Maternity and Neonatal Champions in place, including Healthwatch and MVP representative. • Plan in place for centralised CTG monitoring. • New structure proposed for new organisation. • MIAA audit in relation to compliance against Ockenden 1 recommendations concluded 'Substantial Assurance'. • Joint working between S&O and StHK continues to evolve.	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
				• Continue to engage with the LMNS for regional and national actions	
1.7 Improve Same Day Emergency Care Services to avoid unnecessary hospital admission	COO	• Increase 0 and 1 day LOS • Reduce conversion to admissions 1+ day LOS • Reduced number of patient ward moves • Implement direct to specialty pathways	Finance, Performance and Investment Committee	• In 22/23 there were 3,000 more 0 & 1 day spells of emergency admissions. An increase to 50.4% of total spells, from 45.8% in 21/22 • A 1% reduction in 22/23 compared with 21/22 (from 13% to 12%) • In 22/23 average number of ward moves was 1.87, this was 1.86 in 21/22. • Support from C&M SDEC Lead and Regional team to develop model. • Development of clinical pathways to ensure patients seen in the right place at the right time. • Implementation of Frailty SDEC model working with medicine SDEC to improve clinical outcomes for patients and workforce resilience. • Robust nursing workforce model to deliver service 8am - 8pm 7 days week in place, further work to standardise medical workforce to enable robust 7day model. • Achieved 76% of 22/23 plan for 0 day and 1 day LOS.	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
1.8 Improve frailty services to avoid unnecessary admissions for 65+ patients	COO	• Increase 0 and 1 day LOS for age 65+ patients • Reduce average LOS for age 65+ patients	Finance, Performance and Investment Committee	• 22/23 had 1,500 fewer 0 & 1 day LOS spells than 21/22 for 65+ patients. • ALOS for 65+ patients has gone from 10.5 days in 21/22 to 12.5 days in 22/23 (+19%). • Kendal Bluck review completed and presented to ETM and MEC leadership team with opportunities for improving frailty pathway and offer for winter 2022 • Operational planning session to agree SDEC plans for winter 2022 included frailty • £500k recurrent funding secured for frailty virtual wards to support step up and step down with integrated working with SDEC team and Enhanced Health in Care Home Team to enhance Frailty SDEC opportunity. • £960k funding awarded for 14 beds at Chase Heys to support reablement of patients and reduce acute hospital LOS within Older Peoples wards. March data demonstrates 78% of patents returned home, with 69% of patients with a reduced package of care.	
2. Strategic Objective 2 – Deliver services that meet NHS constitutional and regulatory standards					

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
2.1 Elective Restoration - to deliver against elective levels in line with 2022/23 operating plan	COO	• Deliver 104% 2019/2020 elective activity levels • Deliver 120% 2019/20 diagnostic activity levels • Improve theatre utilisation to pre COVID levels • Improve cancer performance to meet national standards • Improve endoscopy productivity and performance • Reduce long waiters in line with the elective recovery plan targets	Finance, Performance and Investment Committee	• Improving position at 93.7% of elective activity from 19/20. In line with C&M position however delivery of 104% target is a challenge for all NHS providers. • Overall delivering 104% 19/20 diagnostic activity, supported by 122% of 19/20 endoscopy activity • Diagnostic waiting times improved to 32.6%, narrowing gap to average England performance (31.4%) and average North-West performance (30.1%) • Theatre utilisation rates reported at 78% in March 23 compared with 68% March 22. • Best acute trust position for 52+ week and 78+ weeks and 104+ week breaches. Reduction from 46 x 78+ week waits to 3 at March 23. • Cancer 2 week wait performance 77.4% at end of 22/23 to 93.8% at March 23. 62 day performance fallen from 70.5% at the end of 22/23 to 54..2% at March 23. 104 day backlog reduced from 203 at end of 22/23 to 17 at end March 23. • Weekly extraordinary PTL meetings in place chaired by COO to manage elective activity and long waiters.	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
				• Theatre review undertaken by STHK and findings shared with ETM • Theatre improvement plan has been developed and will be monitored via theatre improvement group • Cancer improvement plan developed and weekly monitoring in place by COO • Significant improvement seen in cancer performance; further improvement planned by March 23 • Endoscopy improvement plan in place, significant improvements in endoscopy productivity and activity • Successful achievement of TIF bid £5.9m to support JAG accreditation	
2.2 Improve the effectiveness of discharge processes	COO/DoN/ MD	• Release the maximum number of beds. As a minimum this should be half the current delayed discharges • Ensure sufficient and appropriate information is provided to all patients on discharge • Improve Inpatient Survey satisfaction rates for receiving discharge information • Achievement of 30% target for patients discharged before noon during the week and 85% of the	Finance, Performance and Investment Committee	• Average RFD in 21/22 was 76, average RFD in 22/23 was 77. • On average 68% of patients were discharged before 5pm in 22/23 compared with 63% in 21/22. • Patient discharge leaflets provided upon admission • New discharge lounge opened in July 2022. • Increase in activity through discharge lounge.	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
		weekday average discharges to be achieved before noon at the weekends consistently across all wards.at weekends • Introduce criteria led discharge		• Challenges with RFD/NMC2R patients delaying discharge due to capacity in community and LA. • System response to address challenges being progressed with new PLACE lead. • £960k funding awarded for 14 beds at Chase Heys • Review Ward 11a criteria for RFD patients and promote reconditioning to reduce over prescribing of social care.	
2.3 Delivery of the agreed Trust financial targets: outturn, cash balances and revised capital resource limits	DoF	• Achieve the approved financial plan for 2022/23 agreed under the new NHS financial regime	Finance, Performance and Investment Committee	• The Trust ended the year at £14.7m deficit against the agreed revised forecast of £13.7m, however the additional £1m provision was included with the agreement of the ICB.	
		• Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income		• The Trust ended the year with a cash balance of £1m equating approximately to 1.5 working days balance and aged debt (beyond 30 days) at 1% – having taken steps to secure planned ICB support funding in-year, whilst managing debt and maintaining Better Payment Practice Code (BPPC) performance at 96.8%	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
		• Deliver the approached capital programme		• The Trust spent its full capital allocations of £53.4m by the end of March 2023	

2.4 UEC Delivery – to deliver against UEC levels in line with 2022/23 operating plan	COO	• Improve 4 hour performance (vs TBC).
		• Reduce 12 hour waits in ED (total).
		• Minimise ambulance handover delays
		  ○ Eliminate > 60 mins
		  ○ 95% h/o < 30 mins
		• 65% h/o < 15 mins.
			Finance, Performance and Investment Committee	• Best performing acute trust in C&M for 4 hour performance and upper quartile nationally. Trust average 4 hour performance for 22/23 was 74.4% compared to average national performance of 70.7% and average C&M performance of 71.1%
				• Average of 67.5% against 95% ambulance handover less than 30 mins.
				• Average of 39% against 65% ambulance handover less than 15 mins.
				• 4.5% improvement in ambulance over 60 mins compared to 19/20, although 5.8% variance to plan of 0 for 22/23.
				• 12.5% patients waited over 12 hours in ED in 22/23 which is in line with 21/22
				• Implemented NWAS ambulance handover checklist to improve ambulance handover delays.
				• Kendal Bluck review completed and presented to ETM and MEC leadership team with further opportunities for SDEC which will support improvements in ED.	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
				• Introduction of RATS (Rapid Assessment and Treatment model) to improve triage times and time to treatment October 2022 • Direct referral from NWAS into SDEC pathways from Primary Care commencing from November 22	
2.5 Transformation of diagnostics services by becoming a Community Diagnostic Hub (CDC) to maximise capacity, throughput and patient experience	COO	• Deliver 120% 2019/20 diagnostic activity levels • Reduce waiting times in line with national standard	Finance, Performance and Investment Committee	• Overall delivering 104% 19/20 diagnostic activity, supported by 122% of 19/20 scope activity • Diagnostic waiting times improved to 32.6%, narrowing gap to average England performance (31.4%) and average North-West performance (30.1%) • CDC bid for £4.9m submitted & approved • Capital Programme Assurance Group (CPAG) established to manage programme of work • 2nd CT scanner on order • Scope equipment on order	
3. Strategic Objective 3 – Efficiently and productively provide care within agreed financial limits					
3.1 Reduction in the level of backlog maintenance across the Trust estate	DoF	• Development of a 3 year backlog maintenance strategy • Reduction in backlog maintenance figures reported via ERIC submission 2022/23 by targeted capital investment	Finance, Performance and Investment Committee	• £31.8m external investment received to reduce backlog maintenance. Some of the most pressing risks have been dealt with in 2022/23 from a 3 year strategy and now in 2023/24 the	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
		• Completion of all fire safety actions to achieve a fire safety certificate for both sites • Wherever possible invest to improve the environment for patients and staff		Trust needs to review the timing of the programme of work for the next 2-3 years. • Work is almost complete with regard to fire compartmentation at Southport and Formby Hospital with only 15 a/b left to complete. In terms of the fire alarm at Southport and Formby Hospital only 15a, AMU and the plants rooms are left to complete which will result in the fire notice for Southport and Formby Hospital being lifted, and work is ongoing with regard to fire safety work required at Ormskirk • There have been a number of improvements in 2022/23; number of areas to address the maternity action plan which include theatre storage and theatre recovery, painting programme and way finding signage across both sites, improved external lighting across both sites, Breast feeding room at Ormskirk, theatre forward wait at Southport, CCTV and access control at Ormskirk.	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
3.2 Improve the quality and resilience of Trust IT systems	DoI	• Reduce the number of system outages as a result of poor network resilience • Reduce the cyber security risk across the network by replacing all network hardware with supported systems • Improve the reliance and resilience of the network and therefore reduce the number of system outages	Finance, Performance and Investment Committee tee	• Technical work has taken place on existing network which has reduced outages and improved performance. • The network refresh has started which will reduce the likelihood of failure due to ageing hardware. Approximately 95% complete with final core switch upgrade to be scheduled with the Trust in July which will require a significant site wide outage. • The Trust still have several end-of-life operating systems on the estate. However, this figure has reduced since April 2022. Progress in this area will be reviewed in November 2023, with the intention of producing a robust plan for when all the remaining systems will be appropriately supported	
3.3 Further develop the use of electronic patient information to replace paper based medical records e.g. observation charts, nursing assessments and care plans, AHP assessments and inpatient clinical narrative	DoI	• Reduce the amount of paper in nursing documentation produced as part of the paper based medical record by 25% • Reduce time spent by clinicians using paper-based processes by providing them access to a full and salient electronic documentation trail of a patient's care from wherever they need to access	Finance, Performance and Investment Committee	• Initial nursing documents built in test environment, awaiting access from system supplier to Clinical narrative to progress further. Due April 2023. Project delayed due to access issues; progress has now been made but delivery will be later than expected. Other functionality has been delivered in the interim, supporting the reduction in paper.	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
		• Improve e-observations (NEWS2) to facilitate early identification of deterioration leading to earlier intervention • Enabling speciality reviews of patient pathways resulting in the reduction in variation in patient care		• Paper based process with scanning of paper giving electronic view of historic activity. Introduction of Clinical Narrative will enable the Trust to start to remove paper-based processes. • Electronic observations live Trust wide (excluding Maternity). Upgrade due 02/23, upgrade cancelled as no new functionality available. Continued roll out of the fluid balance functionality which supports the early identification of deterioration. • Awaiting the delivery of Narrative from System C.	
3.4 Maximise the productivity and effectiveness of clinical services using benchmarking and comparative data to reduce unwarranted variation	COO/DoT	• Named productivity programmes for 22/23 and action plan monitoring • Continued participation in national GIRFT programme, including reviews and delivery of the resulting action plans	Finance, Performance and Investment Committee	• Trust has been actively involved in C&M theatre productive review which has supported a significant improvement in theatre utilisation at Ormskirk. • Trust supported the C&M O/P improvement programme. • Service Improvements have actively considered benchmarking and best practice data, which has included GIRFT and Model Health • Trust was part of the long waits and cancer national tier system which supported a significant improvement in the cancer long waits	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
				• Trust involved in implementation of CMAST pathways	
3.5 Implement robotic process automation within CBU's and corporate functions to automate manual tasks and release workforce	COO	• Reduction in delays with referrals due to having a 24-hour service that can process referrals across all specialties • Reduction of spend on Agency and Bank staff as a % of these roles will be automated • Better use of data across the departments, to include an increase in real time reporting in order to improve decision making • Increased capacity to manage the backlog of referrals in a time efficient manner due to robot workers available 24/7 • Improvements in quality of data integrity and reduce errors • Improve DNA rates- Increased accuracy of patient demographics has a positive impact on DNA's and clinic utilisation which results in more patients being seen • Improved patient safety as a result of reduced administrative processing errors and reducing the likelihood of these resulting in delays in the care process • Increased efficiency of administrative processes, releasing time for more value-added activities	Finance, Performance and Investment Committee	• DNA rate in 21/22 was 6.8% this has risen slightly to 7.2% in 22/23 across all specialties. • Phase 1 underway with a number of key areas identified to progress. Discharge planning, ASI lists, C-section data and elective waiting lists. • Presentation to ETM in January 2023 to provide an update on progress. Team Brief live takeover delivered to promote the project and request additional areas. • Currently developing support for clinical coding, capacity issues, to review and agree areas suitable for RPA.	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
4. Strategic Objective 4 – Develop a flexible responsive workforce of the right size and with the right skills who feel valued and motivated					
4.1 Safe Staffing	DoN/HRD	• Real time staffing – Staffing against minimum compliance • Continue international recruitment of nurses up to 160 WTE • Reduce the number of HCA vacancies to below 20 WTE Real time staffing – Staffing against minimum compliance • Reduce the number of HCA vacancies	Workforce Committee	• Safe staffing fill rate consistently above 90% standard. • Significant work has been carried out to ensure that the staffing levels on the roster system provide an accurate picture of the wards. Improvements made to medical rosters to give more detailed view, and this will be rolled out further. • Work is ongoing to review bank and agency use to ensure it is aligned to current establishment. • 172 international nurses recruited and as a result band 5 vacancies are down to 14 WTE. • HCA recruitment has delivered significant reduction in vacancies and further recruits are in the pipeline. 52.45 WTE HCA vacancies currently with new starters reducing this month on month. • Equal emphasis in being placed on retention with the development of a bespoke induction, cohort recruitment to build peer support and	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
				nurturing talent through a 'new to care' programme giving dedicated in-house education support during first 6 months in post and completion of care certificate.	
4.2 Launch and embed the Trust's values known as SCOPE (Supportive Caring Open and Honest Professional Efficient)	HRD	• Formal launch of the Trust SCOPE values • Specific focus on values and behaviours at Induction / Warm Welcome • Evidence of regular, consistent reference to SCOPE values in Trust meetings and staff engagement in sharing stories of living the values • Increase in staff engagement score (Annual staff survey) at least in line with NHS average (6.8 in 2021) • Positive impact on staff survey questions 'Recommend as place to work' and 'Standard of care at this organisation' • Launch of Listening Plan including Exec Back to Floor building OD network and widening participation in Valuing Our People through Inclusion Group work streams • Assurance staff are having at least annual career conversation with line manager (evidenced by >85% PDR compliance) • Roots and branch review of recruitment and selection process	Workforce Committee	• SCOPE values re-branded and aligned under the "You matter to us" logo. • Monthly face to face Corporate Induction reviewed x 2 with SCOPE values as a golden thread throughout • New induction online module developed ready for launch 2023, to be reviewed with StHK post-transaction. • Board & Sub-Board Assurance Committees include staff and patient stories. • Annual Staff Survey shows no significant changes in year. Staff engagement 6.56, 0.2 behind the sector average • Staff Voice Partnership continues throughout the year. Alignment of processes and governance to be finalised with partners. • NED Board to Wards on hold pending the transaction with StHK. • PDR completions remain below target at 79.2% against a target	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
		with a view to introducing values based recruitment		of 85%. Work to commence to align PDR process with partners. • Targeted actions to address high number of staff with no PDR in last 3 years. • 'Addressing inequalities' Working Group to undertake a QI project with PMO and Staff Networks colleagues to undertake full review of recruitment process. • To date an inclusion statement is included on recruitment adverts to offer support to individuals to access and complete online applications via NHS Jobs • Successful re-assessment of Navajo Charter Mark and continued Disability Confident Employer • Achievement of Fair Employment Charter Mark showing a commitment to our staff and working conditions • Staff Networks embedding with a spotlight on delivering the activities identified in the WRES/WDES action plan	
5. Strategic Objective 5 – Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of Trust Values					

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
5.1 Embed just and learning (JLC) principles into people practices	HRD	• Mandated training for line managers ○ All Board/SOC members received JLC training by Dec 22 ○ >30% completion of training for line managers in Year 1	Workforce Committee	• JLC training delivered to Trust Quality Group, ADOs and senior managers as well as a selection of senior medics. 54 staff have been trained in JLC methodology and use of documentation. • HR team working closely with managers when as adverse event occurs. 40 additional managers have been coached and trained in the use of JLC methodology and documentation. • Formal JLC training was on hold due to pending Trust transaction.	
		• Awareness of civility and respect behaviours across all employees ○ Civility and respect workshops delivered to >300 staff members in Year 1 ○ Learning at workshops converted into behavioural objectives set in 2022/23 PDRs (evidenced by audit)		• Delivered to all new starters in the Trust since June 2022 • Added to Trust course directory in Autumn 2022 with poor uptake. To be re-run in June 2023 • Tailored sessions for groups of staff have been delivered by HRBPs within CBUs • Approximately 310 staff aware of C&R across the Trust by end of April 2023	
		• Increase in number of employee relations cases resolved informally and maintain level of formal cases <10 per month		• At the end of April 2023 there were 10 live ER cases (plus 4 appeals) • 33 cases have been dealt with via JLC processes between	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
				April 2022 and April 2023 with three cases ongoing.	
		• Reduction in concerns raised by staff about their treatment at work		• FTSU data shows a significant reduction in the number of cases referred to HR, from 13 cases in 2019/2020, 5 in 2020/2021, and no cases referred in 2021/2022. There have been seven cases referred to HR from FTSU in 2022/2023 and whilst this is an increase in number, we have closer links with FTSU and a very open dialogue.	
5.2 Promote a supportive and inclusive environment	HRD	• Redesigned core leadership and development programme incorporating compassionate leadership	Workforce Committee	• Core leadership development offer & programmes available and advertised through Trust e-Communications & leaflet drops to departments. • 'Leading through transition' programme available for 250 managers to support staff/teams through transition. • 'Foundations of leadership' programme promoted & fully booked. • CPD funding supporting leadership, coaching and mentoring courses for Nurses, AHP and NAs. • Membership of NHS Leadership Academy – all	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
				programmes & offers promoted to staff via Trust e-Communications and core leadership offer. • Promotion of NHSLA 'Developing Inclusive Workplaces' Programme • EDI Training Programme delivered by Purple Infusion Team	
		• Hold 6 weekly Schwartz Rounds		• Programme of Schwartz rounds implemented. 240 staff have attended and the feedback has been overwhelmingly positive.	
		• 40 staff to have completed an individual restoration programme and returned to work		• 40 staff were referred to the IR Programme. 20 have completed the programme so far.	
		• Improvements on staff survey themes linked to compassionate leadership / team / safe and healthy		• Staff Survey results have shown the following: Compassionate Leadership average has improved from 6.5 to 6.8 Safe & Healthy has declined slightly from 5.3 to 5.2 average.	
		• Promotion of flexible working practices (target of >200 staff with formal blended working arrangements in place)		• For year 2022/23 243 requests for agile working. Currently 121 accepted.	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
		• Revised Health and Wellbeing strategy agreed by Workforce Committee by October 2022		• Strategy integrated with the 'people promise' action plan	
6. Strategic Objective 6 – Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire					
6.1 Work with local health care organisations, Place and Cheshire & Merseyside ICB to explore opportunities for collaboration to ensure future-proof services for the local population	DoT	• Implementation of North Mersey Stroke Pathways	Strategy and Operations Committee	• North Mersey Stroke Pathway went live on 19/09/2022	
		• Continue to build on the key relationship with Liverpool University Hospital Trusts for current hub & spoke models in Head & Neck and Vascular		• Bi-monthly Partnership Board now in place. Key focus areas of Vascular and Ophthalmology have been selected due to service fragility	
		• Demonstration of on-going clinical collaboration with STHK		• STHK clinical collaboration continues at pace within Ophthalmology Rheumatology, Therapies, Maternity, Spinal Psychological services, cancer services and theatres	
		• Influence the ICB collaboration areas for focus to achieve maximum impact on fragile clinical pathways at S&O		• Chief Operating Officer, Director of Nursing and Medical Director involved in ICB clinical networks and CMAST work programmes	
		• Development of business cases/cases for change relating to service development and sustainability		• Trust continues to develop business cases/cases for change and have successfully secure over £40m of capital over next 3 years	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
		• Clear alignment to Place/Commissioning and ICB priorities		• Trust continues to align with emerging ICB and Place priorities	
6.2 Continue to address service fragility to ensure we maintain oversight of the risks and opportunities going forward	DoT	• Continued update of service assessment and monitoring of identified key drivers of fragility and work with partners to develop long term plans to meet the health needs of the population	Strategy and Operations Committee	• Continue to monitor services and key drivers of fragility. Escalating as appropriate with key partners	
		• Reduce the number of services assessed as being 'fragile'		• Trust has now de-escalated 4 clinical services from the fragile list of 18 with working continuing in other service areas	
		• Reduction in number of services requiring medium-term transformation input to support sustainability and returned to BAU governance processes		• The above 4 services are now being managed with CBU business as usual processes	
6.3 Work with partners across the local health system to implement Place Based Partnership Boards to improve the health of the local population	DoT	• Be a member of each PBPB in each Place • Continue to be an equal partner in the Shaping Care Together (SCT) Programme to develop a long term plan for the future clinical and financial sustainability of services	Strategy and Operations Committee	• Trust is a member of PBPB • SCT Programme continues, and the Trust remains an equal partner with a focus of the required future clinical reconfiguration to achieve sustainable service. SCT programme has experienced some delays due to ICB/Place changes	
6.4 Continue to work with STHK to deliver the objectives of the	All	• Deliver the agreed milestones to improve services for patients	Strategy and Operations Committee	• S&O and STHK continue to deliver the agreed milestones to support service improvement	

Objective	Lead Director	Outcomes Measures	Governance Route	Year End Progress	RAG
Agreement for Long Term Collaboration					

ENDS

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**07 June 2023**
Agenda Item	**SO104/23**	**FOI Exempt**	**NO**
Report Title	**2023-24 TRUST OBJECTIVES**		
Executive Lead	Ann Marr, Chief Executive		
Lead Officer	Nicola Bunce, Director of Corporate Services		
Action Required	☐ **To Approve** ✓ **To Assure**	✓ **To Note** ☐ **To Receive**	

Purpose

To note the 2023-24 Trust Objectives for the new post transaction organisation.

Executive Summary

The STHK Board has developed objectives for 2023-24 which reflect the assumption that the proposed transaction with S&O will take place to create Mersey and West Lancashire Teaching Hospitals NHS Trust on 1st July.

It has previously been agreed that the new Trust will retain the vision of delivering Five Star Patient Care.

The objectives are therefore split into 9 categories: 5 representing the Trust's Five Star Patient Care criteria of care, safety, pathways, communication, and systems. A further 4 categories covering; organisational culture and support for the workforce; operational performance; financial performance, efficiency, and productivity; and strategic planning are also included.

The same 2023/24 quality improvement objectives have been included in the Quality Accounts of both STHK and S&O and are incorporated into the new Trusts objectives. These were agreed following a consultation exercise with staff and stakeholders:

i. Implement and embed the national Patient Safety Incident Response Framework (PSIRF) (Patient safety)
ii. Continue to ensure the timely and effective assessment and care of patients in the Emergency Department (Patient safety)
iii. Ensure patients in hospital remain hydrated (Clinical effectiveness)
iv. Improve the effectiveness of the discharge process for patients and carers (Patient experience)
v. Improve the overall experience for women using the Trust's Maternity Services (Patient experience)

Recommendations

The Strategy and Operations Committee is asked to adopt the 2023/24 Trust objectives for the new organisation.

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:**
Nicola Bunce, Director of Corporate Services	Ann Marr, Chief Executive

DRAFT 2023/4 Trust Objectives

Objective	Lead Director	Measurement	Governance Route	Comments
1. 5 STAR PATIENT CARE – Care **We will deliver care that is consistently high quality, well organised, meets best practice standards and provides the best possible experience of healthcare for our patients and their families**				
1.1 Ensure patients in hospital remain hydrated, to improve recovery times and reduce the risk of deterioration, kidney injury, delirium or falls (QA)	DoN	• Quarterly audits to ensure all patients identified as requiring assistance with hydration have red jugs in place • Quarterly audits to ensure fluid balance charts are up-to-date and completed accurately • Quarterly audit of most dehydrated patients to ensure appropriate treatment in place, including IV fluids/fluid balance	Quality Committee	Quality Account improvement objective
1.2 Continue to ensure the timely and effective assessment and care of patients in the emergency department (QA)	MD	• % of patients with triage >15 minutes who have observations undertaken prior to triage • First clinical assessment median time of <2 hours over each 24-hour period • Compliance with the Trusts Policy for National Early Warning Score (NEWS), with appropriate escalation of patients who trigger confirmed via regular audits • Compliance with sepsis screening and treatment guidance confirmed via ongoing monitoring	Quality Committee	Quality Account improvement objective
1.3. Recognise our deteriorating patients, providing individualised patient-centred care to achieve the right outcome for the patient	MedD/DoN	• Provide education and training for staff to understand how to identify and respond to patient deterioration. • Timeliness of NEWS observations	Quality Committee	

Objective	Lead Director	Measurement	Governance Route	Comments
		• Completion of deteriorating patient proformas for all patients a NEWS of 5 or above.		
2. 5 STAR PATIENT CARE – Safety **We will embed a culture of safety improvement that reduces harm, improves outcomes, and enhances patient experience. We will learn from mistakes and near-misses and use patient feedback to enhance delivery of care**				
2.1 Implement and embed the national Patient Safety Incident Response Framework (PSIRF) (QA)	DoN	• Approval of business case for required staffing to implement and maintain PSIRF • Development of Trust-wide education plan • Launch and implementation of PSIRF in line with national requirements	Executive Committee	Quality Account Improvement objective
2.2 Create a unified safety culture for the new Trust	DoN	• Align the Incident reporting, risk, and incident management, FTSU, safeguarding and IPC frameworks across the new Trust • Provide clear guidance and appropriate training/guidance for staff where the existing reporting systems need to change. • Agree year 1 quality improvement objectives for each service as part of integration planning	Executive Committee	
2.3 Improve the overall experience for women using the Trust's Maternity Services (QA)	DoN	Demonstrable improvements in the key areas from previous national surveys shown through regular inhouse surveys of women receiving maternity care; • Increasing involvement of women and their partners in their care • Increased access to medical history of the mother and baby • Increased information about induction and labour • Increased information about physical recovery after birth • Support for infant feeding • Increasing involvement of women and their partners in their care • Timely discharge • Increased access to medical history of the mother and baby	Quality Committee	Quality Account Improvement objective

Objective	Lead Director	Measurement	Governance Route	Comments
		Develop an action plan to deliver the National Maternity Strategy (March 2023) recommendations and deliver the year one objectives.		
3. 5 STAR PATIENT CARE – Pathways **As far as is practical and appropriate, we will reduce variations in care pathways to improve outcome, whilst recognising the specific individual needs of every patient**				
3.1 Improve the effectiveness of the discharge process for patients and carers (QA)	MD	• Improved Inpatient Survey satisfaction rates for receiving discharge information • Improved audit results (minimum 75%) for the number of patients who have received the discharge from hospital booklet • Achievement of 20% target for patients discharged before noon during the week • Baseline audit of sample of delayed discharges to identify if delay in receiving take home medications and other hospital processes were the primary factors in the delay, with target to reduce this in subsequent quarterly audits	Quality Committee	Quality Account improvement objective
3.2 Improve access to the Urgent Community Response Team	MD	• Respond to 70% of calls within 2 hours • Increase the number of local pathways for direct access to services and making these more accessible to patients • Reduce unnecessary GP appointments	Finance and Performance Committee	2023/24 planning guidance
3.3 Cancer – Early Diagnosis Ambition	MD/ MedD	• Increase the % of cancer's diagnosed at stage 1 and 2 in line with the 75% early diagnosis ambition by 2028 • Achieve the NHS Faster Diagnosis Standard (FDS) for Cancer to ensure that 75% of patients referred with a suspicion of cancer have a this diagnosed or ruled out within 21 days of referral.	Finance and Performance Committee	2023/24 planning guidance

Objective	Lead Director	Measurement	Governance Route	Comments
		• Ensure that local pathways support the delivery of the FDS through the FDS Prioritisation Group.		
4. 5 STAR PATIENT CARE – Communication **We will respect the privacy, dignity and individuality of every patient. We will be open and inclusive with patients and provide them with more information about their care. We will seek the views of patients, relatives and visitors, and use this feedback to help us improve services**				
4.1 Implement a new speech recognition system to improve the turnaround times for clinic letters	DoI/MD/ MedD	• Implement the new system and train staff in its use • Achieve a 48 hour (working week) turnaround target by June 2024	Finance & Performance Committee	
4.2 Improve complaints response times	DoN	• 80% of first stage complaints to have a formal response within 60 working days by Q4 • % of complaints resolved with the first response to increase to 85%	Executive Committee	
4.3 Create new staff communication and engagement processes that reflect the enlarged organisation, are accessible for all staff, irrespective of where they work and promote a single culture and values.	DoHR	• Achieve a higher level of participation in the new trust communications systems e.g., Trust Brief Live • Create a range of communication channels to suit staff in different roles and locations • Create two way communications mechanisms • Evaluate the success/impact of Trust wide communications in the first year of the new Trust	Strategic People Committee	
5. 5 STAR PATIENT CARE – Systems **We will improve Trust arrangements and processes, drawing upon best practice to deliver systems that are efficient, patient-centred, reliable and fit for their purposes**				
5.1 Deliver the 2023/24 Frontline Digitisation Programme Milestones	DoI	• Achieve minimal digital foundation standards as part of the "What good looks like" framework • Produce the EPR replacement Outline Business Case and achieve NHSE/Treasury approval.	Executive Committee	

Objective	Lead Director	Measurement	Governance Route	Comments
		• Secure the 2023/24 element of the technology funds award		
5.2 Convergence of the digital agenda between the STHK and S&O legacy systems to optimise performance and develop a single IT strategy for the new organisation	DoI	• Create a single digital services team to provide a standardised response across all Trust sites and maintain system access • Create a single EPR team to maximise the potential to improve patient care • Improve the reliance and resilience of technology platforms at the Southport and Ormskirk Hospital sites, so that clinicians have access to the systems they need to provide high quality patient care • Develop a new IT performance dashboard to ensure a consistent service is provided across the Trust as quickly as possible	Executive Committee	
5.3 Improve access to patient information via the implementation of Narrative Digital Clinical Documentation.	DoI	• Clinicians can access the patient information they need • Patient information entered electronically only has to be entered once.	Executive Committee	
6 DEVELOPING ORGANISATIONAL CULTURE AND SUPPORTING OUR WORKFORCE **We will use an open management style that encourages staff to speak up, in an environment that values, recognises and nurtures talent through learning and development. We will maintain a committed workforce where our people feel valued and supported to care for our patients.**				
People Plan Pillars – Looking After our People				
6.1 Align HR policies for the new Trust, ensuring that all staff have access to the same levels of support wherever they work	DoHR	• Harmonise HR policies where appropriate, and ensure all HR policies are reviewed and current by Q3 • Provide a consistent range of support services to improve the health, well-being, and resilience of staff • Develop standardised inclusive leadership training and guidance for managers to implement the new Trust policies.	Strategic People Committee	
People Plan Pillars - Belonging to the NHS				

6.2 Support the integration of the two trusts teams into to a single organisational structure	DoHR	• Agree the priority actions from the two trust 2022 staff surveys to improve staff experience and engagement and deliver them in 2023/24 • Provide a wide ranging package of support for services/staff groups that are integrating to deliver the new trust operating model, including HR, OD and wellbeing • Provide bespoke change management support/training aligned to the Organisational Change Policy as the new management and leadership structure is created.	Strategic People Committee	
6.3. Improve mandatory training compliance, so that all staff across the Trust are equipped with the core skills and knowledge they need to perform effectively.	DoHR	• Achieve 85% compliance with mandatory training collectively and for all staff groups • Align the mandatory training requirements and TNAs across the new Trust, so that all staff are clear on what is expected. • Review delivery models for mandatory training with subject matter experts, to ensure this is fit for purpose for the new organisation	Strategic People Committee	
6.4 Embed a standardised approach to annual appraisals for the new Trust to support staff to deliver high quality patient care.	DoHR	• Working with subject matter experts create a single approach to high quality and effective appraisals for all staff, based on good practice and acting on feedback from the two former Trust's Staff Surveys. • Achieve 85% compliance with staff appraisals collectively and across all staff groups	Strategic People Committee	
People Plan Pillar – New Ways of Working				
6.5 Optimise time to care by implementing a single approach to e-rostering, activity manager and e-job planning systems to ensure the optimal deployment of the workforce to achieve the right number and skill mix of staff	DoHR	• Standardise the application of e-rostering and e–job planning across all sites • Monitor and evaluate the efficacy of the e-rostering and e-job planning applications to support workforce deployment requirements to achieve safe patient care and enable flexible working	Executive Committee	
People Plan Pillar – Growing for the Future				
6.6 Make the Trust the best place to work by increasing opportunities for new staff to join	DoHR	• Recruit additional nurses and medical and dental staff via international recruitment programmes	Strategic People Committee	

the organisation and existing staff to fulfil their ambitions for career development and progression within our organisation.		• In partnership with the Medical Director and Director of Nursing, Midwifery & Governance continue to create a strong pipeline of new clinical roles including Trainee Nurse Associates, Advanced Clinical Practitioners and Physician Assistants • Support flexible approaches to working, maximising the new pensions flexibilities and retire and return options • Expand the internal transfer scheme to all areas of the Trust to improve retention rates • Continue to create diverse and innovative offerings to aid recruitment and retention in staff groups with a traditionally high turnover • Maximise the use of the apprenticeship levy to support more staff to undertake further training in Advanced Clinical Practice and Leadership Development		
7 OPERATIONAL PERFORMANCE **We will meet and sustain national and local performance standards**				
7.1 Elective Care Recovery	MD	• Eliminate waits of over 65 weeks for elective care by March 2024(except where the patient chooses to wait longer) • Deliver the system specific activity targets assigned to the Trust • Maximise the capacity and efficiency of the Trusts resources to reduce long waiting times. • Provide mutual aid in specific specialities to support the delivery of system recovery targets	Finance and Performance Committee	2023/24 planning guidance

7.2 Urgent and emergency care	MD	• Improve A&E waiting times so that no less than 76% of patient are seen within 4 hours by March 2024 • Achieve year 1 planned progress in achieving the 95% target for diagnostic tests to be completed within 6 weeks by March 2025 • Consistently achieve ambulance handover times of less than 30 minutes • Increase the number of direct access pathways for assessment/speciality review	Finance and Performance Committee	2023/24 planning guidance
7.3 Maximise the productivity and effectiveness of clinical services using benchmarking and comparative data e.g GiRFT to ensure that all services meet best practice standards	MD	• Continued participation in national programme of GiRFT and other reviews and delivery of the resulting action plans and use these to inform the new organisations Clinical Strategy • Previous review action plans monitored at committee level to provide assurance that change has resulted in improved metrics • Complete the integration of services across the new Trust and optimise service delivery utilising the available estate and facilities to address the fragile services at Southport and Ormskirk	Finance and Performance Committee	
8 FINANCIAL PERFORMANCE, EFFICIENCY AND PRODUCTIVITY **We will achieve statutory and other financial duties set by regulators within a robust financial governance framework, delivering improved productivity and value for money**				
8.1 Continue working with partner organisations in the Cheshire and Merseyside Integrated Care System to develop and deliver opportunities for collaboration at scale to increase efficiency	DoF	• Deliver services at scale where this supports the strategic direction of the Trust and the wider system • Drive forward other opportunities for collaboration with system partners	Executive Committee	
8.2 Delivery of the agreed 2023/24 Trust financial targets: outturn, cash balances and revised capital resource limits.	DoF	• Achieve the approved financial plan for 2023/24 • Delivery of the agreed Cost Improvement Programme and transaction business case benefits	Finance and Performance Committee	

		• Minimum cash balance of 1.5 working days with aged debt below 1.5% of cash income • Deliver the approved capital programme, to progress the strategic estates delivery plans		
8.3 Deliver the agreed capital schemes	DoCS	• Progress the strategic site development plans, including additional theatre, bed, and diagnostic capacity • Reduce the high risk back log maintenance at the Southport and Ormskirk Hospital sites and improve facilities for patients and staff.	Finance and Performance Committee	
9 STRATEGIC PLANS **We will work closely with NHS Improvement, and commissioning, local authority, and provider partners to develop proposals to improve the clinical and financial sustainability of services**				
9.1 Continue to meet all regulatory and accountability requirements, including post transaction conditions whilst working collaboratively to achieve system success	DoCS	• Meet statutory and regulatory responsibilities/requirements, including for unified reporting for the new Trust both internally and externally • Meet the post transaction integration, performance and delivery plans including the agreed transaction benefits.	Trust Board	
9.2 Work with each of the Place Based Partnerships where the Trust provides services to improve the health of the local population	DoInt/ MD	• Position the Trust as a key partner in each Place Based Partnership • Maximise the potential of the Trust as an anchor institution in our communities to improve health, education, and employment. • Work in partnership to achieve the 92% acute bed occupancy ambition to improve patient flow in hospital and ensure medically optimised patients are discharged at the right time, to an appropriate care setting to meet the patients' individual needs	Trust Board	
9.3 Ensure the Trust continues to influence and fully participate in the Integrated Care System to achieve a clinically and financially sustainable acute provider services.	CEO	• Develop areas for collaboration that bring benefits for patients and partner organisations • Continue the development of effective Provider Collaboratives that enhance collaboration and integration of services and coordinate delivery of the elective activity targets by maximising system capacity	Trust Board	

9.4 Take forward the Shaping Care Together Programme to identify the options to achieve a safe and sustainable service configuration between Southport and Ormskirk Hospital Sites for agreement with the Cheshire and Merseyside and Lancashire and South Cumbria ICBs, to be put forward for public consultation.	MD/ DoCS	• Continue to develop plans to address the fragile clinical services at the Southport and Ormskirk sites, working with clinicians across the new Trust and other providers as necessary • Develop a plan, with the Shaping Care Together programme that will deliver sustainable clinical services	Trust Board	

NHS
Southport and Ormskirk Hospital
NHS Trust

Title Of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**07 June 2023**
Agenda Item	**SO105/23**	**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 23/24 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 April, 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;

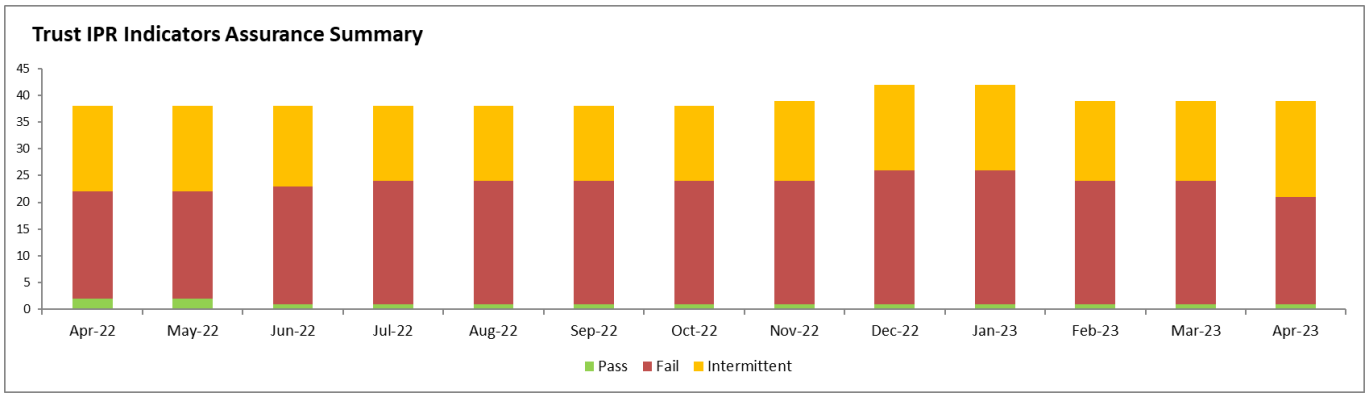
Quality - reflects those metrics aligned to Trust Objective – Care & Safety

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 April 2023 (2023/24 = 0).
There were no cases of MRSA in April. (2023/24 = 0).
There were two C. Difficile (CDI) positive cases reported in April (2023/24 = 2).
The overall registered nurse/midwife Safer Staffing fill rate (combined day and night) for April 2023 was 96.7%. This is based on 100.8% for Registered Nurses and 92.28% for Un-Registered Nurses.
There was one category 3 hospital acquired pressure ulcer reported in April and an additional 3 deep tissue injuries.
There were 49 patient falls in April, with none resulting in moderate or worse 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 91% in April, from 90.4% in March.
The % of complaints responded to within timescales has reduced to 31.6% in April against the 80% target. This has been impacted by the closure of overdue complaints. The enclosed action plan details the wider improvements being made to complaints management.
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

As per the NHS Priorities and Operational Planning for 2023/24, the A&E target has been reduced from 95% to 76%. Overall Accident and Emergency performance for April was 78% (Adults ED 53.8%, Paeds ED 97.3% in April). This compares favourably with peers, with an England average of 72.8%, North-West 72.3% and Cheshire & Mersey 73.15%. 33% of Ambulance Handovers occurred within 15mins, a small decrease on March (36.2%) and behind the 65% target. 83% of Ambulance Handovers were within 30mins, a significant improvement on March (67.6%), against the 95% target. 14 Ambulance Handovers breached 60mins in April, compared to 58 reported in March.

Performance against the 14-day GP referral to Outpatients continued to exceed the 93% target in March 2023 (latest data month), achieving 93.8%, (93.6% in February), this is higher than the average for England (83.8%), North-West (83.1%) and Cheshire & Mersey (77.7%). This is the highest since pre-Covid.

The 62-day cancer standard decreased to 49.2% in March, against the 85% target, from 50.5% in February. This is lower than the National (63.4%), North-West (63.8%) and Cheshire & Mersey (67.4%). 31-day performance declined in March, to 85.9% (92.6% in February) against the 96% target. This is below National performance (91.9%), North-West (91.4%) and Cheshire & Mersey (94.8%).

Operational Performance continued

The average daily number of stranded patients in April 2023 was 219 (March 234). The number of super-stranded patients increased by 2 on the previous month, to 102.

The Criteria to Reside metric decreased marginally in April, to 56. 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 62% in April (63.1% in March). The average for NHS Trusts in England was 58.1%, Northwest 53.1% and Cheshire & Mersey 56.3% (Mar 23).

There were 183 52+ week waiters at the end of April, a reduction on the 206 reported in March, with 28 patients waiting longer than 65 weeks, the target is to achieve 0 by the end of April 2024. There remained no 78 or 104-week waiters. SOHT is the top performing acute trust across C&M for 52 week waits.

As per the NHS Priorities and Operational Planning for 2023/24, the Diagnostics target has been increased from 1% to 5%. Performance deteriorated slightly in April achieving 19.5%, (18.3% in March). The Trust is performing ahead of the National average (25.9%) and North-West (24.5%) but marginally worse than Cheshire & Mersey (18.7%) (NHS Trusts – March 2023).

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

Financial Performance

The Trust is reporting a £675k deficit at Month 1 in line with 2023/24 Plan.
Industrial Action costs totalling £172k have been mitigated by reduced non-pay expenditure during M1.
The Trust has assumed ICB income allocations in line with Plan – with an assessment of PbR activity performance currently being undertaken.
National Guidance regarding the National Pay Award was received on 10 May – budgets will therefore be updated ahead of Month 2 reporting.
The 2023/24 financial plan sets out a CIP requirement of 5.0% (£13.2m). The Trust is reporting full delivery of CIP at Month 1.
Forecast Outturn - The Trust is forecasting delivery of a £breakeven plan and continues to work closely with STHK to ensure alignment.
Cash - The cash balance at the end of April was £3.6m.
The Trust has two headline cash issues this year relating to: £10m Transaction Support deferred in 2022/23; and £14m Transaction Capital requiring national cash support.
In addition the recently announced Pay Award Funding will not be received by Providers in advance of the June payroll date.
The Trust has therefore made an application to the ICB to bring forward £9m of contract payments during Q1 of 2023/24.
The Trust will require SOC approval for £10m of DHSC revenue support relating to the deferred income and £14m of PDC to cover the transaction capital as outlined in the Transaction Business Case.

Workforce

Personal Development Review compliance has decreased marginally in April to 79.2%, against the 85% target. Performance in March was 79.95%. The Trust achieved the 90% stretch target for Mandatory Training in April, achieving 90.1%, an increase on March (89.6%).

In month overall sickness continued to be below target in April, at 5.3% (5.9% in March). The rolling 12-month figure is reducing and is currently 6.5%. This is against sickness targets of 6% (5% non-Covid, 1% Covid). Non-Covid Sickness was 4.8% in April, a reduction on the 5.2% reported in March.

The overall Trust vacancy rate increased in April, to 7.3% against the 7.4% target (6.6% in March). This has been impacted by an increase in the overall establishment. In-month Staff turnover has decreased in month to 0.8% in April from 1.1% in March (target 0.83%).

Southport and Ormskirk Hospital NHS Trust

Integrated Performance Report

Strategy & Operations Committee Report

April 2023

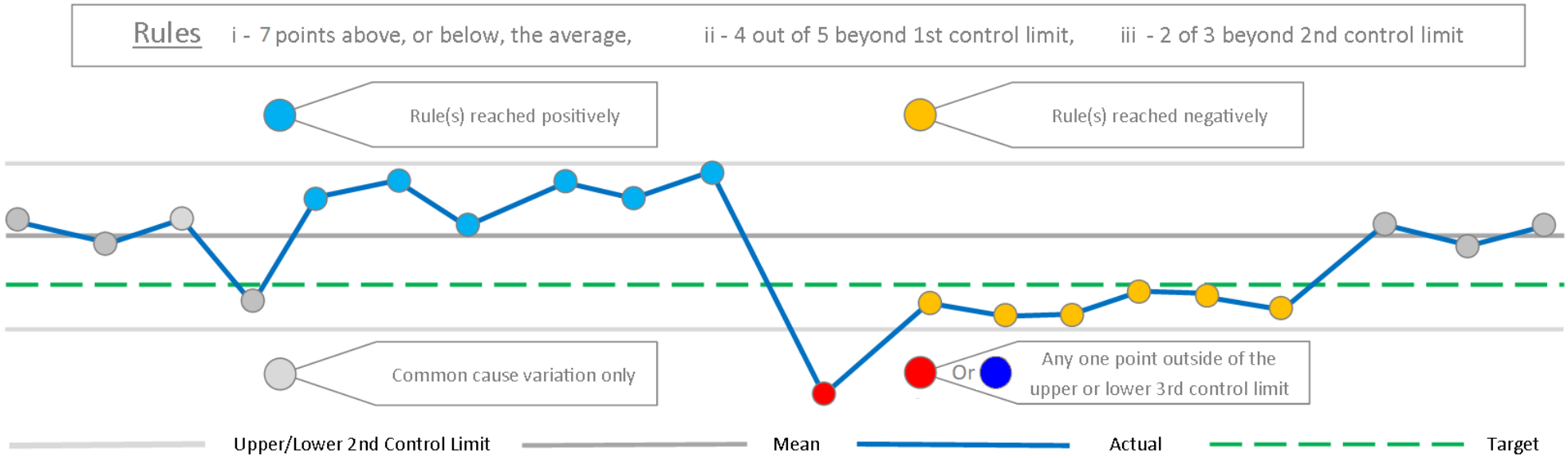
Guide to Statistical Process Control

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

Quality

Harm Free

Hospital Acquired Pressure Ulcers

Issues
• The Trust reported 1 Category 3 pressure ulcer in April. There were also an additional 3 deep tissue injuries reported.
• The pressure ulcers/deep tissue injuries in April relates to acutely unwell, end of life and new serious diagnosis patients.

Management Action

• 10 people spent the day shadowing the TVN team in April including our Director of Nursing, medical students, staff nurses and student nurses.
• Position filled for 6-month secondment 15-hour band 6 TVN – team has full cover from 22/06/23.

Patient Falls

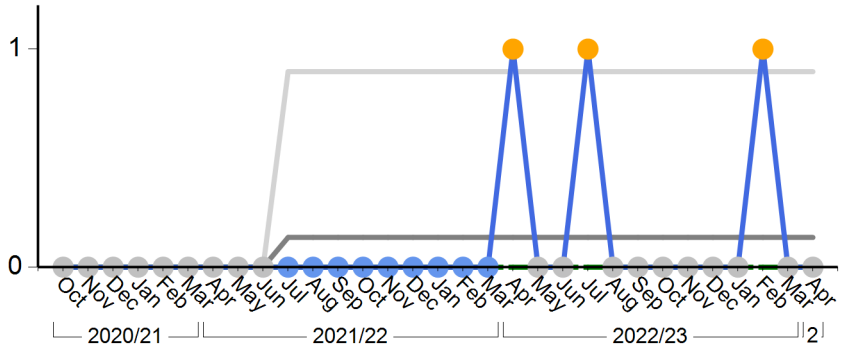
Issues
• The Trust reported the lowest number of falls since September 2022 in April, with 49 reported, a reduction on the 56 reported in March.
• No falls resulting in moderate or worse harm were reported.

Management Action

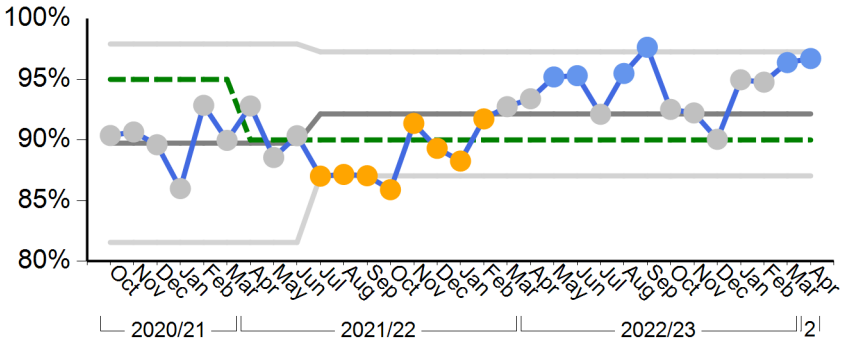
• All fall related incidents are also monitored by the Trust Falls Group and escalated incidents are managed through the CBUs to the Harm Free Care Group.
• Enhanced levels of care continued to be identified as a contributory factor for falls. Plan in place to improve the situation.
• New enhanced care documentation currently being piloted on 14b with positive feedback received from staff.
• Falls eLearning compliance is now at 90.2% trust wide (with a target of 85%)
• Trial without using yellow wristbands on 15a and 10b commenced on Monday 1st May with potential to roll out trust wide if no impact on patient safety
• Additional training sessions for flat lifting (flojac) organised and highlighted to clinical staff with encouragement for staff in each area to book places. Additional flojac due to be delivered to support with training.
• All accessible falls equipment (alarms) reviewed/serviced by Ramblegard w/b 17th April
• Audit from Quarter 4 of 22/23 demonstrated 95% compliance with completion of the falls risk assessment and 93% compliance with completion of the falls care plan.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Never Events	0	0	0	Apr 23		0	0	Mar 23	0	0	
	Safe Staffing	90%	96.7%	N/A	Apr 23		90%	96.4%	Mar 23	90%	96.7%	
	Hospital Acquired Pressure Ulcers - Categories 3 & 4	1	1	1	Apr 23		1	4	Mar 23	12	1	
	Patient Falls - Trust	63	49	49	Apr 23		63	56	Mar 23	756	49	
	Falls - Moderate/Severe/Death	1	0	0	Apr 23		1	1	Mar 23	17	0	
	Percentage of Patient Safety Incidents - Moderate/Major/Death (related)	2.1%	0.4%	3	Apr 23		2.1%	0.7%	Mar 23	2.1%	0.4%	

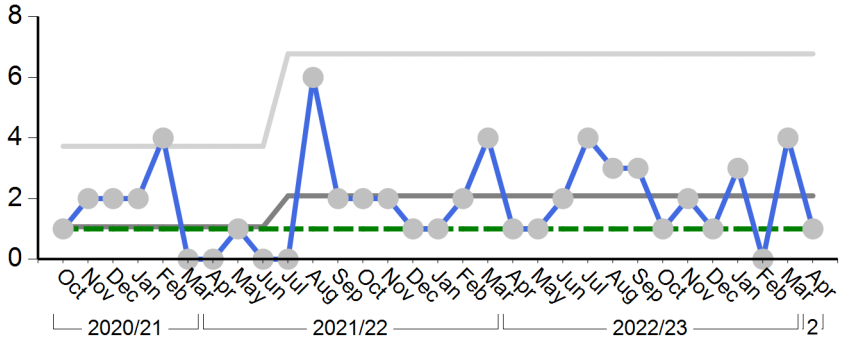
Never Events



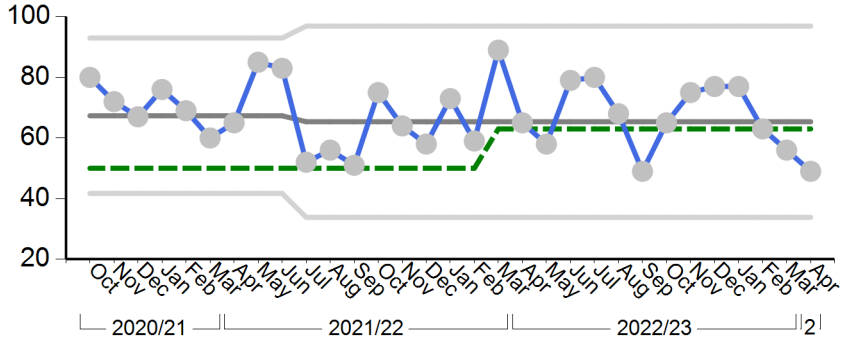
Safe Staffing



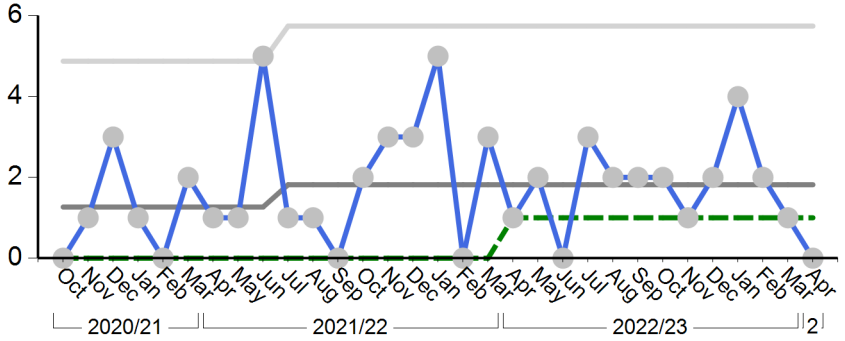
Hospital Acquired Pressure Ulcers - Categories 3 & 4



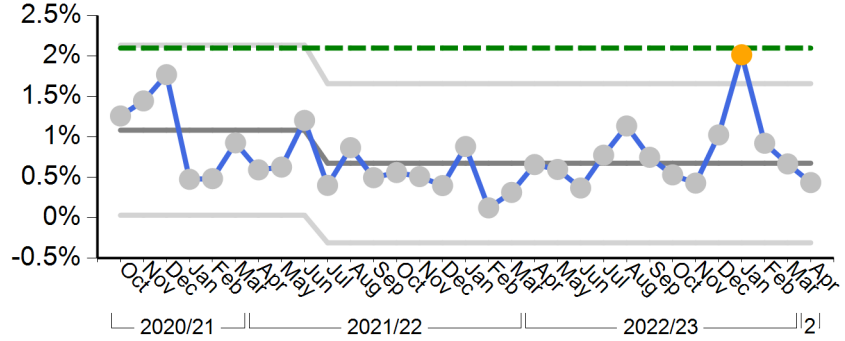
Patient Falls - Trust



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 reported in April.

Management Action
• RCA meetings are scheduled for both cases.
• Each of the patients have been reviewed by the Microbiologist and the clinical team, with Antimicrobial pharmacist also supporting and providing teaching to medics.

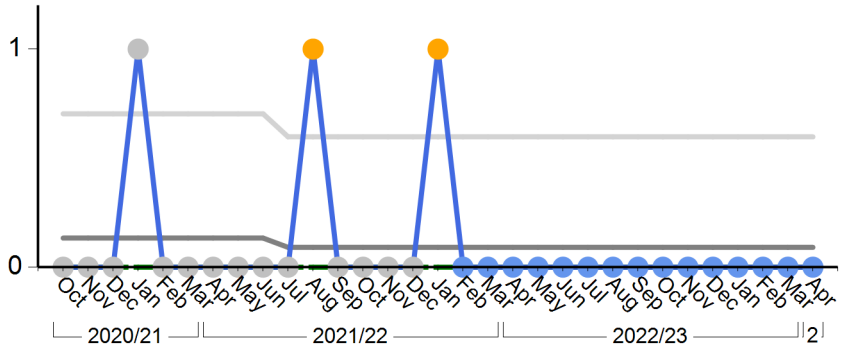
E-Coli

Issues
• The indicator is performing statistically as expected.

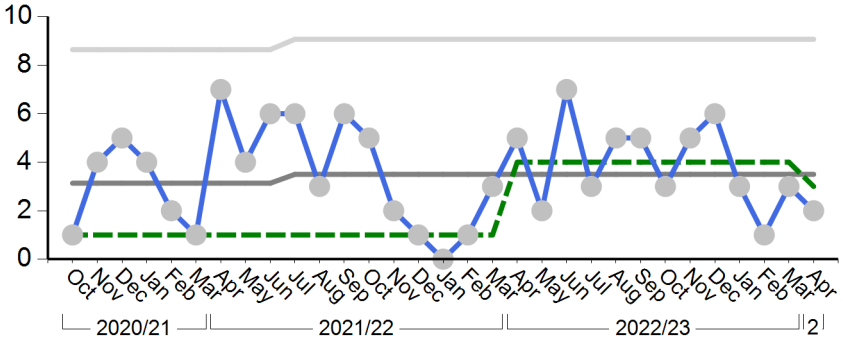
Management Action
• Each E-Coli case was reviewed by the Microbiologist and the patient's doctor, and treatment was prescribed based on microbiological and diagnostic evidence.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	MRSA	0	0	0	Apr 23		0	0	Mar 23	0	0	
	C-Diff	3	2	2	Apr 23		4	3	Mar 23	39	2	
	E. Coli	4	2	2	Apr 23		4	4	Mar 23	48	2	

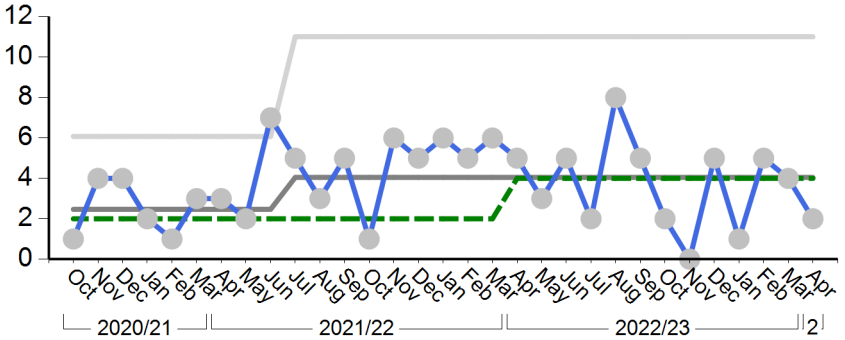
MRSA



C-Diff



E. Coli



Quality

Patient Experience

Complaints - % closed within 40 working days

• See accompanying action plan.

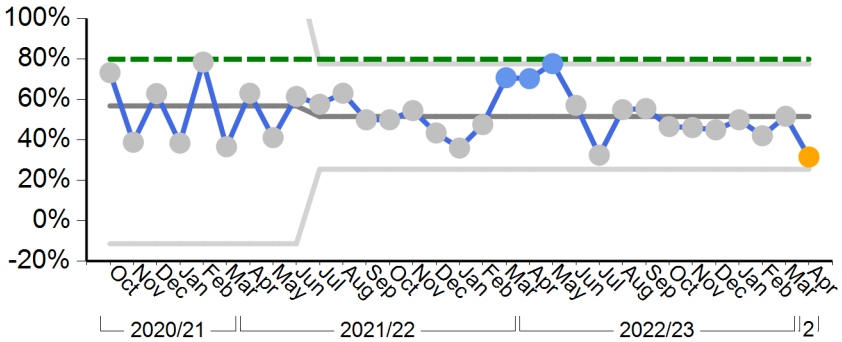
Friends and Family Test

Issues
• The Trust overall indicator continues to fail the assurance measure and has achieved 91% in April, a 0.6% increase on the previous month.
• The overall indicator takes into account Acute Inpatients, A&E and Maternity. 51% of responses in April 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 for Acute Inpatients are staff attitude, implementation of care and environment.
• The top themes attached to negative ratings for Acute Inpatients are staff attitude, environment and implementation of care.
• The score of 94.1% for Acute Inpatients is marginally below the internal indicator of 94.3% and the February NHSE average of 95%.
• A&E achieved 87.8% (85.5% Adult's and 93.5% Children's). This is significantly above the Trust indicator of 77.8% and February NHSE average of 80%. This indicator remains assured.
• The top themes attached to positive ratings in A&E are staff attitude, waiting times and implementation of care.
• The top themes attached to negative ratings in A&E are staff attitude, implementation of care and waiting times.
• Outpatients – achieved 94.4%. 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 8 months.
• Postnatal Ward – achieved 81.8% (based on only 11 responses). This is below the February NHSE average of 93% and internal indicator of 92%. No comments were received in relation to the negative rating.

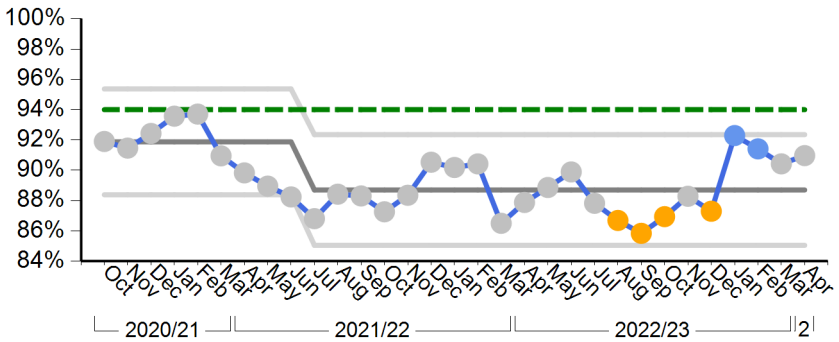
Management Action
• Monthly FFT summaries are shared with CBU's and are monitored through the Patient Experience and Community Engagement (PECE) group where CBU updates and actions to improve FFT are provided.
• Inpatient areas continue to review comments to identify any emerging themes or trends to 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%	31.6%	N/A	Apr 23	L	80%	51.7%	Mar 23	80%	31.6%	F
	Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall	94%	91%	N/A	Apr 23	H	94%	90.4%	Mar 23	94%	91%	F

Complaints - % closed within 40 working days



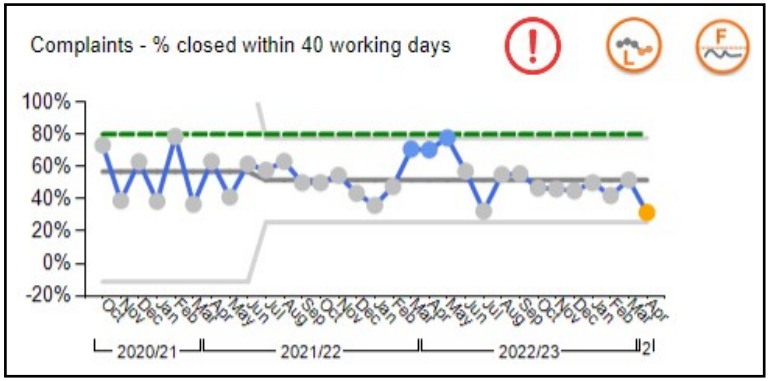
Friends and Family Test - Patients - % That Rate the service as Very Good or Good - Trust Overall



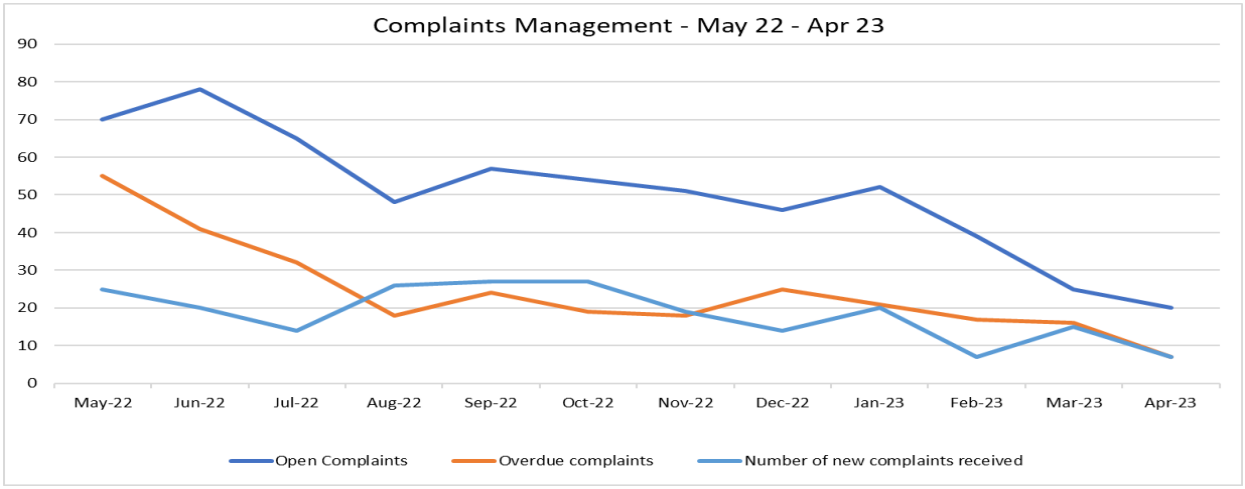
Complaints—% closed within 40 working days

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%	31.6%	N/A	Apr 23	L	80%	51.7%	Mar 23	80%	50.5%	F



Situation: This indicator has historically struggled to achieve the 80% target. Performance in April continues to be challenged and has declined on the previous month. This was expected as the Trust continues to focus on closing overdue complaints.



Issues:

Historic backlog of overdue complaints.

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 May, Planned Care continued to have no overdue complaints. They continue to review and progress all open complaints to ensure they are closed within timescales.

As at the middle of May, Women & Children's have one overdue complaint which is in the Quality Assurance process. They continue to escalate and follow up weekly to ensure the responses are collated within the timeframes, with the support from the Governance team.

Review of the Complaints Policy, including change to allow 60 working days to respond to formal complaints.

Mitigations:

The above graph demonstrates the positive progress being made.

- From May 22 –Apr 23, the number of open complaints has reduced by **71.4%** and the number of overdue complaints has reduced by **87.3%**.
- Re-Opened complaints averaged 2.3 per month from May—Oct 2022. From Nov 2022—Apr 2023 this has reduced to an average of 1.3 per month, demonstrating improvements in the quality of responses.
- The number of complaints over 100 days peaked at 14 in September 2022. At the end of April, this reduced to 2. As at the middle of May, there was just 1, which is in the quality assurance stage.
- The number of new complaints averaged 23 per month from May—Oct 2022. From Nov 2022—Apr 2023 this has reduced to an average of 13.6 per month, this is due to early intervention to prevent patient concerns escalating into formal complaints.

Operations

Access

A&E

Issues
• As per the NHS Priorities and Operational Planning for 2023/24, the A&E target has been reduced from 95% to 76%.
• Performance in April has exceeded the target, achieving 78%, a 4.3% increase on the previous month.
• Local and national performance improved in April but the Trust remains in the top quartile nationally for ED performance, performing ahead of the National average (72.8%), Northwest (72.3%) and Cheshire & Mersey (73.15%) (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%).
• 8.6% of patients spent longer than 12 hours in the department (603 patients). This is the lowest number since December 2021.

Management Action
• Continuation of RATS (Rapid Assessment and Treatment model) to improve triage times and time to treatment.
• Continuation of promotion of use of CDU correctly and avoid using as escalation area.
• Continuation of 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 to maintain privacy and dignity.
• Continue to work with system to support alternatives to hospital and reduce ready for discharge list.

Ambulance Turnaround Times

Issues
• All ambulance indicators showed improvements in April.
• Performance against the 15minute handover achieved 33% in April, against the 65% target.
• Similarly, the number of handovers >60 minutes was at the lowest level since August 2021.
• Average 15 min handover time was 21:33 which was 9 mins improvement on March 23. This showed S&O better than Northwest average of 24:18 and the 2nd best in Cheshire and Mersey (Alder Hey were 1st).
• Whilst a plan of 0 ambulance handovers above 60 minutes has been set, there has been an improvement in April of 4.4% compared to 5.8% of handovers in March 23 and 7.3% improvement compared to same period in 22/23. The improvement has contributed due to improvement in ED performance, less patients spending more than 12 hours in the department and increased discharges.
• Southport's average Turnaround time (34 mins) which was an improvement of 1 minutes compared to March. This was 1 minute better than the overall NWAS average (35:19 mins). Southport had the 2nd shortest time for average ambulance turnaround times in Cheshire and Mersey (Alder Hey were 1st). 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 62% in April. The average for NHS Trusts in England was 58.1%, Northwest 53.1% and Cheshire & Mersey 56.3% (Mar 23).
• The Trust had the lowest number of 52 week waits based on Acute Trusts in Cheshire & Mersey (Mar data).
• There were 28 65-week waits at the end of April. The target is to achieve 0 by April 2024.
• There were 0 78-week and 104 week waits at the end of April.
• Overall ERF activity achieved 97% of plan. C&M latest data reported at 95.5%.
• Gastroenterology - Recovery against 1st outpatient appointment is impacted by the limited capacity within team – there is not enough capacity to meet current demand

and reduce existing backlog, significantly impacted by leave/on-call/sickness.

Management Action
• Gastroenterology - Additional locum identified to commence w/c 15th May which will result in additional capacity of 10 new patient slots per week.

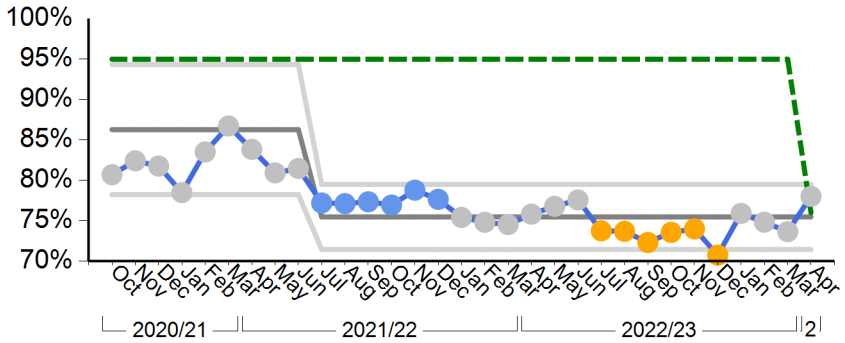
Diagnostics

Issues
• As per the NHS Priorities and Operational Planning for 2023/24, the Diagnostics target has been increased from 1% to 5%.
• The Diagnostic Waits indicator continues to show special cause improvement although has reduced slightly in April to 19.5%.
• Trust performance is better than the average for NHS Trusts in England (25.9%), the North-West 24.1% but marginally worse than Cheshire & Mersey 18.7% (March data).
• Total diagnostics activity is 106.3% of plan for April.
• Diagnostic scopes performance achieved 124.6% of plan.
• Diagnostic scans performance is at 106.9% of plan.
• Endoscopy – The unit is offering all patients a date for diagnostic scope within the six week timescale, Target referrals are being booked within 14 days unless patient choice impacts the offer.
• Radiology – CT: 2nd CT scanner at ODGH became operational in April providing more capacity. Currently covering with substantive staff where possible with additional support utilising WLI and agency staff.
• Radiology – Echo: continuing to work with STHK for mutual aid.

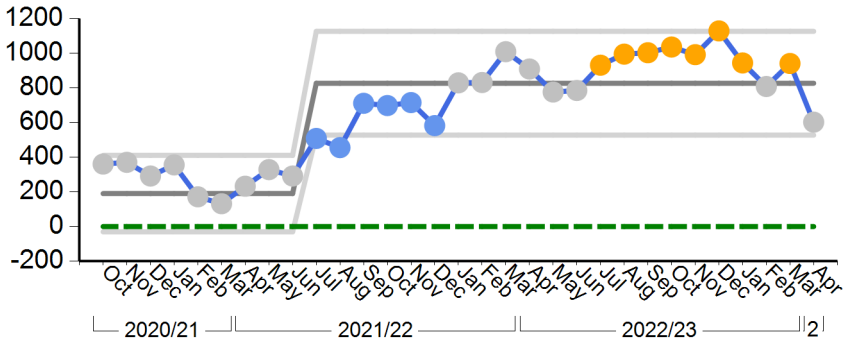
Management Action
• Endoscopy – Overtime offered and activity flexed if sickness occurs to ensure activity not impacted
• Radiology – CT: Currently covering with substantive staff where possible with additional support utlising WLI and agency staff.
• Radiology – Echo: Using agency to support Echo lists whilst out to recruitment for vacancies. A member of the team is currently doing training at STHK in order to carry out independent Echo scanning and reporting.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Accident & Emergency - 4 Hour compliance	76%	78%	2211	Apr 23		95%	73.7%	Mar 23	76%	78%	?
	Number of Patients spending 12+ Hours in ED - Trust	0	603	N/A	Apr 23	H	0	942	Mar 23	0	603	F
	% of Patients spending 12+ Hours in ED - Trust	2%	8.6%	N/A	Apr 23	H	2%	12.5%	Mar 23	2%	8.6%	F
	Ambulance Handovers - % within 15 Mins	65%	33%	0.67	Apr 23		65%	36.2%	Mar 23	65%	33%	F
	Ambulance Handovers - % within 30 Mins	95%	83%	0.17	Apr 23		95%	67.6%	Mar 23	95%	83%	F
	Ambulance Handover Over 60 Mins	0	14	14	Apr 23		0	58	Mar 23	0	14	F
	Diagnostic waits	5%	19.5%	778	Apr 23	L	1%	18.3%	Mar 23	5%	19.5%	F
	Referral to treatment: on-going	92%	62%	7493	Apr 23	L	92%	63.1%	Mar 23	92%	62%	F
	52 Week Waits	200	183	183	Apr 23		0	206	Mar 23	0	242	?
	Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month	1%	0.3%	6	Apr 23		1%	0.6%	Mar 23	1%	0.3%	?
	Stroke - 90% Stay on Stroke Ward	80%	59.5%	15	Mar 23	H	80%	61.1%	Feb 23	80%	60.5%	F
	TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care	60%	78.9%	4	Mar 23	H	60%	52.9%	Feb 23	60%	78.6%	?
	Outpatient Letters to GP's within 7 Days	85%	62.7%	4430	Mar 23		85%	71%	Feb 23	85%	69.6%	F
	E-Discharges within 24hrs	85%	78.6%	270	Apr 23	H	85%	75.2%	Mar 23	85%	78.6%	F

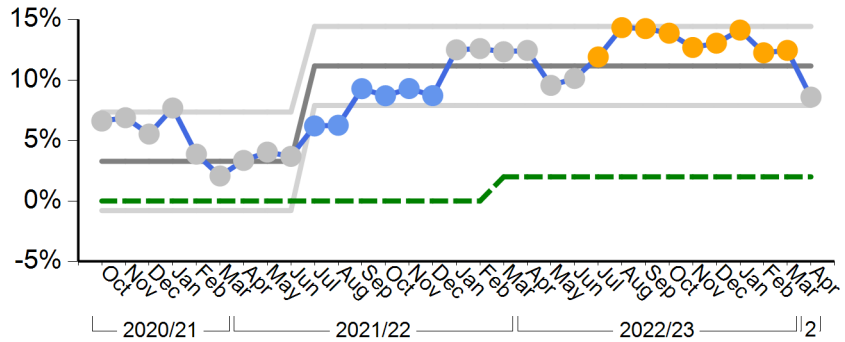
Accident & Emergency - 4 Hour compliance



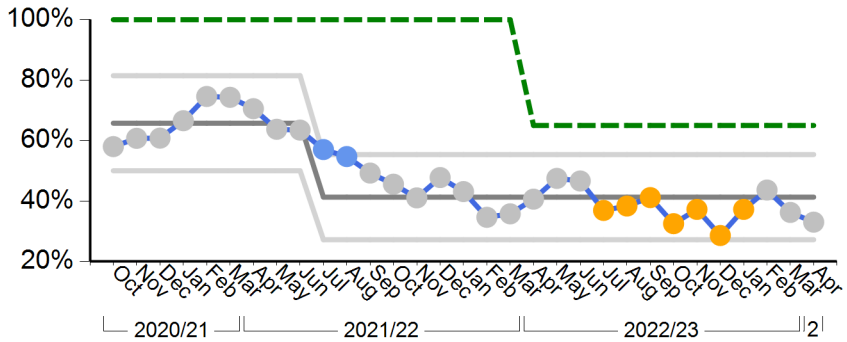
Number of Patients spending 12+ Hours in ED - Trust



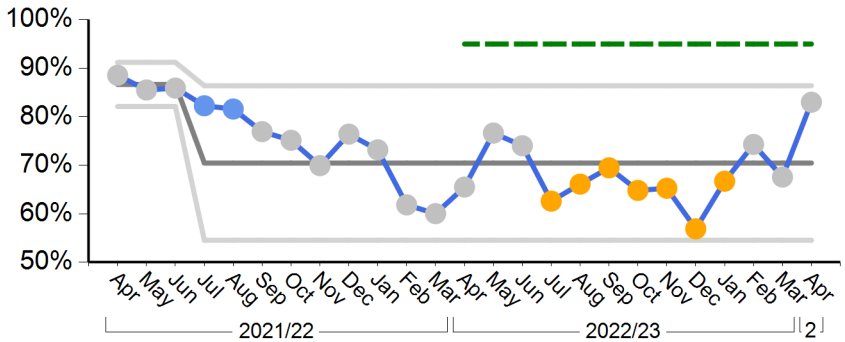
% of Patients spending 12+ Hours in ED - Trust



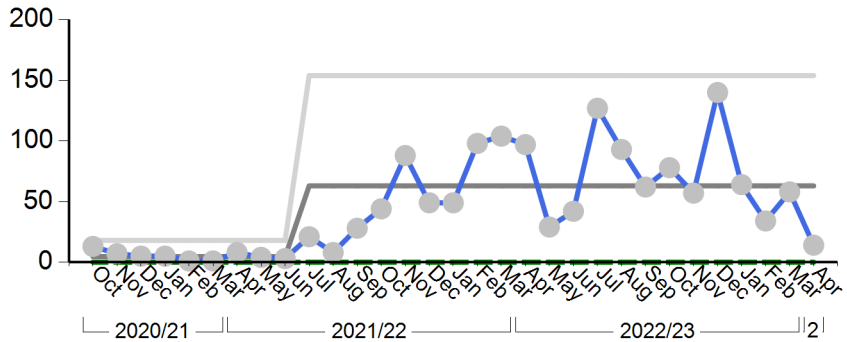
Ambulance Handovers - % within 15 Mins



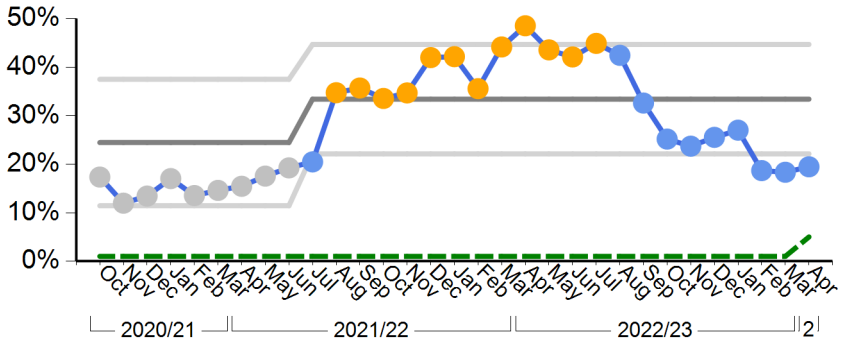
Ambulance Handovers - % within 30 Mins



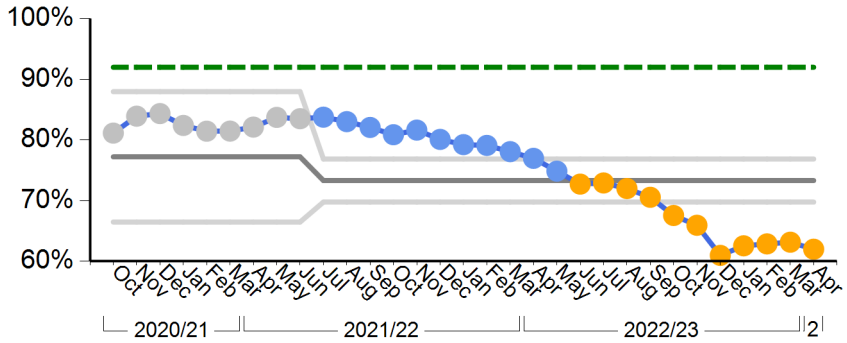
Ambulance Handover Over 60 Mins



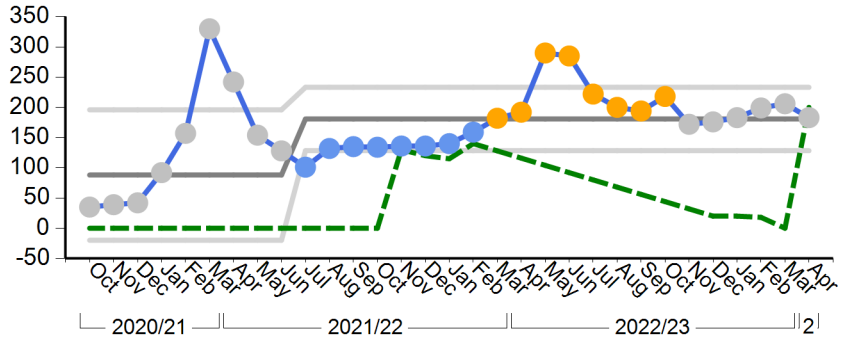
Diagnostic waits



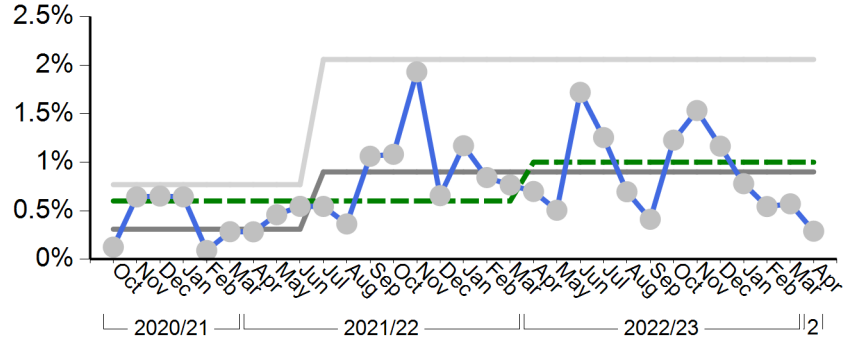
Referral to treatment: on-going



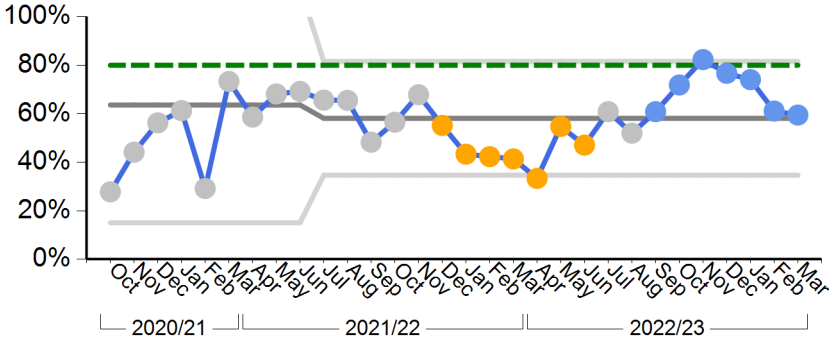
52 Week Waits



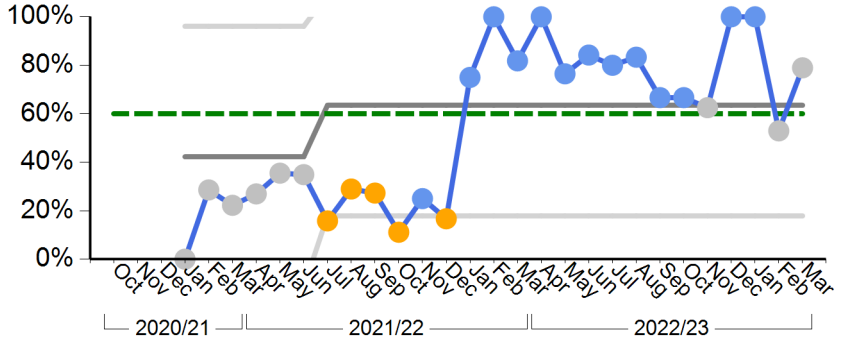
Cancelled Elective Operations (within 24 hours of operation) - % of Total Electives & Daycases in Month



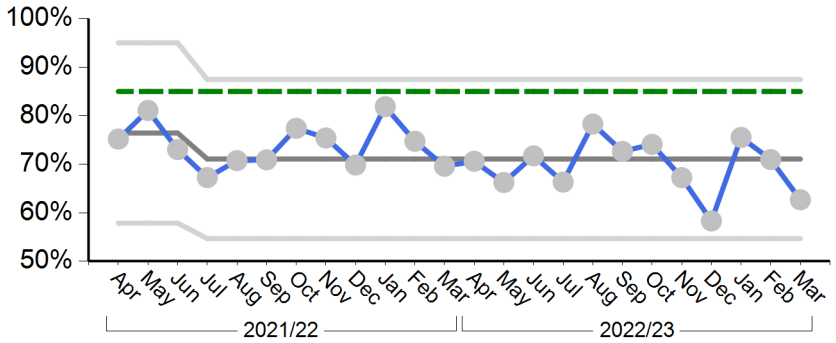
Stroke - 90% Stay on Stroke Ward



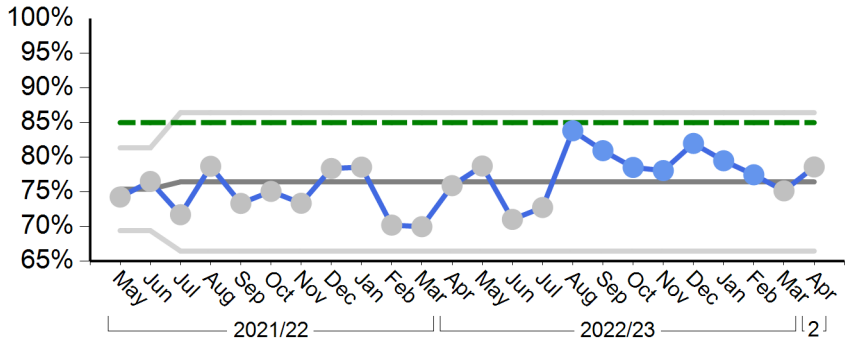
TIA - High Risk Treated within 24Hrs - Medicine and Emergency Care



Outpatient Letters to GP's within 7 Days



E-Discharges within 24hrs



Operations

Cancer

Issues

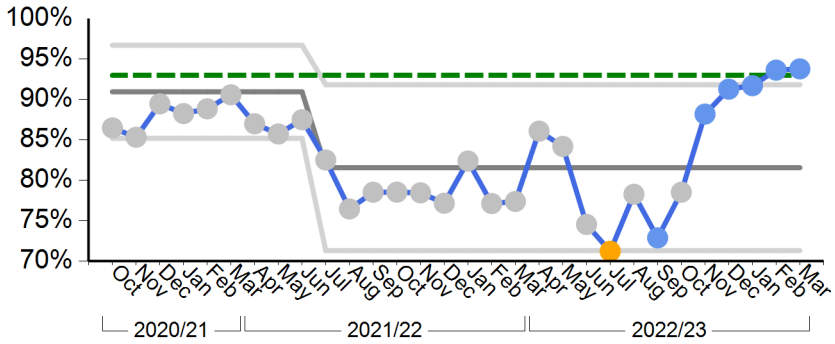
• The 14 day GP Referral to Outpatients continues to show special cause improvement and is at the highest level since pre-Covid, exceeding the target at 93.8% against the 93% target. This is higher than the National (83.8%), North-West (83.1%) and Cheshire & Mersey (77.7%) (NHS Trusts, Mar 23 data).
• 31 day performance has reduced by 6.7% in March, reporting 85.9% against the 96% target. This is below National performance (91.9%), North-West (91.4%) and Cheshire & Mersey (94.8%).
• Performance against the 62 day standard decreased marginally from 50.5% in February to 49.2% in March, this is lower than National (63.4%), North-West (63.8%) and Cheshire & Mersey (67.4%).
• Histology delays continue, currently at 20 days in the urgent pool and 5 weeks routine. KPI's have not been met for 24 months.
• Although successful recruitment of recently qualified trainees to Histopathologist gaps has taken place, 1.5 WTE gaps remain (national shortage of pathologists)

Management Action

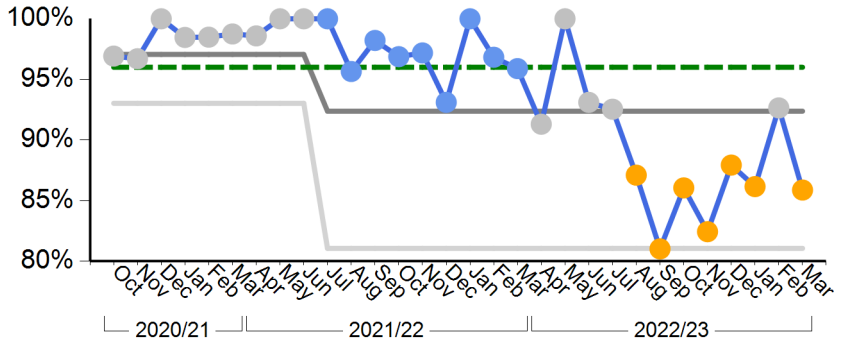
• On track for FIT go live date of 15 May 2023. EDSW's providing safety netting on behalf of the GP's until March 2024 (Alliance funded).
• Histopathologist candidates are going through recruitment checks and are due to commence June and September respectively. Further 8 trainees due to qualify in 2024 therefore STHK are hopeful they will recruit from this pool.
• Band 5 and band 7 posts have gone live to support the Faster Diagnosis programme, interviews to take place early June 2023.
• Upper GI are due to go live with recruitment for 2 x Band 7 Cancer Nurses Specialists which is funded for 24 months via MacMillan
• Interviews for Colorectal Cancer Nurse Specialist took place in early May, unfortunately did not offer however hope to offer an internal secondment opportunity.

		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%	93.8%	88	Mar 23	H	93%	93.6%	Feb 23	93%	83.5%	F
	31 day treatment	96%	85.9%	13	Mar 23	L	96%	92.6%	Feb 23	96%	88.6%	?
!	62 day GP referral to treatment	85%	49.2%	33	Mar 23		85%	50.5%	Feb 23	85%	57.9%	F
	28 Day Faster Diagnosis Standard	75%	75.2%	287	Mar 23	H	75%	75%	Feb 23	75%	66.9%	F

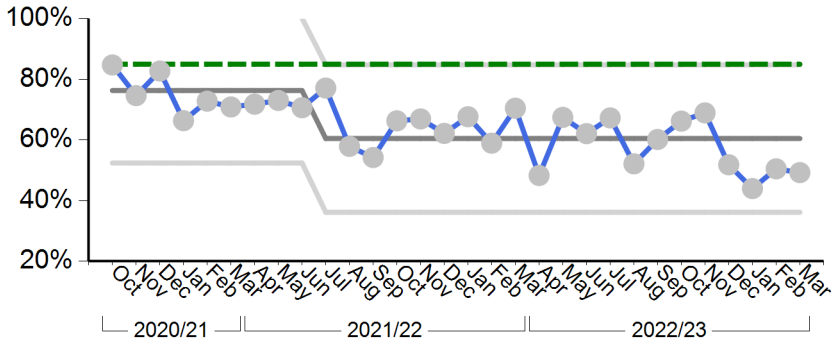
14 day GP referral to Outpatients



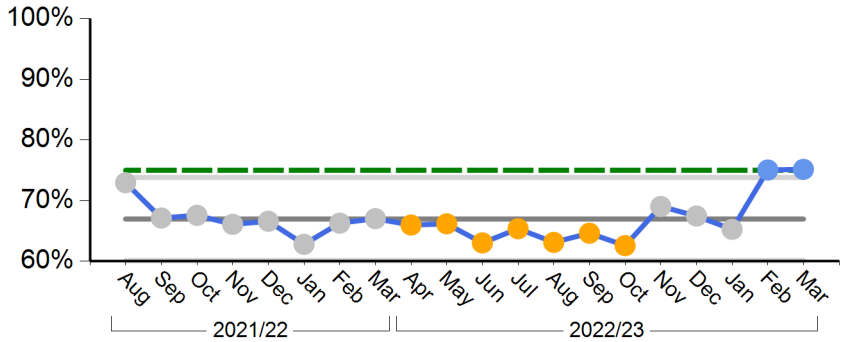
31 day treatment



62 day GP referral to treatment



28 Day Faster Diagnosis Standard



Operations

Productivity

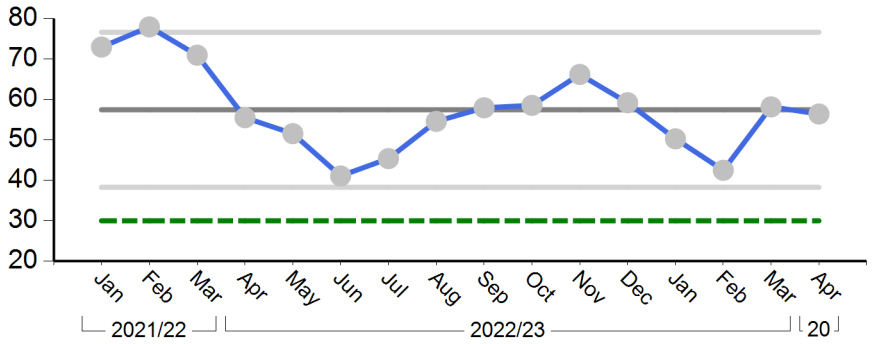
Stranded/ Super Stranded/ Criteria to Reside

Issues
• Both stranded patient metrics continue to fail assurance and show special cause concern, although the number of stranded patients has reduced from an average of 234 in March to 219 in April, 19 above plan.
• The increase in long stay patients can be attributed to patients acuity and ongoing medical needs.
• RFD numbers continue to average around 60-80 per day which is the equivalent to two wards, which can be attributed to delays in 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.
• Capacity of community services, care homes and LA to support patients.
• Additional winter escalation area still in use due to bank holidays.

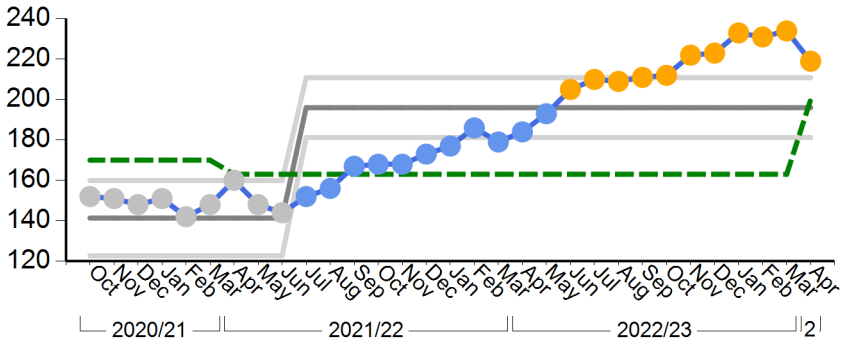
Management Action
• Ongoing Clinical Point prevalence's taking place across wards to ensure progress of discharge plans which has evidenced appropriate plans are in place for patients with criteria to reside and non criteria to reside.
• Focus on improvement of patients discharged at 5pm to ensure meet trajectory, with a 3.5% improvement on the previous month.
• Updated training for wards being implemented for discharge processes and legislation to ensure quality of discharges in timely manner.
• Continue to work with system to reduce ready for discharge list.
• 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	56	56.43	Apr 23		30	58	Mar 23	30	56	
!	Stranded Patients (>6 Days LOS)	200	219	219	Apr 23	H	163	234	Mar 23	200	219	
!	Super Stranded Patients (>20 Days LOS)	100	102	102	Apr 23	H	53	100	Mar 23	100	102	

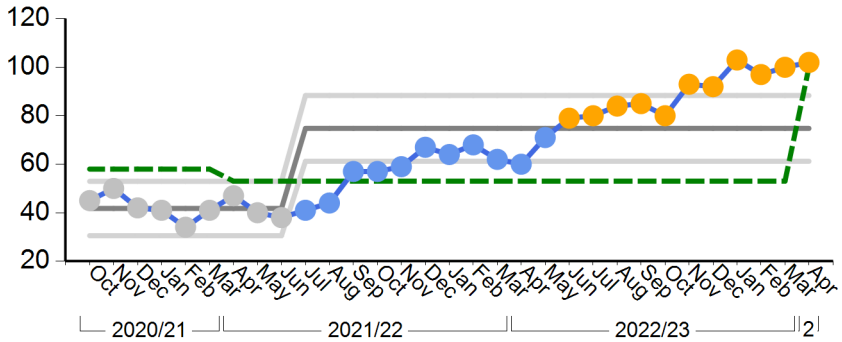
No Criteria to Reside - Avg No of Patients



Stranded Patients (>6 Days LOS)



Super Stranded Patients (>20 Days LOS)



Workforce

Organisational Development

Personal Development Reviews

Issues
• This indicator continues to fail the assurance measure but performance in April is statistically as expected, although there has been a slight reduction on the previous month.
• Capital and Estates have the best compliance in Trust at 84.62%, closely followed by Medicine and Emergency Care and Planned Care at 81.84% and 81.65% respectively.

Management Action
• CBU active monitoring to ensure retaining compliance.
• HRBPs and HRAs working with managers monthly to ensure they know who is about to come out of compliance and to actively work on those who are out of date.
• Discussions have commenced with STHK about an automated PDR system going forward.

Mandatory Training

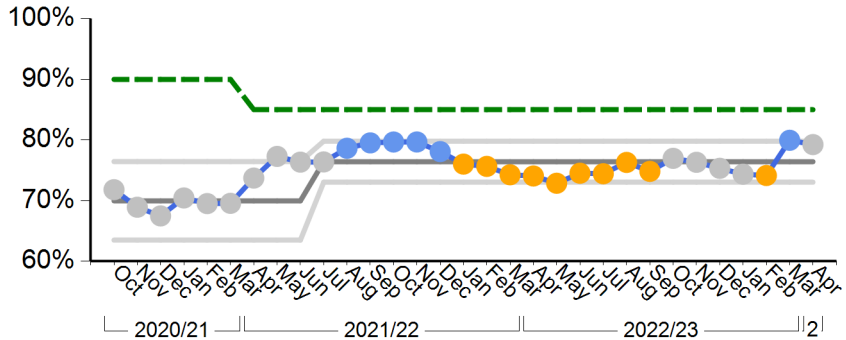
Issues

• The Mandatory Training indicator is showing positive variation and has achieved above target compliance at 90.14% in month.

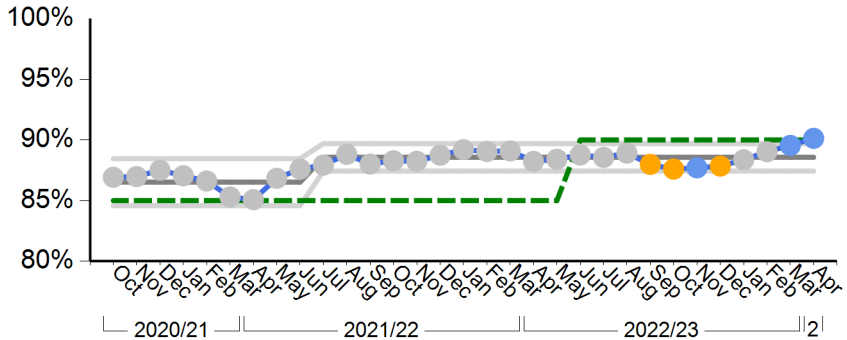
Management Action
• Moving & Handling training moved from eLearning to face to face training from April 2023 and has deteriorated slightly in month, down 3.25% as was expected. There are sufficient courses in place for all staff to remain compliant throughout the year.
• Higher levels of Fire Safety training were introduced in October 2022, good improvement is shown for both subjects - Level 2 up by 5.32% to 45.97% and Level 3 up by 2.17% to 80.43% in month.
• A revised TNA for resuscitation has been implemented in May 2023
• New Adult & Paediatric Level 3 ILS combined course will be rolled out in 2023 to support those individuals who require both competences to update their compliance at the same time. A full programme of resuscitation training is available with a focus to achieve above target compliance.
• Both core mandatory & essential skills training are monitored on a monthly basis and governed via the Executive Team, sub-assurance and assurance committees.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Personal Development Review	85%	79.2%	N/A	Apr 23		85%	80%	Mar 23	85%	79.2%	F
	Mandatory Training	90%	90.1%	N/A	Apr 23	H	90%	89.6%	Mar 23	90%	90.1%	F

Personal Development Review



Mandatory Training



Workforce

Sickness, Vacancy and Turnover

Sickness

Issues
• The in-month sickness rate has decreased by a further 0.56% in April, and is showing special cause improvement, performing 0.7% below target.
• All but one area, Capital and Estates, saw a level which was either maintained or reduced in month. The biggest reductions were seen in Corporate where absence in month reduced by 1.23% and Planned Care whose rate decreased by 1.27%.
• The top three reasons for absence in April were Anxiety/Stress/Depression, Musculoskeletal problems and infectious diseases.
• Covid absences have reduced considerably across the month of April, starting the month as 11.44% of the daily absence rate and ending the month at 7.85%. Sadly, it still factors in our absence figures daily.
• The rolling 12-month sickness rate continues to fail the assurance measure but is reducing and is showing special cause improvement in April.

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 overall vacancy rate has risen, but this can be attributed to an increase of 32 WTE in the overall establishment. Despite this increase, the indicator continues to show positive variation and remains below target.

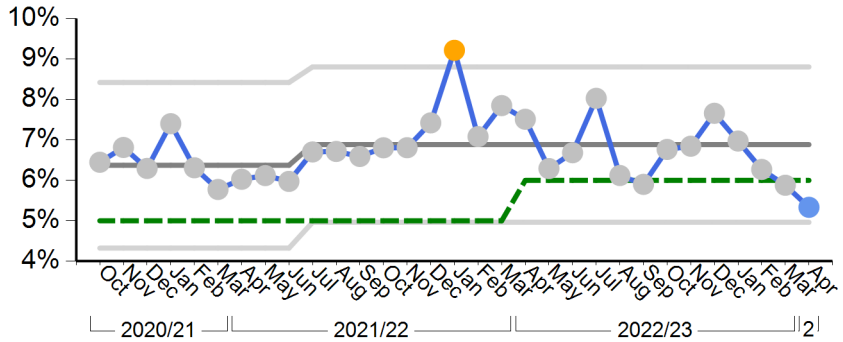
Management Action
• A further 16 Medical posts are under offer and the Trust is busy planning for the August rotation. At present, the number of trainees is favourable.
• The Trust has seen an improvement in the levels of HCAs and band 5 nurses. There are a further 24 nurse posts under offer at band 5, with start dates through to September alongside 27 HCAS.

Turnover

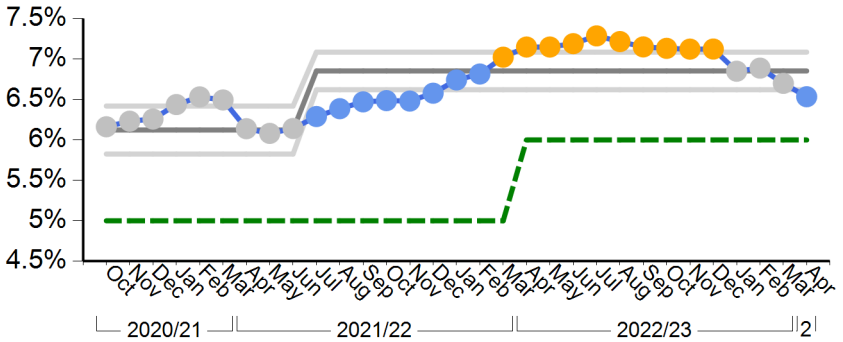
The Trust is seeing improvements across the board. Whilst the medical headline is concerning, looking at the detail it is clear that this generally relates to medics returning to training, which is always encouraging.

		Latest					Previous			Year to Date		
Alert	Indicator	Plan	Actual	Patients	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
	Sickness Rate	6%	5.3%	N/A	Apr 23		6%	5.9%	Mar 23	6%	5.3%	
	Sickness Rate (Rolling 12 Month)	6%	6.5%	N/A	Apr 23		6%	6.7%	Mar 23	6%	6.5%	
	Sickness Rate (not related to Covid 19) - Trust	5%	4.8%	N/A	Apr 23		5%	5.2%	Mar 23	5%	4.8%	
	Trust Vacancy Rate – All Staff	7.4%	7.3%	N/A	Apr 23		7.4%	6.6%	Mar 23	7.4%	7.3%	
	Staff Turnover	0.83%	0.8%	N/A	Apr 23		0.8%	1.1%	Mar 23	9%	6.8%	

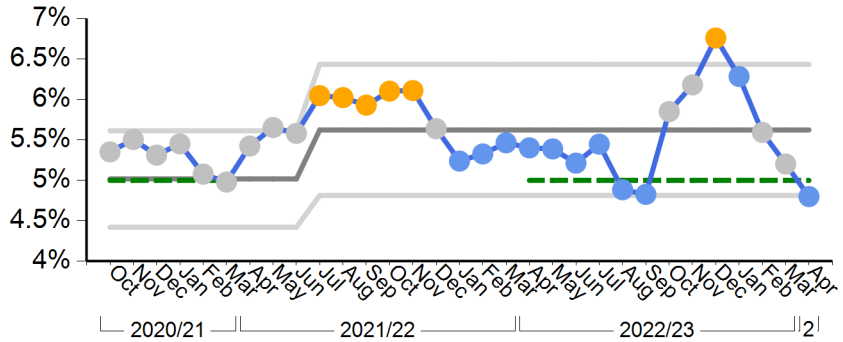
Sickness Rate



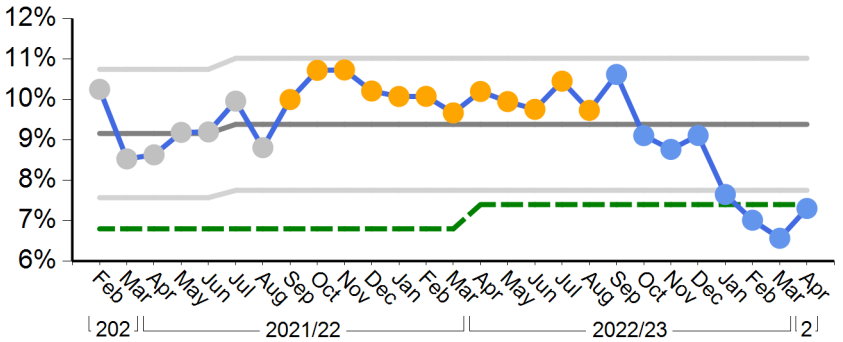
Sickness Rate (Rolling 12 Month)



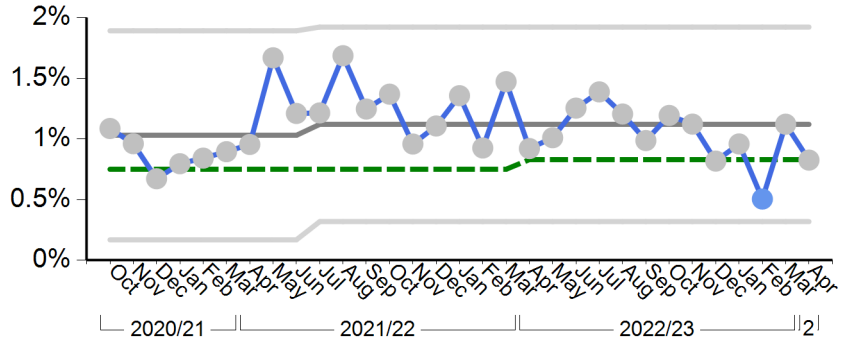
Sickness Rate (not related to Covid 19) - Trust



Trust Vacancy Rate – All Staff



Staff Turnover



Finance

Finance

The Trust is reporting a £675k deficit at Month 1 in line with 2023/24 Plan
Industrial Action costs totalling £172k have been mitigated by reduced non-pay expenditure during M1.
The Trust has assumed ICB income allocations in line with Plan – with an assessment of PbR activity performance currently being undertaken.
National Guidance regarding the National Pay Award was received on 10 May – budgets will therefore be updated ahead of Month 2 reporting.
The 2023/24 financial plan sets out a CIP requirement of 5.0% (£13.2m). The Trust is reporting full delivery of CIP at Month 1.

Forecast Outturn - The Trust is forecasting delivery of a £breakeven plan, and continues to work closely with STHK to ensure alignment.

Cash
The cash balance at the end of April was £3.6m.
The Trust has two headline cash issues this year relating to: £10m Transaction Support deferred in 2022/23; and £14m Transaction Capital requiring national cash support.
In addition the recently announced Pay Award Funding will not be received by Providers in advance of the June payroll date.
The Trust has therefore made an application to the ICB to bring forward £9m of contract payments during Q1 of 2023/24.
The Trust will require SOC approval for £10m of DHSC revenue support relating to the deferred income and £14m of PDC to cover the transaction capital as outlined in the Transaction Business Case.

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

Debt over 90 days - A slight reduction in over 90 day debt.

Capital - Plan is consistent with the national submission at £21.2m. Transaction business case scheme of £14m will require PDC funding.

	Latest				Forecast			Year to Date	
Indicator	**Plan**	**Actual**	**Period**					**Plan**	**Actual**
I&E surplus or deficit/total revenue	0.3%	0.3%	Apr 23					0.3%	0.3%
Capital Spend	£00K	£00K	Apr 23					£00K	£00K
Cash Balance	£2,600K	£3,600K	Apr 23						

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	**QUALITY & SAFETY COMMITTEE (QSC)**
MEETING DATE:	**22 May 2023**
LEAD:	**Gill Brown**

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Updates on Previous Alerts:

- Risk around estates standards and inability to decant wards to complete refurbishments – potential options being reviewed by Executive team.
- On-line Consent training is now linked with Electronic Staff Records (ESR) and is live on system.

New Alerts:

- **Maternity: Concerns / near misses have been raised on Datix regarding the difficulties when a second maternity theatre is required out of hours.** Concerns relate to staffing of the second theatre and proximity to Delivery Suite if emergency cases go to main theatre. Working group has met to identify issues and review processes including the Trust's anaesthetic workforce requirements.

- **No agreed process for accurately recording information of transgender patients –** working with St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) and legal team to review and update policy – remains a concern and clinical risk given the expectations of complying with Gender Recognition Act, 2004, Equality Act, 2010 and European Convention of Human Rights, Article 8 which means historic clinical information may not be easily accessible and could lead to unanticipated harm.

ADVISE

Presentation received from Pharmacy team noting all information had been included in a variety of reports through medicines management, Drug and Therapeutics Committee (DTC) and Clinical Effectiveness Committee (CEC) AAA reports. Presentation provided an opportunity to highlight work completed, despite workforce challenges. Thanks were passed on to the team.

Operational Performance - comparing well against peer for the new Emergency Department (ED) target, elective activity and 14-day cancer waits. Improvements reported for diagnostics. Benefits continue for patients on ward 11a and Chase Heys. Cancer 62-day, 12 hour waits, and bed occupancy remain a challenge and will be an area of focus in the coming months.

Integrated Performance Report

- Trajectories for Healthcare Associated Infections (HCAI) received and noted to be challenging for 23/24.
- Lateral flow device testing with central electronic recording of results rolled out across the Trust.
- Complaints position improving, with reduction in open, overdue, and written complaints.
- Pressure Ulcers: Differences in reporting tissue injury noted with request for this issue to be resolved.
- High response rate in ED FFT noted and congratulated.

Patient Safety Report

- Overview of themes from incident reporting – access, admission, discharge and transfer continue to be highest reported themes.
- Noted high number of falls in ED, staffing reviews and escalation actions discussed.

Maternity Services Quarterly Report (February to April 2023)
- Content noted, congratulated on achievements to date.
- Two outlier measures (Induction of Labour and emergency section at full dilatation) were discussed, noting that measurements for the Trust and Maternity network dashboard were not aligned. Work underway to align Trust reporting.
- The process for elective caesarean sections taking place in Main Theatre is now embedded. The number of elective theatre pathway lists have been reviewed as the seven sessions per week are not being fully utilised. Proposed to reduce to six sessions. Efficiencies brought about by the development of a designated maternity recovery room in main theatre. Pilot underway to assess reduction of sessions to six.

Safeguarding Assurance Group AAA
- Alert regarding Mental Capacity Act (MCA) training. Director of Nursing and Medical Director managing this.
- S&O to support Sefton LA Children's OFSTED inspection improvement plan
- Successes reported for LD nurse, IDVA and ISVA

Learning from Deaths Q4 Report
- Included an overview of where the report is shared, demonstrating the widespread dissemination of learning.
- No avoidable deaths, only one identified poor care, which did not contribute to avoidability.
- Themes included the importance of communication at end of life when discharge planning and transferring care of patients.

Clinical Effectiveness Committee AAA
- See Alert regarding anaesthetic workforce to support second emergency theatre at ODGH.
- Transfusion Administration Record compliance under review to agree consistent recording and storage of document.
- Medical devices annual report noted. Plans ahead of schedule for new financial year following recommendations via extraordinary PSG. Excellent report and group commended for the work undertaken and progress made on the oversight of all components of the lifecycle of a medical device.

Patient Experience & Community Engagement Group AAA
- Delay in ratification of protected mealtimes SOP due to lack of nutrition lead. As post has now been filled, nutrition group to be reinstated and ratify SOP.
- Noted a lack of other patient leads and discussed a collaborative approach with STHK to address gaps.
- Discussion regarding discharge planning and timing and associated complaints. Although number of complaints is low, work continues to improve processes and will feature in safety walkarounds for the next few weeks.

Southport & Ormskirk Clinical Assessment and Accreditation Scheme (SOCAAS) and Review of Ward Dashboards
- Paper presented outlining the work undertaken with all inpatient areas undergoing at least one assessment and work now progressing to non-inpatient areas e.g. ED, Outpatients and maternity triage and assessment.
- Good progress noted in most areas, where areas are not progressing or there is deterioration, a support package from quality matrons is delivered with more formal actions if required.

ASSURE
• Chair thanked Lynne Barnes (Director of Nursing) for her commitment to Quality and Safety and wished her well in her new role as DoN at Salford Hospital. • Lynne Barnes provided feedback regarding meeting effectiveness with relevant content with appropriate and kind challenge posed to members.

New Risk identified at the meeting	• Anaesthetics workforce requirements for second maternity emergency theatre (Out of hours)

Review of the Risk Register

NA

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS COMMITTEE**	**Date**	**07 June 2023**
Agenda Item	**SO107/23**	**FOI Exempt**	**No**
Report Title	**MATERNITY SERVICES QUARTERLY UPDATE REPORT**		
Executive Lead	Lynne Barnes, Director of Nursing, Midwifery and Therapies		
Lead Officer	Dawn Meredith, Associate Director of Midwifery/Nursing and AHP's		
Action Required	☐ **To Approve** ☐ **To Assure**	☐ **To Note** ✓ **To Receive**	

Purpose

To receive the Maternity Services Quarterly Report Reporting February - April 2023. This report will give updates on:

- Three year plan
- Ockenden
- CNST
- CQC
- Midwifery Continuity of Carer
- Quality & Safety
- Workforce
- Research

Executive Summary

Maternity Unit Closure (ASSURE)
There have no closures/diverts within this reporting period.

Safety Champions (ASSURE)
The Safety Champions continue to meet monthly and conduct a safety walkabout bimonthly. Safety concerns are escalated and actioned appropriately

Neonatal Workforce (ASSURE)
Progress made in relation to tier 1 and 2 training, which will enable the Trust to be CNST compliant

Ockenden (ADVISE)
Three Year Plan for Maternity and Neonatal Services launched March 2023. Work ongoing to collate evidence.

Continuity of Carer (ADVISE)
Substantive Matron for Community appointed to develop strategy for MCOC.

Maternity Dashboards (ADVISE)
Performance is monitored through our local and regional maternity dashboards. Region wide dashboards are discussed at forums such as the Regional Clinical Expert Group and Safety Special Interest Group quarterly

Serious Incidents (ALERT)
Serious incidents (SIs) continue to be reported monthly on the regional dashboard by all maternity providers in Cheshire & Mersey and in Lancashire and South Cumbria.

Southport and Ormskirk Hospital NHS Trust

Quality & Safety (ALERT)
Trust continues to work through the action plan and the Entonox national alert process and significant progress had been made, with robust monitoring and measuring processes in place.

Recommendations

The Strategy and Operations Committee is asked to receive the report and confirm that it is assured that Maternity and Neonatal services is:

- Engaging with regional team regarding key priorities within the Three-Year Plan for Maternity and Neonates
- Improve the Care Quality Commission (CQC) rating across Maternity and Neonatal Services
- Developing a strategy for rollout of Midwifery Continuity of Carer (MCOC)
- Working towards completion of Clinical Negligence Scheme for Trusts (CNST) Year 5Yr Safety actions
- Continuing to work collaboratively with Local Maternity and Neonatal System (LMNS) and Maternity Voices Partnership (MVP).
- Maintaining a safe environment for all staff working in Maternity.

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:**
Dawn Meredith Associate Director Midwifery, Nursing and AHP's	Lynne Barnes, Director of Nursing, Midwifery and Therapies

NHS
Southport and Ormskirk Hospital
NHS Trust

Maternity Services Quarterly Board Report

(Reporting period February – April 2023)

May 2023

Title:	Maternity Services Quarterly Report February- April 2023
Responsible Director:	Lynne Barnes, Director of Nursing, Midwifery and Therapies
Presented by:	Maternity Team

Introduction

The aim of this report is to provide the Trust Quality & Safety Committee and Strategy Operations Committee (SOC) with an assurance and update of Maternity and Neonatal Services in line with the Annual Cycle of Business. Maternity Services remains high on the agenda and KPI's are presented monthly at the SOC and the Maternity report is received quarterly.

This report will provide an update regarding:

- Three-year plan
- Ockenden
- CNST
- CQC
- Midwifery Continuity of Carer
- Quality & Safety
- Workforce
- Research

1.The NHSE Three Year Delivery Plan for Maternity and Neonatal Services

This delivery plan was published in March 2023 and sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. It has drawn upon recommendations from independent reports by Donna Ockenden on maternity services in Shrewsbury and Telford and by Dr Bill Kirkup on maternity and neonatal services in East Kent and previously Morecambe Bay.

Over the next three years, services will concentrate on four high level themes.

- **Listening to women and working and families with compassion** which promotes safer care.
- **Growing, retaining, and supporting our workforce** to develop their skills and capacity to provide high-quality care.
- **Developing and sustaining a culture of safety, learning and support** to benefit everyone.

- **Standards and structures that underpin safer, more personalise, and more equitable care** for all women, babies and families.

The LMNS/ICB are keen to support Triumvirate's across Cheshire and Mersey to discuss priority actions across the four themes of the report. An event has been organized in July to commence to this support this process, prior to rollout.

2.Ockenden

The Maternity Services Improvement Committee chaired by Associate Director of Midwifery/Nursing (ADOMN) has oversight of the progress of the Ockenden action plan. Benchmarked against the 92 actions using the Cheshire & Mersey Local Maternity and Neonatal Systems (LMNS) self-assessment template. With PMO support work continues aligning and embedding the Ockenden evidence, staff have been trained in the use of Smartsheet, to collate evidence and monitor compliance for both Ockenden and CNST. The system has been adapted modified to calculate compliance percentage.

Funding for 2023/24 has been confirmed by the NHSE National Maternity Transformation Programme to support specialist roles.

High level objectives have been set out and all systems must:

- Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury

- Increase fill rates against funded establishment for maternity staff

Retention	Bereavement	MSSWs	Preceptorship	Obstetrics	Total
£50,000	£34,269	£27,700	£21,885	£9,500	£143,354

3.Maternity Incentive Scheme (MIS)

Now in its fifth year of inception, the MIS supports the delivery of safer maternity care through an incentive element to discount provider trusts' contributions to CNST. The MIS rewards trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both maternity and neonatal care.

The recommendations for year Five of the MIS have is not yet published and this is anticipated to be released in the next coming few weeks. We are continuing to evidence the 10 safety actions from Year Four for which we provided assurance in February 2023 that all 10 safety actions were met.

The Year 4, 10 Maternity Safety actions are summarised below:

Safety action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Safety action 2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
Safety action 3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Safety action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?
Safety action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?
Safety action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version 2?
Safety action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Safety action 8	Can you evidence that a local training plan to ensure that all six core modules of the core competency framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance, and New-born life support, starting from the launch of MIS year 4?
Safety action 9	Can you demonstrate that the trust safety champions (obstetrician, midwife and neonatologist) are meeting bimonthly with Board level champions to escalate locally identified issues
Safety action 10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification scheme from the 1st of April 2021 to 5th December 2022?

4. Continuity of Carer

Midwifery Continuity of Carer (MCoC) has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births',the NHS Long Term Plan and the newly published Three-Year Plan, the ambition for the NHS in England is for MCoC to be the default model of care for maternity services and available to all pregnant women in England.

Preparation for the roll out of MCoC will hopefully recommence in September 2023 with a scoping exercise reviewing regional delivery of MCoC.

There is a plethora of evidence showing that health outcomes are worse for Black and ethnic minority women, pregnant people and their babies in maternity and neonatal care. Recommendations from Better Births have a target of 75% of ethnic minority pregnant women receiving midwifery continuity of carer by 2024. This has also been included in the most recent NHS Long Term Plan

NHS Race and Health Observatory commissioned a systematic scoping review, mapping existing policy interventions, to tackle ethnic health inequalities in maternal and neonatal health. We will be using this review to map Maternity Services at ODGH.

As we move towards a MCoC model, a high-risk team will be incorporated into the model to ensure Personalised Care Plans are devised for these women taking a holistic approach to their care. Current areas to be reviewed include Health Advocacy, Antenatal and Post -natal education, Perinatal mental health and First trimester screening. Staff will be updated regarding care of BAME women, incorporating the National model. The aim is to reduce ethnic health inequalities to improve outcomes for mother and their babies. The high-risk team will also include women with complex social factors to safeguarded women who may for one

reason, or another be vulnerable to abuse. Collaborative working with the Trust Safeguarding Team will be increased to ensure that women are protected, and their rights respected.

5.Quality and Safety

5.1 CQC

Ratings from 2017:

Safe	Effective	Caring	Responsive	Well Led	Overall
Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

A mock CQC inspection and second SOCAAS took place on Thursday 11th May, which included external representation from external partners. Feedback was positive, women, said they received safe compassionate care, staff said that the senior leadership team are visible, and that culture was good. Staff were aware of resources available to raise any issues.

Some improvements were required regarding medicines management, the Maternity Team will work with the Corporate Quality team regarding all required improvements. In a proactive approach, weekly quality and safety walkabouts have been taking place for CQC and SOCAAS preparedness across both sites.

Maternity Ward achieved a SILVER award rating from their SOCAAS inspection, an improvement from the Bronze from 2022. Results are awaited for the Maternity Assessment Unit and Delivery Suite. On May 10th ,the Neonatal Unit achieved GOLD award in their first SOCAAS inspection. S & O also received recognition from the Maternity and Neonatal Safety Improvement Programme, being the only trust to achieve 100% compliance in the administration of Magnesium Sulphate to mothers, to provide neuro protection to premature babies.

5.2 Clinical Outcomes/ Dashboard

Maternity Dashboards

Performance is monitored through our local and regional maternity dashboards. Region wide dashboards are discussed at forums such as the Regional Clinical Expert Group and Safety Special Interest Group quarterly**.**

Where Maternity Services are outliers with their peers, this is challenged by the Local Maternity & Neonatal System.

The LMNS are streamlining procedures for reviewing spikes or outliers on the Cheshire & Mersey regional dashboard to ensure Trusts are responsive to deadlines and there is a consistent approach to what is reported.

Current areas where the Trust is viewed as an outlier are:

- Induction of labour for the indication reduced fetal movements only – Trust rate 3.75 per 1000, North West coast mean 1.54 per 1000.
  An updated Induction of labour Guideline is in place. Leaflets regarding induction of labour have been designed for women in conjunction with the MVP. Work had been completed regionally which lowered the mean making S&O outliers. An audit is being undertaken to assess the effectiveness of the updated guideline and patient

information on the rate of induction. Our figures for the month of April 2023 showed zero cases of induction of labour for reduced fetal movements only. Work has also been undertaken to understand our reporting mechanisms in order to accurately record our data.

- Emergency caesarean section at full dilatation – Trust rate 5.7 per 1000, North West coast mean 4.31 per 1000.
  A review by the Lead Obstetrician has been completed and findings reported to the LMNS. This review was also shared locally with the team via a joint Obstetric and Anaesthetic audit meeting with discussions around further training for junior doctors in the use of instruments for assisted deliveries and escalation to Consultant.

The guidelines and patient information leaflets relating to these areas have been reviewed to compliance with best practice guidance. The induction of labour patient information was coproduced with the MVP.

There have been collaborative meetings held with data analysts within the regional team and S&O to ensure data reported is timely and correctly,

5.3 Perinatal Mortality

Perinatal mortality includes stillbirths and neonatal deaths in the first week of life. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE UK) is notified of all eligible perinatal deaths and are reviewed using the national Perinatal Mortality Review Tool (PMRT) All stillbirths and deaths are reviewed at the weekly patient safety meetings and reported to SIRG via a rapid review report.

The recent MBRRACE - UK Perinatal Mortality report: 2021 births, confirmed that the mortality rates at Southport and Ormskirk Trust were similar to, or lower than, those seen across similar Trusts and Health Boards and that all deaths were notified to MBRRACE - UK within 7 days of the death occurring.

5.4 Serious Incidents

Never Events

No never events during this reporting period.

STEIS Reportable Incidents

Serious incidents (SIs) continue to be reported monthly on the regional dashboard by all maternity providers in Cheshire & Mersey and in Lancashire and South Cumbria. SIs are also reported to the LMNS by the Trust with the Quality and Safety Surveillance Group having further oversight of all SI's across the region.

During this reporting period there have been two stillbirths:

20/02/2023	G1P0 admitted at 37+2 weeks gestation with constant abdominal pain. Intrauterine death diagnosed on admission.
22/02/2023	G2P0 intrauterine death confirmed during routine antenatal check at 31+4 weeks gestation

5.5 Health Care Safety Investigation Branch (HSIB)

HSIB undertake independent investigations into incidents within maternity services which fall under defined criteria that include maternal deaths, stillbirths and babies that require cooling.

The Trust is provided with a monthly update of cases by HSIB to support effective communication and to support the progression of the investigation. HSIB case reviews are shared with the Trust for accuracy prior to being finalised and shared with the woman and her family.

Cases to date	
Total referrals	16
Referrals / cases rejected	8
Total investigations to date	8
Total investigations completed	7
Current active cases	1
Exception reporting	No cases currently have exceptions

All HSIB cases are reported as StEIS to ensure executive oversight.

5.6 Saving Babies Lives Care Bundle (Version 2)

Saving Babies Lives Care Bundle (version 2) has been produced to build on the recommendations from version one and to further address perinatal mortality. This bundle includes 5 elements which focus on the recognition and detection of risks associated with perinatal mortality and morbidity, reporting and referral processes, training of staff and auditing of practice and outcomes. The five elements being:

- Reducing Smoking in Pregnancy – Smoking Lead Midwife in post with funding from PH Sefton for 23/24 in place. Additionally, 2 Smokefree Pregnancy Practitioners now recruited which will ensure 100% in house service as per NHS LTP. S&O are best performing Trust within Cheshire & Merseyside for smoking at time of delivery rates.
- Risk Assessment and Surveillance of Fetal Growth Restriction – this continues to be audited and reported to the Perinatal Institute regarding any missed Small for Gestational Age babies by Midwife Sonographer
- Raising Awareness of Reduced Fetal movements- RFM information provided from booking and at each contact with midwife. Women are signposted to use Maternity Triage regarding any concerns with RFM and this is a 24/7 service.
- Effective monitoring in labour – Lead Midwife for Fetal Surveillance returned from maternity leave and development of fetal monitoring study day is completed. This will be added to the mandatory training and will be multidisciplinary.
- Preventing Pre-term birth – identified Lead Obstetrician and pathway for referral for women with identified risk factors in place. North West Coast Regional Optimisation winners recently. Representation from S&O at North West Coast SIG.

We have demonstrated full compliance with Saving Babies Lives Care Bundle 2. The leads are continuing to embed the process by monitoring compliance via audits. Saving Babies Lives Version 3 is expected in June of this year and is expected to have an additional sixth element which focuses on Diabetes in Pregnancy. The Trust have a Diabetic Specialist Midwife in post and an identified lead Obstetrician.

5.7 Safety Champion Report

The aim of Safety Champions is to support seamless communication from ‘floor to board’ and to ensure Board focus on Maternity issues and improving safety and outcomes. Regular Safety

Champions walkabouts are in place to speak with staff, women and their families. A Triple A report of the outcomes is submitted to the Clinical Effectiveness Committee. Maternity and Neonatal Champions Committee meeting occurs monthly with representation from MVP Lead, Freedom to Speak up Guardian and maternity and neonatal staff, chaired by Director of Nursing, Midwifery and Therapies/Executive Maternity and Neonatal Safety Champion.

5.8 Staff Exposure to Nitrous Oxide

A second round of testing took place, and the results are awaited. The Estates department confirmed that each room in Delivery Suite meets the requirements of 10 air exchanges per hour which is positive. The SOP in place has been evolved to acknowledge this alongside IPC controls in place. Trust continues to work through the action plan and the Entonox national alert process and considerable progress had been made, with robust monitoring and measuring processes in place.

6. Workforce: Midwifery and Neonatal Staffing

Maternity

Maternity Services have seen significant changes and development over the last decade driven by national safety ambitions and the vision to deliver better quality of care to women and the families. More recently there have been national inquiries and scrutiny of maternity services such as Kirkup (2015), Ockenden (2022) and East Kent (2022) central to these is safe staffing levels.

S&O Maternity Services 'Standard Operating Procedure for Maternity Services Staffing' reflects the guidance, as recommended by NICE "Safe Midwifery Staffing for Maternity Settings (2015)., which also meets the requirement for Safety Action 5 CNST. It also recommends using a nationally recognised midwifery staffing tool and red flag indicators. This data is collected via the DATIX incident reporting system. Any incidents are cross referenced against staffing levels and any incidents regarding staffing levels discussed at weekly patient safety meeting.

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge is informed of the incident. The midwife in charge will then determine whether midwifery staffing is the cause, and what action is required.

The following are the recommended red flags:

- Delayed or cancelled time critical activity.
- Missed or delayed care (delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (e.g.
    - diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 15 minutes or more between presentation and triage (previously 30 minutes, reduced to 15 minutes across Region).
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.

- Delayed recognition of and action on abnormal vital signs (e.g., sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one. care and support to a woman during established labour.

For this reporting period the red flag data demonstrated:

- Delay in transfer to delivery suite for ARM (1) due to high acuity on delivery suite
- Delay of 2 hours or more between admission for induction and beginning of process (6) reported as due to number of inductions already in process.
- Delayed or cancelled time critical activity – delays in category 2 caesarean due to theatre availability and 1 delay in category 1 caesarean by 5 minutes due to patient having spinal anaesthesia.
- 7 delay of 15 minutes or more between presentation and triage. All were seen within the previous standard of 30 minutes.

Maternity Theatre

The process for elective caesarean sections taking place in Main Theatre is now embedded. Monitoring of caesarean section lists continues with weekly MDT planning meetings to ensure appropriate listing of patients.

The number of elective theatre pathway lists have been reviewed as the seven sessions are not being fully utilised now that a dedicated recovery is in place. A Clinical Reference Group has been set up within the Specialist Services CBU to review utilisation of these lists, with a pilot proposed to potentially reduce by one session if safe to do so. Efficiencies brought about by the development of a designated maternity recovery room in main theatre have resulted in the ability to do 4 cases on a full day list instead of 3 cases.

Concerns have been raised via Datix regarding the difficulties when a second emergency maternity theatre is required out of hours. Concerns relate to staffing of the 2nd theatre and proximity to Delivery Suite if emergency cases go to main theatre. A process analysis for out of hours theatre emergency cover at Ormskirk District General Hospital for a second simultaneous obstetric emergency is currently being developed by the MDT led by an Anaesthetic Consultant.

Maternity Unit Closure

During this reporting period there have been no Maternity Unit Closures or diverts.

Staffing Numbers & Outcomes

Staffing is discussed as part of the Delivery Suite Shift Coordinator hand over. This takes place at least twice a day, and ward dependency, acuity and overall staffing ratios/ gaps are discussed. The following actions are agreed to support a reduction of risk:

- Moving from outpatient areas
- Moving staff from one ward to another
- Moving from or to Community midwifery
- Sanctioning additional staff if required due to a patient safety risk
- Consider requesting mutual aid from other maternity units or divert/closure

The *Maternity Standard Operating Procedure for Staffing Levels* and *The Maternity Standard Operating Procedure for Escalation* is in place to support the decision-making process.

Current position 6.83wte vacancy, sickness 6.53%, increasing levels of sickness and vacancy are impacting on staffing levels and levels of fulfilment with NHSP. 6.64wte have been interviewed and offered posts, however 6wte of these will only be available from October as newly qualified. 1 wte band 7 vacancy for Clinical lead Maternity ward is being actively recruited to.

Supernumerary Status of the Delivery Suite Shift Coordinator

The role of the Delivery Suite Shift Coordinator is a key role on the Delivery Suite and therefore the Shift Coordinator is present for 24-hour period 7 days a week. The Delivery Suite Coordinator is supernumerary to enable them to fulfil their role, which is pivotal in providing effective leadership, clinical expertise, facilitating communication between professionals and overseeing appropriate use of resources. Where Supernumerary status cannot be achieved, this is escalated to the Matron and recorded on the Safety Huddle proforma.

The Clinical Leads for each area work in a semi supervisory capacity. However, there are times due to staffing challenges or peak in activity when it is not always achieved as patient care will always take president over management activities.

Oversight of Maternity

The Maternity Unit provides a maternity bleep holder 24 hrs per day. From 07:30-20:00 this is a separate role held on a rota basis and may be a Matron, Clinical Lead Midwife or Delivery Suite Shift Coordinator. From 19:30-07:30 the bleep is held by the Delivery Suite Shift Coordinator

The maternity bleep holder is a key role in supporting the daily operational running of the maternity services based at Ormskirk site. The role also provides senior clinical guidance and oversight to the maternity teams based both within the hospital and community settings. The maternity bleep holder also participates in the Trust Ormskirk site rota.

Following the requirements of HSIB and the Ockenden report work is being done to release midwives from the Ormskirk site rota to facilitate their focus being on maternity. Plans are ongoing to provide a senior midwife on call rota (band 8a and above) out of hours from 1st July.

Birthrate Plus

Birthrate Plus is a framework for workforce planning based on an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG. The most recent Birthrate Plus assessment was in November 2021, based on 3 month's birth data and bookings for the following 6 months to predict the birth rate for this period, the final report being received in January 2022.

Intrapartum Acuity

Utilising the Birthrate Plus tool ensures that Data is inputted into the system every 4 hours by clinical leads across both labour ward and wards areas., this is turn measures the acuity and number midwives on shift to determine the 'acuity score'. This acuity score is defined by Birthrate Plus as the 'volume of need for midwifery care at any one time based on the number of women and degree of dependency' This supports review of staffing to ensure correct numbers of midwives are available to work in the clinical areas which match the acuity levels

and to ensure the Maternity Service Standard Operating Procedure (Number 52) for Staffing Levels and Maternity Services Standard Operating Procedure (Number 53) for Maternity Escalation adequately supports the movement of staff around the unit during periods of high acuity. Within the LMNS all Trust utilise this tool and the acuity of each Trust is visible on the acuity tool, this improves regional oversight of maternity pressures.

The daily sit-rep is submitted to the region via an electronic submission. A weekly Gold Command meeting with the LMNS maintains good lines of communication between HoM's and DoM's across C&M to identify early pressure points in the system and seek mutual aid when required. Additional meetings have taken place in this last quarter providing support during the industrial action for North West Ambulance Services (NWAS). Regional oversight of delivery suites via the birthrate plus acuity app has been successful. However, the success of the ward acuity tool is less clear and Birthrate plus have paused this tool for 3 months whilst improvements are made.

Student Midwives
The Trust has been successful in becoming a site for the Regional Midwifery Learner IT Pilot. £7240 funding has been provided for pre-registration student midwives to have access to Ipads and laptops in the workplace to complete their PARE documentation, access e-learning and complete their work without impacting on the service.

Maternity staff engagement
In February, the ADOMN signed up to the Royal College of Midwives (RCM), "Caring for You Campaign: Working in Partnership". By signing the charter, the Trust is committing to a positive and inclusive culture where staff feel valued, respected, and invested in, as well as committing to providing a safe and healthy working environment, taking a zero-tolerance stance on abuse. The 2022 staff survey reports many positive responses from staff working within Maternity Services. The Cultural Advocate Team plan to launch their action plan within the next few months, to support staff across Maternity.

Consultant Obstetricians
The Consultant Obstetrics & Gynaecology team currently consists of 13 Consultants, in post, 1 consultant due to join the organization in June. An Interim Clinical Director has been appointed.,

Neonatal Medical Workforce
Progress made in relation to tier 1 and 2 training, which will enable the Trust to be CNST and BAPM compliant with 4 Advanced Neonatal Nurse Practitioners now recruited.

Nursing Workforce
Neonatal staffing is aligned to BAPM standards and monitored by the Regional Neonatal Operational Delivery Network. The team are able to roster a supernumerary shift coordinator on neonatal across all shifts. The Associate Director for Midwifery, Nursing and AHP's, and the Matron for Paediatrics continue to work collaboratively with the Neonatal Network

7.Research
There are multiple research projects taking place across Maternity services involving midwives and obstetricians, to improve the evidence-based care for women babies and their families.

Priorities
The following are priorities for the next 3 months.

- Engage with regional team regarding key priorities within the Three-Year Plan for Maternity and Neonates
- Improve CQC rating across Maternity and Neonatal Services
- Develop a strategy for rollout of MCOC
- Work towards completion of CNST Year 5Yr Safety actions
- Continue to work collaboratively with LMNS and MVP'
- Maintain a safe environment for all staff working in Maternity
- Work in collaboration with St Helens and Knowsley NHS Teaching Hospitals

ALERT | ADVISE | ASSURE (AAA) HIGHLIGHT REPORT	
COMMITTEE/GROUP:	Workforce Committee
MEETING DATE:	23rd May 2023
LEAD:	Lisa Knight

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Nil

ADVISE

- Risk Register – risks will be re-assessed post transaction.
- Personal Development Reviews (PDR) – slight decrease overall in April 2023, but Estates & Facilities, Planned Care Clinical Business Unit (CBU) and Medicine & Emergency Care CBU all above 80%.
- Trust vacancies – increased slightly in April, although there were more starters than leavers in month.
- Time to Hire – although increased slightly in April, is sitting at 44 days.

ASSURE

- Presentation received from the Head of Comms on his experience of joining the Trust which has been very positive, he has been made to feel extremely welcome and said that S&O was a lovely place to work.
- Core Mandatory Training – achieved the 90% stretch target.
- Essential Skills Training – consistent improvement month on month.
- Sickness – continues to reduce and is sitting at 5.6% against a target of 6%. Increased monitoring and support for managers in place from HR and H&W.
- Safe Effective Quality Occupational Health Service (SEQOHS) – successfully gained accreditation which has been maintained for 10 years.

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**	**07 June 2023**
Agenda Item	**SO108/23**	**FOI Exempt**	**NO**
Report Title	**WORKFORCE RACE EQUALITY STANDARD REPORT (WRES)**		
Executive Lead	Jane Royds, Director of Human Resources and Organisation Design		
Lead Officer	Tracy Gun, Head of Education, Training and Organisation Design		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ☐ **To Receive**	

Purpose

This report provides an overview and analysis of the Workforce Race Equality Standard (WRES)

Executive Summary

The following is an overview of the Workforce Race Equality Standard **(**WRES) data as of 31 March 2023 for the period 2022/23 as required by the Public Sector Duty for all NHS Trusts. The data below provides a high-level overview of the key data which will be submitted via the online portal by the 31 May 2023.

Overview of key workforce data metrics:

- An **increase** in BME staff in non–clinical bands 2,3,4 and 8a.
- An **increase** in BME staff in clinical bands 2,3,5,6 and 7.
- A **decrease** of **7.41%** in BME staff being appointed from shortlisting.
- **1x** BME member of staff entered the formal disciplinary process (1x higher than last year) compared to 4 white staff who entered the formal disciplinary in the same period.

Staff survey data:

- A **3.5% increase** in BME staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months (based on 130 respondents 2022)
- A **4.3% increase** in BME staff experiencing harassment, bullying or abuse from staff in last 12 months (based on 130 respondents 2022)
- A **5.5% decrease** in BME staff believing that Trust provides equal opportunities for career progression or promotion (based on 128 respondents 2022)
- A **3.2% decrease** in BME staff experiencing discrimination at work from any of the following manager/team leader or other colleagues (based on 126 respondents 2022)

The report includes an action plan to deliver improvements over the forthcoming 12 months.

Recommendations

The Strategy and Operations Committee is asked to note the Workforce Race Equality Standard Report (WRES) report.

Previously Considered By:

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

Strategic Objectives

✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services	
✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards	
☐ **SO3** Efficiently and productively provide care within agreed financial limits	
✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated	
✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values	
☐ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire	
Prepared By:	**Presented By:**
Barrie Morgan-Scrutton, Learning & Engagement Facilitator Tracy Gunn, Head of Education, Training & OD	Jane Royds, Director of HR & OD

Southport and Ormskirk Hospital NHS Trust

WORKFORCE RACE EQUALITY STANDARD (WRES) REPORT 2023

1. EXECUTIVE SUMMARY

This purpose of this report is to inform the members of the Workforce Committee with an overview of the workforce race equality data to be submitted online via the national portal by 31st May 2023. The annual monitoring of the Workforce Race Equality Standard (WRES) is a requirement for all NHS commissioners and NHS provider organisations under the terms of the Public Sector Duty.

2. INTRODUCTION

NHS England and the NHS Equality and Diversity Council introduced the Workforce Race Equality Standard (WRES) in 2015. Since then, NHS organisations have been compelled to review their workforce race equality performance and develop action plans to make continuous improvement on the challenges within this agenda.

The main purpose of the WRES is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff,
- to improve BME representation at the Board level of the organisation.

This report focuses on data drawn from ESR as of 31st March 2023 reflecting the period 2022/23 and includes the results from the NHS Annual Staff Survey 2022 pertinent to WRES.

3. OVERVIEW OF WORKFORCE DATA

The information below provides a comparison of the WRES data from 31st March 2022 and 31st March 2023, where applicable. Any calculations noted in the report are taken from the national WRES template provided by NHS England.

a) Staff Profile

As of 31st March 2023, Southport and Ormskirk Hospitals NHS Trust employed **3467** staff consisting of:

- **11.62%** - Black Minority and Ethnic (BME) staff
- **71.88%** - White staff
- **16.50%** - Not stated / unspecified / prefer not to answer.

b) BME staff increase in clinical and non-clinical bands (see Table 1)

- Non-clinical roles have seen an increase in bands 2,3,4 and 8a.
- Clinical roles have seen an increase in bands 2,3,5,6 and 7.

Table 1.

The Table shows the % of staff in each AfC Bands 1-9 including Board Members compared with the % of staff in the overall workforce.

Where % data does not equate to 100% this is due to information not stated or disclosed by staff

Non-Clinical Roles

Band	2022		2023	
	BME	White	BME	White
Band 2	5.06%	85.57%	5.92%	78.82%
Band 3	2.73%	91.26%	3.52%	81.41%
Band 4	1.18%	91.13%	1.68%	89.39%
Band 5	0%	94.20%	1.39%	80.56%
Band 6	1.78%	89.29%	0.00%	87.69%
Band 7	4.17%	89.58%	0.00%	88.00%
Band 8a	0%	85.71%	6.67%	46.67%
Band 8b	0%	100%	0.00%	96.30%
Band 8c	0%	75%	0.00%	50.00%
Band 8d	12.50%	75%	0.00%	71.43%
Band 9	0%	0%	0.00%	100.00%
VSM	0%	100%	0.00%	80.00%

Clinical Roles (excluding Medics & Dental)

Band	2022		2023	
	BME	White	BME	White
Band 2	7.24%	78.90%	10.54%	68.05%
Band 3	1.91%	77.01%	3.69%	84.33%
Band 4	8.40%	76.33%	5.13%	87.18%
Band 5	6.78%	82.85%	20.74%	56.81%
Band 6	5.53%	88.37%	8.21%	80.56%
Band 7	3.40%	89.36%	3.68%	86.40%
Band 8a	10.77%	84.62%	10.13%	73.42%
Band 8b	0.00%	95.83%	0.00%	88.89%
Band 8c	0.00%	75%	0.00%	83.33%
Band 8d	0.00%	50%	0.00%	100.00%
VSM	0%	0%	0.00%	100.00%
WHO3	0%	100%	0.00%	100.00%
WHO7	16.67%	83.33%	0.00%	0.00%

c) Overview of Medical Staff 2022/2023

Med & Dental Consultant			
2022		2023	
BME	White	BME	White
42.24%	34.48%	41.59%	38.05%
Med & Dental Consultant (Non–Consultant Career Grade)			
2022		2023	
BME	White	BME	White
49.45%	20.88%	53.00%	21.00%
Medical & Dental Trainee Grades			
2022		2023	
BME	White	BME	White
27.94%	50.00%	42.86%	35.71%

d) Overview of Board Members 2022/2023

Board Members					
2022			2023		
BME	White	Not stated	BME	White	Not stated
0.56%	94.44%	0.00%	0.00%	78.57%	21.43%

The information below provides information on the headcount and percentage difference between the organisation's Board membership and its overall workforce for BME and white staff

2023	Workforce Headcount	Workforce Headcount %	Board Headcount	Board Headcount %
BME	**403**	**11.62%**	**0**	**0.00%**
White	2492	71.88%	11	78.57%
Not Stated	565	16.50%	3	21.43 %
2022	**Workforce Headcount**	**Workforce Headcount %**	**Board Headcount**	**Board Headcount %**
BME	**301**	**9.11%**	**1**	**0.056%**
White	2382	72.09%	17	94.44%
Not Stated	621	18.80%	0	0%

The indicator below states the overall % difference of the Board versus the workforce overall

BME	**11.6% less than the workforce**

e) Relative likelihood of BME and white staff being appointed from shortlisting across all posts (see Table 2)

In 2022/23, **3503** BME staff were shortlisted and **96** were appointed (2.74%) compared to 2021/22, where **1557** BME staff were shortlisted and **158** appointed (10%).

The **7.41%** decrease in appointments is due to the 50%+ increase in the number of applicants who are applying for Band 5 Nursing posts without the necessary NMC registration, predominantly from red list countries. This substantial increase in applications versus appointments is the cause of the decrease. The Trust has led a successful international nurse recruitment campaign and put in place good pastoral and educational support, but the vacancy position and recruitment pipeline are not supportive of expanding the international nurse recruitment programme at present.

In 2022/23, **1648** white applicants were shortlisted with **605** appointed (36.71%) compared to 2021/22 where **2433** white applicants were shortlisted with 542 appointed (22.28%).

In 2022/23, 50 applicants did not state or disclose their ethnicity and 48 were appointed (96%) compared to 2021/22, where 86 applicants did not state or disclose their ethnicity and 39 were appointed (45.35%). The high % of non-disclosure will be impacted by the recruitment process for international nurses varying from the normal Trac recruitment system.

Table 2.

2022-23	**Headcount**		**Relative likelihood of white staff appointment from shortlisting**
	Shortlisted	**Appointed**	**% Appointed**
BME	3503	96	2.74%
White	1648	605	36.71%
Unknown	50	48	96.00%
2021-22	**Headcount**		**Relative likelihood of appointment from shortlisting**
	Shortlisted	**Appointed**	**% Appointed**
BME	1557	158	10.00%
White	2433	542	22.28%
Unknown	86	39	45.35%

Therefore, the relative likelihood of **white staff** being **appointed from shortlisting** compared to **BME staff** shows an **11.2** difference from 2021/22 to 2022/23 (see Table 3). *This calculation does not include the 96% of the 48 appointed applicants who did not state or disclose their ethnicity.*

Table 3.

2021/22	2022/23	Difference
White staff 2.20 times more likely	White staff 13.40 times more likely	**+11.2**

(Auto calculated)	(Auto calculated)	

f) Relative likelihood of BME and white staff entering the formal disciplinary process

- 1 BME staff member entered the formal disciplinary process in the period 2022-23.
- 4 white staff entered the formal disciplinary process in the period 2022-23
- 2 staff were recorded as ethnicity unknown for the period 2022-23.

2022/23	Headcount	Relative likelihood of BME staff entering into formal disciplinary process compared to white staff
BME	1	0.25%
White	4	0.16%
Not Stated	2	0.35%
Total	**7**	
2021/22	**Headcount**	**Relative likelihood of BME staff entering formal disciplinary process compared to white staff**
BME	0	0.00%
White	3	0.13%
Not Stated	1	0.17%
Total	**4**	

2021/22	2022/23	Difference
BME staff 0.01 times more likely (Auto calculated)	BME staff 1.55 times more likely (Auto calculated)	+1.54

g) Relative likelihood of white staff accessing non-mandatory training & CPD compared to BME staff.

2022/23	Headcount	Enrolment headcount	Ratio
BME	403	387	96.03%
White	2492	2304	92.40%
Not Stated	565	505	89.38%
2021/22	**Headcount**	**Enrolment headcount**	**Ratio**
BME	301	290	96.00%
White	2376	2229	94.00%
Not Stated	607	580	96.00%

2021/22	2022/23	Difference
White staff 0.97 times more likely (Auto calculated)	White staff 0.96 times more likely (Auto calculated)	-0.01 decrease

4. NHS STAFF SURVEY RESPONSES THAT ARE SPECIFIC TO WRES QUESTIONS

The NHS Staff Survey was completed by **1,107** staff, this equates to a **34%** response rate. The average combined percentage for combined acute and community trusts in England is 44%

The information below is taken from the 2022 Staff Survey Coordination Centre WRES Report for Southport & Ormskirk NHS Hospital Trust and provides the Trust figures compared to the average for combined acute and community hospitals.

a) The percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months

- 3.5% more BME in 2022
- 1.8% more white staff in 2022

The Trust figures compared to the average combined acute and community Trusts is **1.5% higher** for **BME** staff **and 1.0%** higher for **white** staff.

2021	2022	2022 Average (median)
BME staff **28.8**% White staff 26.1%	BME staff **32.3**% White staff 27.9%	Combined Acute and Community Trusts BME staff – **30.8%** White staff – 26.9%

b) Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

- **BME staff** have seen a **4.3% increase.**
- **White staff** have seen a **2.6% increase.**

The Trust figures compared to the average combined acute and community Trusts is **7.1% higher** for BME staff and **+3.5% higher** for white staff.

2021	2022	2022 Average (median)
BME staff **31.1%** White staff 24.2%	BME staff **35.4%** White staff 26.8%	Combined Acute and Community Trusts BME staff - **28.8%** White staff - 23.3%

c) Percentage of Trust staff believing that the Trust provides equal opportunities for career progression or promotion.

- 5.5% decrease for BME staff.
- 0.2% decrease for white staff

The Trust figures compared to the average combined acute and community Trusts is **4.0% lower** for BME staff and **7.9% lower** for white staff.

2021	2022	2022 Average (median)
BME staff **48.5%** White staff 50.9 %	BME staff **43.0%** White staff 50.7 %	Combined Acute and Community Trusts BME staff - **47%** White staff - 58.6%

d) In the last 12 months have you personally experienced discrimination at work from any of the following manager/team leader or other colleagues?

- 3.2% less for BME staff
- 0.2% less for white staff

The Trust figures compared to the average combined acute and community Trusts is **4.9 higher** for BME staff and **0.5% lower** for white staff.

2021	2022	2022 Average (median)

BME staff **25.4%** White staff 6.2 %	BME staff **22.2%** White staff 6.0 %	Combined Acute and Community Trusts BME staff - **17.3%** White staff - 6.5%

5. OUR PEOPLE PLAN

The fundamental purpose of Our People Plan is to identify the Trust's people priorities and to ensure that everyone connected to the Trust understands the contribution they make. There are several people priorities, with specific emphasis on the culture and behaviours we are working towards.

The diversity of our workforce is a key indicator of an inclusive culture by setting the right cultural and behavioural tone by celebrating difference, empowering others to make their own unique contribution, and actively listening and then taking supported action.

The following key actions taken from our overarching action plan have been identified for the next 12 months to increase the diversity in our workforce, promote an inclusive and supportive culture and improve the experience of colleagues with protected characteristics. The impact of these actions will be measured by improvements to the WRES indicators.

- We will promote inclusion
- We will embed a Just and Learning culture
- We will proactively support career development and training for staff from protected groups
- We will engage in key initiatives to support inclusion

6. TRUST ACTIONS REQUIRED TO BE COMPLIANT WITH WRES

- WRES reporting template completed and sent to NHS England (31st May 2023)
- WRES report completed & hosted on the Trust website (31st May 2023)
- WRES action plan in place and reviewed via the Valuing Our People & Inclusion Group, JNC and Workforce Committee
- WRES report and action plan to be shared with the NHS Cheshire and Merseyside ICB

7. RECOMMENDATIONS

The Committee is asked to note the WRES indicators, and the actions identified to address the gaps highlighted

APPENDIX 1 - WRES (WDES) EQUALITY OBJECTIVES & ACTION PLAN

STRATEGIC OBJECTIVES	EDI OBJECTIVE	ACTIONS
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**	**Increase representation of BME & disabled staff at Board & senior management levels**	• Increase % BME & disabled staff at AfC 8a and above and at Board level
	Improve representative workforce across all protected characteristics at all levels	• Increase the % of workforce with equality information recorded in ESR • Review the recruitment process with staff network colleagues
	Improve the belief in equal opportunities	• Increase the % of staff believing the Trust provides equal opportunities for career progression or promotion • Increase the number of staff receiving non-mandatory E & D training • Increase participation in staff networks
	Create equity of experience	• Decrease the % of staff experiencing harassment, bullying and abuse • Decrease the likelihood of BME and disabled staff entering formal disciplinary process and provide support initiatives if they do e.g., RCN Cultural Ambassadors • Decrease the % of staff experiencing discrimination from patients/carers • Increase staff engagement score for staff with protected characteristics through agreed actions with staff networks • Support equity of access to Clinical Excellence Awards in order to reduce the gender pay gap • Deliver the outcomes of the EDS 2022 Domain 2 – Staff Health & Wellbeing and Domain 3 – Inclusive Leadership

Southport and Ormskirk Hospital NHS Trust

Title of Meeting	**STRATEGY AND OPERATIONS (S&O) COMMITTEE**	**Date**	**07 June 2023**
Agenda Item	**SO108/23**	**FOI Exempt**	**NO**
Report Title	**WORKFORCE DISABILITY EQUALITY STANDARD REPORT (WDES)**		
Executive Lead	Jane Royds, Director of Human Resources and Organisation Design		
Lead Officer	Tracy Gun, Head of Education, Training and Organisation Design		
Action Required	☐ **To Approve** ☐ **To Assure**	✓ **To Note** ☐ **To Receive**	

Purpose

This report provides an overview and analysis of the Workforce Disability Equality Standard (WDES)

Executive Summary

The following is an overview of the Workforce Disability Equality Standard **(**WDES) data as of 31 March 2023 for the period 2022/23 as required by the Public Sector Duty for all NHS Trusts. The data below provides a high-level overview of the key data which will be submitted via the online portal by the 31 May 2023.

Overview of key workforce data metrics:

- As of 31 March 2023, the Trust Employee Staff Records (ESR) figures for staff stating that they have a disability is **4.27%**.
- Disabled staff being appointed from shortlisting across all posts is **5.21%** less than non-disabled staff.
- The Trust ESR figures highlight that **no disabled staff** entered the formal capability process on the grounds of performance in 2022-23, this is the same as 2021-22 *(only staff who enter the formal capability procedure on the grounds of performance are included in the figures).*

Staff survey data based on responses ranging from 112-245 per question

- Disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public has seen a **reduction of 1.3%.**
- Disabled staff experiencing harassment, bullying or abuse from managers has seen a **reduction of 1.0%**.
- Disabled staff experiencing harassment, bullying or abuse from other colleagues has seen a **reduction of 4.7%**.
- Percentage of Trust staff believing that Trust provides equal opportunities for career progression or promotion is 41.6**%** for disabled staff this is a **reduction of 1.4%**

The report includes an action plan to deliver improvements over the forthcoming 12 months.

Recommendations

The Strategy and Operations Committee is asked to note the Workforce Disability Equality Standard Report (WDES) report.

Previously Considered By:

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

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

NHS
Southport and Ormskirk Hospital
NHS Trust

WORKFORCE DISABILITY EQUALITY STANDARD (WDES) REPORT 2023

1. EXECUTIVE SUMMARY

This paper provides an overview of the Workforce Disability Equality Standard (WDES) and the Trust's data and responses to the 10 metrics within the Workforce Disability Equality Standard (WDES).

2. INTRODUCTION

The Workforce Disability Equality Standard (WDES) is mandated by the NHS Standard Contract and will apply to all NHS Trusts and Foundation Trusts from April 2019. The WDES is a data-based standard that uses a series of measures (metrics) to improve the experience of disabled staff in the NHS.

The WDES comprises of a set of 10 metrics. All the metrics draw from existing data sources (recruitment dataset, ESR, NHS Staff Survey, HR data) except for one; Metric 9b asks for examples of actions taken.

The annual collection of the WDES metrics will allow the Trust to better understand and improve the employment experiences of disabled staff in the NHS.

3. OVERVIEW OF WORKFORCE DATA

The information below provides a comparison of the WDES data from 31st March 22 and 31st March 2023, where applicable. Any calculations noted in the report are taken from the national WRES template provided by NHS England.

a) Staff Profile

As of March 2023, Southport and Ormskirk Hospitals NHS Trust employed **3467** staff of whom **4.27%** of the workforce has disclosed that they consider themselves to have a disability. **76.72%** of staff have told us they don't consider themselves to have a disability, with the remainder **19.01%** either not declaring, preferring not to say and the others are unspecified.

Disability	Headcount	Percentage %
No	2660	76.72% of staff do not consider themselves to have a disability
Yes	148	4.27% of staff have highlighted they have a disability
Not Declared & Other	659	19.01% of staff have not declared preferred not to say or unspecified
Grand total	**3467**	

b) Recording a disability

- As of 31st March 2023, Trust figures on ESR show **4.27%** of staff from **3,467** staff have a disability

- NHS Staff Survey highlights **22.6%** of staff from the **1,107** who completed the NHS Staff Survey highlighted they have a disability.

c) Shortlisting

- Percentage of disabled staff being appointed from shortlisting is **5.21%** for disabled compared to 87.85% for non-disabled staff.
- Relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff is **0.47**. This is a 0.65 improvement from 1.12 in 2021/22. (A figure below 1:00 indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting).

d) Formal capability process

- ESR data highlights the relative likelihood of staff entering the formal capability process for disabled is 0% which is the same as last year.

e) Staff Survey WDES Results 2022

- Disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public is **7.1% higher** than for non-disabled staff.
- Disabled staff experiencing harassment, bullying or abuse from managers is **5.1% higher** than non-disabled staff.
- Disabled staff experiencing harassment, bullying or abuse from other colleagues is **1.5% higher** than non-disabled staff.
- Percentage of Trust staff believing that the Trust provides equal opportunities for career progression or promotion is **41.6%** for disabled staff, **51.9%** for non-disabled staff, a difference of **10.3%**

4. WORKFORCE INDICATORS IN DETAIL

Workforce Disability Equality Standard Indicators

For each of the workforce indicators, the standard compares the metrics for disabled and non-disabled staff. Where the figures do not equate to 100% this is due to the information not stated / not given

a) **Metric 1.** Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. ***Please Note:*** *Definitions for these categories are based on Electronic Staff Record occupation codes except for medical and dental staff, which are based upon grade codes.*

Non-clinical	**staff**	
Clusters	**Disabled**	**Non-Disabled**
Cluster 1 (Bands 1 - 4)	4.9%	72.8%
Cluster 2 (Band 5 - 7)	5.9%	78.6%
Cluster 3 (Bands 8a - 8b)	0%	78.6%
Cluster 4 (Bands 8c - 9 & VSM)	0%	100.0%
Clinical staff		
Clusters	**Disabled**	**Non-Disabled**
Cluster 1 (Bands 1 - 4)	4.6%	77.3%
Cluster 2 (Band 5 - 7)	4.5%	79.1%
Cluster 3 (Bands 8a - 8b)	2.8%	73.6%
Cluster 4 (Bands 8c - 9 & VSM)	0%	57.1%
Medical & Dental Consultant		
Cluster 5	**Disabled**	**Non-Disabled**
	1.77%	75.22%
Med & Dental Consultant Non –Consultant Career Grade		

Cluster 6	**Disabled** 2.00%	**Non-Disabled** 77.00%
Medical & Dental Trainee Grades		
Cluster 7	**Disabled** 0%	**Non-Disabled** 80.0%

b) Metric 2. Relative likelihood of non-disabled staff to disabled being appointed from shortlisting across all posts

	Shortlisted headcount	Appointed headcount	Relative likelihood of staff shortlisted /appointed	%
Disabled	141	39	0.28	27.66%
Non-Disabled	5019	658	0.13	13.11%
Not declared	93	52	0.56	55.91%
Relative likelihood of relative likelihood of non-disabled staff being appointed from shortlisting compared to disabled staff.			0.47 times more likely	

***c)* Metric 3.** Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. *Please Note: This metric will be based on data from a two-year rolling average of the current year and the previous year.*

Average over 2 years	Entering formal capability Process	Trust	Average over 2 years
Disabled	0	148 (4.27%)	0
Non-Disabled	1	2660 (76.72%)	0.000375
Not declared	0	659 (19.01%)	0
Prefer not to answer	0		
Unspecified	0		
Total	**1**	**3467**	
Relative likelihood of Disabled staff compared to non-disabled staff			0

5. NHS STAFF SURVEY RESPONSES 2022

The NHS Staff Survey was completed by **1,107** staff, this equates to a **34%** response rate. The average combined percentage for combined acute and community trusts in England is 44%

The information below is taken from the 2022 Staff Survey Coordination Centre WDES Report for Southport & Ormskirk NHS Hospital Trust and provides the Trust figures compared to the average for combined acute and community hospitals.

d) Metric 4a. Percentage (%) of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from patients/service users, relatives, or other members of the public

Category	2021	2022	Average
Non-disabled	24.2%	**26.8% (2.6% increase)**	26.2% 0.6% above average
Disabled	35.2%	**33.9% (1.3% decrease)**	33.0% 0.9% above average

e) **Metric 4b. Percentage of staff experiencing harassment, bullying or other abuse from managers in the last 12 months**

Category	2021	2022	Average
Non-disabled	11.3%	**12.3% (1% increase)**	9.9% 2.4% above average
Disabled	18.4%	**17.4% (1% decrease)**	17.1% 0.3% above average

f) **Metric 4c. Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months**

Category	2021	2022	Average
Non-disabled	42.6%	**44.9% (2.3% increase)**	47.3% 2.4% below average
Disabled	51.1%	**46.4% (4.7% decrease)**	48.4% 2% below average

g) **Metric 4d.** Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

Category	2021	2022	Average
Non-disabled	42.6%	**44.9%** **2.3% Increase**	47.3% 2.4% below average
Disabled	51.1%	**46.4%** **4.7% reduction**	48.4% 2.0% below average

h) **Metric 5**. Percentage believing that the Trust provides equal opportunities for career progression or promotion

Category	2021	2022	Average
Non-disabled	52.6%	51.9% **0.7% reduction**	57.3% 5.4% below average
Disabled	43.0%	41.6% **1.4% reduction**	51.4% 9.8% below average

i) **Metric 6.** Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

Category	2021	2022	Average
Non-disabled	21.0%	20.4% **0.6% reduction**	20.8% 0.4**% below average**
Disabled	34.1%	26.9% **7.2% reduction**	30.0% **3.1% below average**

j) **Metric 7.** Percentage of disabled staff compared to non–disabled staff saying that they are satisfied with the extent to which their organisation values their work

Category	2021	2022	Average
Non-disabled	40.5%	40.7% **0.2% increase**	43.6% **2.9% below average**
Disabled	30.0%	27.7% **2.3% reduction**	32.5% **4.8% below average**

k) **Metric 8.** Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

Category	2021	2022
Disabled	74.5%	72.3% **2.2% reduction**

l) **Metric 9.** The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.

Category	2021	2022	Average
Non-disabled	6.9%	6.7% **0.2% reduction**	6.9% **0.2% below average**
Disabled	6.2%	6.1% **0.1% reduction**	6.4% **0.3% below average**
Trust % average	6.7%	6.6% **0.1% reduction**	

m) **Metric 9b.** Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard? **(Yes)**

Disability Confident Employer Scheme 'Ability' Staff Network Occupational Health Service 24-hour Employee Assistance Programme Freedom to Speak Up Culture	Implementing reasonable adjustments passports Wellbeing conversations (Appraisal) Addressing inequalities Task & Finish Group – spotlight on recruitment processes Flexible / agile working

n) **Metric 10.** Percentage difference between the organisation's Board voting membership and its organisation's overall workforce

Category	2022	2023
Non-disabled	28%	25.08%
Disabled	-3%	-3.28%
Not Stated	-25%	-21.8%

Disability	Headcount	Headcount %	Board Headcount	Board Headcount %
No	2660	76.7%	11	78.57%
Yes	148	4.26%	1	7.14%
Not Declared & Other	659	19%	2	14.28%

6. OUR PEOPLE PLAN

The fundamental purpose of Our People Plan is to identify the Trust's people priorities and to ensure that everyone connected to the Trust understands the contribution they make. There are several people priorities, with specific emphasis on the culture and behaviours we are working towards.

The diversity of our workforce is a key indicator of an inclusive culture by setting the right cultural and behavioural tone by celebrating difference, empowering others to make their own unique contribution, and actively listening and then taking supported action.

The following key actions taken from our overarching action plan have been identified for the next 12 months to increase the diversity in our workforce, promote an inclusive and supportive culture and improve the experience of colleagues with protected characteristics. The impact of these actions will be measured by improvements to the WRES indicators.

- We will promote inclusion
- We will embed a Just and Learning culture
- We will proactively support career development and training for staff from protected groups
- We will engage in key initiatives to support inclusion

7. TRUST ACTIONS REQUIRED TO BE COMPLIANT WITH WRES

- WRES reporting template completed and sent to NHS England (31st May 2023)
- WRES report completed & hosted on the Trust website (31st May 2023)
- WRES action plan in place and reviewed via the Valuing Our People & Inclusion Group, JNC and Workforce Committee
- WRES report and action plan to be shared with the NHS Cheshire and Merseyside ICB

8. RECOMMENDATIONS

The Committee is asked to note the WRES indicators, and the actions identified to address the gaps highlighted

APPENDIX 1 - WDES (WRES) EQUALITY OBJECTIVES & ACTION PLAN

STRATEGIC OBJECTIVES	EDI OBJECTIVE	ACTIONS
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**	**Increase representation of BME & disabled staff at Board & senior management levels**	• Increase % BME & disabled staff at AfC 8a and above and at Board level
	Improve representative workforce across all protected characteristics at all levels	• Increase the % of workforce with equality information recorded in ESR • Review the recruitment process with staff network colleagues
	Improve the belief in equal opportunities	• Increase the % of staff believing the Trust provides equal opportunities for career progression or promotion • Increase the number of staff receiving non-mandatory ED&ID training • Increase participation in staff networks
	Create equity of experience	• Decrease the % of staff experiencing harassment, bullying and abuse • Decrease the likelihood of BME and disabled staff entering formal disciplinary process and provide support initiatives if they do e.g., RCN Cultural Ambassadors • Decrease the % of staff experiencing discrimination from patients/carers • Increase staff engagement score for staff with protected characteristics through agreed actions with staff networks • Support equity of access to Clinical Excellence Awards in order to reduce the gender pay gap • Deliver the outcomes of the EDS 2022 Domain 2 – Staff Health & Wellbeing and Domain 3 – Inclusive Leadership

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

COMMITTEE/GROUP:	Finance, Performance, and Investment Committee
MEETING DATE:	22 May 2023
LEAD:	Jeff Kozer

RELATING TO KEY ITEMS DISCUSSED AT THE MEETING

ALERT

- Cancer 62 day performance was 54.2% which is an improvement but lower than the national performance of 63.4% and Cheshire & Merseyside 67.4%.
- In order to mitigate the current cash position and to provide sufficient resources for the pay award payable in June the Trust has requested a £9m advance, similar to the arrangement in 2022/23. Also, in line with the business case FP&I is supportive of the request to SOC to seek £10m of revenue support PDC ,and capital PDC to support the £14m strategic capital.

ADVISE

- The latest financial plan submitted by Cheshire and Merseyside is a deficit of £51.2m with an average CIP target of 5.5%. a cost control regime is currently being worked up as well as a framework for the medium term financial strategy.

ASSURE

- A&E performance reported at 78% in April 2023 at S&O compared with 73.6% across Cheshire & Merseyside and 74.6% nationally.
- Elective activity achieved 106% against 103% target of 2019/20 levels.
- The Trust delivered 107% scans against the target of 103% of 2019/20 levels.
- Continued positive impact on performance metrics and patient outcomes for Chase Heys and Ward 11a.
- The 14 day cancer waiting times performance is 93.8% against the 93% target, and is at the highest level since pre-covid. This compares to 77.7% in Cheshire & Merseyside and 83.8% nationally
- Zero 104+ week breaches or 78+ week breaches.
- The Trust is reporting a £675k deficit at month 1, which is broadly in line with the plan.
- The cash balance at the end of April is £3.6m.
- The Better Payment Practice Code (BPPC) performance at month 1 is 95.8%.

New Risks identified at the meeting: None

Review of the Risk Register: No action taken

ALERT | ADVISE | ASSURE (AAA)
HIGHLIGHT REPORT

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- Zero 104+ week breaches or 78+ week breaches.
- The Trust is reporting a £675k deficit at month 1, which is broadly in line with the plan.
- The cash balance at the end of March is £3.6m.
- The Better Payment Practice Code (BPPC) performance at month 11 is 95.8%.

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:	May 2023
LEAD:	Anne-Marie Stretch, Managing Director

KEY ITEMS DISCUSSED AT THE MEETING

ALERT

Paediatric Dietetic Service (02 May and 15 May 2023)
The committee discussed the continuing lack of decision from Lancashire and South Cumbria Integrated Care Board (ICB) about the funding to continue providing Paediatric dietetic services. This is a longstanding issue, and the Medical Director and Chief Operating Officer were due to meet with representatives from Lancashire & South Cumbria IBC on 10 May, but the meeting had been cancelled by the ICB and will now be rearranged.

Anaesthetic Resource for Second Emergency Obstetric Theatre (23 May 2023)
Paediatric and Maternity anaesthetic on call cover is provided with all other adult services, including ED & ITU at the Southport site. The separation of services between the sites means that an additional tier of Anaesthetic support is needed to respond to emergencies on either site, safely. A business case is in development with immediate actions and a longer-term plan to provide sufficient anaesthetic cover to be able to respond to simultaneous emergencies and this was due to be presented to the Executive Committee on 05 June 2023

ADVISE

Use of Entonox in Maternity (02 May 2023)
In response to the national safety alert Entonox air monitoring tests had been completed and a ventilation survey completed. As a result, the ventilation procedures had been amended and a paper on the final air testing results and action would be presented to the Executive Committee on 12 June 2023

Orthodontics Service (02 May 2023)
On 03 April 2023, the Chief Operating Officer reported that there were concerns that patients had been waiting a long time to be transferred to other providers as part of the managed closure of the service and had escalated concerns to NHSE. 42 of these patients had subsequently been transferred to Alder Hey Hospital NHS Foundation Trust or Primary Care services and six patients would be transferred to the service in East Lancashire. At the end of May 2023, it was reported that all patients had been transferred and the Chief Operating Officer will bring a closure report to Executive Committee containing lessons from the experience.

External Audit 2023/24 (02 May 2023)
Following a delay to the transaction, S&O are required to ensure an external auditor is in place for the part year accounts. A proposal was presented for securing auditors to undertake the part year accounts from 01 April 2023 to the date of the transaction. The Executive Committee supported the proposal to continue working with the Trust's current Auditors, Mazars thereby maintaining consistency. The Audit committee members had also approved the proposal, and this would be formally recorded at the next Audit Committee.

Window Safety - Incident (02 May, 15 and 30 May 2023)
Following a Serious Incident in 2022, the Executive Committee were asked to support the recommendation to install window strengthening film onto windows on high-risk wards at Southport (9a, 9b, 10a and 10b) to mitigate the risk of a repeated incident when a patient

smashed and climbed out of a ward window. A paper was presented to the Committee on 15 May 2023 detailing the cost of the work. It was highlighted that other windows across the Trust might require the same action. A risk assessment on the safety of windows is being undertaken by the Estates Team and when completed a report will be presented to the Committee that will advise on actions and costings for any remedial work. The Executive Committee received an update on the progress, and it was agreed that the action plan would be presented at the Patient Safety Group for feedback and a further update would be provided to the Executive Committee thereafter.

Development of Endoscopy at Ormskirk (02 May and 09 May 2023
The Executive Committee received updates on the continuing discussions with West Lancashire Borough Council to resolve the outstanding planning issues, that led to a temporary suspension of the building works.

Capital scheme costs (02 May and 09 May 2023)
Tenders received for the CDC (Radiology Department) at Southport and TIF (Endoscopy) at Southport were above the budget estimates, partly because of the complexity of the building requirements (ground works needed for the Southport site), building cost inflation and the timescales required. A number of actions were agreed to ensure value for money.

S&O MIAA Audits (09 May 2023)
The Director of Informatics presented a summary of the recent findings of two MIAA Audits that had been completed as part of the 2022/23 internal audit plan: Network Monitoring that received 'Moderate Assurance' and Back-up and Resilience that received 'Limited Assurance'. The Executive Committee noted the areas of concern and the short-term and long-term actions to improve IT network monitoring and back-up/resilience systems.

Interventional Radiology Proposal (09 May 2023)
The Chief Operating Officer informed the Executive Committee that work is being undertaken by Cheshire and Mersey Radiology Interventional Network looking at workforce challenges and the variation in Interventional Radiology services across Cheshire & Mersey. The Executive Committee will be kept informed on how the Trust will fit in to any new proposals.

Decant Capacity Plans (15 May 2023)
Further to the proposals considered for decant capacity in the April Committee meetings, further feasibility considerations were reported including the value for money assessment and agreement to explore alternative capacity for current services/staff that would have to be displaced to make room for more ward accommodation.

Enhanced Levels of Care (ELoC) (15 and 23 May 2023)
The Committee considered a proposal to utilise HCA staff who have undergone additional training in close observation, particularly falls prevention. The Executive Committee approved the plan for ELoC pilot to commence for a three-month period.

Bleeps and ASCOMs (23 May 2023)
There are ongoing issues with the ASCOM system which are impacted when the WIFI fails. All emergency teams utilise the bleep system and daily testing is in place. ASCOMS are used by wards and departments to communicate non urgent information. A piece of work is ongoing to improve the ASCOM system and to reduce the risk of incidents occurring. The Director of Informatics has been invited to an Executive Meeting to provide an assurance paper on telecommunications going forward.

Estates Return Information Collection (ERIC) Backlog Maintenance Submission 2022/23 (30 May 2023)
The Executive Committee received the 2022/23 ERIC backlog maintenance figures and the impact of the works that had been undertaken during the year. The figures had to be reported to NHS Estates via the ERIC portal by 30 July 2023.

Transaction Progress (every meeting)
The Executive Committee received weekly updates on the progress of the Transaction with STHK. The NHSE Ratings Committee confirmed an Amber Rating in support the progression of the Transaction. Transaction updates continued to be provided to staff at the weekly Trust Brief Live Sessions (both at S&O and STHK).

2023/24 Financial Plan Update (every meeting)
The Director of Finance provided weekly updates.

Employee of the Month (May 2023) (30 May 2023)
The Executive Committee reviewed the nominations received and selected the Employee of the Month.

IA Update (every meeting)
The Junior Doctors have announced IA on 14, 15 and 16 June 2023. Gold Command will be reinstated to oversee operational planning.

ASSURE

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

- Chase Heys – The Chief Operating Officer visited Chase Heys as part of the winter plan work and observed the rehabilitation team working with patients, recognising the positive impact this has on their recovery.
- The Medical Director attended a meeting with clinical leaders from Lancashire & South Cumbria to plan how Trust can become an anchor institution for the local population.
- The S&O Quality Account 2022/23 was presented to stakeholders and the feedback was good.

Clinical Director for Obstetrics & Gynae (02 May 2023)
The Deputy Medical Director has been appointed as Interim Clinical Director of Obstetrics and Gynaecology. This will provide support and stability to the team until a substantive appointment is made to the role.

Equality Delivery System (EDS) (15 May 2023)
KC advised the Executive Committee that NHSE confirmed that post-Transaction, S&O and STHK will not be required to resubmit their projects.

International Nurses Recruitment (09 May and 15 May 2023)
A letter was received from NHSE which set out an offer of support to train more international nurses. The Director of Nursing presented a paper to the Committee on 15 May and asked the Executive Committee to approve 15 international nurses to support the winter escalation plan at S&O. Given the current vacancy rates, the demands winter will place on the Trust, and taking into consideration sickness and maternity levels it was suggested that the Trust would benefit from a small programme of international recruitment. The Executive Committee approved the request which was submitted to NHSE on 19 May 2023.

Staff Voice Partnership (SVP) Sessions (15 May 2023)
During a recent SVP session, a concern was raised about the Quiet Room in Maternity being in a noisy and inappropriate area. The request to find an alternative location that is more sensitive to the need of families, and this will be addressed as part of a Maternity Walkabout.

Core Mandatory and Essential Skills Training Update (15 May 2023)

The Executive Committee received a report that provided a breakdown of the current compliance for core mandatory and essential skills as of 30 April 2023 and noted the key highlights and overall compliance breakdown of training data. It was reported that:

- Core Mandatory – 90.14% - up 0.59% in month and 0.14 above target.
- Essential skills – 82.51% - up 1.62% in month and 2.49% behind 85% target and a recognition that this is improving.

Urgent and Emergency Care (UEC) Tiering for NHS Providers (15 May 2023)

The Chief Operating Officer presented a paper that provided the Executive Committee with an overview of the UEC tiering system that is being introduced following publication of the UEC Recover Plan 2023. S&O have been placed in Tier 1 system based on a weighted performance of:

- A&E Type 1 (S&O has been ranked as the second best acute provide for Type 1 A&E performance).
- Percentage of 12-hours (S&O is the best Acute provider for 12-hours in ED (from arrival time).
- Length of Stay (LoS) over 14-days (S&O is 5th out of 9 providers for the percentage of LoS over 14-days).
- Being a tier 1 Trust, this requires the lowest level of support from NHSE. The NHSE support offer for tier 1 trusts includes specialty guidance, peer review and sharing of best practice.

Fire Enforcement Notice (15 May 2023)

The Compartmental work on Ward 15a will be completed ahead of schedule and the Enforcement Notice will be lifted on completion.

Guardian of Safe Working (GoSW) (15 May 2023)

The Medical Director confirmed a new GoSW has been appointed.

Mock CQC Inspection – Maternity (15 May 2023)

The Executive Committee received the positive feedback from the mock CQC inspection that took place in Maternity on 11 May 2023. Improvement actions will address issues that were identified.

Nursing and Midwifery Monthly Staffing Report (23 May 2023)

The Monthly Staffing Report provided an update and assurance on nursing, midwifery and HCA staffing fill rate, costs agency spend and vacancies (April 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 in-month the fill rate was 96.72% - (RN average 100.93% HCA average 94.1%); there had been a decrease in NHSP and Agency spend month in calendar month; and a HCA vacancy reduction.

Trust Objectives (2022/23) Year End Review (23 and 30 May 2023)

The Executive Committee reviewed the Trust Objectives and approved the paper to be presented at the Strategy & Operations Committee (SOC).

Risk and Compliance AAA Report (May 2023)

This was received for assurance at the Executive Committee on 30 May 2023.

Operation Flamingo Silk (30 May 2023)

The Executive Committee received an update on Operation Flamingo Silk in which NHSE tested the Trust's responses around Gold Command.

New Risk identified at the meeting	

Review of the Risk Register