Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Meeting of the Board of Directors

(Part 1 – agenda and papers to be made available to the public via LHCH website)

Tuesday 25th January 2022
Microsoft Teams at 8.00am

Agenda

1	**Welcome and Opening Matters**		
1.1	**Apologies for Absence:** Lucy Lavan, Kate Warriner	**Chair**	**Oral**
1.2	**Declaration of Interests Relating to Agenda Items**	**All**	**Oral**
1.3	**Chair's Briefing**	**Chair**	**Oral**
1.4	**Chief Executive's Report**	**Chief Executive**	**Item 1.4**
1.5	**Patient Story**	**Director of Nursing, Quality & Safety**	**Oral**
1.6	**Staff Story**	**Chief People Officer**	**Oral**
1.7	**Targeted Lung Health Check Programme**	**TLHC Programme Manager**	**Presentation**
2	**Patient Safety and Quality**		
2.1	**Infection Prevention and Control:**		
2.1.1	**IPC BAF Update**	**Medical Director**	**Item 2.1.1, (a)**
2.1.2	**DIPC Quarterly Report**	**Medical Director**	**Item 2.1.2**
2.2	**Learning from Deaths Dashboard**	**Medical Director**	**Item 2.2, (a)**
2.3	**EECS and CQC Quality Assessments Clinical Services Division**	**Director of Nursing, Quality & Safety**	**Item 2.3**
2.4*	***Mortuary Infrastructure***	**Director of Nursing, Quality & Safety**	**Item 2.4**
2.5*	***LHCH Monthly Nurse Staffing Report for Period: November and December 2021***	***Director of Nursing, Quality & Safety***	***Item 2.5***
2.6*	***Deprivation of Liberty and Safeguarding (DoLS)***	***Director of Nursing, Quality & Safety***	***Item 2.6***
2.7*	***Guardian of Safe Working Quarterly Exception Report***	***Medical Director***	***Item 2.7***

3	**Strategy and Development**		
3.1	**Strategic Objectives Quarterly Update**	**Director of Strategic Partnerships**	**Item 3.1**

3.2	**People Plan Delivery Report**	**Chief People Officer**	**Item 3.2**
3.3	**Financial and Operational Planning update**	**Chief Finance Officer** **Chief Operating Officer**	**Item 3.3**
3.4	**Changes to Patient Administration Services (PAS)**	**Chief Operating Officer**	**Item 3.4**
3.5	**Board Strategy Day Proposed Agenda 22.02.2022**	**Chief Executive**	**Item 3.5**
4	**Targets and Financial Performance**		
4.1	**Board Dashboard – period ended 31st December 2021**	**Interim Chief Operating Officer**	**Item 4.1, (a)**
4.2	**Phase 4 Recovery**	**Interim Chief Operating Officer**	**Presentation**
5	**Governance and Assurance**		
5.1	**NW BAME Assembly Annual Report and Anti-Racist Framework**	**Chief People Officer**	**Item 5.1, (a)–(c)**
5.2	**Covid Inquiry Preparation**	**Chief Governance Officer**	**Item 5.2**
5.3*	***Insurance update***	***Chief Finance Officer***	***Item 5.3***
5.4*	***Executive Director Roles***	***Chief Governance Officer***	***Item 5.4***
5.5*	***Communications Report Q3***	***Chief People Officer***	***Item 5.5***
5.6	**Medical Revalidation Annual Report**	**Medical Director**	**Item 5.6**
6	**Board Assurance**		
6.1	**BAF Key Issues Reports and Approved Minutes of Assurance Committee Meetings:**		
6.1.1	**Audit Committee:** • **BAF Key Issues** • ***Approved Minutes for meeting held on 19th October 2021 ****	**Chair of Audit Committee**	***Item 6.1.1*** ***Item 6.1.1(a)***
6.1.2	**Quality Committee:** • **BAF Key Issues** • ***Approved Minutes for meeting held on 19th October 2021 ****	**Chair of Quality Committee**	***Item 6.1.2*** ***Item 6.1.2(a)***
6.1.3	**Integrated Performance Committee:** • **BAF Key Issues**	**Chair of Integrated Performance Committee**	**Verbal**
6.1.4	**People Committee:** • **BAF Key Issues** • ***Approved Minutes for meeting held on 7th September 2021****	**Chair of People Committee**	***Item 6.1.4*** ***Item 6.1.4(a)***
7	**Minutes of the Board of Directors Meeting held (in public) on 30th November 2021 – for approval**	**Chair**	**Item 7**
8	**Action Log from Previous Meeting**	**Chair**	**Item 8**
9	**Legality of Board Documentation and Decisions**	**Chair**	**Oral**

10	**Date and Time of Next Meeting:** Tuesday 29th March 2022, 10.00 hours		
11	**Resolution:** To exclude the public from the meeting at this point by reason of the private nature of business to follow.		

Papers are 'to note' unless any Board member requests a discussion

Board of Directors (in Public)
Item 1.4

Subject: **Chief Executive's Report**
Date of Meeting: **Tuesday 25th January 2022**
Prepared by: **Executive Team**
Presented by: **Jane Tomkinson, Chief Executive**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
All	The report updates on a range of issues including COVID risk and partnership working.

Level of assurance (*please tick one*) *To be used when the content of the report provides evidence of assurance*					
✓	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. COVID 19 and Liverpool Systems Update

The system continues to experience high levels of inpatient Covid patients and general winter admissions through presence in critical care has not increased. The ability to discharge patients who are medically fit is compromised by a lack of suitable places and high community Covid presence. System flow is thus impacted with delays in ambulance arrival and hospital handover. Of major concern is the levels of sickness in the health and social care sector ranging from 7-20% which has required some Trusts to expand nursing/ patient ratios and to utilise non frontline staff to support care. LHCH has been able to maintain safe staffing levels by cohorting and consolidating resources; care impact has been minimal and mutual aid continues.

2. Coroner's Inquest

The inquest of patient has concluded.

There is no criticism of the Trust nor of any of the clinicians involved. There is no Regulation 28 report.

Both Consultants called to the inquest gave helpful and clear evidence.

Notes of the Coroner's conclusions are: -

Cause of death
1(a) Multi organ failure
1(b) cardiac trauma (iatrogenic)
1(c) ischaemic heart disease (operated)
2 obesity, type 2 diabetes mellitus, hypertension

Outcome of inquest - Misadventure. Inadvertent consequence of deliberate act

3. Health Economy / Partnerships Update

ICS Transformational Funds
Directors will be aware that the Cardiac Board under the auspices of LHCH secured non recurrent funding in 2020/21 to advance the programs for which it had developed. The ICS has now confirmed that, in line with other programs, the Cardiac Board will receive 90% of this allocation again for 2021/22. This resource, circa £757k, is earmarked for the following projects

- CVD Prevention Programme management (indicative amount £32k)
- Clinical (GP and pharmacy) leadership and oversight for CVD Prevention (indicative amount £24,8k)
- Population health leadership (indicative amount £10k)
- Happy Hearts Social Media Campaign (indicative amount £30k)
- Happy Hearts Website and Resources (indicative amount £20k)
- Blood pressure kiosks (indicative amount £50k)
- Familial Hypercholesterolaemia (FH) Programme (indicative amount £113k)
- Clinical Leadership of National Pathways improvement Program (£117k)
- Psychology support in Respiratory Care (£360k)

LHCH Institute Development
Exploratory discussions are currently taking place with regards to future estate opportunities.

Partnership Update
A deep dive into partnership opportunity will be undertaken at the Board strategy day 22nd February.

4. Provider collaboratives

The work to establish the Cheshire and Merseyside acute and specialist trust collaborative (CMAST) is in progress with four key workstreams: elective recovery; workforce; clinical pathways and finance each with designated senior responsible officer. The LHCH CEO is the SRO for the finance stream and priorities including values and working principles along with a risk and reward strategy. The work is being driven in conjunction with the incoming ICS CFO. A workshop to progress the agenda further is scheduled for the 11th February.

5. Vaccination as a Condition of Deployment

The legislation was passed on 6th January 2022 which requires staff to be double vaccinated by 1st April 2022. Guidance was issued on 14th January and this is being reviewed in terms of applicability, process and redeployment in advance of 3rd February. At this date, staff must have had their first vaccination to comply with the 1st April deadline. A full analysis of the vaccine status of every member of staff had been undertaken and will inform a Board discussion on 25th January.

6. Recommendations

The Board of Directors are asked to review the content of this report and to raise issues at the meeting.

Board of Directors (in Private)
Item 2.1.1

Subject: **IPC BAF**
Date of Meeting: **25th January 2022**
Prepared by: **Nicola Best, Lead IPN/Deputy DIPC**
Dr Raphael Perry, Medical Director/DIPC
Presented by: **Dr Raphael Perry – Medical Director/DIPC**
Purpose of Report: **For Noting**

BAF Reference	Impact on BAF
BAF 1	Potential impact on nosocomial infection

Level of assurance					
*	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Executive Summary:

- The Covid 19 pandemic has led to a review of all IPC measures with strengthening of IPC processes. The monitoring of measures has been significantly intensified to help manage nosocomial out breaks in line with the ten point plan.

- NHSE has also developed a board assurance framework for IPC. The initial BAF was presented at the May 2020 Board of Directors meeting and updates included at subsequent meetings. There latest update was version 1.6 in July 2021.

- There was a significant revision of the IPC BAF in February 2021 with an additional 42 fields to be completed. Version 1.6 was published and a fully updated BAF with additional assurances is attached; there are very few outstanding actions.

- A further revision (V1.8) was circulated at the end of December with extensive changes and areas where there are new standards have been addressed by the infection prevention team and Silver Command

- The CQC have developed an emergency support framework for IPC.

- In addition, there is an HSE checklist of IPC measures. This has been completed and evidenced by the trust and any gaps are being addressed. There have been no further updates of this checklist.

2. Background:

The Board of Directors receives a quarterly report and regular updates from the infection prevention and control team. This includes information on alert organisms, outbreaks, cleanliness standards and audit information.

NHS England have developed the Infection Prevention and control board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The framework can be used to assure the Trust by assessing measures in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions.

A revised version (V1.6) was issued in July 2021with some changes to previous versions. The infection prevention team updated the framework to reflect these changes and actions have been completed. A further revised version with extensive changes was circulated at the end of December. This version (V1.8) brings in the latest guidance on respiratory virus pathways and a number of updates need to be assessed. The infection prevention team and Silver Command have worked through the documentation and version 1.8 is now attached – the highlighting in yellow shows the updates compared to V1.6.

The fourth peak of the coronavirus pandemic began to surge in November 2021 due to the emergence of the highly infectious Omicron variant of the Covid 19 virus. This has become the dominant strain prevalent in the population and cases have risen exponentially due to the increased infectivity/transmissibility. The numbers of cases requiring hospitalisation increased significantly over the Christmas period and early January 2022 and has put a significant strain on general and acute hospital beds. However, the pressure on intensive care remains manageable. The numbers of cases requiring ventilation remains low due to the effectiveness of the vaccine in preventing severe illness in those infected.

The vaccination program has offered vaccines to cohorts down to the age of 11 and the booster program has been delivered at pace. At present 63% of the eligible population has had a double dose of vaccine and a booster. The focus of hospitals has been to maintain as much normal activity while managing any increase in Covid admissions.

The meticulous processes in place to keep patients and staff safe and prevent cross infection continue. There has been one recent nosocomial outbreak.

Additional measures including enhanced Covid testing and further drive to increase staff vaccination rates are in place. Staff are mandated to test regularly every week. Staff that are vaccinated either with LAMP (weekly) or LFT (twice weekly). Staff who remain unvaccinated require a test at the start of every shift. All staff, clinical front facing, and back office must adhere to this regime. Mandatory staff vaccination will be a requirement from April 2022.

Mask wearing, social distancing and hand washing are continuously reinforced and monitored through the daily safety huddle. Staff are supported to challenge non-compliance.

3. Main body of report:

The present Board assurance is included as an attachment and there is no change to this since the last Board. The actions/gaps from July version 1.6 have been addressed. The latest version, V1.8, is attached with changes highlighted. The BAF will be supported by a verbal update on Covid 19.

4. Conclusion:

The IPC BAF is being managed proactively and any gaps from the latest update will be monitored and managed.

5. Recommendation:

The Board of Directors is asked to note the contents of the report and the accompanying IPC BAF.

Classification: Official

Publication approval reference: C1501

Infection prevention and control board assurance framework

24 December 2021 Version 1.8

Updates from version 1.6 are highlighted in yellow.

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have further developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with UKHSA Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 and other related infection prevention and control guidance to identify risks associated with COVID-19 and other seasonal respiratory viral infections The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors, and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

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

Ruth May

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, guidance on the required infection prevention and control measures has been published, this has now been updated and refined to reflect the learning from the SARS-CoV-2 and to acknowledge the threat from other respiratory viruses. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users, and staff.

This framework has been developed and updated following updates in the guidance to help providers assess themselves as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors, and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislativeframework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co- operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. Local risk assessments should be based on the measures as prioritised in the hierarchy of controls. In the context of SARs-CoV-2 and other seasonal respiratory viruses, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed, and mitigated effectively.

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: a respiratory season/winter plan is in place: o that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services o to enable appropriate segregation of cases depending on the pathogen. o plan for and manage increasing case numbers where they occur. o a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	New respiratory virus policy developed including segregation of patients. LFD is used as POCT for emergency patients. Other methods also being explored. Discussed at Gold Command Elective patients assessed prior to admission. Emergency patients, e.g. PPCI patients assessed on presentation to Cath Lab. Segregation and isolation of patients discussed regularly at Silver Command meetings and escalated when necessary Covid secure workplace measures remain in place	Policy requires ratification	To be ratified at IPC January (20/1/22)
• health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.			
• Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: o based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. o applied in order and include elimination; substitution, engineering, administration and PPE/RPE. o communicated to staff.	Clinical areas risk assessment reviewed by IPT based on hierarchy of controls. Communicated via Command structure		
• safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	Non – clinical areas have been assessed previously	Risk assessments for non-clinical areas not updated	Non -clinical areas to be reassessed in accordance with hierarchy of controls submitted to H&S committee (7/3/22)

• if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems. • risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents. • if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered. • ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services. • the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases • there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas. • resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors). • the application of IPC practices within this guidance is monitored, eg: o hand hygiene. o PPE donning and doffing training. o cleaning and decontamination. • the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board. • the Trust Board has oversight of ongoing outbreaks and action plans. • the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	Risk assessments done for all areas performed with involvement of IPT Incorporated in policy Patients allocated areas according to their specialty. Some will require moves in line with their clinical pathway. Data submissions signed off by Executive during the week and by on call manager at weekends. Daily feedback to senior teams via Safety huddles Audits by Matrons, ward staff and IP Nurses. National standards for Cleanliness Monitored by IP nurses, hygiene supervisors and matrons Submitted regularly to Board of Directors Outbreaks and actions reported to Gold Command A range of masks has been supplied according to national procurement strategy		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level. • the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms • cleaning standards and frequencies are monitored in clinical and non- clinical areas with actions in place to resolve issues in maintaining a clean environment. • increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas. • Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. • if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses. • manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products. A minimum of twice daily cleaning of: patient isolation rooms **and** cohort donning & doffing areas frequently touched' surfaces eg, door/toilet handles, patient call bells, bed tables where there may be higher environmental contamination rates	Implementation group in place including IPNs, Hygiene services and Matrons Areas/rooms have been assessed by Cleaning group Cleaning schedules in place Included in cleaning schedules 1000ppm chlorine disinfectant product (actichlor) used for terminal and deep clean and high risk respiratory virus areas Disinfectant wipes used for equipment. Virusolve solution used for bathrooms. Included in schedules Frequently touched surfaces included as part of cleaning schedule – cleaned x 3 daily. Monitored as part of Matrons audits.		

▯ A terminal/deep clean of inpatient rooms is carried out: o following resolutions of symptoms and removal of precautions. o when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); o following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). • reusable non-invasive care equipment is decontaminated: o between each use**.** o after blood and/or body fluid contamination o at regular predefined intervals as part of an equipment cleaning protocol o before inspection, servicing, or repair equipment. • Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment. • As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities. • the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer. • a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways • where possible air is diluted by natural ventilation by opening windows and doors where appropriate • where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group. • when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Terminal decontamination carried out after patient discharge and is logged onto a database. Area cleaned if AGP for infectious patient e.g. endoscopy room. Additional decontamination using UV-C of single rooms and HPV also used. Cleaning schedules and protocols in place. Certification of equipment prior to repair in place. Audits performed as part of matrons audits and also cleanliness audits Ventilation systems assessed by Estates team Critical systems inspected annually , including POCCU, ITU, Theatres, Cath lab and Cherry ward. Some areas do not have mechanical ventilation. These areas are not used for high risk respiratory virus pathways unless individual single rooms. Window opening encouraged where possible Estate & Hygiene services involved in placement	Alternative technologies e.g. air scrubbers not used currently as there are practical and logistical issues associated with their use on wards	The placement of high risk respiratory virus patients is limited in certain areas. Other technologies will be revisited if cases increase and patients cannot be accommodated in designated areas

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and process are in place to ensure that: • arrangements for antimicrobial stewardship are maintained • previous antimicrobial history is considered • the use of antimicrobials is managed and monitored: o to reduce inappropriate prescribing. o to ensure patients with infections are treated promptly with correct antibiotic. • mandatory reporting requirements are adhered to, and boards continue to maintain oversight. • risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	Critical Care wards rounds and complex patient reviews taking place with microbiologist. Antimicrobial group reconvened and strategy updated. Weekly monitoring, reporting of resistant organisms. Policies in place	Consultant microbiologist time is limited due to ongoing pressures within the microbiology department	Critical Care infection nurse on secondment to provide assistance for microbiologist and for antimicrobial stewardship agenda. Virtual ward rounds in place.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • national guidance on visiting patients in a care setting is implemented. • restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment. • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing. • if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	Suspended at present although allowed in specific circumstances. Visiting advice available on intranet. Information boards and posters in all areas across the trust Visitors offered PPR by staff in relevant area.		

• visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. • visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian. • Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Assessed by ward staff prior to visit Toolkit reviewed by Silver Command. Screen savers, posters and regular updates/reminders in place. Safety huddles walk rounds and audits with feedback to areas.		
5. Ensure prompt identification of people who have or are at risk of develoing an infection so that they receive timely and appropriate treatment			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival. • infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred. • staff are aware of agreed template for screening questions to ask. • screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment. • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance. • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible. • there is evidence of compliance with routine patient testing protocols	Posters displayed. Social distance and screens in place. Signage used to indicate different zones at entrances. Information prior to transfer noted on forms and provided by discharge planning team Screening policy in place, all admissions screened prior to/on admission No emergency dept. PPCI patients assessed on admission Patients assessed by clinicians Audits performed		

• patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated. • patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result. • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing. • patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered. • where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • face masks/coverings are worn by staff and patients in all health and care facilities. • where infectious respiratory patients are cared for physical distancing remains at 2 metres distance. • patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff. • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. • isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative. • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	Facemasks supplied to patients Nursed in single rooms. Policy in place Single room provision allocated on a daily basis, patients prioritised if clinician requests e.g. if on chemotherapy Risk assessed by clinician on individual basis In place, audited Designated areas with distancing or siderooms used Majority of areas exceed 1 metre, otherwise screens/ clear curtains used. In policy Contact tracing undertaken by IPNs Assessed by OP staff on admission		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and processes are in place to ensure that: • appropriate infection prevention education is provided for staff, patients, and visitors. • training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely. • all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it; • adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk. • gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP • the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance. • staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace • staff understand the requirements for uniform laundering where this is not provided for onsite. • all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance. • to monitor compliance and reporting for asymptomatic staff testing • there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals). • positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported	Training provided by education team and also by individual departments e.g. critical care education practitioners regarding PPE and correct donning/doffing. Donning and doffing videos on intranet and staff app. Included in corporate induction Regular audits by Matrons, IPN In IPC policy Hand driers not in situ Laundry not available on site Guidance on intranet re uniforms in uniform policy Highlighted to staff on ongoing basis via safety huddles and corporate comms. Testing is monitored regularly and feedback to managers Surveillance performed by IP nurses. Database maintained Outbreak records available		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients. • patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals. • patients are appropriately placed ie, infectious patients in isolation or cohorts. • ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements). • standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result • the principles of SICPs and TBPs are applied when caring for the deceased	Facemask wearing monitored by ward managers Patients assessed in clinic Infectious patients would generally be postponed. If necessary they would be seen in a department at the end of a list Patients cared for in designated areas/siderooms Regular review by Silver Command Standard IPC policy in place Care of the deceased patient policy in place		

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals. • patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance; • staff testing protocols are in place	Competency tool for staff. Testing protocols in place. Audits performed. Staff screening records held by test and trace team.	

• there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data). • screening for other potential infections takes place. • that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission. • that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise. • that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission. • that sites with high nosocomial rates should consider testing COVID-19 negative patients daily. • that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge. • those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance • there is an assessment of the need for a negative PCR and 3 days self- isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	Priority levels designated in the lab and in testing protocols turnaround times monitored regularly. Data available cases monitored by Infection prevention team. Records available screening protocols in place for other infections, Audits performed. Testing protocol in place, regular audits performed and fed back to clinical areas and through command structure. Discharge to care home/care facility and testing co-ordinated by discharge team Discussed with Silver command and the divisions. Decision made to carry on with PCR testing rather than LFT for all elective patients	

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that • the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice.	Policy and audits in place		
This must include all care areas and all staff (permanent, agency and external contractors). • staff are supported in adhering to all IPC policies, including those for other alert organisms. • safe spaces for staff break areas/changing facilities are provided. • robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak. • all clinical waste and linen/laundry related to confirmed or suspected COVID- 19 cases is handled, stored and managed in accordance with current national guidance. • PPE stock is appropriately stored and accessible to staff who require it.	Audit programme for IPC in place Staff break areas available. Not all staff areas have changing rooms. Shower/changing available for staff in high risk areas Surveillance performed by IPNs. Outbreaks reported via national outbreak system Linen and Waste Policies in place PPE stored in designated areas, managed by supplies department. Delivered to wards upon request		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and processes are in place to ensure that: • staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy. • bank, agency, and locum staff follow the same deployment advice as permanent staff. • staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance • staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE. • a fit testing programme is in place for those who may need to wear respiratory protection. • where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: -lead on the implementation of systems to monitor for illness and absence - facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce - lead on the implementation of systems to monitor staff illness, and vaccination against seasonal influenza and COVID-19 - encourage staff vaccine • staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance	Staff screening team and IP team available for advice and queries, including bank and locum staff Protocol and risk assessments in place Education and training in place. Fit testing programme for all staff – records available Vaccination, screening and monitoring programme is led by the risk and staff screening teams rather than Occupational Health. Close liason between staff screening and IP team regarding all issues. Policy in place		

• a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. o A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; o that advice is available to all health and social care staff, including specific advice to those at risk from complications. o Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. o A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	Robust staff welfare systems in place including at risk groups Risk assessments have been undertaken by departmental heads		
• vaccination and testing policies are in place as advised by occupational health/public health. • staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records. • staff who carry out fit test training are trained and competent to do so. • all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used. • all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation. • those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	Vaccination and testing policies in place according to national guidelines Register of staff maintained. All staff have received training – training records available Fit testing records available for all staff Records kept on central database that can be accessed by individual staff All failed fit tests recorded on central database		

• that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions. • members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health. • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board. • consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance. • health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone. • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing. • staff who test positive have adequate information and support to aid their recovery and return to work.	Staff who have failed fit tests have been allocated air powered respirators after consultation with relevant manager. Records available. Staff redeployment has not been required for this reason as yet Fit testing monitored regularly. Reports available. Risk assessments have been completed Staff testing guidance/FAQs produced by swabbing team, positive staff supported as per sickness process by line managers with additional support provided by HR/OH as required.		

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Board of Directors (in Public)
Item 2.1.2

Subject: **Director of Infection Prevention and Control (DIPC) Quarterly Report**
Date of Meeting: **25th January 2022**
Prepared by: **Nicola Best/Infection Prevention Nurse Specialist**
Presented by: **Dr Raphael Perry – Medical Director**
Reason for Report: **To Note**

BAF Ref	Impact on BAF
BAF 1	Potential for patient harm if IPC standards not maintained

1. Executive Summary

- This paper provides information and an update on infection prevention and control for the 3rd quarter of this financial year, 1st October until 31st December 2021. Previous reports have covered the period up to 30th September 2021.

- This paper provides assurances that surveillance systems and audit programmes are in place to monitor and prevent healthcare associated infections. A number of audits have been performed across the Trust which identified some issues which have been fedback to the relevant managers to address.

2. Background

High standards of infection prevention and control are essential to ensure that people who use health care services receive safe and effective care. The *Health and Social care Act 2008: Code of Practice on the prevention and control of infections* identifies that good organisational processes and a robust assurance framework are essential to ensure effective infection prevention.

In order to demonstrate that infection prevention is integrated into the assurance framework one recommendation is that the Board of Directors receives regular updates from the infection prevention and control team, including information on alert organisms, outbreaks, cleanliness standards and audit information. This report provides such an update.

3. Issues

3.1 Surveillance

There is a requirement that bacteraemias (blood stream infections) caused by certain bacteria and also Clostridium difficile infections are monitored and reported to Public Heath England on a monthly basis.

These cases are also reported to the Clinical Commissioning Group monthly. In addition, the infection prevention team monitor other resistant organisms or organisms of concern.

Mandatory Reporting – Bacteraemias (Blood cultures)

	Attributable cases Oct-Dec 21 **(Year to Date-Trust attributable)**	Threshold
MRSA bacteraemias	0 (**0)**	0
MSSA bacteraemias	1 (**7)**	7
E coli	1 (**4)**	5
Klebsiella sp.	0 **(1)**	5
Pseudomonas aeruginosa	0 **(0)**	3

The probable source of the MSSA bacteraemia was a chest infection and for the E coli bacteraemia this was thought to be due to translocation from the bowel following bowel ischaemia after surgery.

Post infection reviews have been undertaken for all these patients, in conjunction with Critical Care, to identify any learning and actions required. These reviews will be discussed at the relevant divisional governance meetings.

CPE (Carbapenemase producing Enterobacteriaceae) cases

There were 2 new patients with CPE within this time period, both identified as part of admission screening process. Therefore, there were not designated as Trust acquired.

All MRSA cases (non bloodstream)

A number of patients were identified as MRSA positive in this time period. Three were Trust acquired but there was no connection between the patients.

C. difficile Infection

	Attributable cases July - Sept 21 **(Year to Date)**		Threshold for 21/22
Clostridium difficile infection (C. difficile **toxin** positive)	0 **(6)**		6

No patients with C difficile infection were identified in this time period

SARS CoV-2

A number of patients tested positive for SARS coV2 in this period and the breakdown is given below

COVID 19 Patients Oct- Dec 21	**Numbers of Patients**
Community-Onset – First positive specimen date <=2 days after admission to trust.	21

Hospital-Onset Indeterminate Healthcare-Associated – First positive specimen date 3-7 days after admission to trust.	1
Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission to trust.	2
Hospital-Onset Definite Healthcare-Associated – First positive specimen date 15 or more days after admission to trust.	0

There were no outbreaks identified.

3.2 Audits

An audit programme has been developed and audits have been performed by the Infection prevention team within this quarter including. All the audits are discussed at the infection prevention committee and when areas results are not satisfactory

COVID- 19 swabbing compliance
Routine swabs are obtained pre or on admission, day 3, day 6, day 10 and five daily thereafter. The initial screening is 99% compliant and subsequent screens 94% to 95%
Critical Care screening compliance
This screens for MRSA and resistant organism screens being completed. Respectively the rates were 91% and 83% which is an increase in compliance from previous quarter. Work continues to reinforce through the CCA safety huddle
Isolation
This is in line with infection prevention advice and continuously monitored by the infection prevention nurses and matrons
Urinary tract infection treatment
This was audited in the summer of 2021 and some gaps in managing UTI identified. As a result, an education plan in management of UTI has been delivered along with prescribing education. A further audit is planned once the education has had time to embed – likely Q1 22/23
PPE compliance

Audits have been performed by ward staff assessing compliance with hand hygiene, IV care and care of catheters.

Hand hygiene compliance previously has been consistently above 95%. The audit has changed to perfect ward and some education is required to ensure consistent data entry
The audits consistently show 100% compliance with catheter and cannula insertion. There have been improvements in cannula VIP score completion.

Results and action plans have been fedback to wards and relevant areas and through the Infection Prevention committee.

3.3 Cleanliness

A new audit tool and programme to monitor cleanliness across the Trust has been developed in line with the National Standards for Cleanliness. A multi-disciplinary group including infection prevention nurses, matrons and Hygiene service supervisors have performed the audits ensuring a collaborative and standardised approach to monitoring cleanliness. Audits of all inpatient areas have been completed and all areas achieved the required standard.

3.4 Progress against annual plan and Infection Prevention Strategy

A project was undertaken with the antibiotic pharmacist to improve diagnosis, management and prevention of urinary tract infection. An awareness day was held in November, with visits and educational materials

provided to all wards. Repeat audits have been planned along with a plan to improve and standardise products for care and insertion of urinary catheters

The Intravascular (IV) access working group has met and an action plan developed for 2022. Work is underway now to review and further develop all the documentation related to insertion and care of IV devices, as this has been identified as an area that requires improvement.

The Surgical Site Infection working group has met. Reviews of all patients with severe infections is underway and will be collated into a report for the surgical division and Infection Prevention Committee. An electronic surveillance system is currently in development.

4. Summary

The surveillance of infections and routine audit data continue to be monitored and
work is on-going to ensure the infection prevention quality and safety plan is fulfilled and a robust audit programme is in place.

5. Recommendations

The Board is asked to note the contents of this report and progress against the annual plan.

Board of Directors (in Public)
Item 2.2

Subject: **Learning from Deaths Dashboard Q3 21/22**
Date of Meeting: **25th January 2022**
Prepared by: **Dr Raphael Perry – Medical Director**
Presented by: **Dr Raphael Perry – Medical Director**
Purpose of Report: **For Noting**

BAF Reference	Impact on BAF
BAF 1	Assurance regarding learning from deaths and possible avoidable patient harm.

Level of assurance (*please tick one*) *To be used when the content of the report provides evidence of assurance*					
√	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Executive Summary

Guidance on learning from deaths was published by the National Quality Board in March 2017 and was presented to the Board of Directors in May 2017. Quarterly reports have been presented to the Board of Directors since.

Deaths are categorised as to the likelihood of being avoidable or not (on balance of probability >/< 50:50) and the data collected centrally each quarter.

This quarterly report presents the mortality dashboard for Q3 21/22 (Appendix 1).

2. Background

The threshold of defining preventable death is on the basis of more likely than not encompassing the categories of definitely avoidable, strong evidence of avoidability and probably avoidable (greater than 50:50). Deaths are classified using the RCP (Royal College of Physicians) methodology unless they occur in individuals with an identified learning disability. In those individuals LeDeR (Learning Disability Mortality Review) methodology is used and a full review carried out without prior screening.

The mortality review policy was reviewed and updated in October 2021 and the robust mortality review process continues.

All deaths have an initial review by the Deputy Director of Nursing to assess any issues raised by families and carers. In addition, the Medical Examiners and Medical Examiner Officer discuss issues raised by families at the time of death certification. Any concerns raised by the families after a period of reflection are responded to and where appropriate investigated. If the death is considered avoidable or classed as an incident full duty of candour is exercised and the resultant RCA discussed with families.

3. Dashboard Q1 2021/22

There have been sixty-one deaths in the trust between October and December 2021. For comparison the total number of deaths in the trust for Q2 2021/22 was forty-two. In Q3 forty-five of the deaths have been through the mortality review process. There have been no deaths in patients with an identified learning disability. The total quarterly number of deaths is higher than average, and this was driven by a high number of out of hospital cardiac arrest patients in October and November.

In interpreting the attached spreadsheet, it should be borne in mind that there may be an adjustment of the previous quarter's assessment of avoidability. This is because some of the returned full reviews will subsequently have been recalibrated by the mortality review group at their monthly meeting. Some cases rated by reviewer as less than 50:50 may have been deemed avoidable by the MRG and vici-versa.

In Q3 21/22 no deaths have been classified greater than 50:50 chance of avoidability by the mortality reviewer and the MRG. However, two deaths that occurred in Q2 have been reviewed in Q3 and found to be avoidable. One death was definitely avoidable - RCP1 and one death probably avoidable (>50:50) – RCP 3.

Of those less than 50:50 in Q3 no deaths were classed probably avoidable but not very likely (RCP4); two deaths (4.4%) were classed as slight evidence of avoidability (RCP5); forty-three deaths (95.6%) were classed as definitely not avoidable (RCP6).

Annual deaths:

The YTD figures for this year to date are a total of 158 deaths, eighteen of which are yet to complete the full MRG process. There are five avoidable deaths year to date four in Q2 (two of which are as above) and one from Q1 that was RCP3 – probably avoidable (>50:50)

In 20/21 there were a total of 191 deaths compared to 189 deaths in 19/20.

The total number of avoidable deaths during 20/21 was nine; one definitely avoidable (RCP 1), three with strong evidence of avoidability (RCP 2) and five probably avoidable (more than 50:50 – RCP 3).

In 19/20 there were eight potentially avoidable deaths.

4. Conclusion

The trust complies with national guidance and populates the mortality dashboard. There are no avoidable deaths in Q3 but there are two additional deaths assessed with evidence of avoidability during Q2 21/22.

Actions from the MRG process will be taken forward by the appropriate division.

5. Recommendations:

The Board of Directors is asked to note the dashboard data for Q2 21/22.

Item 2.2 (a)

Liverpool Heart and Chest NHS Foundation Trust: Learning from Deaths Dashboard - December 2021-22

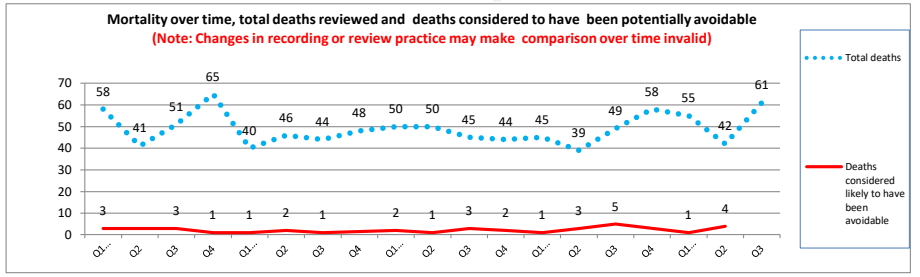
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
26	25	11	24	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
61	42	45	41	0	4
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
158	191	140	190	5	9

Time Series:	Start date	2017-18	Q1	End date	2021-22	Q3



Total Deaths Reviewed by RCP Methodology Score

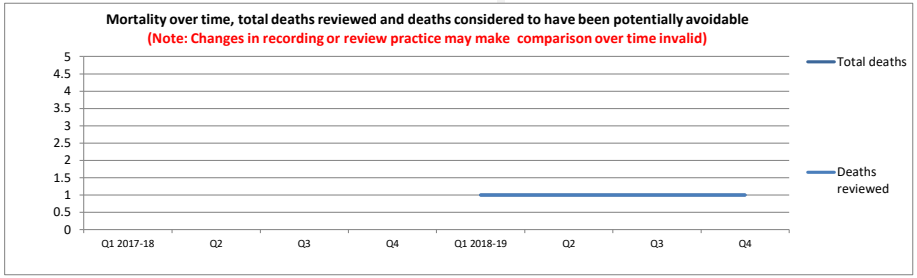
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	11	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	4.4%	This Quarter (QTD)	43	95.6%
This Year (YTD)	2	1.4%	This Year (YTD)	1	0.7%	This Year (YTD)	2	1.4%	This Year (YTD)	9	6.4%	This Year (YTD)	11	7.9%	This Year (YTD)	115	82.1%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	0	0	0	0	0

Time Series:	Start date	2017-18	Q1	End date	2018-19	Q4



Board of Directors (in Public)
Item 2.3

Subject: **EECS and CQC Quality Assessments Clinical Services Division**
Date of Meeting: **25th January 2022**
Prepared by **Angela McKenna safeguarding and EECS lead**
Presented by **Sue Pemberton, Director of Nursing, Quality & Safety**

BAF Reference	Impact on BAF
BAF 1	To provide assurance on CQC and quality standards within the clinical services division.

Level of assurance (*please tick one*) *To be used when the content of the report provides evidence of assurance*					
√	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Executive Summary

The Excellent, Efficient, Compassionate and Safe assessments (EECS) have been on-going in the Trust since 2015. This is an assessment tool to provide assurance of the quality standards across the clinical areas and departments. The assessments have evolved and changed over time; the content is aligned with CQC key lines of enquiry, with additional requirements set by the Trust. Due to overlap with both the EECS and our internal CQC mock inspections, a decision was made to integrate the EECS and the CQC mock inspections to prevent duplication and provide a thorough review of a ward/department/service from October 2021.

The EECS assessments detail a comprehensive review of clinical/non-clinical standards in wards and departments. The document is located within Perfect ward which is a tool to collate the evidence in relation to the standards. The assessments are completed by senior leaders within the organisation independent of the area being assessed. The purpose of the EECS is to ensure that care delivery across our wards, departments and clinical services are monitored as a minimum annually, with the aim of providing assurance of the Trusts standards, to the Board of Directors. Following each assessment robust action plans are developed which are progressed through divisional governance structures until completed. There is a forward plan to cover all divsions throughout 2022/23.

The clinical services division has been assessed in its entirety throughout quarter three 2021/22 and completed in January 2022. The assessments were conducted within outpatients, radiology, the end of life service, pain service, therapies, critical care and pharmacy. The overall outcomes were good with some outstanding features. Areas for improvement have been highlighted as per section 3.

2. Background

During the Covid pandemic and the introduction of the enable app at LHCH (Previously named Perfect ward) a review was conducted in April 2021 of the Trusts' EECS assessment process together with our approach to CQC mock inspections. Enable is an app-based smart inspection tool for use in a variety of clinical settings, which allows users to complete quality inspections digitally and receive instantaneous reporting based on inspection results.

The aim of the EECS assessment is to achieve a green rating against all assessment criteria. When an area achieves three consecutive green assessments and 90% or over in the third assessment overall, they can then apply for Gold status. Many of our wards, clinical areas and departments have now progressed through x3 green assessments and achieved GOLD status.

The new focus of the EECS/CQC plan ensures we gain a divisional overview of care delivery and services. In addition, services such as end of life are asked to complete a self-assessment against the key lines of enquiry as set out by the CQC. The assessment also involves the triumvirate completing a self-assessment of well led, which is followed up with a short interview with the Director of Nursing.

3. Clinical Services Division outcomes of EECS and CQC mock inspection Quarter 3 /4 2021/2022

The areas within the clinical services division are listed below with the outcome of the EECS or service review. For the services (radiology, end of life) they have been rated as good as they do not have an EECS they carry out a self-assessment against the CQC standards. Radiology has received good for the EECS overall with some areas identified as requiring improvement that are aligned to the CQC standards relating to incidents and learning.

Section	Area	Outcome	Key Themes	Improvements Required
1. EECS and Service CQC Self-Assessment	EECS Radiology	93.8% Good (EECS) Was amber at last inspection)	• Environment positive, well-presented, clean, tidy and bright. • Patients and relatives complimentary about staff and witnessed positive patient and staff rapport. • Good staff knowledge on Freedom to speak up, infection prevention and business continuity. • Local Improvement board in use. • Good staff knowledge about the Trust.	• Reception needs to be staffed to support patient's check in and department orientation. • Increase staff dementia, deprivation of liberty standards and mental capacity training. • Address storage of patient identifiable information data confidentiality gaps. Patient information visible that should have

Section	Area	Outcome	Key Themes	Improvements Required
				been out of sight.
	Radiology additional areas for improvement relating to CQC standards incidents, learning and culture.	Requires Improvement	• Duplicate incidents have been reported • The learning from incidents needs to be shared and led by the medical leads in the department.	• There have been several incidents with a similar theme– actions have been put in place and some have been related to individuals and human error. The key improvement required is for the review of incidents to be conducted rapidly and the learning shared. • The department has also had several speak outs which have been investigated and addressed with the relevant people. The triumvirate are continuing to hold listening/engagement sessions with the radiology team. • Discrepancy meetings need to be held more frequently and reported, and evidence of the learning being shared needs to improve with clear medical leadership.
	CQC End of Life Services	Good (Service Review)	• Strong MDT working who were caring and went above and beyond. • Responsiveness to referrals and proactive symptom control. • Consultant/OT and nurse led outpatient clinic appointments was a unique model. • Worked to ensure strategy and policies were in place and met	• Difficulties with nursing and medical training attendance or evidence (especially on communications). Ongoing training required for areas with few end of life patients to ensure their knowledge is up to date. • Lack of engagement and link nurses

Section	Area	Outcome	Key Themes	Improvements Required
			NICE and national standards.	related to the pandemic – needs focus. • Increase and improvement needed to documenting communications on decision making and family communications. • The mortuary requires some environmental improvements which are being led by the RLBULH.
	EECS Outpatients	98.8% Gold – Previous Gold also.	• High standards of cleanliness. • Staff area had lots of information. • Worked to keep clinic floor accurate and patients engaged on waiting times. • Patients appreciated café changes since it reopened. • Visitors supported to attend clinic if bad or complex news expected.	-
	EECS Therapies	96.68% Gold – Previous Gold also.	• Welcomed by team and leaders. • Quiet and nice departmental feel. • Documented meeting communications and staff area information demonstrated good team working. • Governance/incident discussions using the key lines of enquiry framework. • Students and clinical supervision well embedded.	• Speech and language mandatory training below compliance.
	EECS Critical Care	94.1% Gold – previous Gold also.	• Managers and staff were friendly and welcoming, they all presented adhering to the uniform policy.	• Some Patient ID boards and 'what matters to me' boards were incomplete

Section	Area	Outcome	Key Themes	Improvements Required
			• The area was clean and tidy. • Staff checked patient identity when giving medications. Staff explained prescribed medications, including side effects • Patient feedback was excellent, they felt they were given enough information and they felt involved in their care decisions, being given risks and benefits throughout. • Patients received compassionate care and felt comfortable. • They had confidence in the staff caring for them • Staff had good knowledge of Trust wide processes and excellent communication was noted. • Excellent education department in critical care, evidence of extended teaching and role specific progression.	• Not all staff had Natsips/Locsips awareness. • Not all staff were aware of trust targeted savings or aware of Trust's financial position. • Some staff could not recall feedback from team brief which showed the Trust financial position. • Infection Prevention: audits highlighted some areas requiring improvement. Some incidents where cross infection had been identified but actions had been taken to make improvements and staff and managers are very responsive. • Not all staff could name complaints in the last 6 months or could identify complaint common themes. • Staff could not describe how to evacuate the dept or locate evacuation plan. • Not all staff could name Safeguarding Doctor lead.
	EECS Pharmacy	96.3% Gold – previous Gold also.	• Staff were friendly, welcoming and approachable. Morale and teamwork was excellent. • Excellent patient and family feedback, they found the staff knowledgeable and they go above and beyond. Patients said they felt supported and listened to. • Good peer feedback given from supportive	• 6 monthly Infection Prevention and Control Audit to be completed by Infection control team • Rosters available weekly, staff do not work shifts but on call. Department manager to discuss with team.

Section	Area	Outcome	Key Themes	Improvements Required
			information. • Staff knew about Trust procedures such as how to escalate concern's, raise incidents and use HALT. • Staff received effective communication from department manager.	
	CQC Pain Services	Good (Service Review)	• Excellent CQC self-assessment review produced by the pain team • Very thorough review detailing all aspects of CQC expectations • NR equipment work remains on risk register (safety connectors) • Gap analysis with time frames provided which gives the team focused improvements to work on. • Acknowledgement of well-established team and processes in place • Excellent Leadership noted • Complaints/incidents with pain as an issue very minimal • Services hours discussed including Saturday service which is in place • Improvement work and good practice noted, for example- Weight based protocols, Liver patients work, paravertebral work.	Gap analysis produced • E- learning level one for all clinical staff to be implemented. • Key trainer/link nurses to be implemented • Business case put forward for permanent band 6 - with division • Currently working on a data dashboard to help with reporting.
2. Governance Review		Good	Positive feedback regarding the governance meeting observed by the Deputy Director of Nursing. Presentations and papers were informative and prompted discussion – with challenge from colleagues were appropriate.	Some behaviours need to improve whilst meetings are conducted on teams- discussed with triumvirate.

Section	Area	Outcome	Key Themes	Improvements Required
			Minutes read well – professional and followed the agenda items. Actions could be seen being rolled over from meeting to meeting (this appeared to be due to non-attendance of the action owner) Presentations from the ITU services were informative and gave rise to discussion – colleagues found the presentation interesting and gave insight to others on how the ITU functions with individual roles and responsibilities.	
3. Clinical Services Staff Group Discussions		Good	Excellent feedback and positivity from the attendees on the first session Overall, feedback was very positive especially around patient care and LHCH being a great place to work. A second session was planned for Monday 17th January however attendance was poor therefore a further attempt will be made to capture feedback from front line staff in the next couple of months.	The other areas of focus highlighted are; • Recruitment, retention and career pathways • Time out to train • Senior leader and Exec visibility to be present for all staffing levels • Clear and consistent processes • Improve the 'feedback loop' (staff share ideas but we're not great and replying and communicating the 'why not' • The strategic objectives, vision, mission and impact values need to be shared more widely as some staff were not aware of some of this information.

Section	Area	Outcome	Key Themes	Improvements Required
4. Well-Led Interview and CQC Self-Assessment		Good	A well led interview was conducted on 5th January 2022 with the Triumvirate and the Director of Nursing and Quality. A self-assessment had been completed by the division prior to the interview. The interview outcomes included: • The triumvirate consider themselves visible throughout the division and confirmed they are known by their teams in the division. • The triumvirate meet weekly and update/feedback to each other on progress on objectives and agree actions. • All members of the triumvirate confirmed they are aware of each other's objectives. • The division have developed a workplan, so all are aware of the priorities and they utilise this to update each other on progress. • The culture in the division was discussed and no serious concerns expressed across the division. • Current challenges were discussed which included retention of the Advanced critical care practitioners (ACCPs) in critical care due to the changes in the surgical Registrars ways of working. The Associate Medical Director is comfortable that actions have been put in place to address these concerns. Staffing is a challenge particularly international recruits for	The Director of Nursing requested that discrepancy meetings be held as a minimum bimonthly and reported through to divisional governance and Quality safety experience Committee. The number of incidents with similar themes were discussed and the need for these to be discussed at the discrepancy meeting timely, to ensure that learning is shared with the aim of improving practice.

Section	Area	Outcome	Key Themes	Improvements Required
			radiology and nurse staffing in outpatients. The critical care environment was also raised as an area to be enhanced. • Radiology was discussed at length. The division confirmed that the audit days have continued and there is good attendance.	

5. Summary and conclusion

The new focus of the EECS/CQC plan ensures we gain a divisional overview of care delivery and services. The clinical services division has been assessed and has achieved an overall good rating with a small number of areas within radiology identified as requires improvement. The clinical services division will formulate an action plan to address all areas for Improvement and this will be monitored through divisional governance.

6. Recommendations

The Board of Directors to receive assurance of the standards within the clinical services division.

Board of Directors
Item 2.4*

Subject: Mortuary Infrastructure Update
Date of Meeting: 25th January 2022
Prepared by: Laura Allwood Patient and Family Liaison Manger
Presented by: Susan Pemberton Director of Nursing Quality and Safety
Purpose: For Noting

BAF Ref	Impact on BAF
BAF 1	To provide assurance that the improvements to the mortuary arrangements are being progressed by Liverpool University's hospitals.

1. Executive Summary

On 3rd November 2021, a clarification letter was received from NHSI – Estates and Facilities, confirming that all Trusts with either a mortuary or body store, were required to undertake a review of local operational procedures, against the requirements set out in the Human Tissue Authority's (HTA) standards and guidance. The advice included the steps all Trusts should take to assure their Board of Directors of compliance and where actions are required, identify these and implement those actions necessa, to ensure the mortuary/body store meets the HTA updated guidance. The Board of Directors received the action plan developed by Liverpool University Foundation Trust (LUFT) with the progress made in December 2021.

This paper provides an update on progress against the mortuary action plan, showing a number of actions still to be complete.

2. Background

LHCH mortuary provision is provided by Liverpool University Foundation Trust (LUFT) service level agreement. The Head of Business Development at LUFT replied to NHSI regarding the mortuary infrastructure and produced the necessary actions and timeframes to address any remedial works necessary.

3. Updated Actions (LUFT)

Ref.	Action	Date identified	Location	Required completion date	Actual completion date	Progress/ Status
1	Installation CCTV	10-11-21	**BGH**	**25-2-22**		Temporary system to be deployed 23 Nov 21 by Security as interim measure. Survey of site

Ref.	Action	Date identified	Location	Required completion date	Actual completion date	Progress/ Status
						underway
2	Installation of access control	10-11-21	BGH	**25-2-22**		Survey of site underway
3	Reinstate perimeter fence	10-11-21	BGH	**17-12-21**		Works package placed
4	Double gates at rear	10-11-21	BGH	**17-12-21**		Works package placed
5	Installation of intruder alarm	10-11-21	BGH	**25-2-22**		Survey of site underway
6	Update security risk assessments	10-11-21	BGH	**31-11-21**	**23-11-21**	Risks updated
7	Training for CCTV	10-11-21	BGH	**19-11-21**	**19-11-21**	Training undertaken

3. Conclusion

Following the request made by NHSI – Estates and Facilities for all NHS Trusts to assess on site mortuary/body storage facilities, to the standard as outlined in the HTA updated guidance, LHCH Estates Manager contacted the Head of Business Development at LUFT, to work together in progressing the identified actions needed to meet the required standard of the HTA. The current position against the action plan shows a number of actions still to be completed.

4. Recommendations

The Board of Directors is asked to receive the progress update on the LUFT action plan and receive assurance that the improvements required are progressing. Further updates will be provided.

Board of Directors (in Public)
Item 2.5*

Subject: **LHCH Monthly Staffing for Reporting Period for November & December 2021**
Date of meeting: **25th January 2022**
Prepared by: **Julie Roy, Head of Nursing & Quality for Medicine**
Fiona Altintas, Head of Nursing & Quality for Surgery
Kirsty Dudley, Critical Care Manager,
Presented by: **Sue Pemberton, Executive Director of Nursing, Quality & Safety**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
BAF 1	To provide assurance of safe nurse staffing

Level of assurance (*please tick one*) *To be used when the content of the report provides evidence of assurance*					
✓	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Executive Summary

At Liverpool Heart & Chest Hospital, we aim to provide excellent, efficient safe care for our patients and populations every day and our nursing staffing levels are continually assessed to ensure that we achieve this. This continues to be a particularly challenging period for all staff working with reduced staffing levels at times. The Trust has experienced an increase in staff absence during the covid pandemic, which has contributed to increased staffing pressures, experienced across the NHS. Significant effort continues in the recruitment of staff, including successful participation in a Pan-Mersey international recruitment project and further international recruitment through a Cheshire collaborative. Staffing levels are reviewed regularly throughout every day, with senior nurse oversight to ensure safe care is maintained.

2. Background

In line with the recommendations detailed in 'Hard Truths – The Journey to Putting Patients First' (Department of Health, 2014), LHCH publishes staffing levels monthly on the Trust's internet and to UNIFY.

The National Quality Board (NQB) publication Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable, and productive staffing (2016) outlines the expectations and framework within which decisions on safe and sustainable

staffing should be made to support the delivery of safe, effective, caring, responsive and well-led care on a sustainable basis. It builds on National Institute for Health and Care Excellence (NICE) guidelines on safe staffing for nursing in adult inpatient wards and is informed by NICE's comprehensive evidence reviews of research, and subsequent evidence reviews focusing specifically on staffing levels and outcomes, flexible staffing, and shift work.

The purpose of this report is to provide detail of the care hours per patient day (CHPPD) delivered to inpatient areas in LHCH. It will also detail, exceptions to planned staffing levels for the months of November & December 2021 and the impact on nurse sensitive indicators. This report details planned and actual nurse staffing levels for the months of November & December 2021, including any red flag concerns.

3.1. Vacancy Data

All RN vacancies across the Trust are reviewed regularly by the Director of Nursing with the senior nursing team. The Trust's recruitment lead within HR continues to work closely with the senior nursing team, to ensure oversight of all Trust vacancies and recruitment progress against each. This information is validated by the senior nursing team to ensure accurate vacancy reporting data. There are currently 40 band 5 RN vacancies with 9 students due to start in April 2022 and a further 22 in the recruitment pipeline, in addition to the international nurses detailed below.

Table 1-Vacancy data November & December 2021 (all bands)

	November		December	
Unit	**RN**	**HCA**	**RN**	**HCA**
Acute Cardiac Unit	3.02	-2.71	3.88	-1.66
Birch Ward	8.37	-0.16	2.37	-0.16
Cath Lab	0.81	0	0.81	0
Cedar Ward	1.48	0.05	1.48	0.05
Cherry Ward	2.3	-0.8	0.3	-0.8
Holly Suite	4.21	0	1.21	-2
Maple Suite	5.57	0.2	5.57	0.2
Oak Ward	1.28	0.15	1.28	0.15
Outpatients	0.69	0	0.69	0
Rowan Suite	2.64	-0.61	2.64	-0.61
SICU Clinical Roster	18.66	3.43	18.66	3.43
Theatres	11.7	0.05	11.7	0.05
Grand Total	**60.73**	**-0.4**	**50.59**	**-1.35**

The first cohorts of international RNs (22) have successfully completed their OSCE training and all passed the OSCE exam and are now registered with the NMC. These staff are now working in band 5 positions and have proved invaluable support to the clinical teams. A further 6 nurses are due to take their OSCE exam in January 2022. Through the Pan-Mersey collaborative 22 nurses have arrived during December and will commence their OSCE training in January 2022 with an exam date in March.

The first cohort of nurses via the Cheshire International Recruitment Collaborative (CIRC) have arrived at LHCH and these nurses are currently in their supernumerary period in the clinical areas. A further 10 nurses via CIRC are due to take their OSCE exam in January and will then join the Trust.

Considering the current rate of band 5 turnover and the information regarding recruitment challenges nationally, a proposal for further international recruitment to take place in 2022 has been approved and initial international recruitment plans are under way with NHS Professionals. A significant proportion of the international nurses already recruited have critical care skills, and the critical care manager is developing a plan to ensure that they can rotate into the unit to maintain their clinical skills and to be ready to support the area if necessary in the future.

Due to the current high prevalence of covid, a planned face to face recruitment event at LHCH has been converted to a virtual event, with 50 applicants booked in for a virtual information session and Trust overview, and also interviews via TEAMS. This is planned for January 2022.

3.2 Sickness Absence

During November & December 2021, clinical areas continued to experience sickness absence, with a significant increase in covid related sickness absence during December, and this is detailed in the table below.

Table 2- sickness absence data

	NOVEMBER 2021		DECEMBER 2021	
Unit	**RN WTE**	**HCA WTE**	**RN WTE**	**HCA WTE**
Acute Cardiac Unit	3.76	1.00	5.85	1.38
Birch Ward	1.84	2.19	3.16	3.23
Cath Lab	4.30	0.05	3.34	
Cedar Ward	2.91	3.37	3.04	6.10
Cherry Ward	0.23	0.82	0.59	1.09
Holly Suite	2.01	0.69	3.02	0.95
Maple Suite	0.76	1.04	1.61	2.63
Oak Ward	0.87	1.89	1.28	2.78
Outpatients	0.60	0.92	0.78	0.88
Rowan Suite	1.20	1.55	0.17	1.96
SICU Clinical Roster	13.56	2.64	18.16	3.16
Theatres	9.78	1.10	7.45	0.97
Total WTE Unavailable	**41.82**	**17.26**	**48.45**	**25.14**

There is a continued Trust focus on sickness absence management, with support for staff in terms of wellbeing conversations with line managers and additional provision, to support mental health wellbeing, across the Trust. Divisional leads are working closely with HR business partners and managers to review all sickness absence and several long-term sickness cases have resulted in support to return to work. The Trust continues to follow national guidance in relation to covid isolation and contact testing to support staff back into work. The number of covid positive staff significantly increased at the end of December, in line with the latest community surge.

3.3. Temporary Staffing

The temporary staffing team are actively recruiting to the LHCH nurse bank to support during this time. Agency staffing has been utilised during November & December 2021 within critical care and cath lab recovery when required, to cover unfilled vacancies.

3.4. Exceptions

All planned staffing for nursing in LHCH is assessed as required for the ward to run at full capacity, if capacity is reduced then the planned staffing changes accordingly.

In November 2021:

- There were no red flags on Cedar, Rowan, and Maple wards. There was one staffing related incident reported for a night shift on Cedar ward. The shift had an appropriate number of staff but an increased number of confused patients requiring enhanced observation. Support was provided via the hospital coordinator.
- Oak ward reported 1 red flag shift in November. No patient safety incidents or harm were reported, however there was a report that some patient medications were delayed. Advanced Nurse Practitioner support was present on the ward.
- There were no red flags reported on ACU, Birch and Cherry wards in November 2021 and no staffing related incidents were reported via the datix system for these areas.

In December 2021:

- There were no red flags on Cedar, Rowan, Oak and Maple wards and no staffing related incidents were reported.
- There were no red flags reported on ACU, Birch and Cherry wards in December 2021.
- One staffing related incident was reported for Birch ward on a night shift, where there was shortage of HCAs to support the ward and to provide support to confused patients, with enhanced care needs. This was a challenging shift but no patient safety incidents were reported.
- There was one staffing related incident reported on ACU, however staffing levels were appropriate, one patient had complex needs and required a lot of nursing support.
- Acute Cardiac Unit (ACU) has a significantly reduced number of RN vacancies however, the unit has experienced high sickness levels and skill mix remains a challenge. The divisional matron works closely with the ward team to ensure appropriate levels of coronary care trained staff are available for each shift, working flexibly across the 2 areas of ACU and POCCU3 (CCU) and working through a staffing plan to ensure planned levels of staffing are achieved.
- There is ongoing pressure within the anaesthetic nursing/ OPD team across both Cath lab and theatres, which is being managed utilising temporary staffing, ensuring cross-divisional flexibility and with a longer-term plan to merge the two teams planned for April 2022.

4. Summary

This continues to be a particularly challenging period for all staff working with reduced staffing levels at times. The Trust has experienced an increase in staff absence during the covid pandemic which has contributed to increased staffing pressures, experienced across the NHS. As reported by the Institute for Public Policy Research (IPPR, 2021) 29% of nurses and midwives report that they are more likely to leave the sector than 1 year ago, and as such retention of current staff and recruitment of future staff remains a Trust priority.

Recent national press coverage has highlighted a national nursing ‘crisis’, impacted particularly by a significant reduction in recruitment from Europe. LHCH is experiencing significant nurse staffing challenges but has taken robust action to avert a staffing crisis. A successful international recruitment programme is supporting plans to stabilise the staffing position across the clinical areas.

Executive approval has been received to appoint a nursing recruitment lead, for a period of 12 months to support the Head of Nursing staffing lead & HR team with nursing recruitment and retention plans, and to support the international nursing recruitment process.

Each day a review of staffing takes place Trust wide to ensure that all patients can be cared for safely. This has unfortunately resulted in an increasing number of staff moves to manage risk and to provide additional support for areas where acuity of patients is higher, and it is recognised that this is having a negative impact on staff morale at times. The ward manager weekend rota continues with a ward manager working each weekend to support the hospital co-ordinator, in ensuring safe staffing across all areas and keeping in close contact with the duty on-call manager for the Trust.

5. Recommendations

The Board of Directors are asked to:

- Receive assurance related to nurse staffing for in-patient wards, as per national directives, noting actions being taken to ensure patient safety and quality of care are maintained.
- Receive assurance that staffing is appropriate and is flexed according to patient need and patient safety risk assessments, following escalation processes.
- Receive monthly reports of staffing at all planned Board meetings.
- Receive the ‘care hours per patient day’ (CHPPD) data.
- Receive assurance that the review of ward establishments and models of care for each inpatient area has been completed and is being reviewed in 2022, in accordance with covid recovery and escalation plans.
- Receive assurance that a robust recruitment plan continues, including an extended overseas recruitment plan.
- Receive assurance that revised models of nursing care, utilising Registered Nursing Associates and apprentices continue to be implemented.
- Receive assurance that alternative temporary staffing options are being explored.
- Receive assurance that staffing escalation plans are in place to be enacted when significant staffing pressures are seen during the covid pandemic.

Appendix 1
Introduction to Care Hours per patient Day (CHPPD)

One of the obstacles to eliminating unwarranted variation in nursing and care staff deployment across the NHS provider sector has been the absence of a single means of recording and reporting deployment. Conventional units of measurement that have been developed previously have informed the evidence base for staffing models, – such as reporting staff complements using WTEs, skill-mix or patient to staff ratios at a point in time, but it is recognised by Nurse leaders may not reflect varying staff allocation across the day or include the wider multidisciplinary team. Also, because of the different ways of recording this data, no consistent way of interpreting productivity and efficiency is straightforward nor comparable between organisations.

To provide a single consistent way of recording and reporting deployment of staff working on inpatient wards/units we developed, tested, and adopted Care Hours per Patient Day (CHPPD).

- CHPPD is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of in-patient admissions (or approximating 24 patient hours by counts of patients at midnight**)**
- CHPPD reports split out registered nurses, registered & unregistered nurse associates and healthcare support workers to ensure skill mix and care needs are met. (The system calculates this automatically)

CHPPD for November 2021

	Care Hours Per Patient Day (CHPPD)							Day				Night			
	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)
	8.8	3.6	0.1	0.3	0.0	0.0	12.8	94%	101%	68%	87%	94%	99%	-	-
BIRCH	3.9	2.9	0.2	0.2	0.0	0.0	7.2	92%	104%	60%	67%	94%	87%	-	-
ACU	6.5	3.1	0.0	0.0	0.0	0.0	9.6	92%	81%	-	-	93%	95%	-	-
CHERRY	6.1	3.0	0.0	0.5	0.0	0.0	9.6	98%	90%	-	-	83%	93%	-	-
CRITICAL CARE	26.0	3.9	0.0	0.0	0.0	0.0	29.8	99%	88%	-	-	100%	100%	-	-
OAK	4.2	4.3	0.0	0.8	0.0	0.0	9.3	93%	104%	-	113%	79%	105%	-	-
CEDAR	4.7	4.3	0.0	0.2	0.0	0.0	9.2	89%	105%	-	37%	84%	111%	-	-
MAPLE	3.9	3.2	0.6	0.4	0.0	0.0	8.1	73%	148%	77%	30%	82%	87%	-	-
ROWAN	5.1	3.6	0.0	0.1	0.0	0.0	8.8	73%	117%	-	-	82%	87%	-	-
CCU	13.1	3.7	0.0	0.5	0.0	0.0	17.2	95%	113%	-	-	103%	107%	-	-

CHPPD for December 2021

	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)
	9.2	**3.7**	**0.1**	**0.3**	**0.0**	**0.0**	**13.2**	**93%**	**98%**	**69%**	**127%**	**96%**	**80%**	-	-
BIRCH	4.0	3.1	0.3	0.2	0.0	0.0	7.7	82%	111%	97%	65%	100%	73%	-	-
ACU	6.3	3.1	0.0	0.0	0.0	0.0	9.4	85%	80%	-	-	108%	77%	-	-
CHERRY	6.4	3.1	0.0	0.3	0.0	0.0	9.7	90%	90%	-	-	87%	77%	-	-
CRITICAL CARE	28.8	4.1	0.0	0.0	0.0	0.0	33.0	103%	98%	-	-	103%	70%	-	-
OAK	3.9	4.0	0.0	1.0	0.0	0.0	8.8	66%	97%	-	-	75%	94%	-	-
CEDAR	5.1	4.4	0.0	0.3	0.0	0.0	9.8	84%	94%	-	65%	85%	105%	-	-
MAPLE	4.6	2.3	0.4	0.3	0.0	0.0	7.6	84%	131%	42%	39%	73%	-	-	-
ROWAN	6.1	3.8	0.0	0.2	0.0	0.0	10.1	87%	104%	-	-	64%	90%	-	-
CCU	13.6	4.2	0.0	0.6	0.0	0.0	24.4	117%	115%	-	-	102%	52%	-	-

Board of Directors (In Public)
Item 2.6*

Subject: **Deprivation of Liberty Safeguards (DoLS) Update for Q3 21/22**
Date of Meeting: **25th January 2022**
Prepared by: **Terri Marshall – Safeguarding/Risk Management Co-Ordinator**
Presented by: **Sue Pemberton - Director of Nursing and Quality**
Purpose of Report: **To Note**

BAF Ref	Impact on BAF
BAF1	To provide assurance that deprivation of liberty standards are implemented in the Trust.

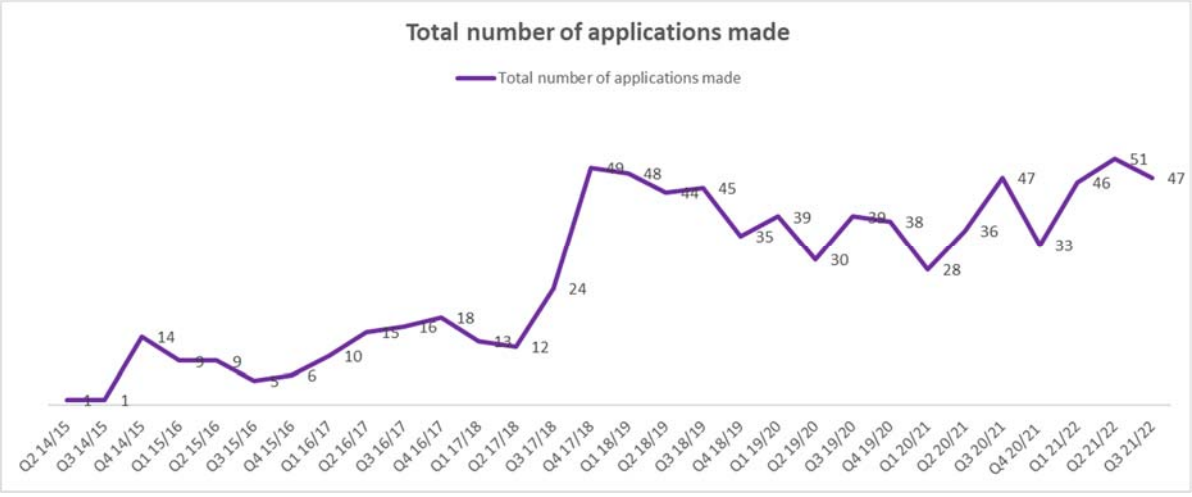
1. Executive Summary

The purpose of this paper is to update the Board of Directors on the number of applications made for quarter 3 – 2021/22 in relation to the Deprivation of Liberty Safeguards (DoLS).

2. Background

The Deprivation of Liberty Safeguards (DoLS) were introduced in 2009 (as an addendum to the Mental Capacity Act 2005 and a strong link to the Mental Health Act 2007). DoLS aim to prevent the unlawful detention of adults in hospitals and care settings who lack capacity to choose where they live and/or to consent to care and treatment. DoLS are compatible with Article 5 of the European Convention on Human Rights (the right to liberty and security of person).

3. Current Position



MCA Assessments and DoLS Applications – Q3 (2021/22)

For Q3 a total of 47 Deprivation of Liberty Applications have been received by the Safeguarding Team for 9 different local authorities across the catchment area. This is a 9% decrease in applications received since the previous quarter.

Of the total 47 applications received by the team, all were standard and urgent applications.

- 8 urgent applications were issued, and the standards were not required as the patients were discharged/transferred within the 14-day urgent period.
- In 39 cases, the applications were reviewed, and the patients were assessed by the safeguarding team, but the applications were not sent. This was due to a number of reasons, either the patients confusion had settled, the patient passed away, the patient met the criteria for a critical care patient and were to be managed under the best interests principle and would be reviewed again once they were ready to be transferred to the ward or the patient was transferred or discharged.

MCA and DoLS Mandatory training is currently at 90.1% across the trust.

There are no new risks to be highlighted on this report; all applications are reviewed on an individual basis.

4. **Recommendations**

The Board of Directors are asked to note the numbers of applications made and assessments undertaken.

Board of Directors (in Public)
Item 2.7*

Subject: **Guardian of Safe Working Q3 Report 21/22**
Date of Meeting: **25th January 2022**
Prepared by: **Lauren Murphy, Business HR Assistant**
Presented by: **Dr Raphael Perry, Medical Director**
Purpose of Report: To Note

BAF Reference	Impact on BAF
BAF 1	Provides assurance that the Trust compliant with the Guardian of Safe working exception requirements and reporting.

Level of assurance (*please tick one*) *To be used when the content of the report provides evidence of assurance*					
√	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Executive Summary

This is the 21/22 Q3 report on safe working hours following introduction of the 2016 contract for Junior Doctors.

At present LHCH has 52 trainees on the new contract currently on rotation at the Trust. All rotas are compliant with the rules within the 2016 Contract.

2. Background

The purpose of this report is to review the working hours of Doctors in training including exception reports, breaches of working hours, fines incurred and how these fines were levied.

Number of Doctors / Dentists in training (total):	52
Number of Doctors / Dentists in training on 2016 TCS (total):	*52*
Amount of time available in job plan for guardian to do the role:	0.25 PAs
Admin support provided to the guardian (if any):	To be reviewed
Amount of job-planned time for Educational Supervisors:	0.25 PAs per trainee

3. Details

Exception Reports (with regard to working hours)

There have been no exception reports in Q3. Only one exception has been received since August 2016.

Issues Arising

- Current gaps in Tier One rota for both Surgery and Cardiology are causing problems with on call cover.
- A WAST Doctor's start date was delayed due to illness. This has caused a problem with the home office and the Doctors right to work visa being revoked.
- There is currently a long list for car parking permits.
- Lead Employer are sending the information for the rotating documents late or incorrect causing problems with work schedules and rotas.

Actions Taken

- Weekly reminders are sent every Monday morning to key stakeholders, including ICU, Anaesthetics, Cardiology, of any gaps in the rota for the upcoming 3 weeks to allow time to cover.
- When gaps arise, an email is sent to all Doctors to ask for support, either as a swap or paid time.
- New starters are allocated empty slots to bridge gaps and to ensure all shifts are covered.
- The WAST Doctor has been interviewed for a Trust Doctor position and has been successful in gaining a new role with LHCH.
- A car parking waiting list process is currently in place. Doctors will need to pay for their tickets initially, however, can then claim the funds back via the general office.

4. Junior Doctor Forum

The last forum was on 23rd December 2021. There was also one on 25th November however, only 3 Doctors turned up which is why another was scheduled a month later.

5. GSW Annual meeting

Dr Holemans attended the 2021 Guardian of Safe Working Annual conference organised by NHS employers on 9th December.

6. Recommendations

The Board of Directors are asked to note the report.

Board of Directors (in Public)
Item 3.1

Subject: **2021/22 Strategic Objectives**
Date of meeting: **Tuesday 25th January 2022**
Prepared by: **Jonathan Develing, Director of Strategic Partnerships**
Presented by: **Jonathan Develing, Director of Strategic Partnerships**
Purpose of Report: **To note**

BAF Ref	Impact on BAF
ALL	Assurance regarding progress against the revised Strategic Objectives as at Q3 2021/22.

1. Executive Summary

This paper provides an update on the revised strategic objectives as at Q3 2021/22.

2. Background

Following review, the Board of Directors approved, at its meeting of December 2021, revised strategic objectives that take into account the situational circumstances arising from the publication of the White Paper, development of Integrated Care Boards, Provider Collaborative and emerging priorities for the NHS in managing the continuing Covid pandemic.

Accordingly, new objectives aligned with the strategic goals within the Trust overarching strategy Patients, Partnerships and Populations, have been developed and are reported within this paper.

3. Strategic Goals (High Level Ambitions)

The Board of Directors have agreed the following strategic goals as part of our five-year strategy.

i) Delivering World Class Care
ii) Advancing Quality and Innovation
iii) Increasing Value
iv) Developing People
v) Leading Through Collaboration
vi) Improving Our Population Health

4. Strategic Objectives

Each strategic goal has several objectives with an identified lead Director responsible for delivery.

The attached appendices describe the delivery of objectives at the time of this report.

5. Recommendation

The Board of Directors is asked to note progress as at the time of report.

Appendix One

World Class Care				2021/22	
	A Director Objective	B Specific Deliverable Actions	WHO	Q3	Q4
WCC1	Implementation of quality and safety strategy	Implementation of quality and safety strategy	Sue Pemberton	The strategy has been implemented and each of the leads for the respective objectives have updated progress January 2022. Good progress has been made and will be reported to quality committee in April 2022. The corporate quality objectives are progressing with: •Implementation of the Be civil be kind initiative and the civility charter •Attend safety training has commenced with several key leaders receiving this to support them in conducting investigations. •Good progress made with the closed loop medicines project work with the aim of reducing medication errors. •Hospital at night reviewed and transformed with 24-hour cover from outreach services and no further incidents regarding deteriorating patients identified/reported. Positive feedback from the ward staff regarding the support for patients from the hospital at night team.	
WCC2	Development of a new research strategy	Development of a new research strategy	Dr Raph Perry and Dr Jay Wright	Research Strategy being developed by Professor Wright and Jennie Crooks. For joint meeting january 2022	
WCC3	Development of a new Clinical Strategy	Development of a new Clinical Strategy	Dr Raph Perry	Clinical Strategy presentation discussed at Board of Directors development day. Details shared with divisions and further feedback on divisional plans January 2022. Narrative to be compiled in february 2022.	
WCC4	Develop world class facilities	Cath Lab Refurbishment	Karen Edge	Phase 1 complete and Phase commenced	
WCC5	Operational Excellence	Utilisation and hospital flow Review of GIRFT reports Review of Model Hospital Data	Jonathan Mathews	Flow delivery group and standardised reports now developed Action plans for GIRFT Developed ACS Pathway work being taken through the Cardiac Board. Use of the additional ACU beds being explored.	

Advancing Quality				2021/22	
	A Director Objective	B Specific Deliverable Actions	WHO	Q3	Q4
AQI 1	Develop the Trusts academic expertise.	Increase in the numbers of academic appointments made	Dr Perry and Dr Jay Wright	New objective for 2022/23	
AQI 2	Develop a recognised learning and academic facility (The LHCH Institute)	Development of strategic outline business case for the LHCH Institute	Jon Develing / Katie Fitzsimmons	Development of scope has not been possible and will now be picked up during Q4	
AQI 3	Implementation of the digital strategy	Establish Digital Excellence Committee Further develop the iDigital service	Kate Warriner	Operational IT delivery and cyber security performing against KPIs. External assurance continues with NHS Digital Milestones to secure funding approval for year 2 of the digtal aspirant programme have been achieved. LHCH achieved an international digital accreditation in December 2021 with the achievement of HIMSS Level 6.	
AQI 4	Develop a Strategy for Innovation	Develop a Strategy for Innovation	Jon Develing / Jenny Crooks	Planned development session for the strategy planned for in Q4	

Increasing Value				2021/22	
	A Director Objective	B Specific Deliverable Actions	WHO	Q3	Q4
IV 1	Implementation of financial strategy	Develop Financial Strategy	Karen Edge	Interim financial regime precludes medium term planning. Tactical approach to manage cost base and develop CIP in place	
IV 2	Develop capacity for program and quality improvement	Develop capacity for program and quality improvement	Sue Pemberton	The lead for service improvement forms part of the quality and safety strategy progress group and supports the leads as required. The team are available for improvement support as required. A reprioritisation exercise is being conducted to ensure that the team are linking themes to improvement priorities	
IV 3	Utilise benchmarking and performance data to drive quality, productivity, efficiency and improvement	Utilisation and hospital flow Review of GIRFT reports Review of Model Hospital Data	Jonathan Mathews	Flow delivery group and standardised reports now developed Action plans for GIRFT Developed ACS Pathway work being taken through the Cardiac Board. Use of the additional ACU beds being explored.	
IV 4	Implementation of green strategy	Progress toward the NHS Commitment for Net Zero Carbon emissions by 2030	Jon Develing	BOD update provide at December 2021	

Developing People				2021/22	
	A Director Objective	B Specific Deliverable Actions	WHO	Q3	Q4
DP 1	Development of a recruitment and retention strategy	Development of a recruitment and retention strategy	Karen Nightingall	The framework for the recruitment and retnetion strategy went to People Delivery Group for discussion and feedback. The stratgy overview was presented at People Committee at the beginning of Q3.	
DP 2	Development of an education and OD Strategy	Development of an education and OD Strategy	Karen Nightingall	The OD & Education strategy was launched in Q£ and a comprensive action plan has been developed for 2022.	
DP 3	Development of an equality, diversity, inclusion & belonging strategy	Development of an equality, diversity, inclusion & belonging strategy	Karen Nightingall	The current strategy has come to the end of its term. The HR lead for EDIB has launched a project group to start the early thinking on a new 3 year strategy. This will be taken to Exec, People Delivery Group, Partnership Forum in Q4	

Leading Collaborations				2021/22	
	A Director Objective	B Specific Deliverable Actions	WHO	Q3	Q4
LC 1	Lead the Cardiac Disease programme, and deliver the NHS Long Term Plan and CVD Ambitions for Cheshire and Merseyside	Programs that support the Long Term Plan	Jon Develing / Katie Fitzsimmons	Leading the Specialised Provider Alliance, Cardiac Board, and CVD Prevention Group	
LC 2	Take a leadership role within the new ICS and provider collaboratives	Development of proposals for LHCH to host networks within a governance framework	Jon Develing / Katie Fitzsimmons	Active member of the Cheshire & Merseyside Acute and Specialist Trust Alliance (CMAST) and the One Liverpool Integrated Care Partnership	
LC 3	Take leadership role in clinical Networks	Development proposals to support LHCH hosting networks as appropriate	Jon Develing / Katie Fitzsimmons	New objective for 2022/23	
LC 4	Explore new relationships with Public Health, industry and academia.	Development of a value proposition	Jon Develing / Katie Fitzsimmons	New objective for 2022/23	

Improving Population Health				2021/22	
	A Director Objective	B Specific Deliverable Actions	WHO	Q3	Q4
IPH 1	Develop an approach for health inequalities	Direct intervention of LHCH in those areas of highest health inequality	Jon Develing	New objective for 2022/23	
IPH 2	Support improved primary and secondary prevention and detection of cardiac and respiratory disease. (Lead, Orchestrate Deliver approach)	Implementation of the ICS Prevention Pledge	Jon Develing / Katie Fitzsimmons	Mapped prevention activities and working with the ICS on the C&M Prevention Pledge and accreditation	
IPH 3	Develop ourselves as an anchor institution	Implementation of the ICS Anchor Institution Charter	Jon Develing / Katie Fitzsimmons	By March 2023 we will become an accredited Anchor Institution	

Board of Directors (in Public)
Item 3.2

Subject: People Plan Delivery Report
Date of Meeting: 25 January 2022
Prepared by: Beth Williams-Lally, HR & OD Manager
Presented by: Karen Nightingall, Chief People Officer
Purpose of Report: To Note

BAF Reference	Impact on BAF
BAF4, BAF5, BAF6.	Provides assurance on the delivery of LHCH People Plan which will directly contribute to the Trust's strategic workforce objectives.

Level of assurance (*please tick one*) *To be used when the content of the report provides evidence of assurance*					
✓	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Executive Summary:

The Trust launched its People Plan in January 2021 following publication of the national NHS People Plan by NHS England and NHS Improvement (NHSEI) and Health Education England (HEE) in July 2020. The purpose of this paper is to update the Board every quarter in relation to the progress made against the objectives.

This report was presented to the People Committee on 8 December 2021. The Trust is making good progress and further updates to Q4 actions have been included in this paper.

2. Background:

The LHCH People Plan 2021, which was launched in late January 2021, replaces the previous people strategy 'Team LHCH at its best 2017-2020' and was developed in response to the national NHS People Plan. It will be an interim 12-month plan setting out key priorities that are to be achieved within the year. The plan has been aligned to the 'Developing People' section of the LHCH five-year strategy 'Patients, Partnerships & Populations'.

3. Progress Highlights:

The delivery plan sets out the key actions and timescales for delivery of the people plan objectives. Key highlights from Q3 together with key actions for the upcoming quarter are shown below.

	20/21 Q3	20/21 Q4
Looking after our people	• 3yr People Strategy created at HR, Education & OD away day. • Be Civil Be Kind (BCBK) Campaign successfully launched trust wide 8 November '21 to spotlight the importance of positive behaviours. • Staff survey successfully launched October 2021, closed 26 November '21 with a 57.9% response rate* **Final total provided 10 December '21.* • Provide alternative ways of learning to provide HR training, in the last quarter we have held the following virtual e-learning modules; ➢ Supporting staff absent with COVID/Long COVID sickness. ➢ How to have meaningful return to work interviews. ➢ How to have supportive informal/formal sickness review meetings. • NHS/E introduced the wellbeing pledge to introduce a movement away from sickness absence management towards a holistic wellbeing approach. Our recommendation is on item 5.4 • New HWB newsletter launched, including mental health support and 'moments for the mind initiative' • Wellbeing conversations ➢ 60% - Yes ➢ 17% - No ➢ 23% - Not selected • HWB charter - **UPDATE** A review of the offer was conducted money/time vs value add. Feedback was also gained from LCC & private who deemed it as a laborious admin/audit task. Decision was made to not proceed but rather run our own internal, trust wide initiatives to combat the challenges we were facing specifically rather than a generic approach. • Mental Health Support & Resource Toolkit was created for all.	• Finalise 3yr People Strategy in collaboration with divisions and with alignment to trust objectives. • BCBK recognition initiatives and e-learning modules to be circulated trust wide. • Staff survey results to be shared • Staff survey action plans to be created over the proceeding months by divisions. • Meet wellbeing pledge deadlines. • Flexible working approach to be finalised following data collated from retention group engagement, exec approval required. • Virtual HR training to be delivered; ➢ The importance of occupational health. • 22 Mental Health first aiders to be upskilled to 'psychology champions' by internal clinical psychology team to enable us to improve listening and signposting support for staff. • Several 'Blue Monday' events taking place 17 January 2022 for mental health and wellbeing including; ➢ Mindfulness sessions ➢ 'Brew Monday' hugs in mugs with warm drinks sachets. ➢ Appreciation & Kindness cards ➢ Wellbeing activities • People pulse survey launched for January 2022 to understand how staff are coping, results to be shared in February 2022. • Mock CQC listening rooms took place to gain feedback on patient and employee experience, including safety and also raise awareness around understanding LHCH strategic, objectives, vision, values and mission.
Belonging in the NHS	• Launched our first staff inclusion network, introduced as 'The importance of equality, diversity & belonging' (EDIB) at LHCH. Very well received, nearly 40 employees attended the lunch and learn with many more watching the replay with engaging guest speaker Paul McEvoy Clark, LJMU HRM program Lead and CIPD Chair. • A Recruitment strategy has been developed to incorporate the work that needs to be done surrounding our recruitment and selection procedures. The strategy has an	• Leadership program launched September 2021, initial numbers low. Second cohort January 2022 had 19 express interest and13 attend, much improved engagement. To monitor the ethnicity of attendees at each session to encourage ethnic minority groups to attend if required. • Recent engagement conversations provided feedback that some of our international recruits have not fully

	action plan that will deliver an inclusive recruitment process reflective of the communities we serve. The EDI strategy will also further enhance this work so that we are making continuous improvements. • Four tier leadership programme launched September 21. Foundations of Leadership (Tier 2) and Building Quality Leadership (Tier 3) proving popular, programmes for Jan 22 fully booked, and capacity extended. Reviewing Master Classes for Leading with Excellence (Tier4) in planning for 2022. applications also taken for formal leadership programmes across the apprenticeship and Leadership Academy portfolios. • NHS Employers published guidance in October 21 setting out requirements for formal EDI training across NHS Trusts. • Submitted WRES and WDES results and presented to the Board end of September 21. • New integrated EDI action developed to support change of focus following the pandemic and to include all national, regional and local requirements.	settled in to LHCH as they haven't had chance to meet many people. As a result of this we are hosting an 'LHCH Belong' event to welcome all our new starters and international employees and encourage them to meet others. • The Trust continues to support the recruitment and promotion of a diverse workforce but there is more work to do as identified within the Recruitment and EDI strategies. • Scope EDI training provider and cost analysis to meet requirements of NHS/E which stipulates all employees attend formal EDI training. • Commitment statement developed in line with Anti- racism framework recommendation's ratified at People Committee in December prior to a trust-wide launch. • 'Think Tank' Session arranged to scope our new EDIB strategy on 15 December '21. • Weekly Virtual HR support session in place to guide Managers on the application of policies and procedures in a fair and consistent manner. NHS Employers published guidance October 2021 setting out requirements for formal EDI training across NHS Trusts. Scope of training provider and costs to be carried out - options appraisal to be developed. • LHCH has signed up to become a Veteran Aware Trust and is applying for the Employee Recognition Scheme (ERS). Good progress is made in relation to the action plan. The Trust signed the Armed Forces Covenant in December which sets our commitment to this agenda.
New ways of working and delivering care	• Work experience policy has been ratified. Work experience pathway reinstated following pause due to COVID. • Working with Volunteer Co-ordinator to support wider roles for volunteers. • Volunteers reinstated following pause due to COVID, with interviews for new cohort of volunteers, reaching into new roles. • Careers events at HEIs and Schools not yet re: established. • Attendance of clinical and Recruitment teams at recent Nursing Times Career event was successful.	• Review calendar of events for 2022 including career fairs, school, college and HEI events. • Full programme of events to be publish on HR intranet. • Throughout pandemic leadership and other face to face session converted to virtual, including coaching conversation in partnership with LWH. • New CPD introduced on top on these conversions include DSE for all staff, competency-based learning and access to the eLearning for Health schedule which covers a multitude of learning across all professionals and throughout all levels. • Work experience re-established.

		Working with Volunteer Coordinator to support new roles being developed for Volunteers, and to ensure all training & development deliver for volunteers. • Work experience re-established and relationships with schools and colleagues on track. • Attendance of clinical and Recruitment teams at recent Nursing Times Career event was successful. Calendar of events for 2022 including career fairs, school, college and HEI events being compiled. Full program of events to be publish on HR intranet.
Growing for the future	• We continue to increase the number of apprenticeships and training places in the shortage professions. ➢ 81 apprenticeships currently active (against a target of 72). ➢ A new cohort of 6 HCA apprentices have started in the Trust following on from the 1st successful cohort in Dec 2020. ➢ Successful completion of apprenticeship from Health Care Scientists and Nurse Associates in September and October 2021. ➢ New intake of Healthcare Scientists in Sept 2021. • We continue to strive towards increasing trainee positions to >50%, September traineeship cohort successfully completed. • Recruitment & retention strategy has now been developed. • We have now moved over to the new NHS jobs system. • International Recruitment campaign for 2021 has seen 70 international Nurses offered jobs within the Trust. We will continue our International Recruitment efforts into 2022 and develop a longer-term plan to use international recruitment where we are unable to recruit in-country.	• Cadet programme continues as per planned. New cohort of Cadets will start on placement in Feb 2022. • A number of clinical apprentices - Healthcare Scientists, Nurses Associates, Nurse Degree Top Ups, Assistant Practitioner & Pharmacy Technicians planned for October 2021. • New cohort of Cadets will start on placement in Nov 2021. • Additional traineeship cohort planned for early 2022. • Continue to enhance the recruitment process in line with the recently developed Recruitment strategy. • Working with wider retention task and finish group to establish different ways of working. Hybrid policy agreed in principle at Executive Team, policy developed and going through ratifying process. Support given to managers via bitesize learning sessions to support hybrid working where appropriate, and to support managers articulate expectations where not appropriate. Working with wider group of clinical staff to deliver increase flexibility within teams, to enable more flexible recruitment.

4. Next steps:

NHSE/I is developing People Plan 2 and a people promise. The People Plan will come to the end of its life at the end of March 2022. It's anticipated that People Plan 2 will be an extension of People Plan 1 and the same themes will continue. Separately, the Trust is developing its own People Strategy. A working group has met to develop the strategy and the early thinking has been shared internally with the People Delivery Group and an overview was shared with the People Committee in December. Further work will be done over the next two months to shape the strategy further which will then be shared with the Board of Directors.

5. Conclusion:

Additional resources invested into the team have enabled further progress to be made against the key actions of the People Plan. The NHS 12-month people plan was intended to run January – December 2021. However, as our trust did not begin work until April '21 due to staffing changes our completion report will be reported in a 12-month frame resulting in the final submission being delivered March 2022.

6. Recommendations:

The Board of Directors is requested to note the contents of this paper.

Board of Directors Report (in Public)
Item 3.3

Subject: **2022/23 Annual Planning Progress Report**
Date of Meeting: **25 January 2022**
Prepared by: **Stephen Baily, Divisional Head of Operations – Surgery**
James Bradley, Deputy Director of Finance
Rachael McDonald, Strategic HR Business Partner
Presented by: **Jonathan Mathews, Chief Operating Officer**
Karen Edge, Director of Finance

Purpose of Report: **For information**

BAF Reference	Impact on BAF
BAF 2, 3, 7	This report sets out the available national guidance related to the 2022/23 financial year. The Operational Guidance sets out the key priorities and in addition draft Financial Guidance sets outs the expected financial regime within which Trusts and Systems will operate. Trust performance and the rate of recovery will be set within the parameters of the guidance, internal planning is progressing and further updates will be provided on conclusion and the publication of additional and final guidance.

Level of assurance (*please tick one*)					
☐	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	X	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Executive Summary

The 2022/23 Annual Planning guidance was published on 24th December. The Trust's annual planning process for 2022/23 commenced in early December 2021 based on assumptions made from the 2021/22 guidance whilst awaiting final guidance to be released.

This paper provides an update on progress to date, ahead of the deadline for submission of the first draft plan due at the end of March 2022, with final submission due late April 2022. The paper also provides a summary for each of the key steps required in the annual planning process along with the expected timeframe for completion.

2. Priorities

As seen in the 2021/22 Planning guidance, a list of priorities have been identified with a focus on the recovery of services from COVID-19 and the need to address gaps in service provision highlighted by the pandemic e.g. addressing health inequalities. The priorities from 2021/22 have all been carried over into 2022/23, however some changes have been made, the detail of these changes will be highlighted in section 3.

The priorities that are relevant for the Trust are provided below.

1. Invest in our workforce including new ways of working along with embedding a compassionate and inclusive culture enabling the delivery of outstanding care
2. Responding to COVID-19 effectively through the delivery of the vaccination programme ensuring we meet the needs of our patients
3. Over delivery of elective care to reduce the backlog, reduce long waits and deliver an improved performance with cancer waiting times
4. Continue with the development of the Trusts approach to population health management with a focus on addressing health inequalities using data analysis. The outcomes should be measured with the expectations that a redesign of pathways may be required to enable improved access and health equity for underserved communities
5. Increase the use of digital technologies supporting the transformation of services and the delivery of care, measured by improved patient outcomes.
6. Ensure the Trust makes the most of its resources, moving back to and above pre-pandemic levels of productivity where possible.
7. Drive forward with collaborative working on the back of the establishment of the ICS, developing a five-year strategic plan for their system and places.

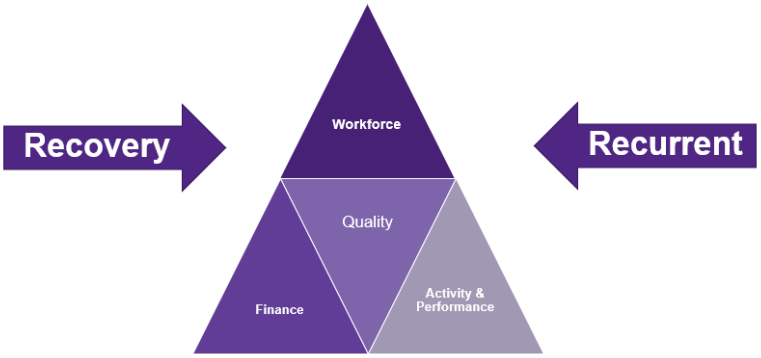
Those priorities that directly influence the financial and performance planning for next year will be included as part of the submission due at the end of April however, those that are deemed as long-term actions will be included as part of the future Divisional Business Plans which will be completed in early quarter one of 2022/23.

Divisional Business Plans will incorporate the output of the operational planning process along with the Divisional Clinical strategies that are currently in production.

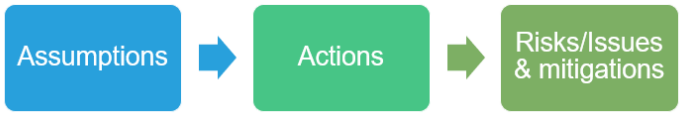
3. Operational Planning

The approach to the Trusts annual operational planning process has been adapted this year to ensure that each key element of service delivery is brought together and is coherent in its approach with the 2022/23 planning guidance priorities. The priorities have been grouped into three keys areas which are Finance, Workforce and Activity & Performance with the expectation that the delivery of the three areas will ensure a high overall quality of care.

The Trust is required to consider how service delivery will be provided through core activity plans and recurrent funding, along with an increase in activity as part of COVID recovery and the potential of accessing non-recurrent funds from the system.



In order to achieve the finalised plan for the 3 key areas, the Divisions are to follow the process outlined below. The Divisions are asked to highlight any risks on the back of the assumptions within the annual plan priorities and what actions are being implemented to mitigate or reduce risk.



To ensure that a consistent approach is provided across the Divisions for budget setting and workforce planning, leads from HR and Finance have developed templates that will support the annual planning submission and will also feed into the Divisional Business plans.

To provide assurance that progress continues to be tracked, a weekly meeting has been established with relevant leads in attendance to review each of the actions from the key areas, holding those to account on meeting the timescale required for submission.

a. Capacity and Demand

In line with the time scales provided in section 6 of the paper, the capacity and demand process is nearing completion. The business intelligence team have provided the divisions with referral data allowing for forecast for demand for 2022/23 to be reviewed. The referral demand along with the current waiting list backlog is to be factored into the modelling which will likely identify gaps in core capacity.

The additional capacity to support the demand will be presented as part of the financial modelling for 2022/23 including any financial consequences required to support recovery at the end of January.

b. Activity

As per the priorities set within the 2022/23 Planning guidance, Systems are expected to forecast an over achievement of 10% for elective activity and 25% for diagnostic capacity against 2019/20. This is a change from previous year which focused on the achievement of 100% of 2019/20 activity outturn for H1 which then later altered to 100% achievement of waiting list clock stops for H2 as per 2019/20 outturn.

For the Divisions to understand what this would mean for service delivery for elective and non-elective activity, four activity models are being considered.

The current models that are in development are:

2019/20 outturn (funded capacity in current contract baselines)
2019/20 outturn + 10% (Operational planning guidance ask)
2021/20 plan (core capacity)
2021/20 plan + 10% (maximum capacity)

The divisions and corporate teams are currently reviewing the impact of each model prior to agreeing the final plan. This work will continue over the coming weeks in line with the agreed milestones for completion.

c. Performance

As seen in 2021/22, the Divisions have developed recovery trajectories for the national statuary targets with a plan to work towards a level of improvement and an aim to achieve compliance.

The targets highlighted in the planning guidance are;

- Zero tolerance for patients waiting over 104 weeks
- Reduction in patients waiting over 78 weeks
- Reduction in outpatient follow-ups as a system by a minimum of 25% against 2019/20 activity levels by March 2023. The guidance also outlines plans to reduce follow-ups through a more personalised approach; patient-initiated follow-ups (PIFU)
- Improve performance against national targets for cancer including the faster diagnosis standard

The Divisions already have developed trajectories of improvement for a number of the national standards however as part of the annual planning process for 2022/23 the trajectories will be reviewed. The additional trajectories will be developed for the new performance measures required for 2022/23 based on the final activity plans.

4. Finance

The financial planning guidance has been published in draft form and could be subject to change when the final version is released in January. The underlying assumption is that COVID will return to low levels, and the principles will be kept under review as the pandemic evolves.

As established in previous planning processes, Integrated Care Systems will continue to be the key unit for financial planning purposes. All systems have a breakeven requirement.

The COVID-19 pandemic necessitated the introduction of an interim allocations approach to ensure that systems had sufficient resource to respond to the pandemic. From 2022/23, the allocations methodology will be reset to move systems back towards a fair share distribution of resource at the levels affordable within the Spending Review 2021 settlement. Allocations will be based on current system funding envelopes but will begin a glide path to fair share allocations. A convergence adjustment will be applied to bring systems towards their fair share of NHS resources over time.

The nature of the contract with commissioners will follow the Aligned Payment and Incentive (API) Model, which has a fixed and variable element. The fixed element should fund an agreed level of activity, with the variable element being primarily linked to elective recovery.

Additional revenue (£2.3bn) and capital resources (£1.5bn) will flow to systems to support elective recovery. The guidance states that each system is required to develop an elective care recovery plan for 2022/23, to meet the ambition for systems to deliver over 10% more elective activity than before the pandemic. Where systems deliver activity above a target, they will earn an additional 75% of tariff. Where systems do not deliver against this target then allocated funding worth 75% of

tariff will not be earned. Activity below the agreed baseline for elective activity would be deducted at 50% of national or unit prices in provider contracts.

Further detailed guidance, along with confirmation of the system funding allocations, are expected to be published in January 2021. Maximising activity through efficient use of existing resources and seeking to expand capacity to address waiting lists will remain the focus, and the funding framework is designed to support this.

The Trust has commenced its budget setting process. Important in this process is ensuring that budgets are linked to activity plans, with additional elective recovery actions separately reviewed (elective recovery attracts additional non-recurrent funding). Any cost pressures and developments will be scrutinised. With income largely on a fixed basis, any investments will need to be cost neutral or will result in an increased CIP requirement.

5. Workforce

In order to ensure that realistic plans are translated in the 22-23 operating plan, the HR Business Partners are working closely with divisional management colleagues and Finance Business Partner's to develop divisional workforce plans within each division.

It is vital that the importance of workforce planning is embedded within the planning process. If the organisation is not able to effectively anticipate its future workforce needs, it risks lacking enough time to develop plans and make changes that will support the effective delivery of services. In order to support the divisions and provide a consistent approach, a workforce planning template has been developed. In addition, a 4 Step Integrated Business Planning template has been designed for department leads to help prompt thinking which will inform the divisional and Trust workforce plans.

Resilience and recovery of our workforce is paramount to ensure both a sustainable recovery and the best possible outcomes for our patients:

- This will include longer term investment, particularly in health and wellbeing of staff
- The flexible use of our resources, including adopting agile/hybrid working models
- Supporting our staff to lead and transform

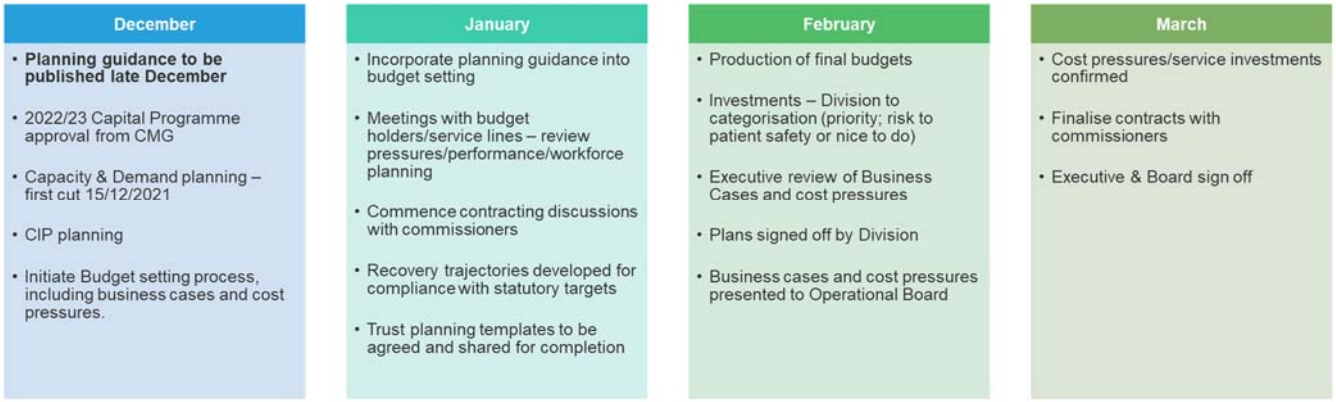
There are some specific workforce challenges which need to be considered and addressed as part of the 22-23 annual planning process and will be translated into divisional workforce plans.

- Bank & Agency usage and spend – plans should include a realistic profile of bank and agency usage and spend across the Trust with reduction plans being developed were usage has been high using hard data and soft intelligence.
- Understanding workforce KPI's and developing reduction trajectories to reduce sickness absence to the Trust target of 3.6%
- Plans should show the steps to be taken to improve recruitment and slow down turnover considering the national context as set out in the NHS People Plan and through understanding the local challenges e.g. exploring new roles and maximising on the benefits of apprenticeship roles

As part of the annual planning process it is expected that any changes in workforce and plans to address the 3 points above, would be documented and monitored as part of the Divisional Business Plans.

6. Milestones

The below outlines the timeframe for delivery in achieving the deadline for final sign off at the end of April.



7. Recommendations

The Board of Directors are asked to:

- NOTE the early implications of the 2022/23 planning guidance
- NOTE the progress made thus far and that the identified timescales

Board of Directors Report (in Public)
Item 3.4

Subject: **2022/23 Changes to Patient Administration Services (PAS)**
Date of Meeting: **25 January 2022**
Prepared by: **Jonathan Mathews, Chief Operating Officer**
Kate Warriner, Chief Digital & Information Officer
Presented by: **Jonathan Mathews, Chief Operating Officer**

Purpose of Report: **For information**

BAF Reference	Impact on BAF
BAF 2, BAF 12	Assurance regarding the administration developments.

Level of assurance (*please tick one*)					
☐	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	X	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Executive Summary

Due to the challenges and changes highlighted to clinical administrative services the executive team agreed that a full review was required. This paper updates on the process of realignment of clinical administration services from the corporate services to the clinical divisions.

2. Background

The LHCH clinical administrative departments have historically reported through corporate services under a central leadership structure. Several challenges have been identified over the past 12 months which has highlighted pressures with workforce, service delivery along with governance concerns due to issues in consistently following process.

The COVID pandemic has also resulted in a change to some of the tasks required within specific groups of staff which has had a potential impact of an increase in workload.

As part of the Digital Excellence Strategy and the Digital Aspirant Programme, LHCH has committed to a significant financial investment in implementing new digital systems that will impact on the roles and functions of the administrative teams.

A modernisation programme of work has been developed to support the modernisation of administration services, enabled by closer alignment to clinical teams and digital transformation.

3. Clinical Administration Modernisation Objectives

The programme of work will look to engage with the teams along with the wider organisation to understand the opportunities with improving service delivery. There will be a focus on addressing the historic workforce challenges and gaps in assurance with administration teams not complying with Trusts standard operation procedures.

3.1 Outputs

- Implementation of a new administrative model, closer to patient care aligned to clinical teams
- Clinical/patient administration teams integrating with the Divisional operational teams
- Integration of digital developments to support quality, efficiency and safety

3.2 Outcomes

- Improve compliance with administrative key performance indicators
- Improved quality and accuracy of service lines waiting lists
- Clear roles, responsibilities and accountability for each post
- Implementation and sign off Standard Operating Procedures (SOP) at Divisional and Service line level
- Potential financial savings to contribute to the divisions cost improvement programme
- Reduction in delays with referral management process
- Reduced span of control to support team engagement and leadership
- Enhance and embed accountability and assurance mechanisms through divisional governance processes
- Improved patient experience with clear communication and scheduling of appointments / visits.

4. Project Costs

The project assumes that the new administration model would be managed within the current budget however this is dependent on the outputs and acknowledging the increase demand on the services and potential teams that are under resourced.

It should be noted that there are already financial constraints within the patient administration services with zero CIP identified for 2021/22 and a significant overspend within medical secretaries.

Costs for the digital project implementation would be excluded as the costs are funded through a different budget line.

5. Project Timelines & Governance

Scope and stakeholder engagement began in Q3 with a final proposed structure expected to Executive Committee by March 2022. If formal consultation is required, then the HR process would be followed, and communication shared through due process.

The Project Team will report to the Executive Committee via the Chief Operating Officer and provide monthly updates via the Patient Pathway & Administration Working Group & Operational Board.

6. Recommendations

The Board of Directors are asked to:

- NOTE the progress made thus far and that the identified timescales outlined in the paper are accepted.

Board of Directors (in Public)
Item 3.5

Subject: **Board Strategy Day Proposed Agenda**
Date of Meeting: **Tuesday 25th January 2022**
Prepared by: **Executive Team**
Presented by: **Jane Tomkinson, Chief Executive**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
None	None

Level of assurance (*please tick one*) *To be used when the content of the report provides evidence of assurance*					
✓	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Recommendations

The Board of Directors are asked to review the content of the proposed agenda for the Board of Directors Strategy Day on 22nd February 2022, and to raise proposed amendments during the meeting.

	Timing	Session	Lead	Composition
Morning	8.30 - 9:00	Arrival, tea and coffee		
	9:00 - 9:15	Introduction and scene setting	Neil Large	
	9:15 - 11:15	Developing New Models of Care in Cardilogy	Jon Develing	
		Provider Frameworks	Rob Mcgough	Hill Dickinsons
	11:15 - 11:30	Comfort Break		
	11:30 - 12:30	Integrating Care / Services	Jane Tomkinson / Jon Develing	
		Liverpool Univeristy Hospital	All	
		LHCH @ Model (Warrington)	All	
LUNCH				
Afternoon	13:30 - 14:00	Population Health Improvement (Cheshire and Warrington LEP)	Jane Tomkinson / Jon Develing	
	14:00 - 14:30	Faciliattion thorugh the Digital platfrom	Kate Warriner	
	14:30 - 15:00	Future of the Specialised Provider Alliance	Jon Develing	
	15:00 - 15:30	LHCH role in Provider Alliances	Jane Tomkinson / Jon Develing	
	15:30 - 16:00	Update on NHS Planning Guidnance and impact on LHCH	Jonathan Mathews	

Board of Directors (in Public)
Item 4.1

Subject: **Month 9 SOF Performance Report**
Date of Meeting: **Tuesday 25th January 2022**
Prepared by: **Executive Directors**
Presented by: **Jonathan Mathews, Chief Operating Officer**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
BAF2	Provides assurance in terms of the performance against the statutory indicators and that this risk remains in line with the risk appetite.

Level of assurance					
✓	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Executive Summary

The purpose of this paper is to present an update on the Trust performance for the period ending 31st December 2021 and should be read in conjunction with the performance dashboard that is attached at Appendix 1. The Trust is operating in an environment that is focused on safely restoring high levels of elective activity to treat the backlog of patients as an output of the COVID-19 pandemic. In terms of the Trust's statutory performance the following exceptions should be noted:

- Referral to treatment waiting times remain below target as expected due to the significant backlog accumulated during the surge. Performance in month stands at 81.5% for English commissioned activity and 77.0% for welsh commissioners, a slightly declined position compared to the previous month. This performance is in line with the Trust recovery trajectories.
- Bed Occupancy was below 80% in December (75%) but is expected above the target threshold through Q4. Mutual aid is being reviewed to support the system with G&A bed capacity.
- There were 62 patients waiting longer than 52 weeks at the end of December, an

increased position compared to previous months. Q3 challenges have been seen in relation to Anaesthetic support, theatre workforce and increased urgent demand. In Q4 we have seen an increase in staff sickness and Urgent pressures that may impact on performance against the recovery trajectory

- In Hospital Mortality was high during the end of October going into November. This was driven by clustering of a large number of admissions after out of hospital cardiac arrest which carries a high mortality. The numbers improved in December.
- VTE compliance has dropped below target in month, with plans in place to support compliance. The overall figure is driven by a reduction in 24-hour re-assessment of VTE. The divisions have met with the VTE lead and an action plan agreed. The figures for January have improved.
- Sickness increased to 6.6% in month, 0.8% higher compared to the same period last year. The teams are focused on clear and early intervention to avoid long term sickness where appropriate. This has seen an increase where staff have been absent due to testing positive for COVID due to the Omicron variant.
- Staff recommending LHCH as a great place to work remains static at 76% as we await the national survey result early 2022.
- There is continued focus to bring mandatory training at 94.7% back to 95% target.
- Turnover has increased slightly in all areas except surgery where the main reasons are promotion and broader experience and relocation. Improved intel is now available due to the refreshed exit interview process and the retention group continues its work on improving retention.

Safely restoring maximum levels of elective activity amongst COVID system support remains the focus for the operational teams, delivering against the ambitious recovery trajectories which the Board will be updated on monthly.

Other performance exceptions to note are summarised as follows:

- 28-day faster diagnosis standard – performance in month stood at 75%, which was a significant achievement given staffing challenges. Continued work is being undertaken to review EBUS and CT Guided Biopsy capacity for compliance in Q4.
- HSMR – both indicators showing as non-compliant for the Trust, reasons and mitigations were discussed under the Mortality Improvement Strategy on the Board of Directors meeting (November 2021).

2. Financial Position

The Trust reported a surplus of £321k in the period ending 31st December. The financial position for the second half of the year (H2) has been agreed as a break-even plan. Income from the Integrated Care System (ICS) had been agreed and supports the target position

The 2021/22 financial year has been split into two six month planning periods (H1 and H2). The planning guidance for H2 was released at the end of September and many of the existing contractual arrangements have rolled forward to the second half of the year. ERF will continue into H2, albeit with a revised calculation methodology based on RTT pathways as opposed to activity.

The Trust is planning a break-even position for H2 with a number of risks and mitigations to be worked through in the coming months.

Non-NHS income was favorable in month leading to the better than anticipated surplus position. Expenditure in the month of December was in line with expectations with no significant variances to note.

The Trust continues to make progress in the development of its Cost Improvement Plan with slippage from earlier periods covered by non-recurrent mitigations.

Capital expenditure is showing slippage related to Estates schemes and equipment replacement purchases, but the forecast remains line with the programme value agreed for the financial year with no significant risks identified to date.

The Trust retains a strong cash position.

3. Conclusion

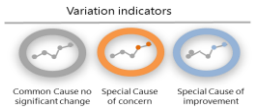
The Trust is performing well against the suite of statutory and Trust level KPIs as well as the recovery trajectories that were developed earlier in the year. The Trust is experiencing challenges with staffing across Cath Labs, Theatres and Radiology but these are being mitigated as far as possible. The clinical and operational teams are well sighted on the required performance which is managed through the divisional governance structures and Operational Board.

4. Recommendation

The Board of Directors is asked to note the content of the paper and associated actions detailed within it.

Item 4.1 (a)

LIVERPOOL HEART AND CHEST HOSPITAL PERFORMANCE REPORT



Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Operational Performance

measure	target		in month	variation
RTT 18 weeks in aggregate - Incomplete Pathways	92.0%		81.48%	
All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85.0%		88.9%	
Maximum 6-week wait for diagnostic procedures	99.0%		99.11%	
Dementia - Find	90.0%		91.0%	
Dementia - Assess	90.0%		100.0%	
Dementia - Refer	90.0%		100.0%	
Cancelled Operations for non-clinical reasons	2.0%		1.5%	
Patients not booked in within 28 days (non clinical cancellations)	0		0	
Delayed Transfers of care	5.0%		2.98%	
Bed Occupancy	80.0%		75.6%	
Referral to treatment - Incomplete Pathways 52+ weeks	0		62	

Operational Performance

measure	target		in month	variation
Cancer: 14 day GP referral to 1st Outpatient Appointment	93.0%		100.0%	
Cancer: 31 day diagnosis to 1st treatment for all cancers	96.0%		100.0%	
Cancer: 31 day Second or subsequent treatment (surgery & drug)	94.0%		100.0%	
Cancer: 62 day Consultant Upgrade	85.0%		100.0%	
Welsh Patients: 26 weeks Referral To Treatment waiting times - Incomplete	95.0%		76.97%	
In-Hospital mortality	17		25	
Quantity of complaints	6		1	
Occurrence of any Never Events	0		0	
Mixed sex accommodation breaches	0		0	
Inpatient scores from Friends & Family Test - % positive	95.0%		99.03%	

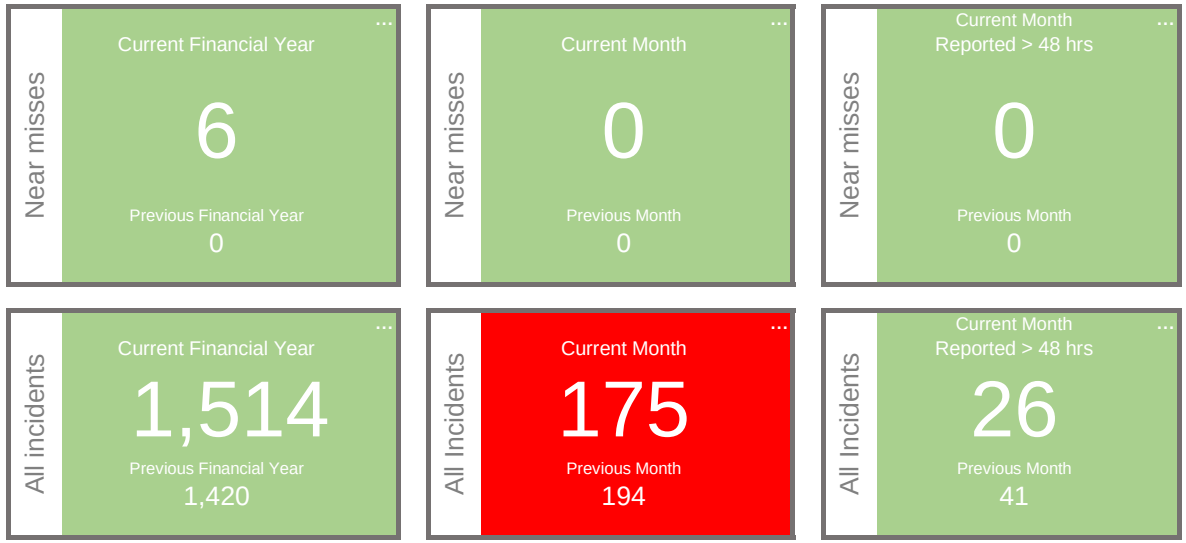
Quality of Care

measure	target		in month	variation
Venous thromboembolism (VTE) risk assessment	95.0%		93.1%	
Clostridium Difficile	0		0	
MRSA Bacteraemias	0		0	
MSSA Bacteraemias	0		1	
Gram Negative Bacteraemias	0		1	
Hospital Standardised Mortality Ratio (HSMR) - basket diagnoses	101		124	
Hospital Standardised Mortality Ratio (HSMR) - all diagnoses	101		121	
Incidents - Serious incidents, Never Events, Adverse Events (Red)	1		0	
Clostridium difficile – infection rate	0		0	
Patient Safety Alerts not completed by deadline	0		0	
NHS Staff Survey - Staff recommendation of the organisation as a place to work	76.0%		76.0%	
NHS Staff Survey - Staff recommendation of the organisation as a place of treatment	96.0%		92.0%	

Organisational Health

measure	target		in month	variation
Staff Sickness (All Staff)	3.4%		6.6%	
Staff Turnover	10.0%		11.36%	
Executive Team Turnover	25.0%		34.05%	
Mandatory Training Compliance	95.0%		94.7%	
Appraisals Compliance	90.0%		92.0%	
Recurrent CIP identified	100.0%		76.43%	
Liquidity (days)	0		25	
I & E distance from target (cumulative) - £,000	0		146	
Better Payment Practice Code	95.0%		99.0%	

Dec-21

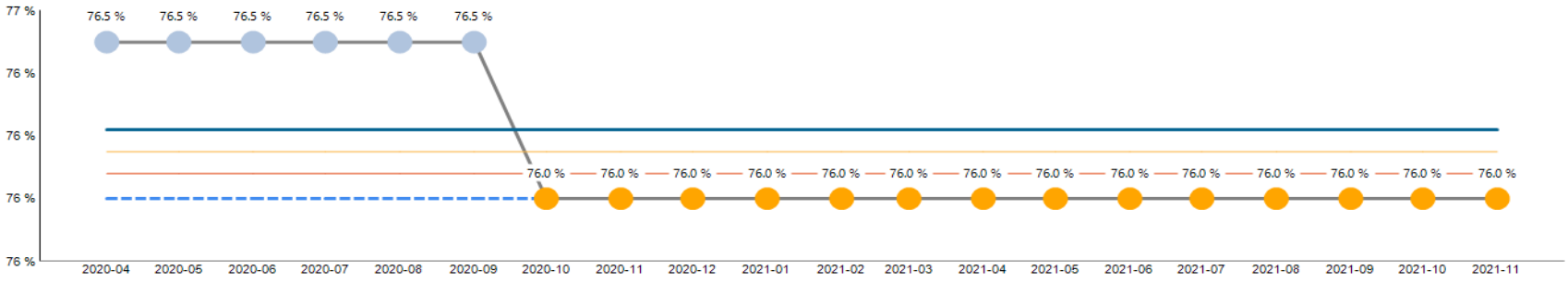

Near misses
Current Financial Year
6
Previous Financial Year
0
Near misses
Current Month
0
Previous Month
0
Near misses
Current Month
Reported > 48 hrs
0
Previous Month
0
All incidents
Current Financial Year
1,514
Previous Financial Year
1,420
All Incidents
Current Month
175
Previous Month
194
All Incidents
Current Month
Reported > 48 hrs
26
Previous Month
41

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

NHS Staff Survey - Staff recommendation of the organisation as a place to work

Target	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11
>=76%	76.5%	76.5%	76.5%	76.5%	76.5%	76.5%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%	76.0%



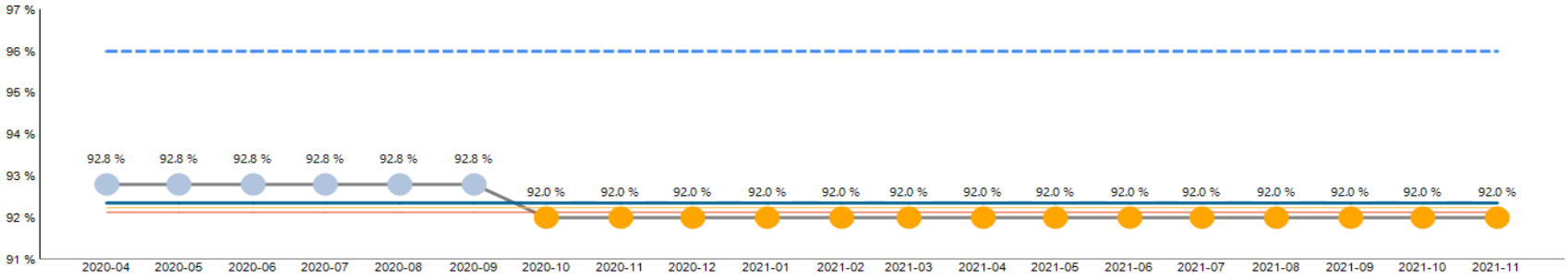
Concern

ucl	76.22%
mean	76.15%
target	76.0%
lcl	76.08%

commentary:

NHS Staff Survey - Staff recommendation of the organisation as a place of treatment

Target	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11
>=96%	92.8%	92.8%	92.8%	92.8%	92.8%	92.8%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%



Concern

ucl	92.35%
mean	92.24%
target	96.0%
lcl	92.13%

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

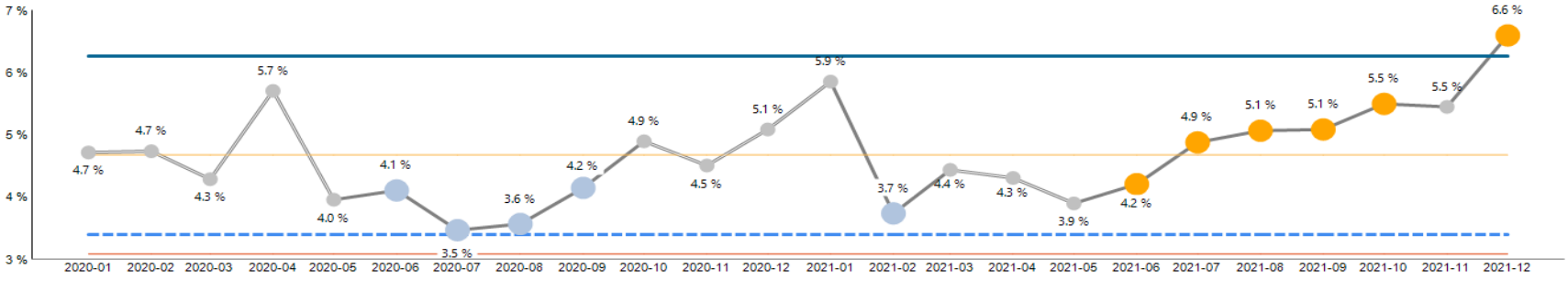
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Staff Sickness (All Staff)

Rate of sickness across all staff

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
<=3.4%	4.7%	4.7%	4.3%	5.7%	4.0%	4.1%	3.5%	3.6%	4.2%	4.9%	4.5%	5.1%	5.9%	3.7%	4.4%	4.3%	3.9%	4.2%	4.9%	5.1%	5.1%	5.5%	5.5%	6.6%

Concern



ucl	6.27%
mean	4.68%
target	3.4%
lcl	3.09%

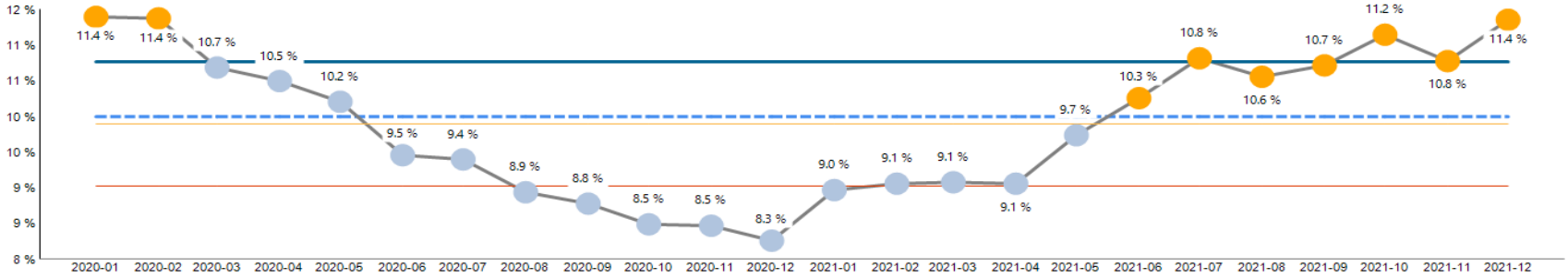
commentary:

Staff Turnover

Rate of turnover among voluntary leavers

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
<=10%	11.4%	11.4%	10.7%	10.5%	10.2%	9.5%	9.4%	8.9%	8.8%	8.5%	8.5%	8.3%	9.0%	9.1%	9.1%	9.1%	9.7%	10.3%	10.8%	10.6%	10.7%	11.2%	10.8%	11.4%

Concern



ucl	10.77%
mean	9.9%
target	10.0%
lcl	9.03%

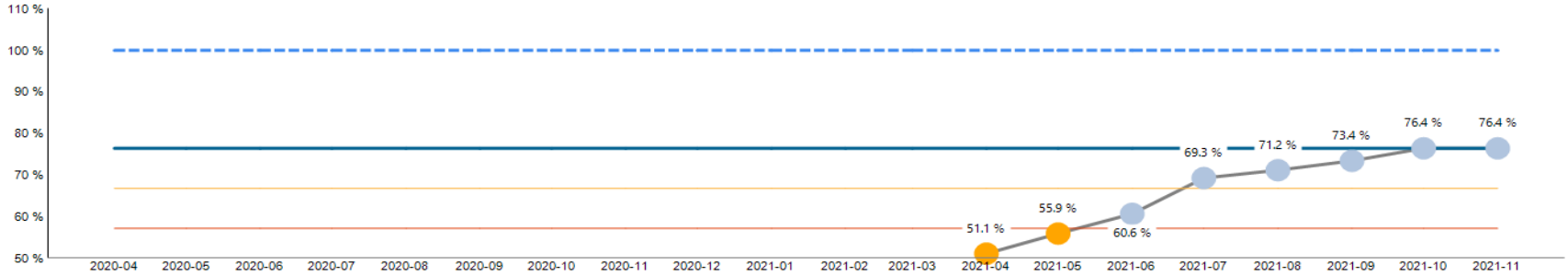
commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Recurrent CIP identified

Target	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11
100%													51.1%	55.9%	60.6%	69.3%	71.2%	73.4%	76.4%	76.4%



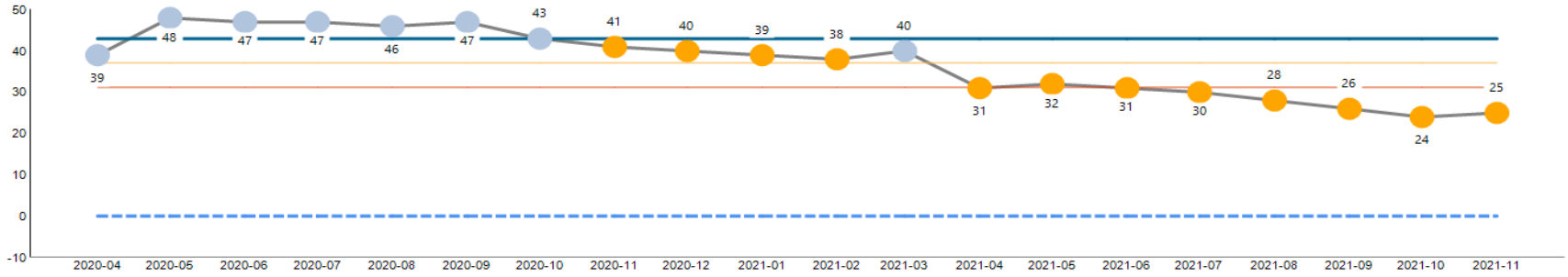
Improvement

ucl	76.43%
mean	66.79%
target	100.0%
lcl	57.15%

commentary:

Liquidity (days)

Target	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11
0	39	48	47	47	46	47	43	41	40	39	38	40	31	32	31	30	28	26	24	25



Concern

ucl	43
mean	37
target	0
lcl	31

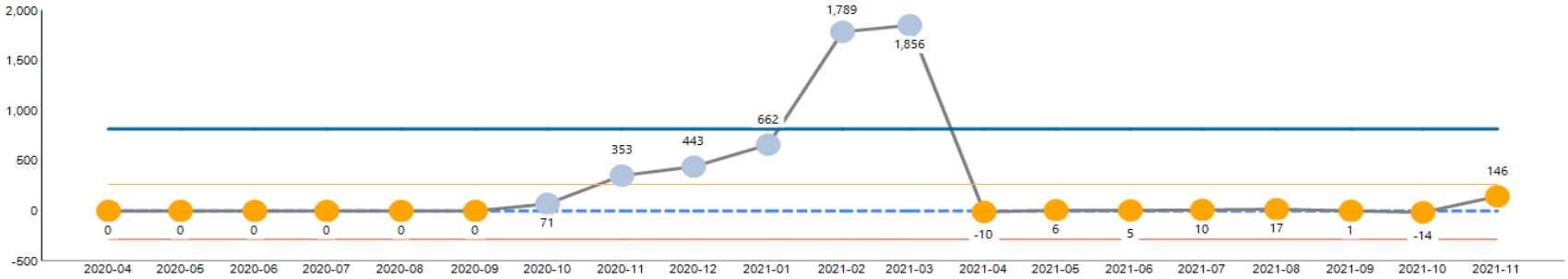
commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

I & E distance from target (cumulative) - £,000

Target	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11
0	0	0	0	0	0	0	71	353	443	662	1,789	1,856	(10)	6	5	10	17	1	(14)	146



Concern

ucl	819
mean	267
target	0
lcl	-285

commentary:

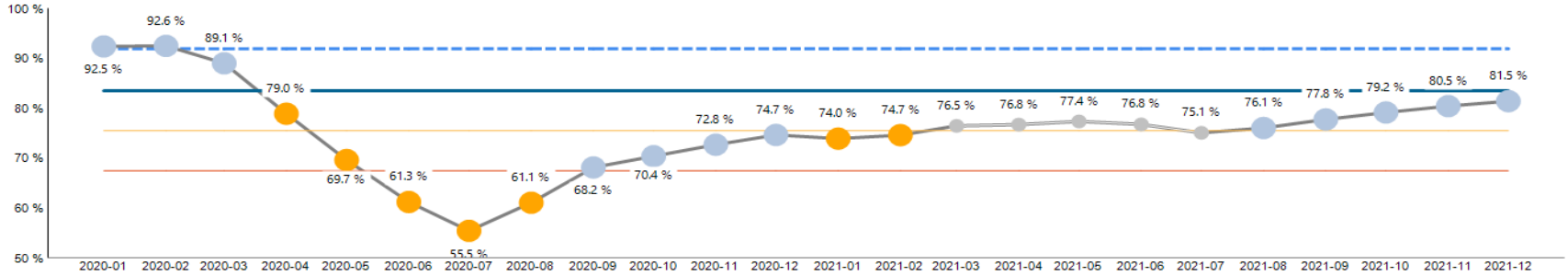
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

RTT 18 weeks in aggregate - Incomplete Pathways

Percentage of patients whose clock has not stopped during the calendar month where the clock period is less than 18 weeks

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=92%	92.5%	92.6%	89.1%	79.0%	69.7%	61.3%	55.5%	61.1%	68.2%	70.4%	72.8%	74.7%	74.0%	74.7%	76.5%	76.8%	77.4%	76.8%	75.1%	76.1%	77.8%	79.2%	80.5%	81.5%



Improvement

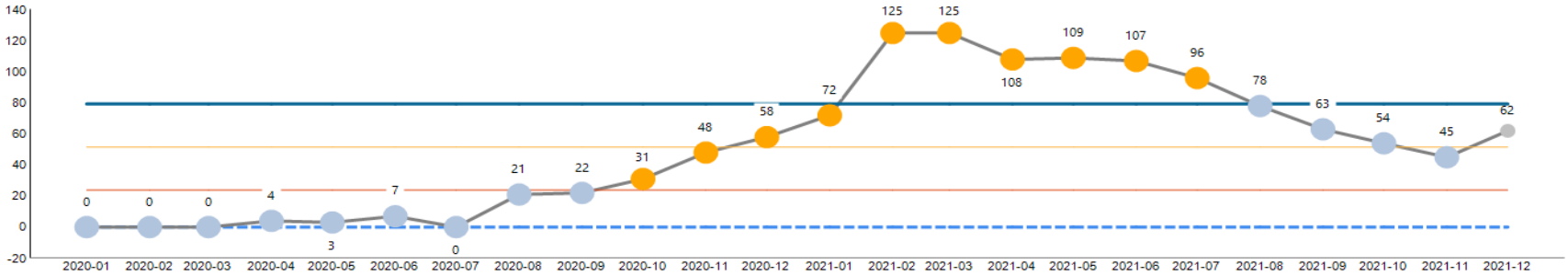
ucl	83.56%
mean	75.55%
target	92.0%
lcl	67.53%

commentary:

Referral to treatment - Incomplete Pathways 52+ weeks

Count of all patients on an incomplete pathway waiting over 52 weeks (English & Non-English)

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
<0	0	0	0	4	3	7	0	21	22	31	48	58	72	125	125	108	109	107	96	78	63	54	45	62



Common Cause

ucl	79
mean	52
target	0
lcl	24

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

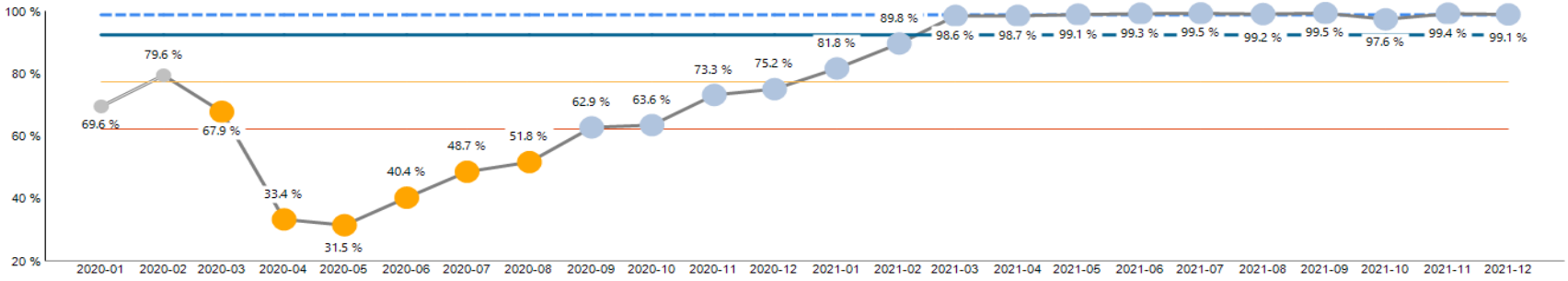
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Maximum 6-week wait for diagnostic procedures

Proportion of patients referred for diagnostic tests who have been waiting for less than six weeks

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=99%	69.6%	79.6%	67.9%	33.4%	31.5%	40.4%	48.7%	51.8%	62.9%	63.6%	73.3%	75.2%	81.8%	89.8%	98.6%	98.7%	99.1%	99.3%	99.5%	99.2%	99.5%	97.6%	99.4%	99.1%

Improvement



ucl	92.56%
mean	77.47%
target	99.0%
lcl	62.38%

commentary:

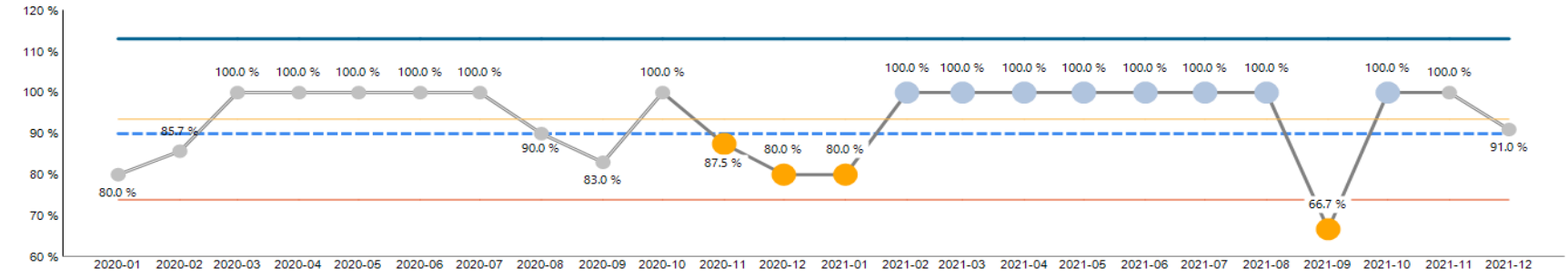
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Dementia - Find

The proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who have a diagnosis of dementia or delirium or to whom case finding is applied

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=90%	80.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	83.0%	100.0%	87.5%	80.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	91.0%



Common Cause

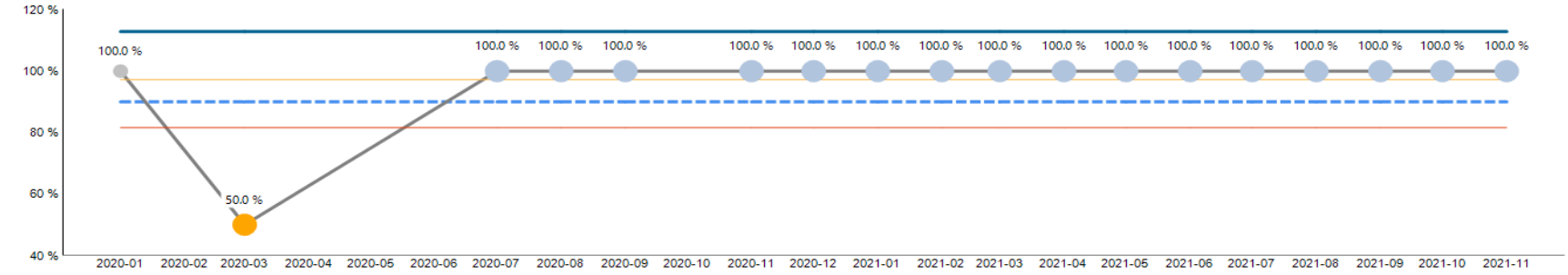
ucl	113.11%
mean	93.5%
target	90.0%
lcl	73.88%

commentary:

Dementia - Assess

The proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who, if identified as potentially having dementia or delirium, are appropriately assessed

Target	2020-01	2020-03	2020-07	2020-08	2020-09	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11
>=90%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Improvement

ucl	112.87%
mean	97.22%
target	90.0%
lcl	81.58%

commentary:

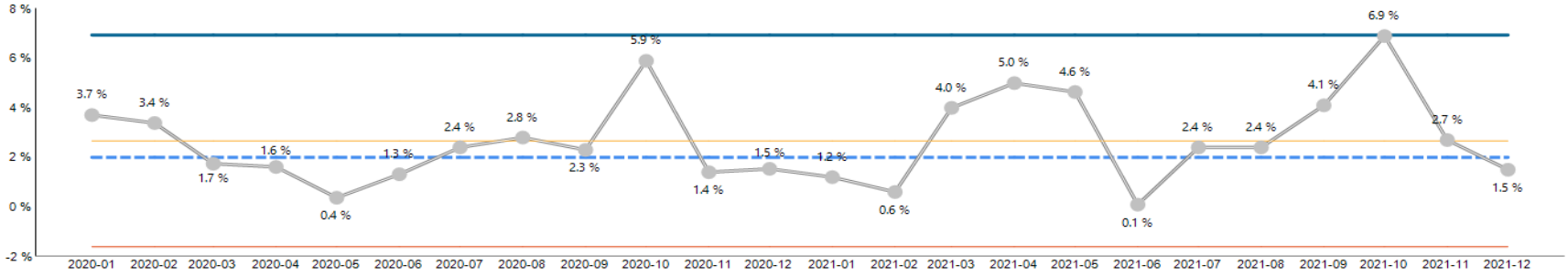
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Cancelled Operations for non-clinical reasons

Count of the number of last minute cancellations by the hospital for non clinical reasons

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
<=2%	3.7%	3.4%	1.7%	1.6%	0.4%	1.3%	2.4%	2.8%	2.3%	5.9%	1.4%	1.5%	1.2%	0.6%	4.0%	5.0%	4.6%	0.1%	2.4%	2.4%	4.1%	6.9%	2.7%	1.5%



Common Cause

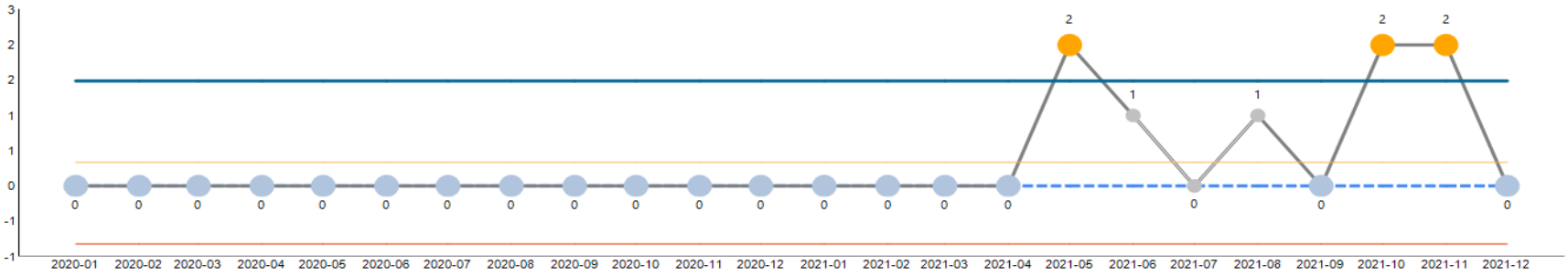
ucl	6.94%
mean	2.67%
target	2.0%
lcl	-1.61%

commentary:

Patients not booked in within 28 days (non clinical cancellations)

Count of operations cancelled for non-clinical reasons and not offered a new date within 28 days

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	1	0	2	2	0



Improvement

ucl	1
mean	0
target	0
lcl	-1

commentary:

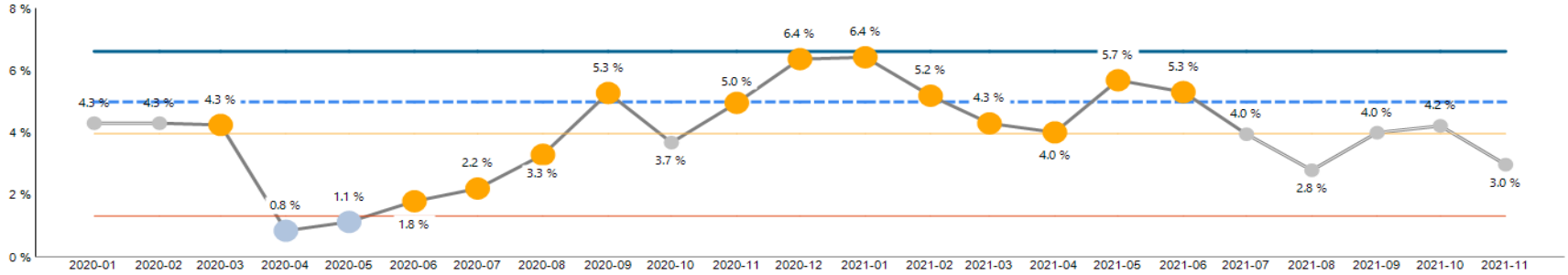
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Delayed Transfers of care

A delayed transfer of care occurs when a patient is ready to depart from such care and is still occupying a bed.

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11
<=5%	4.3%	4.3%	4.3%	0.8%	1.1%	1.8%	2.2%	3.3%	5.3%	3.7%	5.0%	6.4%	6.4%	5.2%	4.3%	4.0%	5.7%	5.3%	4.0%	2.8%	4.0%	4.2%	3.0%



Common Cause

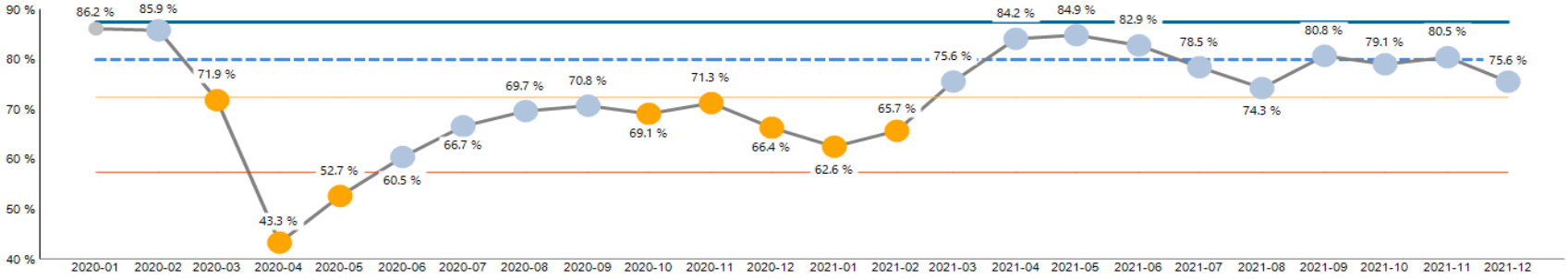
ucl	6.63%
mean	3.98%
target	5.0%
lcl	1.33%

commentary:

Bed Occupancy

Count of beds occupied over all wards/ count of bed available

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=80%	86.2%	85.9%	71.9%	43.3%	52.7%	60.5%	66.7%	69.7%	70.8%	69.1%	71.3%	66.4%	62.6%	65.7%	75.6%	84.2%	84.9%	82.9%	78.5%	74.3%	80.8%	79.1%	80.5%	75.6%



Improvement

ucl	87.53%
mean	72.46%
target	80.0%
lcl	57.39%

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

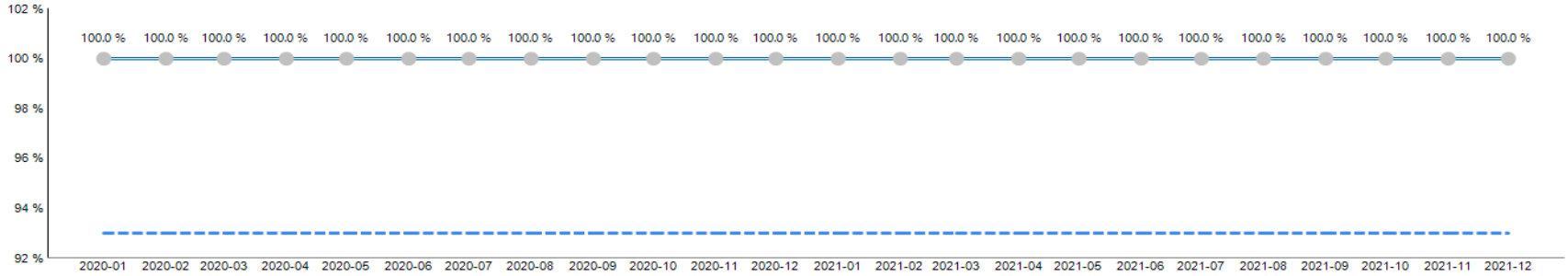
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Cancer: 14 day GP referral to 1st Outpatient Appointment

Patients waiting a maximum of two weeks from an urgent GP referral for surspected cancer to date first seen by specialist

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Common Cause



ucl	100.0%
mean	100.0%
target	93.0%
lcl	100.0%

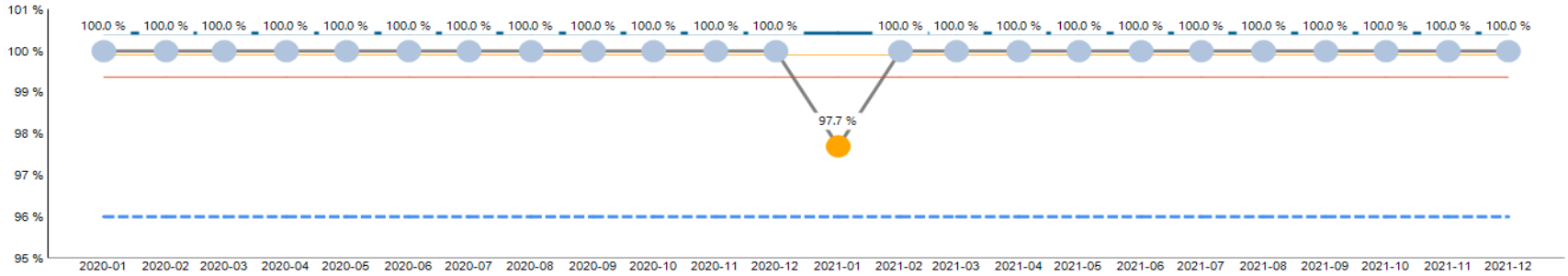
commentary:

Cancer: 31 day diagnosis to 1st treatment for all cancers

Patients witing a maximum of 31 days from diagnosis to first definitive treatment

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=96%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Improvement



ucl	100.44%
mean	99.9%
target	96.0%
lcl	99.37%

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

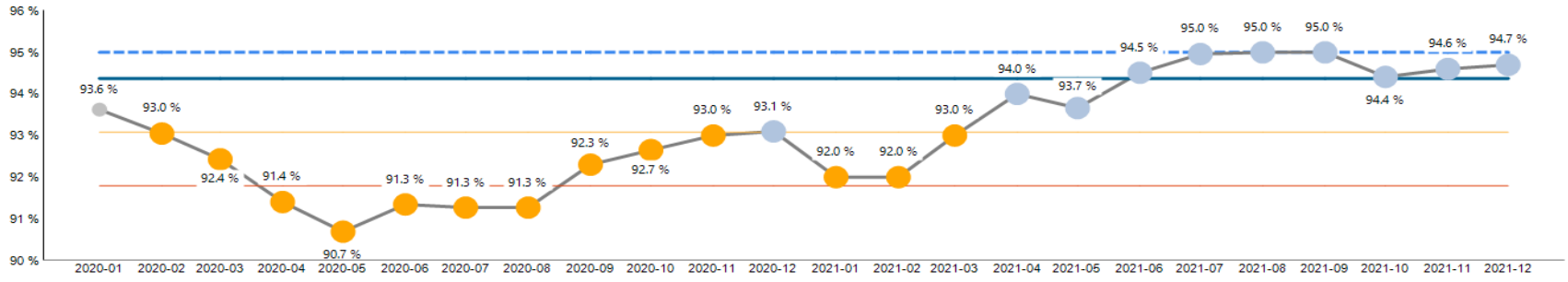
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Mandatory Training Compliance

Percentage of completed mandatory training

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=95%	93.6%	93.0%	92.4%	91.4%	90.7%	91.3%	91.3%	91.3%	92.3%	92.7%	93.0%	93.1%	92.0%	92.0%	93.0%	94.0%	93.7%	94.5%	95.0%	95.0%	95.0%	94.4%	94.6%	94.7%

Improvement



ucl	94.37%
mean	93.08%
target	95.0%
lcl	91.79%

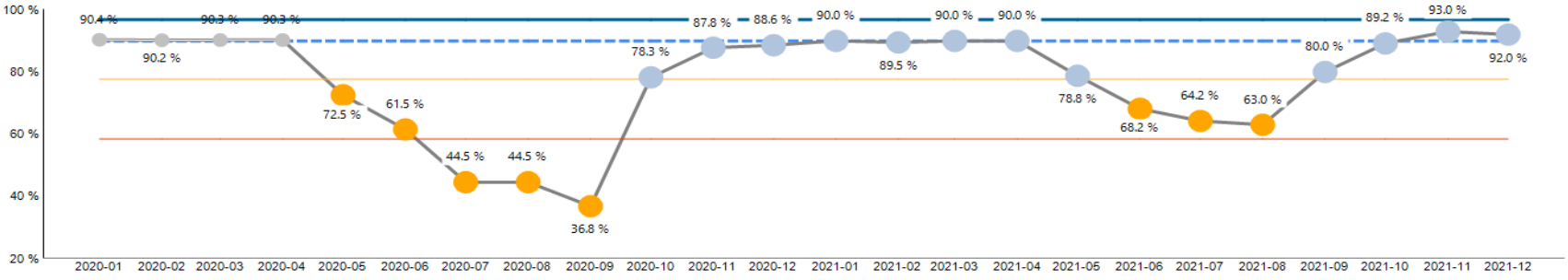
commentary:

Appraisals Compliance

Percentage of annual appraisals completed

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=90%	90.4%	90.2%	90.3%	90.3%	72.5%	61.5%	44.5%	44.5%	36.8%	78.3%	87.8%	88.6%	90.0%	89.5%	90.0%	90.0%	78.8%	68.2%	64.2%	63.0%	80.0%	89.2%	93.0%	92.0%

Improvement



ucl	96.83%
mean	77.64%
target	90.0%
lcl	58.46%

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

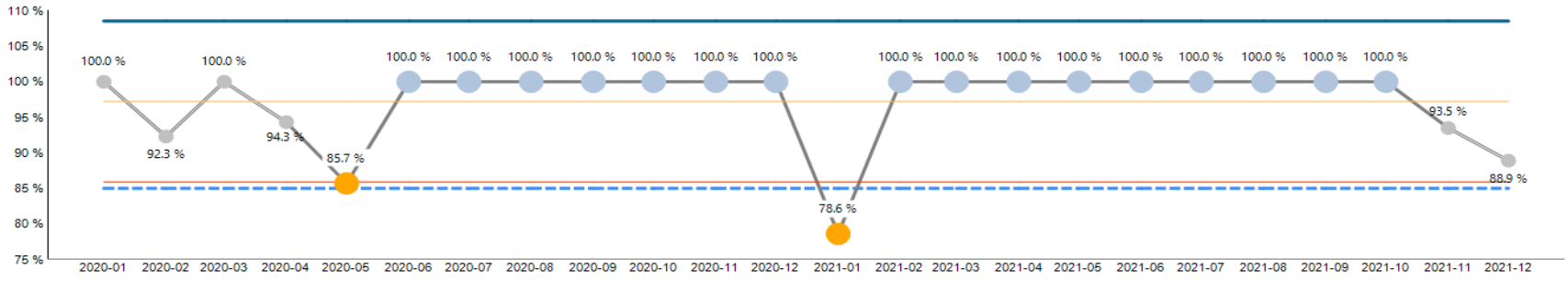
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer

Proportion of patients referred for cancer treatment by their GP who have currently been waiting for less than 62 days for treatment to start

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=85%	100.0%	92.3%	100.0%	94.3%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	78.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.5%	88.9%

Common Cause



ucl	108.54%
mean	97.22%
target	85.0%
lcl	85.9%

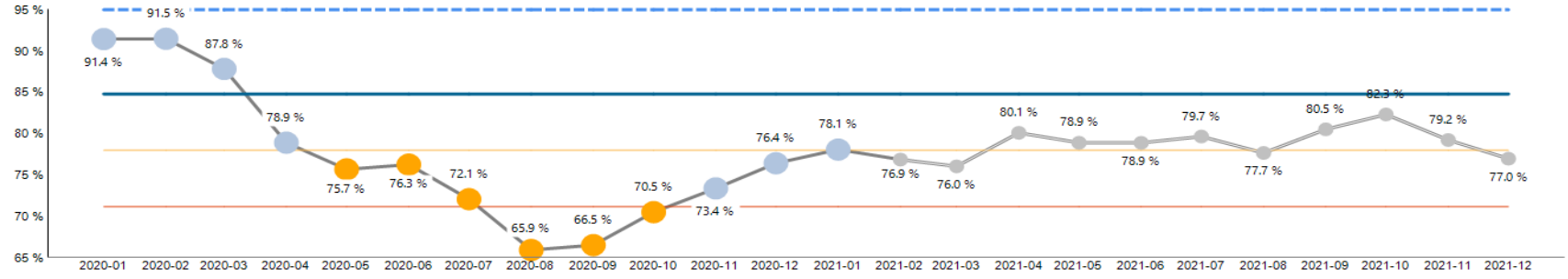
commentary:

Welsh Patients: 26 weeks Referral To Treatment waiting times - Incomplete

Proportion of patients referred for cancer treatment by their GP who have currently been waiting for less than 62 days for treatment to start

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=95%	91.4%	91.5%	87.8%	78.9%	75.7%	76.3%	72.1%	65.9%	66.5%	70.5%	73.4%	76.4%	78.1%	76.9%	76.0%	80.1%	78.9%	78.9%	79.7%	77.7%	80.5%	82.3%	79.2%	77.0%

Common Cause



ucl	84.8%
mean	77.98%
target	95.0%
lcl	71.16%

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

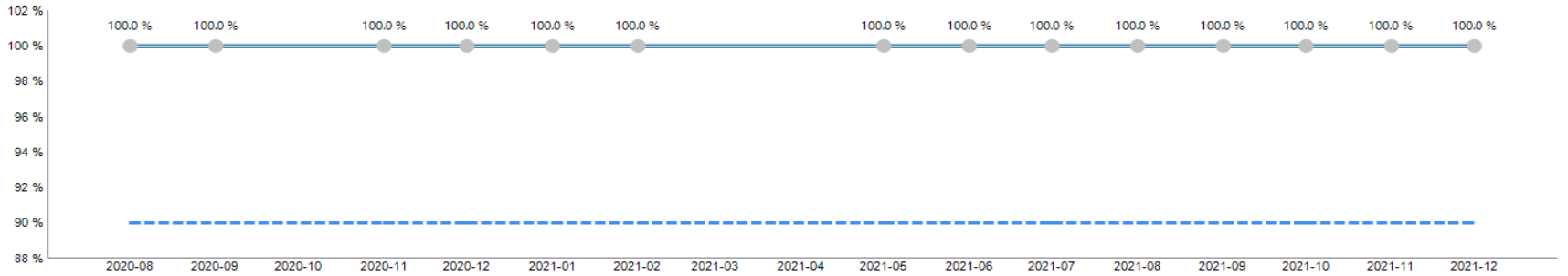
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Dementia - Refer

The proportion of patients aged 75 and over admitted as an emergency for more than 72 hours identified as potentially having dementia or delirium where the outcome was positive or inconclusive who are referred on to specialist services

Target	2020-08	2020-09	2020-11	2020-12	2021-01	2021-02	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Common Cause



ucl	100.0%
mean	100.0%
target	90.0%
lcl	100.0%

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

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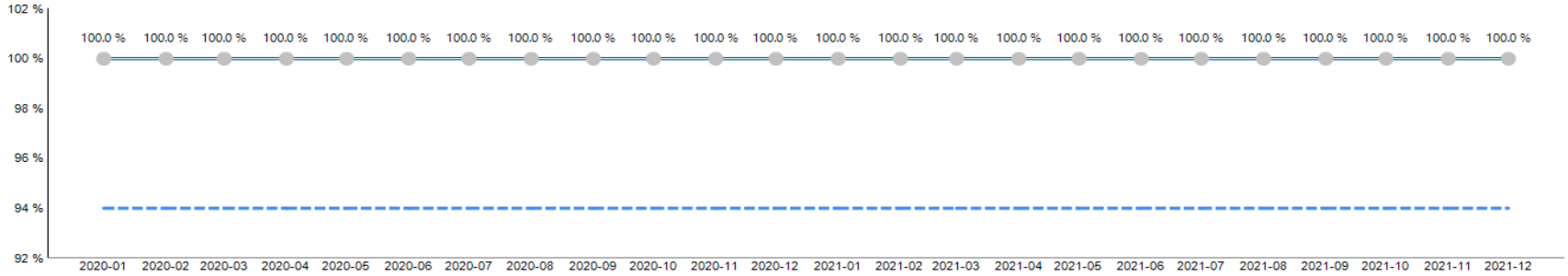
NHS Foundation Trust

Cancer: 31 day Second or subsequent treatment (surgery & drug)

Patients waiting a maximum of 31 days for all subsequent treatments

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Common Cause

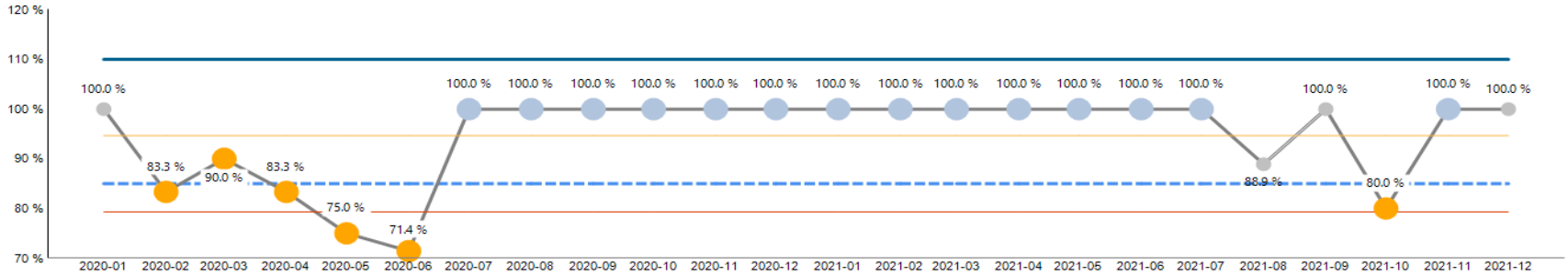
ucl	100.0%
mean	100.0%
target	94.0%
lcl	100.0%

commentary:

Cancer: 62 day Consultant Upgrade

Patients waiting a maximum of 62 days from a consultant decision to upgrade the urgency of a patient they suspect to have cancer to first treatment

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=85%	100.0%	83.3%	90.0%	83.3%	75.0%	71.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	80.0%	100.0%	100.0%



Common Cause

ucl	110.01%
mean	94.67%
target	85.0%
lcl	79.32%

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

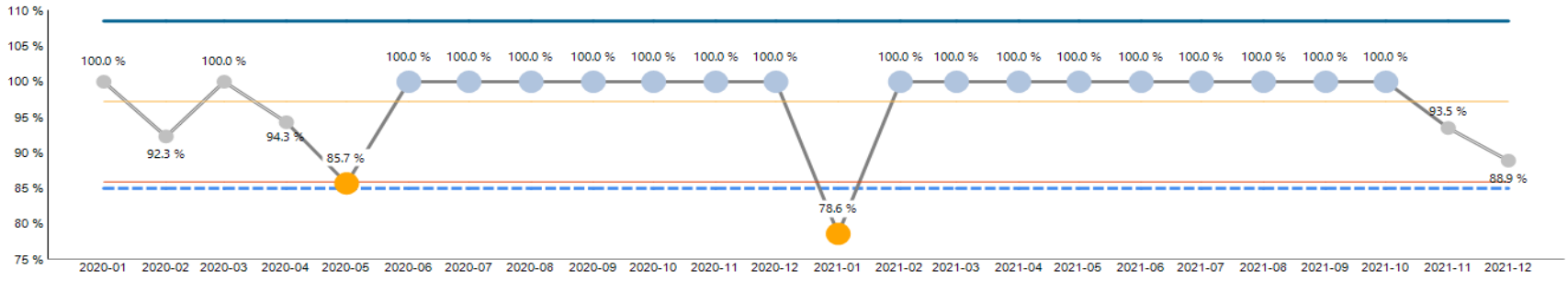
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer

Proportion of patients referred for cancer treatment by their GP who have currently been waiting for less than 62 days for treatment to start

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=85%	100.0%	92.3%	100.0%	94.3%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	78.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.5%	88.9%

Common Cause



ucl	108.54%
mean	97.22%
target	85.0%
lcl	85.9%

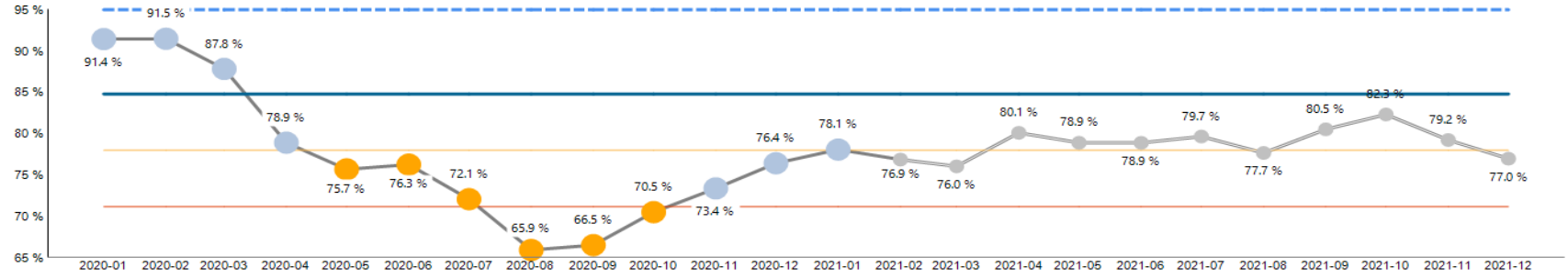
commentary:

Welsh Patients: 26 weeks Referral To Treatment waiting times - Incomplete

Proportion of patients referred for cancer treatment by their GP who have currently been waiting for less than 62 days for treatment to start

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=95%	91.4%	91.5%	87.8%	78.9%	75.7%	76.3%	72.1%	65.9%	66.5%	70.5%	73.4%	76.4%	78.1%	76.9%	76.0%	80.1%	78.9%	78.9%	79.7%	77.7%	80.5%	82.3%	79.2%	77.0%

Common Cause



ucl	84.8%
mean	77.98%
target	95.0%
lcl	71.16%

commentary:

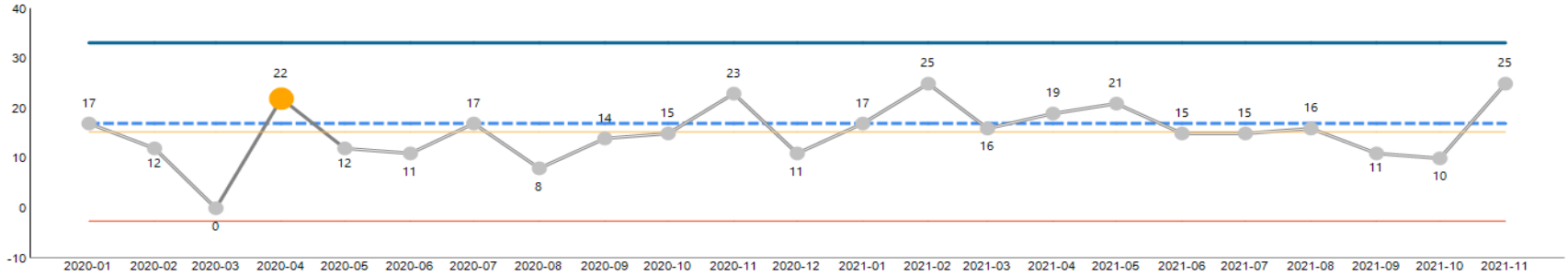
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

In-Hospital mortality

Count of Hospital deaths across the trust for the month/YTD

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11
<=17	17	12	0	22	12	11	17	8	14	15	23	11	17	25	16	19	21	15	15	16	11	10	25



Common Cause

ucl	33
mean	15
target	17
lcl	-3

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

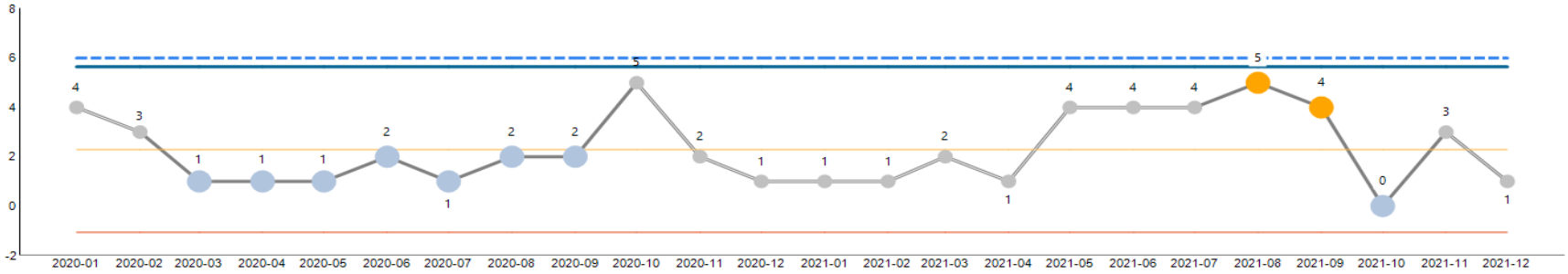
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Quantity of complaints

Quantity of complaints

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
<=6	4	3	1	1	1	2	1	2	2	5	2	1	1	1	2	1	4	4	4	5	4	0	3	1

Common Cause



ucl	6
mean	2
target	6
lcl	-1

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

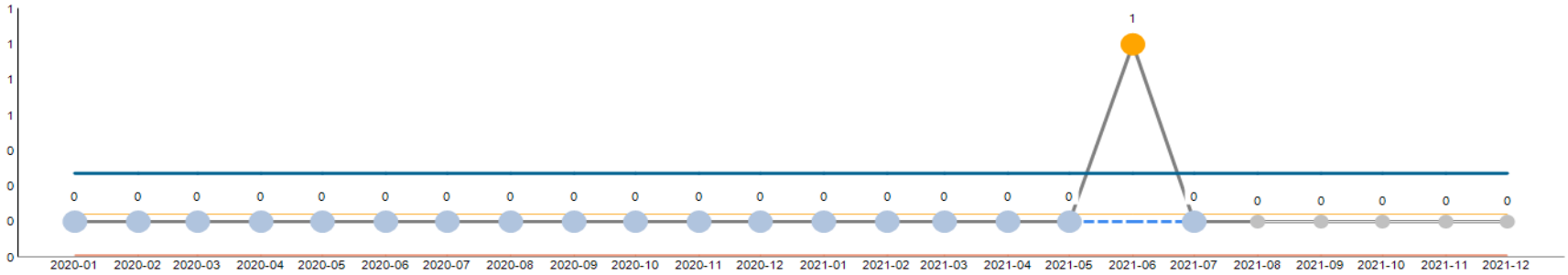
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Occurrence of any Never Events

Count of Never Events

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0

Common Cause



ucl	0
mean	0
target	0
lcl	-0

commentary:

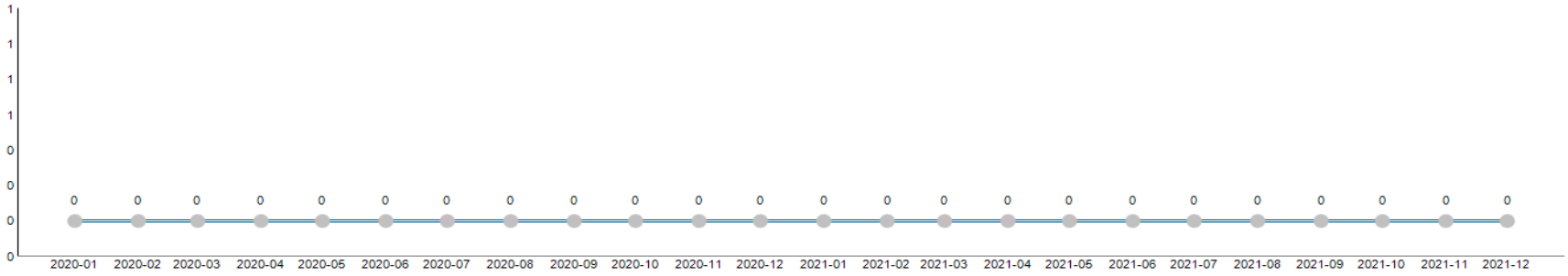
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Mixed sex accommodation breaches

Count of number of occassions sexes were mixed on same-sex wards

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



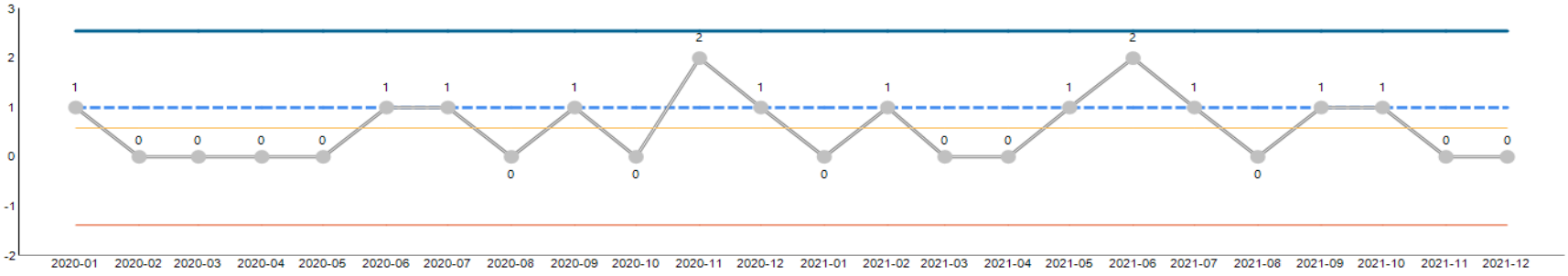
Common Cause

ucl	0
mean	0
target	0
lcl	0

commentary:

Incidents - Serious incidents, Never Events, Adverse Events (Red)

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
1	1	0	0	0	0	1	1	0	1	0	2	1	0	1	0	0	1	2	1	0	1	1	0	0



Common Cause

ucl	3
mean	1
target	1
lcl	-1

commentary:

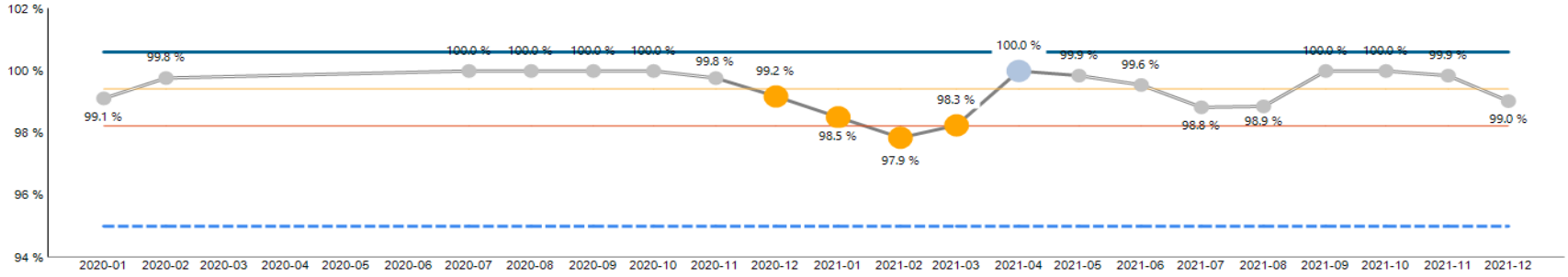
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Inpatient scores from Friends & Family Test - % positive

Percentage of inpatients rating the service good or very good

Target	2020-01	2020-02	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=95%	99.1%	99.8%	100.0%	100.0%	100.0%	100.0%	99.8%	99.2%	98.5%	97.9%	98.3%	100.0%	99.9%	99.6%	98.8%	98.9%	100.0%	100.0%	99.9%	99.0%



Common Cause

ucl	100.61%
mean	99.42%
target	95.0%
lcl	98.23%

commentary:

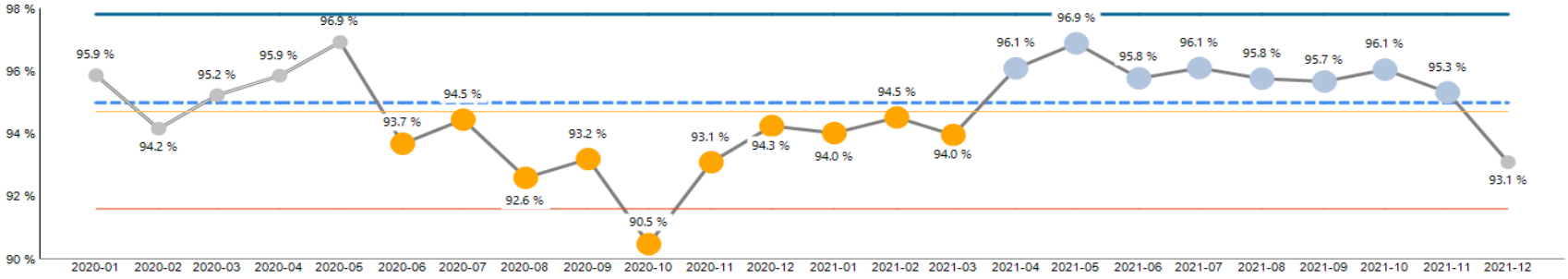
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Venous thromboembolism (VTE) risk assessment

Number of patients admitted who have a VTE risk assessment/number of patients admitted in most recent month

Target	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
>=95%	95.9%	94.2%	95.2%	95.9%	96.9%	93.7%	94.5%	92.6%	93.2%	90.5%	93.1%	94.3%	94.0%	94.5%	94.0%	96.1%	96.9%	95.8%	96.1%	95.8%	95.7%	96.1%	95.3%	93.1%



Common Cause

ucl	97.83%
mean	94.72%
target	95.0%
lcl	91.61%

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

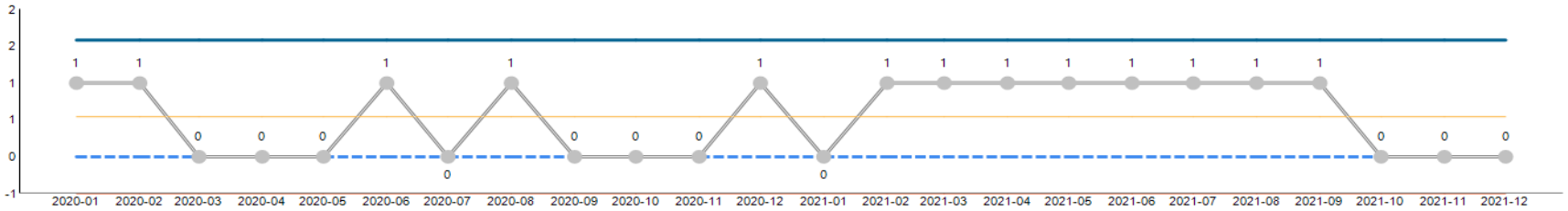
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Clostridium Difficile

Count of trust assigned C. difficile infections in patients aged two years and over compared to the number of planned C. difficile cases

	2019/20			2020/21												2021/22								
	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
6	1	1	0	0	0	1	0	1	0	0	0	1	0	1	1	1	1	1	1	1	1	0	0	0
				0	0	1	1	2	2	2	2	3	3	4	5	1	2	3	4	5	6	6	6	6

Common Cause



ucl	2
mean	1
target	0
lcl	-0

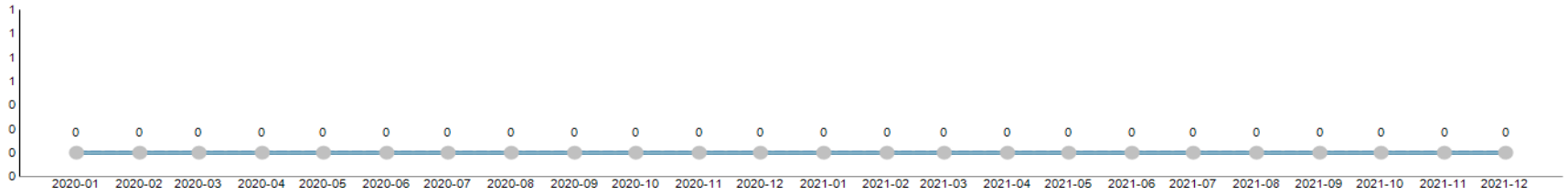
commentary:

MRSA Bacteraemias

Count of trust assigned MRSA infections

	2019/20			2020/21												2021/22								
	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
				0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Common Cause



ucl	0
mean	0
target	0
lcl	0

commentary:

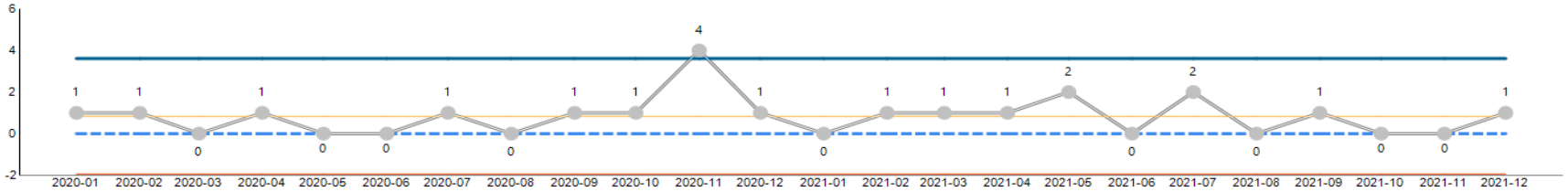
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

MSSA Bacteraemias

Count of trust assigned MSSA infections

	2019/20			2020/21												2021/22								
	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
9	1	1	0	1	0	0	1	0	1	1	4	1	0	1	1	1	2	0	2	0	1	0	0	1
				1	1	1	2	2	3	4	8	9	9	10	11	1	3	3	5	5	6	6	6	7



Common Cause

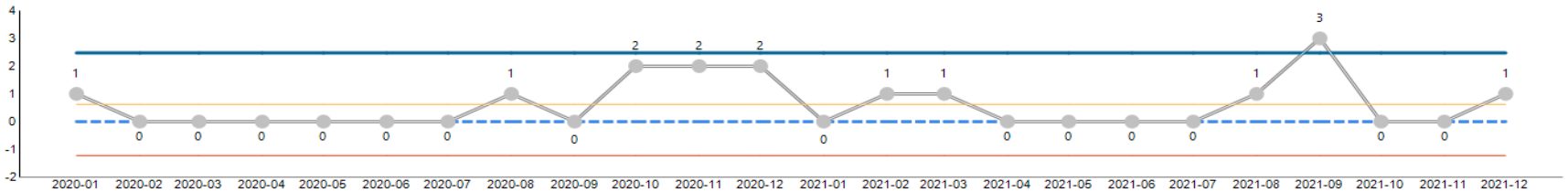
ucl	4
mean	1
target	0
lcl	-2

commentary:

Gram Negative Bacteraemias

Count of trust assigned Gram Negative Bacteraemias infections

	2019/20			2020/21												2021/22								
	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
13	1	0	0	0	0	0	0	1	0	2	2	2	0	1	1	0	0	0	0	1	3	0	0	1
				0	0	0	0	1	1	3	5	7	7	8	9	0	0	0	0	1	4	4	4	5



Common Cause

ucl	2
mean	1
target	0
lcl	-1

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

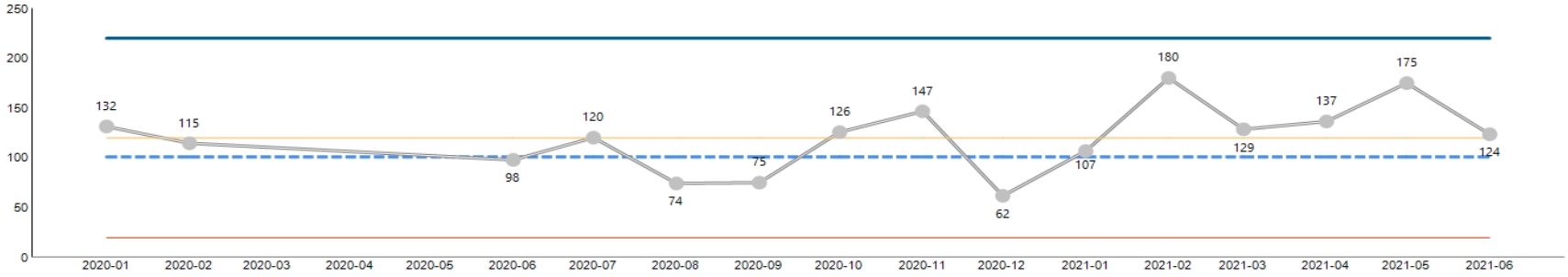
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Hospital Standardised Mortality Ratio (HSMR) - basket diagnoses

patient characteristics for those treated there.

Target	2020-01	2020-02	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06
<=100	132	115	98	120	74	75	126	147	62	107	180	129	137	175	124

Common Cause



ucl	220
mean	120
target	101
lcl	20

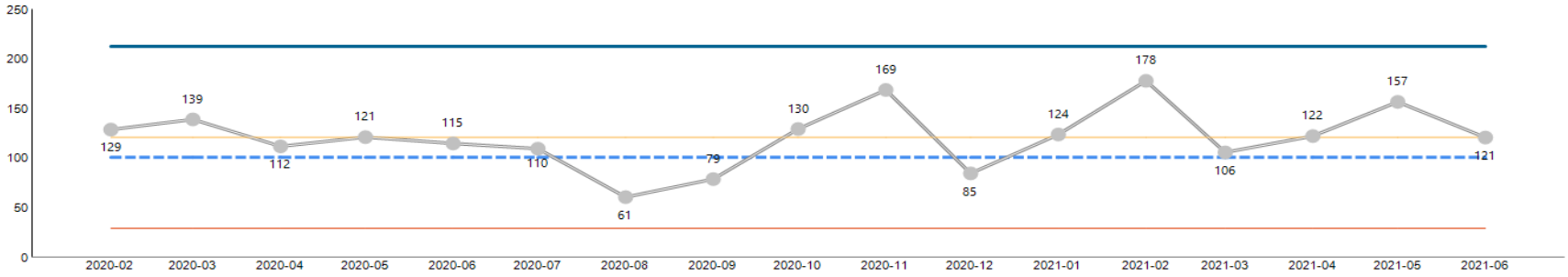
commentary:

Hospital Standardised Mortality Ratio (HSMR) - all diagnoses

of patient characteristics for those treated there.

Target	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06
<=100	129	139	112	121	115	110	61	79	130	169	85	124	178	106	122	157	121

Common Cause



ucl	213
mean	121
target	101
lcl	29

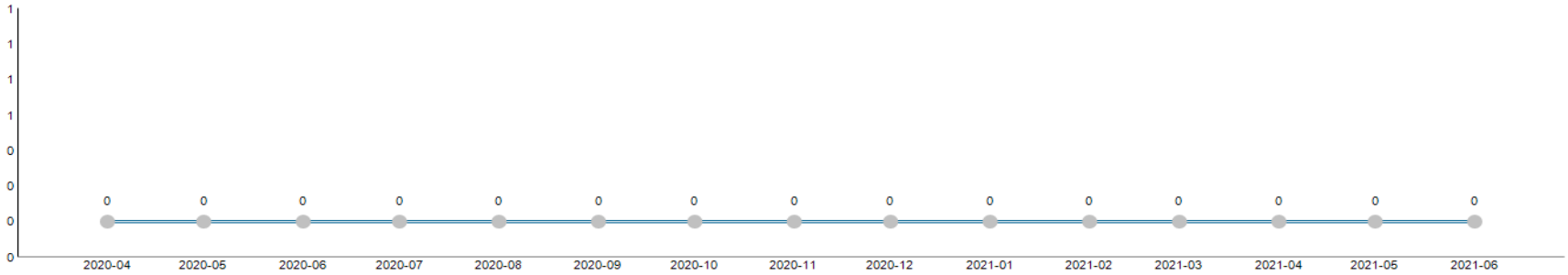
commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Patient Safety Alerts not completed by deadline

Target	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



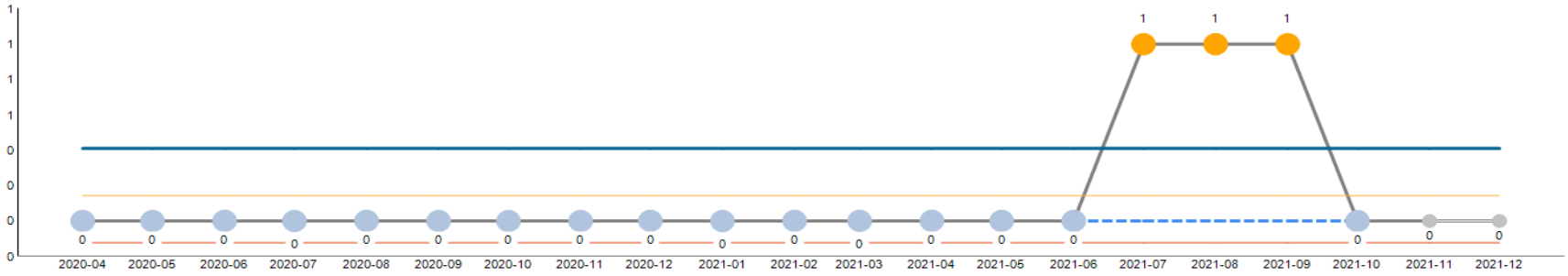
Common Cause

ucl	0
mean	0
target	0
lcl	0

commentary:

Clostridium difficile – infection rate

Target	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0



Common Cause

ucl	0
mean	0
target	0
lcl	-0

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

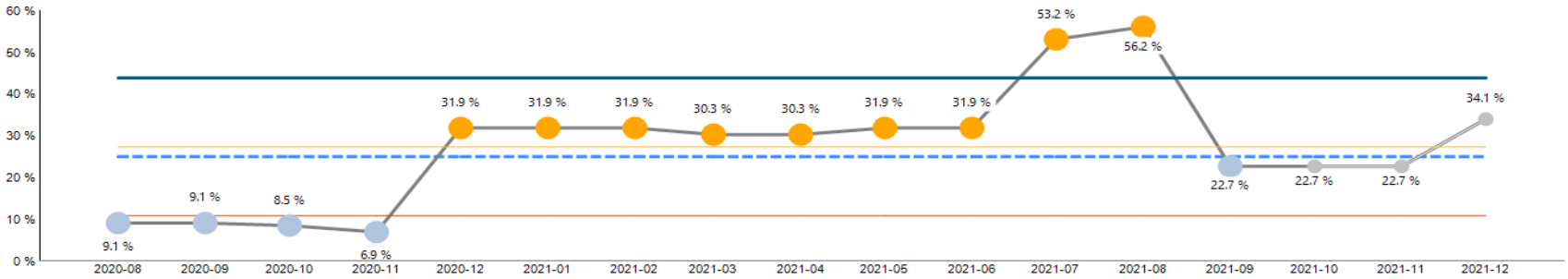
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Executive Team Turnover

Rate of turnover among the executive team

Target	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12
<=25%	9.1%	9.1%	8.5%	6.9%	31.9%	31.9%	31.9%	30.3%	30.3%	31.9%	31.9%	53.2%	56.2%	22.7%	22.7%	22.7%	34.1%

Common Cause



ucl	43.89%
mean	27.36%
target	25.0%
lcl	10.84%

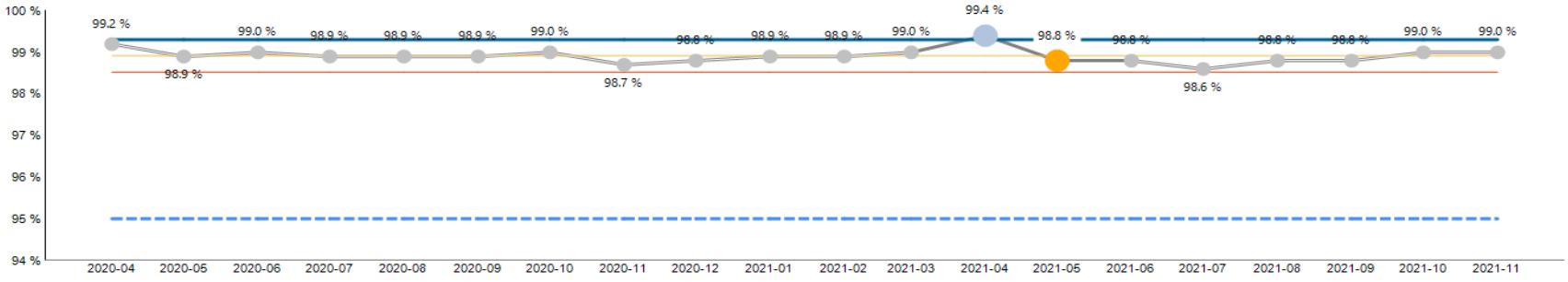
commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Better Payment Practice Code

Target	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11
1	99.2%	98.9%	99.0%	98.9%	98.9%	98.9%	99.0%	98.7%	98.8%	98.9%	98.9%	99.0%	99.4%	98.8%	98.8%	98.6%	98.8%	98.8%	99.0%	99.0%



Common Cause

ucl	99.31%
mean	98.92%
target	95.0%
lcl	98.52%

commentary:

Board of Directors (in Public)
Item 5.1

Subject: **Anti-Racist Annual Report and Framework**
Date of Meeting: **25th January 2022**
Prepared by: **Rachael McDonald, HR Business Partner**
Presented by: **Karen Nightingall, Chief People Officer**
Purpose of Report: To Note

BAF Reference	Impact on BAF
BAF 4	An inclusive approach to our workforce will help support overall workforce wellbeing. This framework will ahlp support this

Level of assurance (*please tick one*) *To be used when the content of the report provides evidence of assurance*					
√	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Executive Summary:

This paper provides the Board with a summary of the 2020/21 North West BAME Assembly Annual Report and Anti-Racist Framework which was published in October 2021.

The paper also includes an Anti-Racism Statement and Commitment which was ratified by the People Committee on 8th December 2021.

2. Background:

2.1 The North West BAME Assembly

The North West NHS has taken the decision to establish a Black, Asian and Minority Ethnic Strategic Advisory Committee (the Assembly).

The committee comprises of over 70 NHS leaders from BAME backgrounds and aims to bring together and harness the collective will of our system, to make a significant and sustained change to what really matters to BAME communities as we advance on the challenge of tackling inequalities.

The ambition for the Assembly is for the NHS in the North West to be Anti-Racist and at the forefront of challenging and tackling racism and the health inequalities faced and experienced by people in our communities, brought into stark relief by the coronavirus pandemic.

The NW Assembly published its Annual Report in October 2021 (refer **Appendix 1)**

2.2 The NHS North West Anti-Racism Framework

The Anti-Racist Framework has been produced by the North West Black, Asian and Minority Ethnic Assembly, the Northern Care Alliance's Inclusion Centre of Excellence and NHS England and NHS Improvement North West (refer **Appendix 2).**

It provides a framework for all our regional NHS organisations to embrace both the spirit of the commitments, but to also put into action quickly the steps needed to turn powerful words into the actions needed to reduce the inequalities we still see everyday across our workforce.

Both publications will be presented to Council of Governors in February 2021 to ensure better understanding of the agenda.

3. Anti-Racism Statement & Commitment

Becoming an intentionally anti-racist organisation is a continuous journey that involves organisations continually reviewing their progress and being intentional about their actions for change. Organisations need to commit to the principles of becoming anti-racist and the BAME Assembly have asked organisations to set out their commitment to supporting the vision, mission and objectives and describe our aspirations in terms of tackling racism.

To support, a draft commitment statement has been attached (refer **Appendix 3)**. This statement was considered by the People Committee and ratified for publication. This will be published and communicated across the organisation.

4. Future Focus

In response to the annual report and framework, there are number of actions the organisation will progress including: -

- Assign a board level sponsor to ensure that the Assembly Mission sits within their portfolio.
- Refresh the Trusts EDIB (Equality, Diversity, Inclusion and Belonging) Strategy to ensure that the strategy is align to national, regional and local requirements, including the actions from the NW BAME Assembly. A 'think tank session has already been arranged to progress this.
- Update the Equality, Diversity and Inclusion integrated action plan to reflect specific action within the framework
- Hold an LHCH Belong Inclusion Event and invite a guest speaker from the Assembly to support and launch our commitment – scoping meeting held 17th January.
- Create an environment that supports "safe space conversations", which are vital if we are to make a cultural change, which promotes equality for all.
- Explore and develop programmes which address bias and cultural competency
- Work closely with EDI regional group to share best practice

5. Recommendations:

The Board is asked to: -

1. Note the content of this report, the attached publications
2. Note the response and actions from the Trust
3. Note ratification of the Anti-Racism Statement

Item 5.1 (a)

North West unites to tackle inequalities

Annual Report 2020/2021

NHS North West
Black, Asian and Minority
Ethnic Assembly

Co-Chairs Forewords

One of the first things we learned about COVID-19 was the disproportionate impact that this virus has on people from Black, Asian and minority ethnic backgrounds. We are more vulnerable to the disease and more likely to die from it.

This led to a groundswell of action from senior regional NHS leaders across the North West. Following discussions with colleagues who share Black, Asian and minority ethnic backgrounds, we took the decision to establish a Strategic Advisory Group (known as the Assembly), with the initial aim of creating an authoritative source of advice to help steer our NHS response to COVID-19 across the North West region, ensuring that all our patients and staff got the care and support they needed.

This soon expanded, to encompass the need to address some of the wider inequalities within our NHS organisations that are faced by colleagues from ethnic backgrounds; as well as the wider health inequalities and challenges that our communities face.

As senior leaders from Black, Asian and minority ethnic backgrounds, many of us have lived experience of racism. Each year the NHS Staff Survey records many incidents of racist actions experienced by staff, while data shows that patients from Black, Asian and minority ethnic backgrounds both wait longer for care and then have less favourable outcomes.

We believe that the NHS in our region should be unapologetically Anti-Racist; taking positive action to eliminate racism in our organisations, standing with our colleagues when they experience racism, eradicating the inequalities in access, outcomes, and experience of health care that some of our communities face.

This report sets out our progress in our first year. We have achieved much, but we are only starting. We will both challenge and support every Board in the region to ensure that they dismantle the structures which have been barriers for both patients and for staff for too long. At all stages, we have been supported by Bill McCarthy, the regional director, whose commitment has been essential to creating our solid foundations, which mean that the Assembly will be sustainable, and also our rapid progress in our first year.

The Assembly relies on its members, who, working together, make us more than the sum of our parts.

I would like to thank every member of the Assembly for their support so far, and for helping us face the challenges to come.

EVELYN ASANTE-MENSAH OBE
Chair, Pennine Care NHS Foundation Trust
Co-Chair, North West Black, Asian and Minority Ethnic Assembly

I am proud to have played a role in the development of the Assembly.

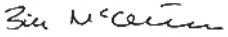
It is an important platform to ensure that the voices of Black, Asian and Minority Ethnic leaders from NHS organisations across the region are not just heard but are acted on.

Without drawing on the lived experience of its members, the NHS would not be serving our patients and staff in the way that we should be.

Reading this report, it is heartening to see all the progress of the Assembly in its first 12 months, despite the challenges of COVID-19. I would like to thank everyone involved for all they have done in such a short period of time.

However, this work is only just beginning.

We must maintain this focus going forward to ensure that the gains we make lead to real change for patients and staff.



BILL McCARTHY
North West Regional Director, NHS England & Improvement
Co-Chair, North West Black, Asian and Minority Ethnic Assembly
Posts held to July 2021

INTRODUCING THE ASSEMBLY

The North West NHS Black, Asian and Minority Ethnic Assembly was formed by 70 senior leaders from organisations across the region in 2020.

The Assembly aims to ensure a strategic approach to making the NHS Anti-Racist by tackling inequalities in outcomes and experience for patients and staff. Assembly members offer a wide range of lived experience and positional authority which can be used to accelerate improvement in addressing inequalities. It provides challenge, peer support and capability to NHS organisations in the North West, including individual trusts and the new Integrated Care Systems. The Assembly both delivers specific projects and acts as a source of advice and guidance to other organisations.

ⓘ ACCESSIBILITY

If you would like an alternative format of this report, including a printed copy, a version in a different language or a plain text version then please contact Naheed Nazir, Programme Director, at naheed.nazir@srft.nhs.uk

The national and regional perspective

What matters most, at all times, is to effect change at the level of the individual and their community of family, friends and neighbours. The work we do at a national, regional, system and organisational level is closely connected to the impact our communities desire, even though occasion it may seem distant. I think the Assembly has made good progress over the last year in influencing the national and regional agendas on racial inequalities and racism so that the NHS at senior levels is more focussed on our Mission. This progress has helped build momentum and, in turn, started to make a difference to the communities we serve. There is much more to do.

Over the years, we have seen reports which cast doubt on the impact of racism on the lives of our patients and staff. The lived experience of our Assembly members and a significant body of academic research tell a different story.

We cannot afford to let ourselves be diverted or distracted.

By working with groups such as NHS England and Improvement's Inequalities Oversight Group, and individuals such as the National Directors of Inequalities the Assembly has secured a first for the NHS – the incorporation of a national annual planning priority aimed at directly tackling race inequalities.

This has never happened before in the 73-year history of the NHS, yet within 12 months of the Assembly starting our work, we have helped secure this groundbreaking development. This priority hardwires addressing race inequalities into the strategic thinking of the NHS, in a way which will directly shape financial investment in services across the country.

The Assembly relies totally on the work of its members, and we have supported them in improving their skills and confidence to influencing at a regional and national level. Challenges have been made and have been successful in matters such as data collection for the vaccine programme and to have inclusion as a key criterion for developing ICS

"The North West is now seen as an exemplar"

boards. The visible, collective, and senior leadership that the Assembly has as its constituent parts has resulted in it being able to directly influence the NHS England and Improvement Regional Leadership Group. Members are also called on to participate in reviews and development programmes. Through having a clear purpose, to tackle racism, our members are able to align their influence and thereby optimise our impact.

Our work has not gone unnoticed. The North West is now seen as an exemplar in how it is leading and enabling the mission of becoming Anti-Racist. National leaders are engaged with the Assembly to seek its support, including developing and piloting initiatives that have the ambition of significant impact at a national scale.

This is our first year. In this year we have seen our national and regional colleagues and organisations support and encourage. Key actors have been our staffside organisations, the WRES national team, NHSEI Directors and, of huge importance, staff Black, Asian and Minority Ethnic Networks. These relationships combine with the collective of the Assembly to give me great optimism that we will have the energy and expertise to drive harder and faster to deliver improvement that is felt by individuals, whether they be staff or patients.

RAJ JAIN
Chief Executive of Northern Care Alliance and founding member of the Assembly

Inequalities in outcomes for patients and staff

The national rate of women dying during pregnancy or up to a year after birth was four times higher for Black women and nearly double for Asian women than for White women in 2016-18.

Screening rates nationally for breast and cervical cancer are lower among women from ethnic minority backgrounds, particularly women from South Asian backgrounds. Men and women from South Asian backgrounds also have lower rates of bowel cancer screening.

People from African Caribbean communities nationally are three times more likely to be diagnosed and admitted to hospital for schizophrenia than any other group, while people from Black, Asian and Minority Ethnic communities are 40% more likely to access mental health services via the criminal justice system than people from White communities.

The North West is the worst region against recruitment metrics nationally since the NHS Workforce Racial Equality Standard was introduced in 2015, with a rating of 1.73 against a target of 1.00 – equity would mean a rating of 1.00. White applicants are more than twice as likely to be appointed from shortlisting as Black, Asian and Minority Ethnic applicants in 8 trusts out of 34 in the North West. Black, Asian and Minority Ethnic staff are less likely to access training than their White colleagues.

The North West disciplinary metric shows that staff from Black, Asian and Minority Ethnic backgrounds have a rating of 1.45 against a target of 1.00, meaning that they are more likely to face formal disciplinary action than their White colleagues.

Our Vision and Mission explained

Assembly members explain our Vision and Mission below in their own words.

You can read our full Vision and Mission on our webpage, by clicking here.

A group of **70 NHS leaders from Black, Asian and Minority Ethnic backgrounds** united to form the Assembly in 2020. We did this because there is strong evidence that patients from Black, Asian and Minority Ethnic backgrounds have poorer outcomes from NHS care. At the same time, NHS staff from Black, Asian and Minority Ethnic backgrounds have poorer career progression and report regular incidents of racism.

FAYE BRUCE
Deputy Lieutenant
Greater Manchester Lieutenancy

The Assembly's Vision is to move the NHS in the North West to a position where we are **clearly and unashamedly Anti-Racist and eradicate racial inequalities.** We have committed to a **10-year Mission** because we believe that sustainable change will take time and require real effort from everyone in our system. The Assembly involves senior leaders, who have the ability to drive change at both a system level and within their own organisations.

ADAM JANJUA
Chairman
Fylde & Wyre / Blackpool CCG

We are working to dismantle the structures that mean it is difficult for our Black, Asian and Minority Ethnic communities to access services and to enter the NHS workforce and progress. To do this, we must **unapologetically and purposefully identify, discuss and challenge issues of race and colour and the impact they have on** our organisations, our systems, and our people and communities.

DR ANUSHTA SIVANANTHAN
Joint Medical Director
Cheshire and Wirral Partnership NHS Trust

The Assembly, which is supported by the Regional Director for NHS England and Improvement, will deliver our Mission by working on three priority areas – **COVID-19, employment and health inequalities.** We will keep the priority areas under review, so that we are putting our focus where it can make most difference.

SHARMILA KAR
Director of Workforce and Organisational Development
Manchester Health & Care Commissioning

These problems have been acknowledged for many years in the NHS. However, there has been a lack of unrelenting NHS leadership attention, so we have only seen marginal gains in tackling these issues. **COVID-19 brought the issue into stark focus**, and led to this movement for change.

CHARLES KWAKU-ODOI
Chief Officer
Caribbean and African Health Network

We will support NHS organisations to **drive out racially-based discrimination**, helping deliver year-on-year improvement in priorities which will be exemplars and will catalyse action in other areas. We will not limit our activity to the NHS but will actively reach out to community and organisational partners that share our Mission, making the sum of our work greater than its parts.

MAJID HUSSAIN
Chair
Oldham CCG

Our Ask, and the response of NHS organisations

The Assembly wrote to all NHS organisations in the North West in 2020, asking them five questions about their work to support our Mission.

The areas where we sought information are set out below.

There was a strong, positive response to our ask, with many organisations highlighting areas of progress. Some of these examples are highlighted on this page. There was also candour from organisations who acknowledged that they are at the start of their journey.

This approach of honesty combined with a willingness to share best practise, which will stop Boards having to re-invent the wheel, is to be applauded. It is only by having open and honest discussions about what needs to be done, and ensuring that Boards are adequately prioritising and supporting the necessary actions, that we will achieve our Mission to move the NHS in the North West to be Anti-Racist.

These are the questions which the Assembly asked each NHS organisation in the North West.

The actions that organisations are taking

Organisations told us of a wide range of actions they were taking to help tackle inequalities and support staff and patients. Analysis of the reports they submitted highlighted key themes which several organisations were undertaking. These are listed below and are recommended steps for all organisations.

- Assigning Board-level sponsors to ensuring that the Assembly Mission sits within their portfolios.
- Relaunching or developing Black, Asian and Minority Ethnic staff networks – with the commitment to engage with staff through the networks supported by Executive sponsors.
- Anti-Racist pledges and promotional material produced and promoted, along with a review of existing policies, updating them to include 'belonging'.
- Several organisations, including the Northern Care Alliance and Lancashire and South Cumbria NHS Foundation Trust, established Black, Asian and Minority Ethnic Leadership Councils to give staff direct engagement with Executive Teams, an approach highlighted as good practice by the national NHS Workforce Racial Equality Standard team.
- Developing programmes which address bias and cultural competency.
- Providing peer-to-peer support via closed Facebook pages and WhatsApp groups.

Organisations from across the region sent the Assembly details of the actions they were taking. Follow the link below to read those from Lancashire and South Cumbria NHS Foundation Trust, the Northern Care Alliance, Manchester University NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust.

You can read these returns by clicking on this link.

The Assembly journey

Launch of the Assembly by 70 regional Black, Asian and Minority Ethnic leaders

Assembly members supporting organisations and their staff in offering and taking up COVID-19 risk assessments

Gaining commitment from regional HR Directors to create a formal project to drive Anti-Racism in the NHS workplace

ESTEPHANIE DUNN
Royal College of Nursing North West Regional Director
"As a member of the Assembly, I am representing members from organisations across the North West, and all the unions are very supportive of this work".

Assembly members gaining places on the Integrated Care System recruirment panels for senior leaders, and role in assessing how regional plans will tackle health inequalities

Assembly members on the Communications and Engagement sub-group creating resources to promote COVID-19 vaccination uptake

SHEILA LLOYD
Director of Nursing
"As a Director of Nursing, it is so important to make sure that all staff from all backgrounds and heritage feel included, listened to, have a voice, and can contribute to the wellbeing of all patient".

NHS organisations across the region making formal commitments to be Anti-Racist

Developing an Inclusive Communications Toolkit to support effective, culturally appropriate engagement with all communities

DR GUNJIT BANDESHA
Consultant in Healthcare Public Health for Public Health England North West
"The Assembly provides a 'living lens of professionals' to shine a light on and improve the access, experience and outcomes for our minority ethnic citizens in the North West, which will help both our new ICSs and our organisations in tackling inequalities".

Our response to COVID-19

COVID-19 is the biggest health challenge which we have faced in our lifetimes. Assembly members were at the forefront of the NHS response across the region, not only through their roles for their organisations, but in the additional support they offered in relation to insight into how to reach diverse communities to encourage greater uptake of the vaccination.

We have seen very good examples of organisations supporting our communities by going beyond their previous approaches to engage more widely in planning their response.

There were significant levels of engagement with community and faith leaders, which saw pop-up clinics hosted in mosques and churches, along with community centres and sports venues across the region. NHS clinical staff from Black, Asian and Minority Ethnic backgrounds volunteered to record videos and take part in drop-in sessions to answer questions about the vaccines. Efforts were made to ensure that staff from Black, Asian and Minority Ethnic backgrounds were involved in delivering these clinics, helping generate further trust.

Significant support was also offered to staff across the region, including providing information to encourage risk assessments by Black, Asian and Minority Ethnic staff, "health MOTs" and arranging for a consultant virologist to participate in question and answer sessions.

Key to the success of these approaches, both for communities and for staff, has been research and co-creation in terms of planning and delivering both the operational and the communications systems which supported the vaccine roll-out. However, it also needs to be recognised that these involved additional resources, both financially, and in terms of time, for clinical and operational staff to properly design and plan the sessions.

Co-creation with our communities will be essential if we are to take the learning from our response to COVID-19 and apply it to tackle other health inequalities. The Assembly will remain focused on championing this approach so that it becomes the norm and not simply a response to the pandemic.

The insights which have shaped our engagement activity have been brought together in our guide to Inclusive Communications. The guide includes useful principles, advice and key takeaway points which can be applied across all communities, along with useful contacts. To read the guide, please click here.

COMMUNITY INSIGHT LEADS TO VACCINE SUCCESS

Manchester Health and Care Commissioning established the COVID Health Equity Group to reduce inequalities in access to, and uptake of, vaccinations. The group formed partnerships with local communities with high infection rates, high mortality and relatively low vaccination uptake. Community insight, supported by a wider network of community influencers and 'cultural connectors', supported culturally competent messages and preventative measures for communities.

READ MORE

FLO ENCOURAGES OTHERS TO HAVE THEIR VACCINATIONS

Greater Manchester Health and Social Care Partnership and NHS England and Improvement worked with the Caribbean and African Health Network to establish pop-up clinics and campaign materials to encourage greater uptake of the vaccine. These were widely shared through community social media networks, such as WhatsApp groups, along with the social media accounts of NHS organisations. In this video, volunteer Flo describes her initial vaccine hesitancy and how finding out the facts led her to get protected.

WATCH FLO'S VIDEO

POP UP CLINIC OPENS IN MOSQUE

Faith leaders at the Masjid E Saliheen Mosque in Blackburn worked in partnership with NHS Blackburn with Darwen Clinical Commissioning Group and Blackburn with Darwen Council to establish a pop-up clinic, which was open to people of any faith. The mosque's location offered convenient access for many people and helped re-enforce the message that people could still have their vaccinations even during Ramadan. Other mosques across the region also hosted similar sessions.

READ MORE

CO-CREATING EFFECTIVE ENGAGEMENT CAMPAIGNS

The Getting Under the Skin research programme involved seeking the views of people from Black, Asian and Minority Ethnic communities across Cheshire and Merseyside. The research highlighted issues including a lack of trust because of previous injustices along with a need for clear language. This research informed the development of videos and social media content which were designed from an inclusive communications perspective.

READ MORE

Health inequalities workstreams

The Assembly has agreed a number of workstreams to help drive forward our mission. These are regularly reviewed to ensure that they are making the greatest possible impact. All of the workstreams are detailed in the Assembly's Annual Plan, and the focus will be reviewed as the Assembly progresses and new challenges or issues are identified. You can read about two of the Assembly workstreams below.

The Greater Manchester Maternity Workstream

RAJ JAIN, Assembly workstream lead

The case for change is dramatic – the outcomes for service users from Black, Asian and Minority Ethnic backgrounds are far worse than for people from White backgrounds. What was comforting was to find that at every level - regional, system and organisational - there was already some excellent work in flight.

Inequalities have been given a high priority, and action is underway. The Assembly was able to give some advice and support, including helping identify that the recruitment and retention of more midwives from Black, Asian and Minority Ethnic backgrounds should be a key priority.

Work is now underway with NHS organisations, the University of Salford and local community groups such as the Caribbean and African Health Network to develop a pipeline of people from Black, Asian and Minority Ethnic backgrounds who have the ambition to become a midwife. We expect this to be launched by the end of summer 2021. But, we are fired up by the gross inequities experienced by mothers and their babies from Black, Asian and Minority Ethnic backgrounds, and we know that there is still much more to do.

The Cheshire and Merseyside Cancer Care Workstream

NIKHIL KHASHU, Executive Director of Finance and Information, St Helens and Knowsley Teaching Hospitals NHS Trust

SHEILA LLOYD, Director of Nursing, Florence Nightingale Foundation Academy

Joint workstream leads

The first step in solving any problem is to understand the drivers that created it.

We were delighted when the Cheshire and Merseyside Cancer Alliance gave an early commitment to support the Assembly in identifying and eliminating racial inequalities in cancer care.

Our immediate priority, as a partnership, was to analyse the existing data on ethnically-related inequalities. That is when the extent of the challenge became clear. Because we found that there were real challenges in interpreting data at the level of individual communities because of statistically-low numbers compared with the general population and potentially data quality.

We therefore recognised the need to gather information directly from patients with Black, Asian and Minority Ethnic backgrounds. Their lived experiences will tell us the stories behind the data and help us understand the scale of the issues and maybe what could be done to fix this.

Macmillan Cancer Support kindly offered financial support to drive this forward, enabling the Cheshire and Merseyside Cancer Alliance to appoint two staff whose focus would be on inequalities.

Our new team have already started developing a programme of work focussing on health inequalities and patient experience, including ethnicity-related inequalities.

They have secured further support from the NHS England and Improvement regional communications team to help them co-design this work with local communities.

This will include engagement aiming to increase participation in NHS cancer screening programmes in under-represented communities.

Screening programmes save lives, and this will only be our first step in ensuring that treatment and care for cancer is offered equitably to everyone in our region.

Workforce

When the Assembly was first formed, it was clear how important the role of Chief People Officers/ Workforce/Human Resources Directors in NHS organisations across the region would be in delivering our Mission. In addition to being the responsible officers for our total workforce of 200,000, these Directors are usually the leads for Equality, Diversity and Inclusion.

Recognising this, a well-supported engagement event was held for them, which led to the three specific areas of activity set out on this page.

I am very pleased to say that this group of senior NHS leaders have embraced the challenge which the Assembly has set to them, and have been quick to commit to meaningful actions.

Not unexpectedly, the need to focus on the response to COVID-19 has impacted on the timescales of progress, but this is still a very strong foundation. In addition to these actions, we are currently developing a programme to support all NHS organisations in becoming Anti-Racist, which will build on this early progress, and help us deliver real change across our region.

ANTHONY HASSALL
NHS North West Chief People Officer

Our three workforce workstreams were established to support staff by:

MINIMISE THE RISK OF COVID-19

- Region acting on information from workforce assessment data
- Region supporting the development of organisations' Staff Networks

ADDRESS UNDERLYING RACISM IN OUR TALENT STRUCTURES

- Set improvement trajectories for colleagues in all grades across the region
- Grow colleagues cultural competence and understanding of equality issues

TACKLE INEQUALITIES OF ACCESS AND HEALTH INEQUALITIES

- Understand data to identify and boost community confidence that they will meet their needs
- Target Pre Employment activity & Reset programmes to ensure EDI agenda is central in their design

Among the actions and plans are:

- Establishing reverse mentoring programmes for senior leaders, based on Workforce Racial Equality Standard (WRES) data.
- Identifying an HR lead for each sub-region (Cheshire and Merseyside, Greater Manchester and Lancashire and South Cumbria)
- Plans to build line manager capability
- Plans to support existing Black, Asian and Minority Ethnic Staff Networks and to create them where they do not already exist, including developing a toolkit to establish and run networks.
- Developing a guide to introducing Just Culture principles across organisations

- Creating Model Employer action plans to share best practice across organisations
- Carrying out a baseline review of disciplinary cases to understand where bias might exist
- Improving people practices, promoting civility and respect
- Ensuring changes to support inclusive career progression and recruitment processes, including 'blind' recruitment, diversity advocates and written explanations for non-appointment.
- Closer working with colleges to increase local employment

Photo above: Edna Panambo, Senior A&E sister at the Royal Liverpool University Hospital won the Royal College of Nursing Outstanding Contribution to Equality, Diversity and Inclusion in Health and Social Care Award 2020 for her work in supporting overseas nurses who moved to Liverpool over two decades.

Celebrating staff success

NHS staff from Black, Asian and Minority Ethnic backgrounds across the North West have achieved a wide range of success in different fields in 2020/21, from being recognised for their contributions in Honours by HM The Queen to winning awards and having books published. You can read just some of their stories on the next two pages. If you have any other success stories which you would like us to celebrate then please contact us using the details at the back of this report.

Husband and wife, Akinola and Olubukola Adewunmi, who are both biomedical scientists at Liverpool Clinical Laboratories, won the Health and Wellbeing Advocate award at the National BAME Health & Care Awards 2021 for founding PathLab Support, which helps adults and children with sickle cell disease.

Dr Roshelle Ramkisson, a consultant child and adolescent psychiatrist and NICE Fellow, with Pennine Care, was one of 25 women to be highlighted as part of a special Royal College of Psychiatrists project that celebrates the stories of 25 amazing women psychiatrists.

Accrington GP Dr Murthy Lakshmi Narayana Motupalli, of NHS East Lancashire Clinical Commissioning Group, received a MBE in the Birthday Honours 2021 for services to education, training and support for Black, Asian and Minority Ethnic doctors and to General Practice. Photo credit: Lancashire Telegraph

Florance Makurira, a senior mental health practioner and A&E mental health liaison nurse based in Bury, who works for Pennine Care, received a Royal College of Nursing North West award for her outstanding contribution to equality, diversity and inclusion. Originally from Zimbabwe, Florance has worked tirelessly to raise awareness of mental health issues in the Black, Asian and Minority Ethnic communities. She said: "Within Black, Asian and Minority Ethnic communities there is less awareness of mental health issues. People may not access services early enough, which can be detrimental to their long-term health and build more complex issues in the future."

Celebrating staff success

Dr Ade Akinola, of Pennine Care, was named as the Royal College of Psychiatrist's North West Trainer of the Year for his work in supporting trainees who had their studies affected by COVID-19. He supported trainees not just in the UK, but those who were affected by lockdowns overseas.

Dr Harnovdeep Singh Bharaj, a Consultant in General Medicine, Diabetes, Endocrinology and Metabolism at Bolton NHS Foundation Trust received a MBE in the New Year Honours for services to people with diabetes in the South Asian community.

Bolton GP Dr Abdul Hafeez, Founder and Chief Executive of the Association of Pakistani Physicians and Surgeons of the United Kingdom, received the MBE in the Birthday Honours 2021 for services to the NHS particularly during Covid-19, for his work in developing clinical primary care guidelines to tackle the disease and establishing a community support helpline.

Picture credit: Manchester Evening News

The Northern Care Alliance was highly commended in the Health Service Journal Workforce Race Equality Standard Awards 2020, for its work on the Race Equality Change Agents Programme. This crowd-sourced over 30 change projects aimed at reducing racial workforce inequalities across the public sector in Greater Manchester. Delegates on the course participate in academic programme over six months looking at three modules covering: What inequalities, Why inequalities and enabling change. A mix of leading academics and EDI professionals deliver the content across each module. For the final six months delegates are given EDI specific coaching to support them in delivering their change idea. Impact is evaluated based on system wide data and aims agreed by each participant.

Assembly relationships

The Assembly has a strategic role in ensuring that the NHS in the North West is actively Anti-Racist, which means that we focus very heavily on influencing our key stakeholders. Change must be owned by the organisations providing care across the region.

The Assembly is a critical friend. It offers both challenge and support, helping share best practice and quick wins, while seeking the assurance that action is delivering real change for our communities and our staff.

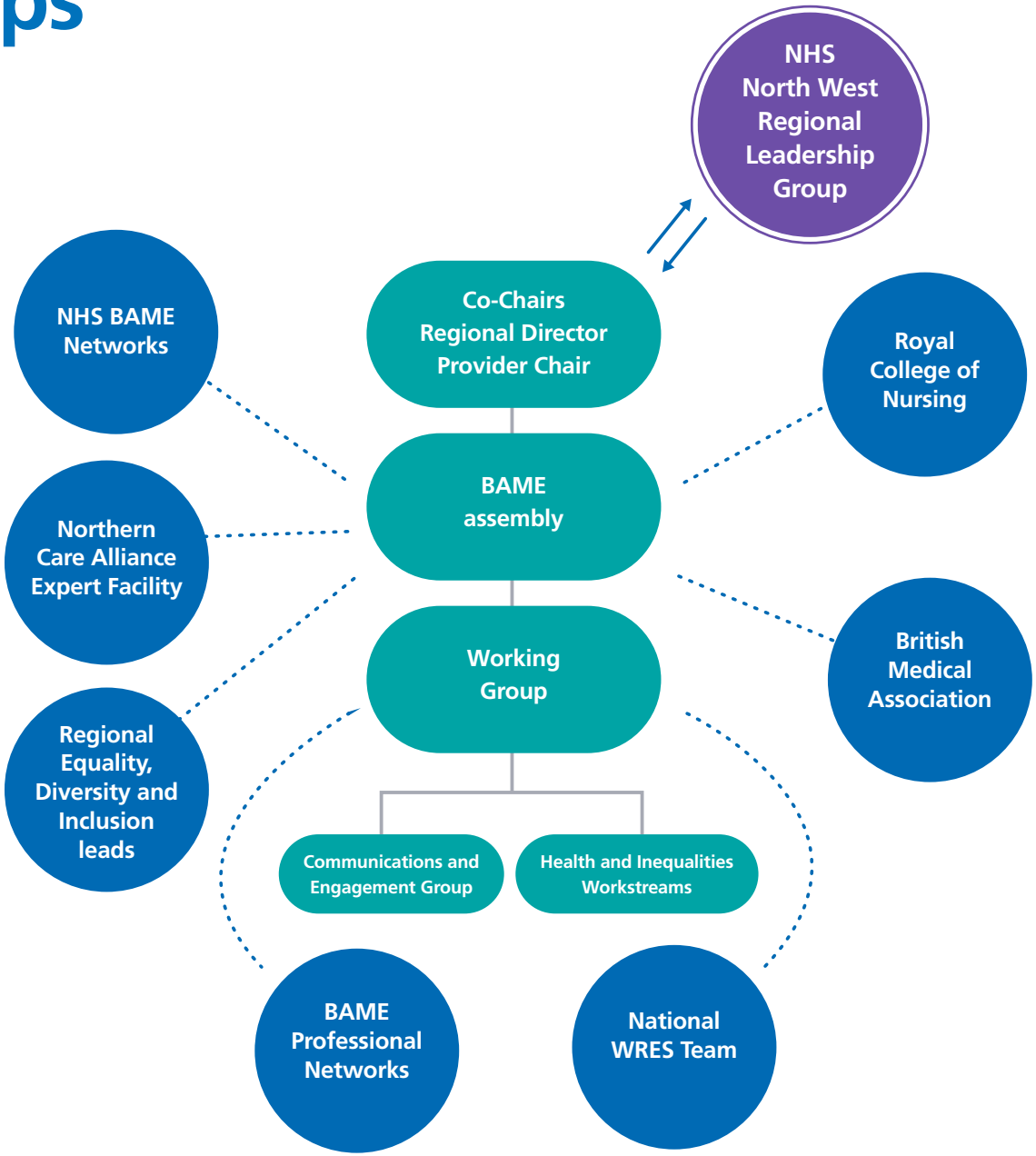
"The Assembly has a vital role to play in ensuring that the NHS in the region is actively Anti-Racist, helping our organisations tackle inequalities for both patients and staff."

Dr Amanda Doyle,
Regional Director for the North West
– Co-Chair of Assembly

The Assembly is a trusted advisor to the NHS England and Improvement Regional Leadership Group, acting as a trusted advisor. Our Co-Chair attends Regional Leadership Group meetings to ensure that our Mission is constantly considered as part of all discussions. This relationship is essential to influencing Boards, even though many Assembly members already sit on Boards. While they will advocate from their own roles, it is key that this is seen as a core NHS issue.

The Assembly also has to reach beyond Boards. The support offered to staff networks and Equality Diversity and Inclusion leads ensures that frontline staff know of our advocacy and can have their voices heard at a strategic level.

Our work also relies on the support of a wide range of partner organisations. Being Anti-Racist is everyone's business, and the relationships the Assembly has will enable us to co-ordinate effective action across North West and beyond.



Taking action across the North West

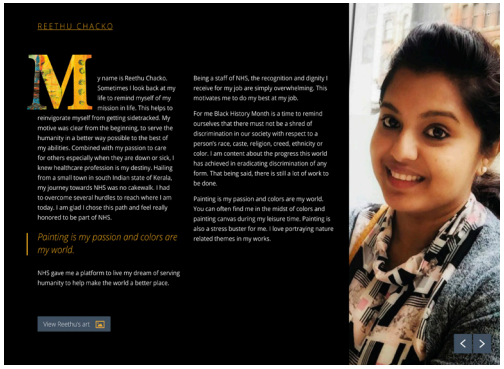
SHOWING THE RED CARD TO RACISM

Organisations across the region responded to the Assembly's call to use the United Nations' International Day for Elimination of Racism 2021 as an opportunity to re-state their commitment to create equality for patients and staff. Evelyn Asante-Mensah, Co-Chair of the Assembly, wrote a blog highlighting the need for organisations to build on the work they had already done. Staff from the Black, Asian and Minority Ethnic Network at Arrowe Park Hospital were joined by staffside representatives, colleagues and Hazel Richards, Chief Nurse, who is the Executive partner for the network, to show red cards to racism.

HELPING REFUGEES HELP THE NHS

The NHS England & Improvement North West nursing team worked with the Refuaid charity and John Moores University in Liverpool to develop a pioneering scheme to in Liverpool which helps refugees with nursing or healthcare experience join the NHS. The course lasts four weeks and involves practical exercises in an NHS hospital simulation environment, work on how to communicate with patients and assistance with the English language. Nurses are given support in having their qualifications and previous employment checked and in registering with the UK Nursing and Midwifery Council. Nurses from Ethiopia, Sudan, Iran, Philippines, Gambia, Honduras and Myanmar have already benefitted from the course.

(Photo credit: John Moores University)

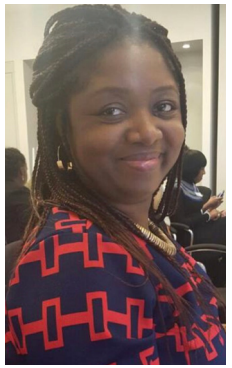


TELLING OUR HISTORIES

Coming out of South Asian Heritage Month and Black History Month events at Manchester University NHS Foundation Trust, staff from Black, Asian and Minority Ethnic backgrounds have shared their personal and family stories through an e-book called Making Histories. The Trust serves some of the most diverse communities in the country, which is reflected in their workforce, and the book celebrations the contributions of staff from Black, Asian and Minority Ethnic backgrounds.

Click here to read the Making Histories e-book.

HAVING MY VOICE HEARD BY BOARD MEMBERS



Several organisations across the region have started reciprocal mentoring, where senior leaders are paired with staff from Black, Asian and Minority Ethnic backgrounds to help give them insights into life within their organisations. Pennine Care runs an equality mentoring scheme where staff with a disability, from a BAME background or identifying as LGBT+ are paired with Board members. Sheila Bekoe, medical secretary, mentors Nicky Littler, workforce director. Sheila is calling for other staff to join the programme. She said: "It's been a delightful experience, I couldn't have asked for a nicer or more caring mentee. I felt senior management were interested in our experiences, both positive and negative and what they could learn. I hope more people join up at the next cohort."

To read more about Sheila and Nicky's mentoring experience, please click here.

Assembly objectives 2021/22

STRATEGIC OBJECTIVES	PRINCIPAL OBJECTIVES	2021/22 MEASURES	RECURRING MEASURES
Address inequalities in service outcomes experienced by BAME citizens	Covid: support access to vaccination programme	1. % of BAME citizens vacinated. 2. % of BAME staff vacinated.	Compliance with regional/national vaccine programme
	Covid: NHSEI 2021/22 Planning Gudiance - support development and deployment of elective restart gateways	Region' assesments of completeness of ICS/organisational operational plan	% reduction in access inequalities
	Health Inequalities: Support GM's plans to reduce gap in outcomes and exerience of BAME maternity patients	1. Still birth rates 2. Maternity related harms 3. Experience measures	1. Still birth rates 2. Maternity related harms 3. Experience measures
	Health Inequalities: Support C&Ms improvement in cancer access and experience of BAME patients	Implementation of strategy	1. % improvement of Cancer's diagnosed at stage 1 & 2 2. Cancer pt experience measures
	Health Inequalities: Support L&C's plans to reduce gap in outcomes and exerience of BAME mental health patients	Implementation of strategy	Acess and experience measures
Address inequalities in recruitment, progression and experience of BAME Staff	Structural: support organisations & education to adress ethnic disparities in employment in all professions	1. Test of change - access to midwifery 2. Target pre employment and job opportunities at most disadvantaged (Synergies with broadening application pilot)	1. % increase of BAME into midwifery 2. % of BAME in programme 3. % transition into employment
	Structural: achieve NHS Model Employer representation ambitions	1. ICS Board and Board minus 1 diversity measure 2. NW Region to determine improvement trajectory for NW organisations	Distance to target
	Structural: enable NW Region's organisations to move to best quartile of WRES ratios	1. Assure that each organisation is implementing a WRES imrpovement plan	Distance to target
	Engagement: Support BAME staff networks to have their voices heard at their boards and in the Assembly	1. Establishment of communication channel to and from BAME networks to/from Assembly 2. Support in deployment of Toolkit	Distance to target
	Capacity & Capability: Support EDI teams to develop	Target 10 Organisations	EDI Team development programme
	Capability & Will: Support Board's development programmes	1. Support the bottom quartlie (WRES) organisations. 2. Support & influence NWLA board / director EDI programmes.	WRES results Progress on Model Employer Trajectories
	Covid: support all BAME staff to have risk assessments and action plans	% of BAME staff with risk assessments	% of BAME staff with risk assessments
Build an effective and flourishing NW BAME Assembly	Develop and implement Health Foundation's framework for network development	Member survey on value to the mission and to them	Member surveys
	Implement mult channel communication and engagement between members	Member survey on value to the mission and to them	Member surveys
	Programme and ongoing support for Assembly's operations	Assess support provided by NCA	Sign off by Contract meetings
	Produce Annual Plan	Sign off by Co-chairs	Sign off by Co-chairs
	Produce Annual Report	Performance against agreed milestones and outcomes	Performance against agreed milestones and outcomes

Engaging with communities across the region enabled NHS staff to successfully deliver easily-accessible help to respond to the COVID pandemic. Greater Manchester pharmacists Aneet and Maneet developed a pop-up vaccination clinic, and their father Suneel was one of their first patients. To read their story, please click here.

More information

The Assembly welcomes contact from senior NHS leaders from Black, Asian and Minority Ethnic backgrounds who wish to find out more about how they can help us.

We can also provide a range of resources and support for chairs of Black, Asian and Minority Ethnic Staff Networks and Equality, Diversity and Inclusion leads.

You can find out more information about the Assembly, our work, and links to useful national organisations and resources by visiting the Assembly web page – please click here.

In the first instance, for more information about the work of the Assembly please contact
Naheed Nazir, Programme Director,
on naheed.nazir@nca.nhs.uk
or call 0161 778 2150.

Item 5.1 (b)

NHS

NHS NorthWest

Anti-Racism Framework

Published October 2021

INCLUSION CENTRE OF EXCELLENCE
inspiring change together

NHS North West
Black, Asian and Minority
Ethnic Assembly

Contents

Foreword from Evelyn Asante-Mensah OBE Chair NW BAME Assembly and Anthony Hassall NHS North West Regional Chief People Officer

We have made a commitment as a region to embrace the intentionally inclusive language and approach of becoming actively anti-racist organisations. We all recognise the history and impact of institutional racism across our organisations and the harm caused to both our colleagues and communities through the continued inequalities we still see across our society.

This document has been produced by the North West Black, Asian and Minority Ethnic Assembly, the Northern Care Alliance's Inclusion Centre of Excellence and NHS England and NHS Improvement North West. It provides a framework for all our regional NHS organisations to embrace both the spirit of those commitments but to also put into action quickly the steps needed to turn powerful words into the actions needed to reduce the inequalities we still see everyday across our workforce.

From higher rates of bullying & harassment, disproportionate referrals into disciplinary processes, recruitment and selection where ethnicity still impacts your chance of appointment after shortlisting all these issues and many more needed to be tackled intentionally and as a priority by all our organisations.

As intentionally inclusive leaders it is vital that we look at each of the areas set our in this anti-racist framework and seek to embed the change needed to transform our own departments and teams into places where this activity is not seen as just a nice to do but is seen as mission critical to all that we stand for and that messaging is backed up by senior colleagues across the region being clear that actions to tackle inequalities are a priority in all that we do.

In using the framework leaders should use the practical steps and suggested actions to support existing change activity, to add focus to future equality action plans and to build on any long term inclusion strategies you may have. While there is not a one size fits all solution to advancing equality within any one organisation we hope that the guidance and structure provided will help with the task of co-creating the solutions that will work for your organisation easier.

Why does an intentionally anti-racist approach matter?

- Racism is very real both in society and across our NHS organisations. Yet despite a large number of reports and pledges over the years we have seen inequalities persist and some areas even get worse.

- The NHS is built on a founding principle of equality and social justice. That the service is free at the point of need, anchors the NHS is social egalitarianism and makes equal rights part of our core business.

- We have seen a growth of hate incidents and racism across our communities in the UK despite existing equality and human rights legislation. Its more important than ever that as public sector organisations we are contributing to ensuring racism has no place in our society and is addressed across the communities we serve.

- Racism and discrimination are major drivers behind the health inequalities we still see today. Its our role as a health care system to be intentional in tackling those inequalities we see across our communities, but we should also be ensuring discrimination experienced by our staff is not contributing further to the problems we see.

Our Anti-Racism Journey

Becoming an intentionally anti-racist organisation is a continuous journey that involves organisations continually reviewing their progress and being intentional about their actions for change.

The Fear, Learning, Growth Zone tool can help you as both an individual and an organisation to consider honestly where you are on that path to become more anti-racist.

Anti-Racist Zones	Approaches to move through the zones
Fear	- Provide clear factual information that challenges and supports the overcoming of any fears.
Learning	- Consider more development building on any existing learning. - Steps and opportunities that increase confidence with existing learning
Growth	- Empower inclusive leaders through allyship programmes and activities

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Five Anti-Racist Principles

1. Prioritise Anti-Racism – What does this mean?

As the NHS we have always been instinctively supportive of equality as social justice is the bedrock and foundation of our creation as an institution back in 1948. However prioritising Anti-Racism work is more than simply caring about equality or stating support for inclusion its about ensuring we are giving it the same attention and response as other mission critical work we manage across the NHS.

The two main commodities we give to a task or area of work when we prioritise it is both time and resources. When equality activity is seen as an add on or a nice to do other mission critical work is seen as more important, time and resources are directed elsewhere and progress around tackling inequalities slows and stops.

Organisations need to commit to the principle that anti-racism work matters and ensure leaders see it as a priority for them as well. There will always be competing time and resource pressures when it comes to managing any large organisation, but anti-racist organisations understand that by investing the time and resources needed to tackle the inequalities that exist across their workforce and in services in the long term is more effective and will support them in meeting their other long term goals.

A good check to see how much you are personally prioritising this work is to consider asking yourselves as leaders how much of your time have you actually spent on anti-racism work in the last month?

Prioritise Anti-Racism – What does this look like?

We have highlighted four key drivers that organisations should consider reviewing and taking more action to ensure they are p rioritising Anti-Racism across all that they do:

1. **Leading from the front**
   Leadership matters and while being a leader often involves the management of multiple priorities the amount of dedicated timewe give to an issue is a key indicator of how much we have prioritised that area of work.

2. **Dedicated EDI Resource**
   The amount of dedicated resource we have allocated to focus on an area of work is a key indicator of how much it has been prioritised. EDI Professionals are experienced experts who can support leaders with this work. They must however be considered an important part of the organisations leadership for their activity to be impactful and transformational over the longer term.

3. **Mission Critical**
   Anti-Racism activity need to be at the heart of all work across an organisation, not simply a central equality action plan. Orga nisations that have got this right can clearly demonstrate how anti-racist practice is considered mission critical in plans around service delivery and the development of their workforce.

4. **Actions Not Words**
   Organisations that are committed to anti-racism do more than the minimum ask, their work is driven by a desire to transform and have a big impact on the inequalities they see. This should be clearly visible in the activity and actions of any anti-racist organisation.

Prioritise Anti-Racism – Making it happen

Key Drivers	Direct deliverables	Resources
1. Leading from the front	- Executive EDI Lead has a clear role description including annual PDP goals - Executive EDI Lead must Chair/Co-Chair an EDI committee at least quarterly	Change the Race Ratio - Guidance from KPMG Board Diversity – More Action Less Talk
2. Dedicated EDI Resource	- Dedicated EDI Lead in place and as a minimum must report into a direct report of an Executive Director. - Must be considered part of the wider senior leadership team to support and enable change.	Why companies need a chief diversity officer Competency Framework for Equality & Diversity Leadership CIPD Diversity Management that works
3. Mission Critical	- Evidence of how the organisation has acted to make anti-racism work mission critical must be published annually within the organisational annual report	Embed anti-racism in the NHS
4. Actions Not Words	- An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.	CIPID – Go Beyond Legal Compliance Fact Sheet

2. Understand Lived Experience – What does this mean?

It is everyone's reasonability to tackle racism not just Black, Asian & Minority Ethnic colleagues, but meaningful involvement of people who experience racism and inequalities across your organisation will ensure decisions on how to tackle it are informed by real insights that reflect the different challenges people may face.

Meaningful involvement of people you would like to share their lived experiences involves committing to acting on what you hear and embedding their voices into change focused activity and decision making. Leaders need to be intentional in seeking out lived experience perspectives and consider what may be preventing some people feeling able to be involved.

When reaching out to seek the lived experiences of Black, Asian & Minority Ethnic communities its important that leaders acknowledge and value intersectionality and understand the need to get more than a single person's perspective. When engaging others to hear their lived experiences we should be intentional in ensuring we are hearing from a diverse range of voices rather than simply identifying a single individual to invite into a space.

Sharing lived experiences can have weathering effect on people's wellbeing and any activity that looks to involve and encourage others to share their lived experiences to support leaders and an organisation make better decisions should also include a clear and intentional focus around the wellbeing of those involved.

2. Understand Lived Experience – What does this look like?

We have highlighted four key drivers that organisations should consider reviewing and taking more action to ensure they are understanding the lived experience of their workforce:

1. **Listen and Learn**
   Leadership matters and while being a leader often involves the management of multiple priorities the amount of dedicated timewe give to an issue is a key indicator of how much we have prioritised that area of work.

2. **Empowering Your Talent**
   As well as hearing the lived experiences of staff it's important that the under utilised potential of talented leaders from ethnic minorities is considered and empowered to support decision making. Where can you diversify the decision makers in a space and how can you ensure the full talent potential of your diverse workforce is being used.

3. **Growing Cultural Competency**
   Connecting a diverse range of lived experiences with leaders is vital to improving the cultural competency of an organisation over a longer period of time. Leaders who understand their colleagues, service users and local communities are better placed to make decisions that are fair for all.

4. **Data Plus**
   Organisations need to be intentional about understanding the experiences of Black, Asian & Minority Ethnic staff and serviceusers.

2. Understand Lived Experience – What does this look like?

Key Drivers	Direct deliverables	Resources
1. Listen and Learn	- An executive director must attend BAME staff Network Meeting at least four times a year	CIPD – Guide to establishing staff networks
2. Empowering Your Talent	- Set up a local BAME leadership council within your organisation - Ensure BAME talent is intentionally included across organisational talent programmes. Numbers should reflect the need for positive action to increase diversity within leadership roles.	NHS England WRES Board Briefing - BAME Leadership Council Case Study
3. Growing Cultural Competency	- At least 50% of all Executive Directors and their direct reports have been part of a race equality reverse mentoring programme over the last 3 years.	Leadership Academy Reciprocal Mentoring Programme
4. Data Plus	- A detailed breakdown by ethnicity of the staff survey report should be presented to the board annually including the involvement of BAME staff network members to ensure more than just data is presented.	Building Narrative Power for Racial Justice and Health Equity Kings Fund lived experiences of ethnic minority staff in the NHS

3. Grow Inclusive Leaders – What does this mean?

Inclusive leadership is vital if an organisation aims to be anti-racist in all that it does and aims to tackle the inequalities they see across their workforce and services.

Where an organisation has a mature inclusive leadership culture you will see diversity clearly represented at all levels across the workforce and one where colleagues feel they belong and are included at work. On that journey growing an inclusive leadership culture it's vital that there is an approach and strategy for reducing inequalities not just at the top of the hierarchy but also a commitment to increase diversity and reduce inequalities across middle leadership too.

Too often the focus around developing Black, Asian & Minority ethnic leaders has been on providing them with more skills and academic development to help them move up to the next level in the leadership ladder, which reenforces a deficit stereotype rather than tackling the institutional racism that has been holding them back. Positive action measures should be targeted around going around the bias and prejudice that has led to ethnic minority colleagues not been given the opportunities to demonstrate the skills they have.

Inclusive leadership is not a detitanation but a continuous journey to look at how you can do more to reflect and own your own privilege, understand others more, act to tackle bias in the decisions you make and to ensure that change is seen as a positive step to tackle inequalities and injustice rather than simply a threat to the status quo.

3. Grow Inclusive Leaders – What does this look like?

We have highlighted four key drivers that organisations should consider reviewing and taking more action to ensure they are p rioritising Anti-Racism across all that they do:

1. **Visibility Matters**
   Our most senior public sector leaders should come from a wider diverse range of backgrounds and should broadly represent the communities they serve. This diversity and visibility helps build communities' trust in our institutions and also leads to better decision making overall.

2. **Where is Your Talent?**
   Understanding your talent trajectory in respect to Black, Asian & Minority Ethnic colleagues helps an organisation know wereactions need to be to increase diversity and tackle departmental or structural inequalities. Diversity should be visible across all levels of an organisation.

3. **Levelling Up Middle Leadership & Inclusion**
   If we only focus development on our most senior leaders, commitment to change is often not followed through my those leaders tasked with implementing decisions across the organisation

4. **Real Opportunities**
   We have seen for a long time sending colleagues on dedicated learning programmes as the solution to under representation in leadership roles. But so often that development doesn't lead to an opportunity for promotion and centres the idea that Black, Asian & MinorityEthnic colleagues need to work harder and learn more in order to achieve the same as their white peers.

3. Grow Inclusive Leaders – What does this look like?

Key Drivers	Direct deliverables	Resources
1. Visibility Matters	- An organisations Board of Directors diversity by ethnicity must match closely the diversity of the local population or at the minimum include 1 Black, Asian or Minority Ethnic member (which ever figure is higher).	NHS England a case for diverse boards NHS Confederation Taskforce on increasing Non-Executive Director Diversity in the NHS
2. Where is Your Talent?	- Must have set targets and a published talent trajectory for BAME representation across every level of the organisation.	CBI - develop a strong talent pipeline from entry level to executive roles CBI – Practical Guide Bridging the Gap
3. Levelling Up Middle Leadership & Inclusion	- All leaders at Band 8A and above must have a PDP goal agreed around equality, diversity & inclusion and a process to report annually the percentage of these goals that have been met.	Deloitte Six traits of inclusive leadership Northern Care Alliance NHS Foundation Trust Intentional Inclusion Model
4. Real Opportunities	- An organisation should have a dedicated positive action secondment or stretch projects programme in place to give Black, Asian & Minority Ethnic colleagues the chance to gain experience to support with career progression.	Personnel Today – Black Jobs Matter

4. Act to Tackle Inequalities – What does this mean?

Let my actions speak for themselves is a famous saying but that represents the mantra by which an organisation truly committe d to anti-racism needs to run by. Words alone can often become a shield through which organisations are able to justify either consciously or unconsciously their inaction over time, whether they have followed through with meaningful actions or not to tackle an inequality.

Initiatives like the Workforce, Race Equality Standards, Model Employer plans and others are not a solution in themselves, bu t can be a positive tool to measure existing inequalities and target actions to have the biggest impact. These tools need to be used actively to support equality activity across an organisation rather than simply as an assurance framework completed once a year and not looked at again.

The inequalities we see across our communities today will only be addressed when organisations use their resources collective ly in partnership to tackle their main causes. Building a critical mass of activity built around neighbourhoods, localities and our region as a whole is key to seeing the numerous health inequalities and social injustices that harm so many being relegated to history instead of being a painfu l reality of today many are forced to live with.

The amount of action needed to tackle inequalities is large it reflects the generations of institutional racism and injustice developed over decades in this country. But when viewed as mission critical and delivered through embedded priorities across all areas of an organisations structure the task is not insurmountable and the outcomes will be transformation for our communities as a whole.

4. Act to Tackle Inequalities – What does this look like?

We have highlighted four key drivers that organisations should consider taking more action around to ensure they are tackling inequalities:

1. **More Than a Tick Box**
   While assurance frameworks have at times been labelled as just a tick box for an organisation to deliver against, this doesn't have to be the case. Tools like the Workforce Race Equality Standards and others can be used to prioritise, leverage and monitor real change. Anti-Racist organisations use all the resources and tools available to them to achieve their goals of reducing inequalities and tackling discrimination.
2. **Zero Tolerance Matters**
   Being anti-racist is an active stance and means more than simply not acting to do harm, but actively tackling the harm we see. Organisations that are on the journey to getting this right are clear in the zero tolerance they have for racism from anyone including colleagues and service users. It's vital that organisations consider how they are handling these types of incidents and are constantly learning to do more to tackle racist abuse.
3. **We Do This Together**
   Many inequalities are too big to tackle on your own as a single organisation. It's vital organisations work in partnership to tackle racial inequalities we see across our communities. When looking at Health inequalities NHS organisations should be working with their local community and other statutory sector bodies to tackle these collectively rather than them staying in the too hard to do pile.
4. **Fair and Just**
   The processes which exist across an organisation that look at grievances and disciplinaries for staff should feel fair and equitable for all. Where this is not the case the outcomes experienced by colleagues lead to mistrust and a clear weathering affect on the wellbeing of Black. Asian & Minority Ethnic Staff.

4. Act to Tackle Inequalities – What does this look like?

Key Drivers	Direct deliverables	Resources
1. More than a tick box	- The organisation must be able to demonstrate two years of consecutive improvements against at least five Workforce Race Equality Standard Measures.	NHS England WRES Team Best Practice Case Studies
2. Zero Tolerance Matters	- The organisation must of communicated clearly that it takes a zero tolerance approach to racist abuse from service users or staff members. - A sample audit must be carried out of reported racist incidents annually with key learning identified on how the organisation can better response to racist incidents.	BME Charter for medical schools to prevent and address racial harassment BBC News Hospital CEO on zero tolerance
3. We do this together	- The organisation can demonstrate progress over the last 12 months of reducing an an identified health inequality. - The organisation can demonstrate working in partnership to reduce a specific health inequality.	Kings Fund – Addressing Race inequalities needs engagement NHS England Health Inequalities Hub
4. Fair and Just	- The organisation can evidence diverse representation within their disciplinary and grievance processes.	NHS England WRES Best Practice Case Studies

5. Review Progress Regularly – What does this mean?

The NHS is no stranger to performance measures and the need to be intentional about tracking progress with a clear and detailed approach. However when it comes to anti-racism and wider equality, diversity and inclusion activity this has often lacked the same rigour in monitoring performance as other areas of our organisations.

Research from the USA (Why Diversity Programmes Fail Prof. Frank Dobbin and Prof. Alexandra Kalev Harvard Business Review July-August 2016) has shown us that one of the most important aspect to diversity and equality activity is grounding this work in social accountability and taking time to measure and be clear about whether progress is being made.

While an organisation may have implemented actions elsewhere to tackle and reduce the impact on bias within decision processes and decision making, it's vital that the same consideration is taken when reviewing an organisations overall performance around anti-racism and equality as a whole. What this means in practice is ensuring progress is reviewed by more than simply the people that have led or commissioned any activity and that there is intentional consideration to the diversity of those involved in reviewing and monitoring progress.

As an NHS we are the biggest employer in the country but yet as we are split up into 100s of separate organisations we often look inward for ideas and feedback around change. As a North West region through the work of the BAME Assembly we have an opportunity to collaborate and ensure reviewing organisational progress is a task we support each other with, with ideas, success and failure shared in equal measure to support our anti-racism journey.

5. Review Progress Regularly – What does this look like?

We have highlighted four key drivers that organisations should consider reviewing and taking more action to ensure they are p rioritising Anti-Racism across all that they do:

1. **How are we performing?**
   It's vital that organisations consider the management of performance around inclusion as seriously as they monitor performance of other areas of work. Leaders at all levels should have an understanding of how their area is doing in relation to key targets.

2. **What's our approach?**
   Becoming and anti-racist organisation takes a clear intention to deliver a range of actions and measures consistently over a pro longed period of time. Understanding where the organisation is on its journey to become anti-racist is vital.

3. **Our Voices Matter**
   The voices of Black, Asian & Minority Ethnic people should be at the heart of an organisation considering where they are on their journey to become anti-racist. This helps ensure that actions that have been meaningful and had an impact are prioritised and where progress hasn't been made this isn't hidden by positive activity and behind the detail of a report.

4. **Open and Transparent**
   To have credibility around a statement that an organisation is anti-racist its vital the label is not just coming from the organisation themselves but that the statement is supported by the community it serves.

5. Review Progress Regularly – What does this look like?

Key Drivers	Direct deliverables	Resources
1. How are we performing	- An organisation must use an EDI performance dashboard that is presented quarterly to at least a sub group of the board and include performance against the race disparity ratio, WRES and other race specific targets. - Organisation should record and publish their ethnicity pay gap annually	Health Education England Diversity Performance Dashboard Civil Service Diversity & Inclusion Dashboard
2. What's our approach	- Organisation should review progress against each of the key drivers and direct deliverables within the NHS North West Anti-Racism Framework at least annually.	NHS North West Black, Asian and Minority Ethnic Strategic Advisory Group
3. Our Voices Matter	- The organisation should bring together annually Black, Asian & Minority ethnic staff to review EDI progress and any learning be built into the following years plans.	HPMA Newsletter - The Value of Lived Experience
4. Open and Transparent	- The organisation should submit an application to the BAME Assembly to receive feedback against their Anti-Racism framework at least every two years.	PWC – Diversity and the Case for Transparency

The BAME Assembly Anti-Racist Accreditation

The North West BAME Assembly's mission is to support NHS organisations from across the region to become Anti-Racist and to be at the forefront of challenging racism and tackling inequalities by people in our communities and our workforce.

To achieve this mission the assembly recognises that there will need to be intentional and sustained actions by all NHS organisations to turn the commitment to become an anti-racist organisation into a reality. So often in the past many communities have felt that pledges and commitments to equality haven't been followed through and the assembly feel it has a role to ensure that when we use the phrase "anti-racist" organisation here in the North West our communities and workforce can have confidence in what that means.

Recognising the number of assurance and compliance mechanisms that already exist, the BAME Assembly Anti-Racist Organisation Accreditation has been developed to be both clear on what's needed to implement and simple to apply when an organisation is ready to receive their assessment. Following the completion of a short application form that asks for examples of evidence across each of the five principles of our anti-racism framework. A panel of assessors brought together by the BAME assembly will judge whether an organisation has delivered against the minimum direct deliverables for each domain.

The make up of the assessment panel:

- Four BAME Assembly Members
- One NHS Provider or ICS EDI Lead
- Two BAME Staff Network Chairs
- Head of Equality from NHS England Northwest

Process for The BAME Assembly Accreditation

Self Assessment

- ❑ Review organisation against each of the dirt deliverables under the five principles of the anti-racism framework. If happy all have been completed move to application stage.

Application

- ❑ Complete application form downloaded from the BAME Assembly internet page. Each of the direct deliverables will require written evidence how they have been delivered by your organisation.

Assessment Panel

- ❑ The assessment panel will meet twice a year to review applications from organisations wanting to receive the BAME Assembly Anti-Racism Accreditation.

Publish & Review

- ❑ Organisations that are successful in receiving will have their name published on the BAME Assembly internet page, case studies shared via NHS England events and be able to use an Anti-Racism graphic on their website and email signatures.

Additional Anti-Racism Resources

National Education Union Anti Racism Framework – Click Here
NHS Leadership Academy Allyship Toolkit – Click Here
NHS Leadership Academy Resources on Racism – Click Here
NHS Employers Resources to Tackle Racism – Click Here
NHS England WRES 2020 Data Analysis Report – Click Here
NHS England Patient Carer Race Equality Framework – Click Here
NHS Race and Health Observatory – Click Here
NHS Confederation BME Leadership Network – Click Here

Produced by the Northern Care Alliance

Equality@nca.nhs.uk

Item 5.1 (c)

Liverpool Heart and Chest Anti-Racist Statement & Commitment

As an organisation, we do not tolerate racism, and are committed to improving when it comes to being actively anti-racist.

Liverpool Heart and Chest Hospital has long valued and respected racial, ethnic, cultural and religious differences. We acknowledge that more work is needed to confront inequalities and embrace the institutional change necessary to make the world a more just and inclusive place.

We commit that our diversity, equity, inclusion, belonging and anti-racism work will be open, transparent and accountable. We will listen to our people and create opportunities to generate real transformation.

This work is imperative for our future. We will invite all who are part of our organisation to join us, so that we are better able to improve.

We will be single minded in our approach and proud to oppose racism, through a wide range of actions: -

- We will advocate for the diverse and marginalised groups in our communities
- That our Black, Asian and minority ethnic patients have the same quality of care and access.
- We will improve the patient experience, ensuring that Black and minority ethnic service users and carers feel understood and supported.
- We will improve the experience of Black, Asian and minority ethnic colleagues as reported in the annual staff survey
- We will continue to strengthen the voice of our staff networks through LHCH Belong, enabling staff groups to influence
- We will address areas of under-representation across our workforce, with a focus on improving diversity.

For further Information about the NHS Black, Asian and Ethnic Minority Assembly, please watch this video below: -

https://youtu.be/UcQOdP7mtGw

Board of Directors (in Public)
Item 5.2

Subject: **Covid-19 Inquiry Preparation**
Date of meeting: **25th January 2022**
Prepared by: **Karan Wheatcroft, Interim Chief Governance Officer**
Presented by: **Karan Wheatcroft, Interim Chief Governance Officer**
Purpose of Report: For Noting and Approval

1. Executive Summary

The National Covid-19 Inquiry is due to commence in Spring 2022. The Chair is yet to be appointed and the Inquiry Terms of Reference published.

In terms of NHS preparedness, NHSEI has issued a notification regarding document preservation, and there have been a number of webinars including Hill Dickinsons, NHS Providers and a recent NHSEI update.

To date it has been clear that whilst NHSEI will share their approach, they will not produce guidance and organisations will be responsible for their own preparedness.

This paper sets out the Trust's proposed approach to preparation for the Inquiry, which is a pragmatic approach based on what we know so far. This will be kept under review as the Inquiry Terms of Reference and approach are confirmed.

2. The Covid-19 Inquiry 'what we know so far'

The following provides a summary of the basis and expected scope of the Inquiry.

The Inquiry will have significant architecture and powers, and is expected to:

- be on a statutory basis under the Inquiries Act 2005. This means it will be independent, have power to compel witnesses and evidence, and its hearings will be held in public. A statutory inquiry cannot make findings of civil or criminal liability.
- "commence" in Spring 2022 with the terms of reference and appointment of the chair to take place before then. The Prime Minister has committed to appointing a chair by Christmas and the terms of reference will be in place before Spring 2022. However, it's likely that hearings will not start until later in 2022 following the submission of evidence.
- be UK-wide, covering all four nations in some form. However, Scotland has committed to a judge-led inquiry, which is expected to start this year.
- be wide ranging, with the scope extending beyond health and social care, and so we understand to include the economy, education, and national lockdowns.
- take into account the experience of the bereaved.

NHSEI know they will be participating in the Inquiry, but it is not clear yet whether the Inquiry will reach into regional and local organisations. NHSEI will not provide detailed instructions to other NHS organisations on their individual Inquiry responses, in the event other NHS bodies are called or seek to participate.

Source: NHSEI update (NHS Futures Platform workspace)

In terms of likely focus, the following have been suggested through the webinars (although it is recognised that this is speculative at this stage):

- Patient treatment and deaths,
- NHS preparedness,
- Guidance and decision making,
- Procurement (national and local)
- Test and trace, tracking and vaccines,
- Interaction with care home sector,
- Collaboration with social care and others.

In terms of preparation the following key messages have been:

- Keep calm and maintain a proportional approach given uncertainty
- Appoint inquiry lead as point of contact
- Identify Inquiry Team including IT, governance and communications leads.
- Keep track of key individuals leaving the organisation, including contact details and ensure any 'local' records are transferred
- Ensure teams are culturally managing records
- Decision logs are helpful
- Organisations should continue to respond to DPIA and FOI requests as normal

In terms of other organisations, there has been some uncertainty about the expectations and organisations are working through their approach. For NHSEI, they have suggested they are taking quite a thorough approach to cataloguing and collating information as they expect to be a key contributor (e.g. the control and command structures adopted in response to the Covid-19 pandemic). For other organisations, there is a perception that the Inquiry is likely to be focussed on outliers/ anomalies, and where organisations may fall into this area they may already be doing additional work to look at deaths, infection control, outbreaks etc.

There is also an expectation that FOI and DPIA requests may increase during the Inquiry and this is something we will need to be aware of.

3. LHCH preparedness

At this stage whilst NHESI will not direct organisations, there is a general sense of being pragmatic and measured in terms of preparation. Whilst some organisations/ bodies may feel they will play a key role in the inquiry, and undoubtedly the NHS will be called upon for evidence, it is unlikely that every NHS organisation will be approached to contribute.

The following actions are being taken to ensure we preserve documentation and are prepared for any request that may be made. At this stage our focus is on developing a high level 'map' of the information we hold, where this is held, by whom and how to access it. The full collation and cataloguing of information would take a significant amount of resources at a time when we are recovering and resetting services, as well as responding to new variants. We will continue to track guidance and publications and take stock of our approach, as we may need to take further action as the Terms of Reference and approach to the Inquiry become clearer.

The Trust has clear record keeping for Gold and Bronze command meetings demonstrating the diligent approach already taken to retaining these records. The rolling action log is also extensive and should provide a good reference point for decisions and actions (this will be tested as part of the mapping exercise). Other documents that will need to be considered will include notebooks, social media (e.g. whatsapp), phones (e.g. messaging), emails, communication channels (e.g. intranet) etc.

Planned Action	Responsibility/ timeframe	Progress Update
1. Identify an Inquiry Lead	JT (Nov 21)	**Complete** – KWh providing the lead role
2. Establish an Inquiry Team*	KWh (Nov 21)	**Complete** – an initial team has been established and Teams Channel established to share intelligence
3. Communications Plan	KWh/ MB / WT (ongoing)	**In progress** – initial communications regarding the inquiry and document preservation planned January 2022.
4. Initial mapping of key information	KWh (February/ March 22)	**In progress** – initial discussions with the Inquiry Team to start the mapping and walkthrough examples of Gold and Bronze records.
5. Keeping up to date with Covid-19 Inquiry progress, guidance etc.	Inquiry Team (ongoing)	**In progress** – attendance at a number of webinars, sharing notes and access to NHS Futures platform covid inquiry workspace for NHSEI updates.
6. Revisit approach once the Inquiry TOR are published.	KWh (TBC)	**Planned**

*The initial team includes:

- Karan Wheatcroft – Interim Chief Governance Officer (Lead)
- Joan Mathews – Deputy Director of Nursing & Quality
- Helen Martin – Risk and Safety Lead
- Wyn Taylor - Head of Information Governance & Administration / Data Protection Officer
- Matthew Back – Head of Communications
- Rachel Dyer – Improvement Support Officer
- Laura Doran – Governance Systems Analyst
- Terri Marshall – Risk Management Coordinator

Assurance on progress as well as national guidance updates will be reported through the Executive Team, Operational Board and the Board of Directors.

4. Recommendations

The Board are asked to note the update and approve the proposed approach to preparing for the Covid-19 inquiry as we await further clarification of the Terms of Reference.

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Board of Directors (in Public)
Item 5.3*

Subject: **Trust insurance arrangements**
Date of Meeting: **25th January 2022**
Prepared by: **James Bradley, Deputy Chief Finance Officer**
Presented by: **Karen Edge, Chief Finance Officer**
Purpose of Report: **To note**

BAF Reference	Impact on BAF
BAF 7	Assurance that the Trust has insurance (through NHS Resolution, and also buys additional top-up insurance through commercial insurance providers) in order to manage risk.

Level of assurance (*please tick one*)					
X	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Executive Summary

NHS Trusts' insurance arrangements are primarily provided through membership of NHS Resolution (NHSR). In addition to the cover provided by NHSR, some Trusts also purchase additional cover through commercial policies where they have identified risk exposures in the indemnity offered by NHSR.

In line with the Standing Financial Instructions, the Chief Finance Officer shall ensure that insurance arrangements exist in accordance with the risk management programme, and that the Board are informed of insurance arrangements, consider the adequacy of the insurance cover in place and decide whether the Trust will insure through the risk pooling schemes administered by NHS Resolution.

The commercial policy was renewed in November 2021, consistent with the cover arrangements previously presented to the Board. This paper provides a summary of the cover in place and options for expanding cover if desired relating to property damage caused by terrorism.

2. Trust insurance arrangements

The Trust has insurance from both NHS Resolution and additional cover from commercial insurance, as detailed below:

2.1 NHS Resolution

a. Clinical Negligence Scheme for Trusts (CNST)

The Clinical Negligence Scheme for Trusts handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). It covers loss or injury arising from Trust negligence in diagnosis and treatment.

b. Liability to Third Parties Scheme (LTPS)

The Liabilities to Third Parties Scheme (LTPS) was established in April 1999, and typically covers employers' and public liability claims from NHS staff, patients and members of the public. These range from straightforward slips and trips to serious workplace manual handling, bullying and stress claims. LTPS covers claims arising from breaches of the Human Rights Act, the Data Protection Act and the Defective Premises Act, as well as defamation and professional negligence claims.

The cover extends to personal liabilities of the members of NHS boards, including non-executive directors. The scheme is designed to meet the costs of defending or settling claims against individual Directors.

Personal injury cover is unlimited in value and there is no limit on the number of claims that can be made in any membership year.

NHSR does not provide Public Liability cover for a number of income generation activities which are provided to non-NHS organisations (although this exclusion does not apply to Directors and Officers liability for NHS Trusts).

c. Property Expenses Scheme (PES)

The Property Expenses Scheme covers "first party" losses for material damage to buildings and contents from a variety of causes, including fire, theft and water damage. The Scheme will not be liable for any amount above the Scheme limit of cover of £1,000,000. PES also offers business interruption expense cover arising from property damage.

2.2 Commercial Insurance

a. Property Damage

This policy insures the Trust for loss of, or damage to, Trust property above the NHSR limit of £1m.

This does not cover property damage as a result of terrorism. Any damage caused by terrorism above the £1m limit provided by NHSR is not currently covered by the Trust's commercial insurance. The insurance broker has given an estimated quote of £17.5 to £20k (plus tax) to provide full cover for

buildings/contents damage to full reinstatement value.

b. Contract works

This policy insures the Trust for loss of, or damage to, Trust contract works and associated materials and other property during the course of construction. Cover is arranged on the basis of refurbishment, extension or a new build contract, with an estimated turnover of £2,500,000 per contract. The cost of this cover has decreased this year resulting from the conclusion of the Electrical Infrastructure works.

The insurance implications of the works relating to the Surgical corridor are being reviewed as part of the project and any further insurance requirements can be added at a later date if deemed necessary.

c. Goods in Transit/Cargo

This policy insures the Trust for loss of, or damage to, Trust property whilst in transit, loading/unloading, but not storage. The locations for transit are community clinics in Liverpool, Huyton, Kirkby and Southport as well as patient's homes in these locations.

d. Business Travel

The policy insures any member of the Trust for trips related to the business of the Trust outside the UK. This also includes any additional days added by the insured person for personal reasons. Any trips to areas not recommended by the Foreign and Commonwealth Office will require additional insurance.

e. Directors and Officers Liability

The NHSR policy covers the Corporate Legal Liability risk (The Entity) and past Directors and Officers, in addition to existing Directors and Officers. The charity is deemed outside of the relevant functions, and is not considered to be covered by the NHSR scheme. The cover for The Liverpool Heart and Chest Charity has been renewed.

f. Commercial Loss Recovery

This policy provides expert assistance from an independent loss adjuster to assist the trust in the preparation and negotiation of a property insurance claim, which exceeds £100,000.

g. Motor Fleet

This insurance is for the vehicles owned by the Trust.

2.3 Uninsured Risks

a. Clinical Trials – NHSR: CNST provides cover for the treatment risk of clinical trials, but LTPS contains a clinical trials exclusion, irrespective of whether the trial is NHS or non-NHS funded.

b. Business Interruption Cover (Loss of revenue and/or increased costs of working). Under NHSR: PES cover is provided to a £1m limit. Insurance for a higher limit could be obtained, but is not currently covered.

c. Terrorism – Under NHSR: PES cover is provided to a £1m limit. As outlined above, any damage caused by terrorism would not be covered above £1m. The insurance broker has given an estimated quote of £17.5 to £20k (plus tax) to provide full cover for buildings/contents damage to full reinstatement value.

d. Public/Products Liability and non-clinical Professional Indemnity for services considered "Outside the NHS" – "outside the NHS" means the provision of services, supply of facilities or products to any party other than NHS Trusts, other NHS organisations, NHS Staff (in their capacity as employees) and NHS

patients (in their capacity as patients). This is not considered a significant risk as services provided by the Trust fall under the remit of NHS services. The most significant non-NHS income relates to the private patient service. NHS bodies are not responsible for a health care professional's private practice, even in an NHS hospital. However, where junior medical staff, nurses or members of professions supplementary to medicine are involved in the care of private patients in NHS hospitals, they would normally be doing so as part of their NHS contract, and would therefore be covered by the NHSR scheme. It remains advisable that health professionals who might be involved in work outside the scope of his or her NHS employment should have professional liability cover.

3. Summary of Trust insurance arrangements

Policy Type	Insurer	Excess per claim	Indemnity Limit	Premium 21/22
Clinical Negligence	NHS-R	Nil	Unlimited	£ 1,155,790
LTPS	NHS-R		Unlimited	£ 85,552
Employers Liability		£ 10,000		
Public and Products Liability		£ 3,000		
Pollution		£ 10,000		
Directors and Officers		TBC		
Professional Indemnity		£ 3,000		
Personal Accident		Nil		
PES	NHS-R	£20,000	£1,000,000	£ 23,288
Goods in Transit			£100,000	
Fidelity Guarantee			£250,000	
NHS Resolution sub-total				**£ 1,264,630**

Policy Type	Insurer	Excess per claim	Indemnity Limit	Premium 21/22
Property Damage	Allianz	£ 1,000,000		£ 36,626
- Buildings				
- Temporary Buildings				
- Machinery, plant				
- Stock				
- Computer Equipment				
Contract Works	Allianz	£1,000		£ 5,264
Goods in Transit	Lloyds	Nil		£ 941
Business Travel	Chubb European			£ 640
Directors' and Officers' Liability (Charity)	Dual			£ 2,352
Commercial Loss	Lorega	£5,000		£ 993
Service Fee	Griffiths & Armour			£ 6,000
Non NHS Resolution Sub-total				**£ 52,816**
Fleet (Van)	QBE			£ 962
Total				**£ 1,318,408**

4. Conclusion

The paper sets out the insurance arrangements that the Trust has in place. The commercial insurance has been reprocured with the same specification as the previous year. There is an option to increase the insurance relating to damage caused by acts of terrorism above the £1m limit provided by NHSR but after review, this is not to be taken up.

5. Recommendation

The Board of Directors is asked to:

- NOTE the insurance arrangements in place

Board of Directors (in Public)
Item 5.4*

Subject: **Executive Director Roles**
Date of meeting: **25th January 2022**
Prepared by: **Karan Wheatcroft, Interim Chief Governance Officer**
Presented by: **Jane Tomkinson, Chief Executive**
Purpose of Report: For Approval

BAF Reference	Impact on BAF
ALL	Confirmation that BAF lead roles are aligned to Director portfolios and responsibilities.

1. Executive Summary

The purpose of the paper is to provide an overview of the Director roles and voting rights following recent changes as approved through the Nominations and Remuneration Committee.

2. Director Roles

Current Director roles are set out in the table below.

Post/ Postholder	Voting Board member	Role
Jane Tomkinson Chief Executive	YES	• Accountable Officer
Raphael Perry Medical Director and Deputy CE	YES	• Infection prevention and control (DIPC) • Caldicott guardian • Clinical leadership
Sue Pemberton Director of Nursing and Quality	YES	• Quality and patient safety • Nurse leadership
Karen Edge Chief Finance Officer	YES	• Finance • Capital and estates
Karen Nightingall Chief People Officer	NO	• People • HR • Learning and Development
Kate Warriner* Chief Digital Officer	NO	• Digital • Information

Post/ Postholder	Voting Board member	Role
Jonathan Mathews Interim Chief Operating Officer	NO	• Performance and Activity • Divisions
Jonathan Develing Director of Strategic Partnerships	NO	• Strategy • External Partnerships • Sustainability/ Green
Lucy Lavan Director of Corporate Affairs**	NO	• Governance • Charity • FTSU
Jay Wright* ** Director of Research	NO	• Research
Vacancy Director of Risk and Improvement	NO	• Risk • Improvement • Organisation Learning

*Joint role with AlderHey Childrens' NHS Foundation Trust
**Karan Wheatcroft – Interim Chief Governance Officer is providing part time cover for the governance and risk aspects of this role via a secondment
***Advisor to the Board

The voting Director roles include all the roles as set out in the constitution (chief executive, finance director, registered medical practitioner and registered nurse).

In terms of the recent changes:

- there is no change to the overall number of executive team members.
- in the short term the composition of the Board of Directors now has four voting executive directors rather than five. The Board of Directors can increase or reduce the number of voting directors in accordance with the provisions of the Trust's constitution. The Chief Executive will review this position and make a recommendation in the new financial year.

3. Recommendations

The Board is asked to note the current Director roles and the plan to review the number of voting directors in accordance with the provisions of the Trust's constitution in 2022/23.

Board of Directors (in Public)
Item 5.5*

Subject: **Communications Report Q3**
Date of Meeting: **25th January 2022**
Prepared by: **Matthew Back, Head of Comms**
Presented by: **Karen Nightingall, Chief People Officer**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
N/A	None

Level of assurance (*please tick one*)					
✓	**Acceptable assurance** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partial assurance** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Low assurance** Evidence indicates poor effectiveness of controls

1. Executive Summary

The purpose of this report is to keep the Board of Directors informed and provide a high level update on Trust communications activities during quarter 3 (Oct-Dec 2022).

2. Background

This is the third quarterly communications update provided to the Board of Directors.

3. Highlights During Quarter 3 (Oct-Dec):

- We organised the Annual Members' Meeting, including a brief highlights of the year video, and the production of a summary annual review
- We received positive media coverage.
- We supported comms for multiple vacancies.
- We supported a number of awareness days/events
- We provided brand support for new staff health and wellbeing resource packs
- Provided ongoing comms support for covid booster, flu campaigns and mandatory vaccination programmes

- Helped to coordinate the formal opening and filming of Lady Dodd at the opening of Sir Ken Dodd Education Centre
- Provided extensive support for the LHCH Charity Christmas campaign – 12 Days of Christmas
- Coordinated the staff Christmas gift voucher mailing
- Started exploring new comms framework/strategy planning
- Developed new process for collating national award submissions
- Comms support for NHS staff survey
- Comms support for the launch of Be Civil Be Kind
- Comms support for October's Green Month and other awareness days/events (Pain Awareness, Pressure Ulcer Awareness, Allied Health Professionals Day, Remembrance Day, Radiography Day etc)
- New podcast guests interviewed and shared via social media.
- Planning for launch of LHCH photography competition in 2022.
- Live filming Cath Lab case with Prof Dhiraj Gupta
- Online membership events: cardio-oncology event with Ainsdale Medical Centre; CPR training at Marine FC

Q3 was a busy quarter for the communications team

- Positive engagement and reach was seen on all three main social media channels. Facebook performs best with patient experience/staff story content; and Twitter engagement with clinical content was positive.
- Overall, total social media impressions for Q3 was just under 300,000 with audience growth, year to date, across all three platforms between 8-15%.

SOCIAL MEDIA MONITORING

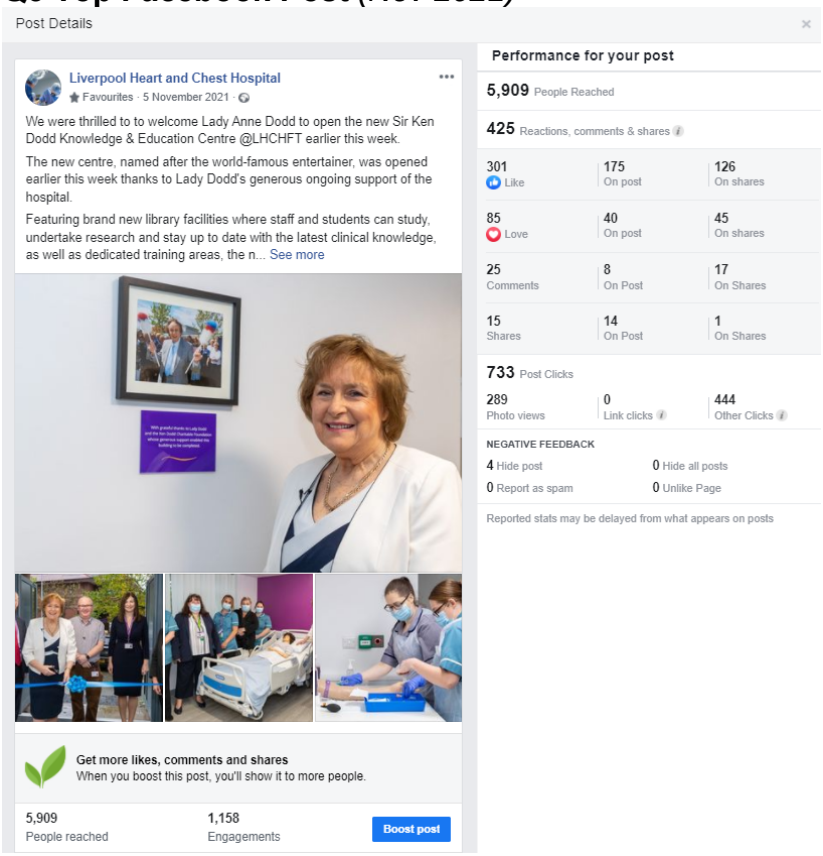
Q3 2021/22	Twitter	Facebook	Instagram
Audience	6,885	73100	1,384
Audience Growth YTD	8.66%	8.52%	14.23%
Reach	N/A	688091	27,172
Impressions	123,700	107966	60,178
Number of Posts	66	26	31

SOCIAL MEDIA ACTIVITY HIGHLIGHTS

Q3 Top Tweet *(Nov 2021)*

Q1 Top Mention *(Nov 2021)*

Q3 Top Facebook Post *(Nov 2021)*



MEDIA COVERAGE

- A total of 24 pieces of media coverage were picked up in quarter 3 with no negative Coverage.
- Positive media coverage on BBC Radio Merseyside on the Targeted Lung Health Check Programme in November
- Positive media coverage of LHCH's HIMSS Level 6 rating in digital trade media
- Positive media coverage of thanks for Dr Rob Cooper's actions in treating a player from Wigan Athletic FC

PLANS FOR Q4

- Development of new communications strategy
- Exploration of informal comms collaboration with specialist trusts
- Planning and preparation for Annual Report & Accounts 2021/22
- Implement new process for collating national award submissions
- Members Matters newsletter to be written and distributed electronically.
- New chair appointment comms
- Ongoing comms support for covid and flu campaigns
- Comms support for NHS staff pulse checks
- Comms support for Blue Monday, health awareness days, and staff health and wellbeing initiatives
- New podcast guests interviewed and shared via social media.
- Cath Lab/Care Cube filming scheduled in February.
- OSCEs filming in Critical Care.
- Online membership event scheduled in March around sleep apnoea.
- Start planning for summer governor elections
- Planning for 2022 staff recognition activities/events.
- Planning LHCH photography competition in 2022.
- Development of membership engagement plan for 2022/23 with membership and comms sub-committee
- Covid inquiry document retention comms plan

4. Conclusion

- Overall positive media coverage.
- Positive engagement across social media channels. Ongoing work to identify strong patient / staff stories, to deliver greatest reach.
- Extensive comms/membership planning ongoing
- Positive internal communications activity with Christmas gift for staff.

5. Recommendations

The Board of Directors are asked to note the contents of the report.

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Board of Directors (in Public)
Item 5.6

Subject: **Medical Revalidation Annual Report**
Date of meeting: **25th January 2022**
Prepared by: **Lauren Murphy – Business HR Assistant, Dr Raphael Perry – MD**
Presented by: **Dr Raphael Perry - Medical Director**
Purpose of report: **For Noting**

BAF Ref	Impact on BAF
BAF 1	Assurance regarding doctors being able to practice. Impact on safety and reputation.

1. Executive Summary

Revalidation continues to be a five-year cycle leading to a recommendation to the GMC that a doctor is fit to practice and retain their medical licence. The first five-year cycle completed in December 2017. All doctors who have LHCH as their designated body (DB) (their prescribed connection) have the Medical Director (Dr Raphael Perry) as their Responsible Officer. The Responsible Officer (RO) is the only individual who can make the recommendation for revalidation and relies on the following evidence;

- Evidence of regular satisfactory medical appraisal
- Peer and patient feedback at least once in any cycle
- No on-going disciplinary procedures or GMC sanctions

The Trust has a robust medical appraisal system, an adequate number of trained appraisers and good culture of reflection on untoward events.

The electronic online appraisal system, Allocate, enhances tracking of appraisals and ensures timely completion. Dr Tim Fairbairn is the assigned Appraisal lead and continues to monitor progress of completion and feeds back to NHSE Revalidation Team (North)

There are no doctors who have failed to provide evidence for revalidation.

2. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

The first Revalidation cycle aimed to have all doctors through the appraisal for revalidation process in the first three years. By the end of that time period, all doctors registered with the GMC underwent revalidation. After the first cycle, approximately one fifth of all our doctors will revalidate each year.

Provider organisations have a statutory duty to support their Responsible Officers in

discharging their duties under the Responsible Officer Regulations and it is expected that provider boards oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors;
- ensure that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2. Revalidation Governance Arrangements

The Medical Director, Dr Raphael Perry is the Responsible Officer for the trust and has overall responsibility for the Governance processes and conduct of revalidation for Medical Staff at LHCH. The RO has undergone all the national required training requirements for the post, attends national annual update meetings and quarterly regional RO/appraisal lead meetings

The RO has undertaken the following training**.**

1. February 27 2014 RO Northern Conference Leeds
2. July 1 2014 Responding to concerns meeting Manchester
3. September 2016 RO conference Leeds
4. June 2018 RO (north) conference Leeds
5. January 2021 RO (north) conference MSTeams

The RO also attends the quarterly Revalidation Team (north) RO network meetings. These meetings are now virtual since to Covid 19

The RO meets three times a year with the GMC ELA (now virtually) addressing doctors' performance, quality and regulatory updates.

The RO underwent satisfactory annual appraisal as in December 2021 and will be able to revalidate in 2022.

Dr Tim Fairbairn is the Trust's Appraisal lead and has undertaken appropriate training. He attends the quarterly regional Revalidation Team (north) network appraisal meetings. The appraisal lead, liaising with the RO, has the responsibility of ensuring all appraisals were completed on time and to a good standard.

The RO role is supported by the HR department (HR Business Partner and a Business HR Assistant), the recruitment team undertake all pre-employment checks.

Revalidation Performance 2021

The GMC maintains a list of medical staff with a prescribed connection to the Trust on the GMC connect website. The RO reviews this list weekly to ensure clinicians are on track to revalidate at the date set by the General Medical Council. Email warnings are given to all clinicians four months before the date of their revalidation. New, permanent medical staff are

required to inform the GMC that the Trust is their designated body for the purposes of Revalidation.

In early 2020, the GMC made changes to revalidation dates in response to the pandemic. This was in order to give doctors and responsible officers more time to be ready for revalidation and prioritise clinical care for patients. The appraisal system was changed to be more light touch and doctors could ask to defer or skip appraisal altogether for a year.

Doctors who were due to revalidate between 17 March 2020 and 16 March 2021 had their revalidation submission dates moved back by one year. Given the ongoing challenges that doctors are facing, The GMC decided to extend this approach to doctors who are due to revalidate between March and July 2021, if their dates haven't already been rescheduled. We've moved back their dates by four months, but all doctors were able to revalidate with no significant delay.

The extension to revalidation dates has been continued where required and the GMC continues with the structure of light touch appraisal introduced since the pandemic. Much of the appraisal focuses on wellbeing and previously required data has been scaled down. The timing of appraisal windows can be extended at the RO's discretion

All consultants and staff grades who were required to revalidate in 2021 complied with the requirements of revalidation within the expected time frame. Notwithstanding the effects of the pandemic the deferral of doctors is allowed for up to twelve months if there are difficulties in assembling appropriate supporting evidence (recent starters) or periods of significant sick leave. No LHCH doctors have been deferred for poor compliance. All nondeanery trainees have LHCH as their designated body for the period of their attachment.

Trainees employed by LHCH have an appraisal in line with their previous appraisal time frame and do not necessarily need or get an appraisal during the period the majority of consultant appraisals are carried out. If only at LHCH for a four or six month rotation period they may not require any appraisal. On arrival their need and time of appraisal is evaluated and communicated to their educational supervisor

Policy and Guidance

The Trust has an approved Medical Appraisal and Revalidation Policy. The governance and requirements of revalidation are evolving and growing. The policy was updated in September 2018 and passed through the relevant committees including the LNC, the next review date is June 2022.

Medical Appraisal

This is the cornerstone of the revalidation process, with annual appraisal now mandatory**.** Appraisal is conducted annually, using the GMC Medical Appraisal Guide. The appraisal window is from September to December and covers the previous financial year. The aim is for the majority of appraisals to be scheduled for September to November. A number of appraisals are undertaken outside of this window with most being completed by December.

Doctors should have an appraisal not less than three months and not more than fifteen months since their last appraisal. They are not expected to have an appraisal during maternity or long-term sick leave.

Since the pandemic the LHCH appraisal window has been extended to the end of March to

support the increased work of the NHS during the various Covid 19 surges and elective restoration.

The interval between April and June is the time required for the clinical audit department to generate the full raft of outcome data that is required as supporting evidence. An online database of medical appraisals is maintained by the RO, the appraisal lead and HR, any delays or missed appraisals are followed up to completion.

Completion of Medical Appraisals 2021

The Trust was the designated body for **82 consultants and 11 trust doctors** in 2021. Of the trust doctors only **8** were due an appraisal during this period. The Trust also acts as the designated body for a palliative care doctor from the Marie Curie Hospice in Liverpool. Deanery Trainees have the Deanery as their designated body and the postgraduate dean as their RO. The appraisal window generally runs from September to December but has been extended due to work pressures associated with Covid 19 for both appraises and appraisers.

To date **44 consultants and 6 trust doctors** have been appraised and fully signed off for 20/21 appraisal period which is the subject of the present appraisal window. Of the remainder 18 the main body of the appraisal completed and are ready for sign off. **Three** doctors have had extended sick or maternity leave and have deferred their appraisal. Of the remainder there are **14** appraisals requiring a meeting with the appraiser and **3** of these have not yet engaged with the process. All these appraisals are being chased up by the AMDs and the appraisal lead.

Noe of these doctors will breach the requirement for appraisal within fifteen months of their last appraisal. Extended timescales have been agreed for the completion of the process for the remaining individuals in line with GMC and revalidation guidance. Delays beyond April 2022 may result in the risk of disciplinary sanction by the Trust. This would not apply to trust doctors whose timing is governed by their attachment and previous appraisal outside the LHCH.

There have been five new consultant starters who have been appraised for the first time.

Meaningful appraisal cannot be undertaken during their first six months and this group is frequently delayed. A very small proportion require revalidation during their time at LHCH. Work is being undertaken by the HR team to ensure the appropriate information is provided in order for the database to be used to its full potential. This remains on going.

The Trust completes the mandatory quarterly appraisal returns to the NHS North revalidation Team. The RO also completes the Annual organisational Audit and Statement of Compliance to the Revalidation Office.

Appraisers and Training

The Trust has currently **37** trained medical appraisers all of whom have undergone training/refresher training since starting as appraisers. Training was undertaken in April 2019 as part of the clinical lead's development programme. A refresher update session was also held in October 2020 and a further update training was carried out in October 2021. In addition, new clinical leads receive training soon after appointment. There is comprehensive cross specialty representation, with appraisal where possible done by an appraiser in the same specialty. The trust follows the appraisal guidance on the number of times an appraiser appraises individuals.

Quality Assurance of appraisals including Involvement in serious untoward events

All appraisals are reviewed for content and completeness by the Responsible Officer and the appraisal lead. The online Medical Appraisal Document now used by the Trust (Allocate) supports all aspects of whole practice appraisal in line with the National Revalidation Support Team. It includes the requirement for doctors to reflect on any complaints and to declare their involvement in investigations or serious untoward events.

In addition, should the RO in his capacity as MD, identify issues that he feels need to be discussed at an individual's appraisal. If this is the case then the appraisee and appraiser will be contacted, and following completion, the appraisal document will be reviewed to ensure this has occurred. All consultants involved in investigations/disciplinary procedures have reflected appropriately in the 2020/2021 appraisal document.

A quality review was carried out by the Higher-Level RO and team from NHSE Revalidation north in January 2020. This was initially in response to a low number of trust doctors having appraisal. The principal reason for this was a problem with the Allocate system data. The session was very constructive and the few actions arising have been completed. This includes the establishment of an Appraisal Consistency Group running I tandem with the Job Planning Consistency Group. All actions were completed, and no further issues have arisen.

Quality assurance of the appraisals is carried out by the RO and appraisal lead after each appraisal period and fed back to the Appraisal Consistency Group with areas of improvement in the narrative of the appraisal document.

The quarterly and annual reports to the revalidation team and the statements of compliance have not led to any negative feedback form the higher RO

Whole Practice Appraisal

Inclusion of non-NHS practice performed outside the Trust needs to be included in the appraisal. The requirement also includes a governance sign off from the Medical Director/RO or Appraisal lead of any hospitals where this practice occurs. Whilst these documents are generally received, there can be delays at these hospitals. Appraisal will not be undertaken without either the documents being received or a sign off that consultants are not engaging in external practice.

In addition, additional roles such as educational supervisors or research and management roles are appraised.

For the 2020/2021 appraisal round, all relevant consultants will be contacted for feedback on their appraisals and any issues will be reported to RO and Appraisal lead. In the future this will be formalised using a standard 360 form. The results will be reviewed by the appraisal lead on completion and feedback given to appraisers.

Access, Security and Confidentiality

Individual appraisal documents are shared between appraiser, appraisee and the Responsible Officer. All documentation is visible on the Allocate system with appropriate access only. Medical staff are fully aware of the requirement not to include patient identifiable data and this

has not been an issue when documents have been reviewed.

The Trust software from Allocate will allow in depth scrutiny of appraisal data if required.

Clinical Governance

Good governance is the foundation for Medical Appraisal and the Trust needs to ensure it has in place those processes required to ensure good medical practice.

As stated above, the appraisal window for the Trust is September to December following the relevant financial year. The reason for this delay to September is the requirement for the provision to medical staff of comprehensive, risk adjusted outcome measure to be included in the appraisal document.

The data available provides comprehensive assurance of the performance of the individual clinician and is more detailed than that required in a non-specialist Trust. As well as mortality, details of complication rates are also included. Trust data requirements are reviewed by the Clinical Leads annually.

Details of any complaints over the relevant time period are sent to all medical staff, as are multisource feedback from patients and peers. This information is included in the appraisal document.

Appraisal windows and revalidation dates have been extended during the pandemic

Monitoring Performance

Whilst annual appraisal is an opportunity to review a doctor's performance, the Trust Governance systems allow closer scrutiny. Consultant risk adjusted mortality is reviewed six monthly by the Quality committee. Consultant specific complications are discussed openly at monthly audit meetings.

All deaths are scrutinised independently in the Trust. This is done by the Mortality Review Group that meets monthly. This focusses on system but also individual operator failures. Patterns of poor or unexpected performance are discussed with the Clinical lead and Medical Director if they become a concern to the Mortality Review group. The Trust has routinely collected detailed information on consultant performance. A more robust MRG system with the emphasis on organisational learning is being developed.

No consultant staff have been on restricted practice in 2019. One deanery trainee has been on restricted practice supervised by the training programme director and HENW.

Referrals to the GMC

There were no GMC investigations in 2021 in relation to medical staff still employed by the Trust.

Recruitment and engagement background checks

100% of appointed medical staff completed identity, GMC, DBS (or appropriate police check), Occupational Health and reference checks. No issues have arisen. At the commencement of employment, a document is sent to the doctor's previous Responsible Officer, asking for appraisal history and evidence of performance problems in the past. The response to these

requests in generally poor nationally and is no different here, and has been raised as an issue at the RO national meeting.

3. Summary

There are no significant risks with the revalidation process within the Trust. The outstanding appraisals are being addressed and will be completed within the extended time window and within the recommended time frame for annual appraisal.

The revalidation and appraisal processes have been improved during the pandemic and the appraisal content focussed on well-being. Revalidation dates and appraisal windows have been extended; LHCH doctors revalidated with no delays

The Trust online appraisal and revalidation system which has improved the process, the systems are in line with the job planning software. This allows better tracking of the status of appraisal and easier access to supporting evidence.

4. Recommendations

The Board is asked to note this report as evidence that the Trust is compliant with the processes necessary for medical revalidation.

Board of Directors (in Public)
Item 6.1.1

Subject: **Audit Committee BAF Key Issues Report**
Date of Meeting: **Tuesday 25th January 2022**
Prepared by: **Megan Underwood, Senior Executive Assistant**
Presented by: **Julian Farmer, Chair Audit Committee**
Meeting Held: **Tuesday 11th January 2022**

Agenda Item	Lead Exec	Assurance Received	New/Emerging Risks	Actions/Comments
3.1		**Risk Management KPIs** KPIS continue to be kept under review, with improved reporting and training several of the KPIs have improved. The Risk Management Committee oversee this and the actions and developments. Incident reporting was included within the report – work was to be done on this with the Director of Nursing, Quality and Safety, Risk and Safety Lead and Chief Governance Officer to look at how the incidents over 28 days could be broken down to improve understanding. Incidents are discussed on a weekly basis within the Executive team, the incidents were spread across the organisation and Divisions receive a 21-day notice on incidents with a forewarning of one week for the KPI to be met. The Chief Governance Officer was to look into collating the data to produce a monthly trend. An additional risk of 16 had recently been added to the report, this would be discussed during the upcoming Board of Directors, however, this was in relation to theatre sessions – staffing absences and recruitment gaps.		Further development of 28 day incident reporting to improve assurance.

3.2		**Review Clinical Audit Plan & 6 Monthly Progress Report including NICE Guidance Review** The department have achieved development of an automated process for registering of projects and educating across the organisation to ensure clear registration of clinical audit, service evaluation and survey. Close links have been developed with the Research and Innovation Committee (R&I) to ensure projects were being reviewed and discussed at R&I Committee as an extra step in governance. New National Clinical Audits are currently being worked on in which the Trust would like to participate in, the Stroke service were keen to participate in the sentinel stroke national audit, work has been ongoing with the Physiotherapists looking at current documentation within EPR and copies of the dataset to build the documentation to collect the relevant dataset, the next steps would be to work with the Data Warehouse team and i-Digital team to get these into the data warehouse to commence work on national audits with uploads.	None	Good progress noted
3.3		**Compliance with Licence: Review of Quarterly Checklist** An overview of the 2021/22 year to date compliance with the licence was received. Diagnostic performance was impacted earlier in the year and whilst this was not a concern currently the team continued to work incredibly hard to bring the waiting list down. The Integrated Performance Committee will continue monitoring the diagnostic and performance targets and receiving assurance.	None	
3.5		**Digital Systems Partnerships Working: Alder Hey & LHCH** New service was set up in June 2021 – the iDigital Service, this was an integrated digital service across LHCH and Alder Hey, this has been a fast-moving pace of change, the aim was to provide a strengthened digital service across both Trusts. Strategically, looking at the shape and professional model of the service. There was an emphasis on staff engagement and staff development during	None	Committee noted excellent progress on integrated working.

		last year, including a number of external accreditations in which the workforce have been looked at particularly the North West Informatics Skills and Development Network and the Excellence in Informatics Accreditation, both Trusts achieved level one with a view to go jointly for level 3. A joint staff forum has been set up, this was led by the staff and sat across the whole service. A significant piece has been done on equality, diversity and inclusion and ensuring staff opportunities are equitable. There has a been a significant amount on communications and engagement, the Chief Digital and Information Officer leads a twice week all staff briefing. For information, year one, was around going back to basics and building the foundations with the Board backing the investments, a brand new infrastructure was in place across the partnership, priority one incidents have reduced significantly, and this was due to the additional investment and the digital aspirant programme.		
4.1		**Progress Report on Delivery of Plan** Four reports had been issued for the Committee: • ESR/HR payroll – this was a core piece of work with some good results achieved in those areas. • Secure health messaging – this was a management requested piece of work with plans being put in place. Value has been added with a request for the action plan be taken forward with a view to this being discussed further at the Quality Committee. • Hosted services – this was also a management requested review. This included cyber security which was a hybrid review around partnership working arrangements with Alder Hey. The other aspect was around financial governance on the three organisations in which the Trust host: Liverpool Health Partners, Innovation Agency and Liverpool Network Alliance. Substantial assurance provided on this with a small number of actions to be completed. • Key financial systems – this was a core piece of work with High assurance achieved.	None	

4.3		**Follow Up Report** This is reported to the Audit Committee formally twice a year. Since the last report, 11 recommendations implemented with a further 13 in progress, 2 high risk recommendations have had some progress on them and residual risk has been reduced. In terms of Research Finances, this was a Trust management instigated report with significant recommendations which required a significant amount of work in terms of changing how the Trust approach research financial management, who was involved and the governance. Significant changes have been made along with improved processes.	None	
4.4		**Anti-Fraud Update Report** There was a significant amount of work being undertaken on strategic governance around fraud risks with a fraud risk register embedded in the organisation, this is due to be reviewed in quarter 4 with work commencing imminently. National fraud initiative was focused on purchase orders year, within the report, one duplicate payment was noted of £2,208, this was successfully recovered from the review by the finance team. Within the report it was noted there was one payroll to payroll match that was being reviewed, this has since been closed. Key performance indicators for the counter fraud governance standard including the anti-fraud bribery corruption strategy which has moved to a green rating. Component three which was amber will be reviewed in quarter 4, once this has been complete it will be changed to green and submitted in May 2022 with a draft to come to March Audit Committee. Bribery compliance review to be added which was concluded in June 2021, there were six actions and six no actions taken, five of these were in relation to procurement and updating policies and procedures, assurance received that the policy has been updated and will be ratified at the end of February 2022. All six no actions were partial and should be concluded by	None	

		the end of March.		
5.1		**External Audit Update Report** Regular progress update report in a slightly different format. The report set out responsibilities and key information. From the last committee the Auditors Annual Report was discussed, and this will be the second year of the new value for money arrangements. Plan to be issued for the next committee in March – including risks identified and how they will be addressed which will be discussed in more detail.	None	

Item 6.1.1a*

minutes

E- Meeting of the Audit Committee

Minutes of the Audit Committee Meeting held on Tuesday 19th October 2021

Committee Members:	**Julian Farmer**	**Non-Executive Director-Chair**
	Nick Brooks	**Non-Executive Director**
	Bob Burgoyne	**Non-Executive Director**
	Karen O'Hagan	**Non-Executive Director**
Committee Attendees:	**James Bradley**	**Deputy Chief Finance Officer**
	Jennifer Crooks	**Associate Director of Research & Innovation (item 4.3 only)**
	Karen Edge	**Chief Finance Officer**
	Laura Hunter-Cross	**Head of Financial Services**
	Michelle Moss	**Anti-Fraud Specialist-MIAA**
	Kate Warriner	**Chief Digital & Information Officer (item 3.8 & 3.9 only)**
	Karan Wheatcroft	**Chief Governance Officer**
	Chris Whittingham	**Senior Manager-Grant Thornton**
	Nigel Woodcock	**Senior Internal Audit Manager-MIAA**
	Jennifer O'Brien	**Senior Executive Assistant (Minutes)**
Apologies:	**Margaret Carney**	**Non-Executive Director**
	Lucy Lavan	**Director of Corporate Affairs**

Action

In accordance with the Trust's response to COVID-19, the meeting was conducted remotely via video conferencing to maintain social distancing.

1. Apologies for Absence

As noted above.

2. Declarations of Interest

Karan Wheatcroft declared herself as a senior member of MIAA, the Trust's internal auditors, and confirmed that she would not take part in any discussion relating to any compromised agenda items. All other participants declared that they had no interests.

3. Governance and Risk

3.1 Mid-Year Review of Assurance Committees:
3.1.1 Integrated Performance Committee

The Audit Committee noted the report and received assurance that the Integrated Performance Committee (IPC) was performing well against the objectives set out in the IPC terms of reference.

The IPC Chair highlighted the work of the Trust's Chief Finance Officer (CFO) and wider finance team in keeping up to date with the regularly changing financial landscape under which organisations were operating.

3.1.2 People Committee

The Audit Committee noted the report and received assurance that the People Committee (PC) was performing well against the objectives set out in the PC terms of reference.

It was noted that there had been a recent change of Committee Chair, however a full handover between the outgoing and incoming Committee Chair had taken place.

3.1.3 Quality Committee

The Audit Committee noted the report and received assurance that the Quality Committee (QC) was performing well against the objectives set out in the QC terms of reference.

3.2 Risk Management KPIs

The Audit Committee noted that following the Risk Management Committee meeting in October 2021, further discussions and actions to improve the KPI performance in some areas was required. It was also highlighted that work was progressing to improve the reporting functionality in order to automate the reports, allowing divisional leads to fully utilise the reports and identify any gaps with individual risks.

The key messages for the Audit Committee included:

- Compliance with risk reporting requirements as set out in the risk management policy for risks.
- Inclusion of MIAA reported risks, CQC risks and QIA risks on the risk registers.
- 100% completeness of information with the following exceptions
  91% assurances against a target of 95%
- The Trust had 545 active risks and regular review of risks was in line with policy expectations with the following exceptions:
  - 2 risks 12 or over with a review outstanding
  - 40 risks below 12 with a review outstanding
- 68% of incidents had been closed within 28 days. The current number of incidents open over 28 days was 28. Included in this figure were 16 external incidents that had breached the 28 working days target.

It was recognised that further measures were needed to boost performance in the divisions, particularly within Clinical Services, however it was confirmed the new reporting style allowed for live

updates to the risks and it was anticipated that a much improved performance would be reported at the next Audit Committee.

The Audit Committee noted the content of the report and were assured that the Risk Management Committee continued to ensure oversight of the Trust systems and processes in place for the identification, management and escalation of risks, with actions being taken to increase compliance in some areas.

The Audit Committee also noted the KPI position with regard to incidents over 28 days and received assurance that the risks were monitored weekly by the Executive team. In reference to total number of incidents, these numbers were low and comparator information suggested a similar pattern in other organisations through the COVID period.

3.3 Review Losses and Special Payments

For the period 1st June to 31st August 2021 there had been no fruitless payments, no losses and no special payments in excess of £10,000. Details of amounts less than £10,000 were reported at Appendix 1 of the report.

The movements on the bad debt provision were set out in Appendix 2. However, it was noted that the bad debt provision was more than sufficient to cover 78% of non-NHS debt over 90 days, which currently stood at £1,171k.

The Committee noted that non-NHS debt had decreased since the last report in July 2021. The CFO confirmed that there were no concerns relating to the existing BUPA and AXA debt as the processes had changed quite significantly following the internal audit review and were working well.

The Audit Committee noted the full contents of the report.

3.4 Review Single Supplier Tender Waivers

Between the 25th June and the 7th October 2021 there had been 9 tender waivers raised for a total value of £233k. None of the individual tender waivers raised were over £100k and full details of all tender waivers raised in this period were provided in Appendix 1 of the report.

Following a query regarding the Highfield House waiver, which was noted as 'specialist nature', it was confirmed that this related to the audio visual equipment required to support simulation training as the equipment had to be able to link into the equipment in the Cath Labs, the specifications were therefore over and above the standard AV requirements.

3.5 Review of SORD: LHP Updates

The paper detailed a request from Liverpool Health Partners (LHP) to bring further clarity to their element of the Scheme of Reservation and Delegation (SORD), relating to the delegate authority for each Executive Director.

The proposed revisions clarified what could be approved and would allow each LHP Executive Director the ability to approve expenditure up to £25,000. Approvals were made within the overall funding available and the expenditure plan agreed at the beginning of each financial year. The proposed expenditure limits were shown in Appendix 1 of the report and an extract from the existing SORD was detailed at Appendix 2.

The Audit Committee reviewed and approved the requested amendment to the SORD for recommendation to Trust Board.

3.6 Compliance with Licence: Review of Quarterly Checklist

The quarterly checklist had been updated at Q2 2021/22 and the areas to bring to the attention of the Audit Committee were:

- **Diagnostic Performance-**The COVID pandemic placed considerable pressure on the diagnostic services with reduced throughput taking account of safe IPC measures. Coming out of the pandemic the Trust responded quickly to restoring diagnostics services to almost pre-pandemic levels. There was a significant backlog of patients waiting longer than 6 weeks, in line with the majority of NHS organisations, but the Trust was able to achieve compliance with the 6 week target from May 2021. There were still a number of risks associated with achievement of the target than mainly relates to availability of workforce.
- **RTT** -Due to reduced operating during the COVID pandemic the Trust accumulated a backlog of patients that were waiting longer than 18 weeks for treatment, predominantly on the admitted pathway. In line with national standards the Trust approached recovery prioritising the most clinically urgent patients first and then by waiting time on the waiting list, This inevitably meant that patients would continue to breach the RTT standards until the backlogs were fully recovered, which at present would be further into the second half of the next financial year. This position and forecast demonstrated strong performance and recovery when benchmarking across the country.
- **Rollover of Contracts-**Due to the COVID-19 pandemic, the contractual process for 2021/22 had been suspended.

The above areas continued to have strong oversight through the Executive Team, respective assurance committees and the Board of Directors.

The Audit Committee reviewed the checklist and confirmed its satisfaction that there were effective systems and processes in place to identify and manage risks in relation to compliance with the licence.

Assurance was provided on the Trusts 18 week wait times in comparison to other providers. ERF changes for H2 focussed on RTT clock stops and it was reported that LHCH were one of the highest performers in the region.

3.7 Regulatory Action Plans

It was confirmed that there were no outstanding actions or new regulatory action plans with either the CQC or NHSE/I.

3.8 Cyber Security Update

The report provided the Audit Committee with an update relating to cyber security assurance, highlighting key controls, developments and performance against standards.

There had been good progress made with regards to investment and deployment of cyber security tools and resources as well as strong compliance with the national Data Security and Protection Toolkit. Over the next reporting period, progress with regards to cyber essentials accreditation was planned.

NHS X produced a list of 6 national cyber security priorities and the priorities highlighted nationally were consistent with cyber priorities and processes in place at LHCH. These were monitored through the sub-groups of the Digital Excellence Committee. Current performance against the national priorities was detailed within pages six and seven of the report, with all but one compliant against national requirements.

The amber priority of ensuring secure, well tested backups were in place required an area of development relating to immutability; three different options were currently being explored to extend the controls already in place. This priority was expected to be green by January 2022.

The Committee were informed that the Trust were aiming to secure the Cyber Essentials accreditation by the end of March 2022, although it was hoped that this could be achieved sooner.

The Audit Committee noted the paper which provided robust assurance and showed strong development plans.

3.9 Data Quality Assurance Report

The Audit Committee received the report which detailed the significant amount of work that had been carried out over the last six to nine months relating to the Data Quality (DQ) policy, DQ Strategy, and a significant piece of work relating to waiting list management. The Patient Pathway Assurance Group (PPAG), weekly performance meeting and weekly report to the Executive Team provided assurance that this work was being monitored regularly.

Committee members were informed about a new approach to data quality that was in the process of being mobilised in partnership with Alder Hey through the iDigital service. This would help to strengthen the leadership and ensure resilient resources were in place with regards to data quality assurance. This proposal had been approved by the Executive teams at both LHCH and Alder Hey.

The Chief Digital & Information Office informed colleagues that there was a roadmap of future developments included within the report, although this was dependant on the DQ strategy being developed and implemented.

It was proposed that an annual report on Data Quality be presented to the Audit Committee from April 2022 onwards, providing monitoring information on all aspects of DQ. The Committee accepted that proposal and the 2022/23 work plan would be updated accordingly. **JO'B**

It was confirmed that appointments as part of the iDigital Partnership would be considered to be a 50/50 allocation to each Trust, however dependant on the Trust requirements at the time. This would be managed through the partnership governance arrangements.

The Chief Digital & Information Officer confirmed that approximately 60-70% of the data warehouse transfer was complete and a much better reporting experience was being achieved. There were governance and operational processes in place to support the quality of the data, with the team working with operational and clinical colleagues to have the oversight, in order to identify issues and then provide the education and training needed to fix the problem at the source.

The Committee noted the report and the Chair thanked the Chief Digital & Information Officer who left the e-meeting at this point.

3.10 Third Party Assurances

The Committee were informed that the internal audit of the outsourced payroll function to St Helens & Knowsley Teaching Hospitals NHS Trust (STHK) had been completed for 2020/21 with an outcome of substantial assurance. The final report was included as Appendix 1 to the paper.

The review undertaken on behalf of NHS SBS was included as Appendix 2 of the paper and the Audit Committee noted the unqualified opinion in respect of 22 out of 23 control objectives.

The external reviews at both St Helens and Knowsley NHS Trust and SBS did not identify any material issues relating to the controls in place.

The Audit Committee noted the full contents of the report.

4. Internal Audit

4.1 Progress Report on Delivery of Plan

The Senior Internal Audit Manager confirmed that since the July 2021 Audit Committee the following reviews had been finalised:

- Data Security & Protection Toolkit-substantial assurance
- Delivery of Capital Plan-substantial assurance
- Attendance Management-Substantial assurance. The Audit Committee noted that testing of the operation of these controls in

practice did identify a number of omissions due to the impact of COVID-19 when some controls had to be temporarily postponed.

Appendix C of the report detailed the key areas and actions to be delivered. Following up on an action from the July 2021 Audit Committee the appendix now provided further comments which would give context to the Audit Committee and also confirmed the actions already taken by the Trust. Key dates were now also included in this section.

Page five of the report provided details on the reviews currently in progress and page seven gave an overall status summary of each audit, with good progress against the audit plan noted.

Following a query raised relating to the Data Security review showing a self-assessment substantial assurance compared to a moderate given for national standards, the Head of Technology Risk Digital function at the internal auditors would provide a comprehensive response to the Audit Committee Chair offline to the meeting. However, the Senior Internal Audit Manager did confirm the ratings were correct, a thorough assessment of each factor had been undertaken and no concern was raised. The Committee was asked to note that six of the ten national standards did achieve substantial assurance. **NW**

The full report was noted by the Committee.

4.2 Anti-Bribery Report

The report followed a review of bribery compliance in order to identify any gaps or improvements needed.

Pages 7 to 25 of the report provided details of the work undertaken, findings management and the action plan. 12 recommendations were made, several of which had already been implemented. Progress on the remaining follow up actions would be monitored throughout the year and updates would form part of the Anti-Fraud progress reports presented to the Committee.

A briefing on the on the Bribery Act 2010 and the Trust Anti-Bribery Strategy, based on six key principles, was provided to the Trust Board of Directors at the 27th September 2021 meeting.

It was confirmed that fraud and bribery training now formed part of staff mandatory training and this was considered robust enough. However, a more in-depth fraud and bribery awareness session would be delivered to Board colleagues. **MM**

The Audit Committee noted the full contents of the report.

4.3 Research Finances Audit Report Action Plan

During the audit of the Research department finances in March 2021, a number of weaknesses in the system of internal control were identified and therefore only limited assurance could be given. As a result, senior

research and finance colleagues had been working together to improve the controls in this area.

Full details of the action plan and the progress made was provided within the paper and it highlighted a number of key areas that would significantly improve the controls in place.

The plan also detailed where further work was needed and this was summarised:

- Whilst there were system notes in place for some elements of finance, further SOPs were in various stages of development and would be submitted to the R&I Committee for approval in November2021.
- Record keeping and reporting had focused on the historic balance, therefore further work was required in the ledger or database to ensure all income and expenditure was appropriately assigned to each study to allow comprehensive reporting at individual study level.

In response to a query relating to individual cost centres and the issue with developing those, it was confirmed that working with the unique identifier number linked to each study was a more efficient way to work and much easier to manage.

The Committee noted the very useful overview of the action plan, although requested that it was developed to include implementation dates and timescales in order to provide greater assurance. **JB/JC**

The Associate Director of Research & Innovation left the e-meeting.

4.4 Summary of Stakeholder Feedback: Internal Auditors

The Trust carried out a survey to assess the effectiveness of the internal audit service provided by Mersey Internal Audit Agency (MIAA). The survey was sent out to 16 people, with 12 responding. The full responses were set out in Appendix 1 of the report.

The results of the survey were very positive and indicated that MIAA highlighted and investigated the key areas of risk, had clear reports and their staff were responsive and professional. No areas for improvement were highlighted.

The Audit Committee noted the report and commented that the results were well deserved.

5. External Audit

5.1 Finalised Auditors Annual Report

The external auditors final annual report was presented which detailed the conclusion of the audit for 2020/21 and reflected on the work on the enhanced Value for Money (VFM) arrangements.

The external auditors thanked LHCH finance colleagues for their timely and through responses throughout the auditing period.

Pages four and five of the report provided the Executive Summary and confirmed that a qualified audit opinion had been issued on the Trusts financial statements. One area of significant weakness was identified in respect of the Trust's arrangements for financial sustainability, due to the Trust initially forecasting a year end deficit within the 2020/21 financial plan due to the uncertainty surrounding funding as a result of the impact of the pandemic. The Committee noted that further work in respect of that risk did not identify any issues or concerns that would indicate significant weakness and work in that area was now complete.

The Committee also noted that no Public Interest Report was issued and no referrals to the NHS Regulator were required.

Commentary on financial sustainability, governance and improving economy, efficiency and effectiveness, together with the impact of COVID-19 was set out on pages 8-19 of the report and further detail on how the external auditors approached this work was included at Appendix B of the report.

It was acknowledged that the Trust had responded to all necessary findings or recommendations and there were no areas of concern to highlight.

The Audit Committee were assured with the very positive report and noted the full contents and appendices.

6. Review of Audit Committee Work Plan

Committee members were satisfied that work was being carried out per the work plan schedule.

It was agreed that the Risk Management KPIs could be reviewed again at the January 2022 Audit Committee due to the upgrades being implemented with the reporting functionality and a focus on improving KPI performance in some areas. **JO'B**

It was agreed that an update on the partnership working between Alder Hey and LHCH would be provided at the January 2022 Audit Committee. **JO'B**

7. Minutes of e-Meeting held on Tuesday 6th July 2021

It was noted that the minutes of the Audit Committee meeting held on 6th July 2021 had been reviewed for accuracy by all meeting participants and were approved.

8. Action Log

Item 1-It was confirmed that there had been some engagement with NED colleagues post Office 365 deployment and access to the staff intranet had now been provided through Citrix. This item would be marked as complete and removed from the action log.

Item 2-It was confirmed that comparator information suggested a similar pattern in other organisations through the COVID period in relation to incidents over 28 days. This item would be marked as complete and removed from the action log.

Item 3-It was confirmed that both the Head of Education & Organisational Development and Deputy Head of Education could fulfil the junior doctor's trainer role should that be required. This item would be marked as complete and removed from the action log.

Item 4-The timeframes for completion of recommendations was now included as part of the internal audits progress report. This item would be marked as complete and removed from the action log.

The key areas of work section in the internal audit progress report now included a comments section that actions had been agreed, where applicable. This item would be marked as complete and removed from the action log.

The Chair of the Quality Committee and the Director of Nursing, Quality & Safety had been emailed on the 6th July 2021 regarding the Sepsis audit and the need to monitor the progress against the recommendations. Both colleagues had acknowledged receipt of the request. This action would be marked as complete and removed from the action log.

Item 5-It was confirmed that the controls were in place relating to goods received yet to be invoiced, with a reduction from £500k to £100k. The Senior Internal Audit Manager confirmed that these had been more difficult to manage during the COVID-19 response. These would be monitored as part of the financial systems audit and therefore it could be removed from the action log.

Item 6-A summary of the stakeholder feedback given on the Trust's internal auditors was provided above under agenda item 4.4. This item would be marked as complete and removed from the action log.

9. AGS Issues

It was noted that the limited assurance report on the research finances was included within the previous AGS. No further AGS issues were identified.

10. Evaluation of Meeting

The Audit Committee was content with the mechanism in place for the e-meeting, given the on-going social distancing measures.

11. Date and Time of Next Meeting:
Tuesday 11th January 2022, 8.30-10.30am

Board of Directors (in Public)
Item 6.1.2

Subject: BAF Key Issues Quality Committee
Date of Meeting: Tuesday 25th January 2022
Prepared by: Sue Pemberton, Director of Nursing, Quality & Safety
Presented by: Dr Nick Brooks, Non-Executive Director
Meeting Held: Tuesday 4th January 2022
Purpose of Report: To Note

Agenda Item	Lead Exec	Assurance Received	New/Emerging Risks	Actions/Comments
6.1	SP	**Quality Dashboard** **Delirium** The assessments were relatively new to the ward areas, there have been challenges when being pulled through into the data which could be influencing the performance. The Digital Team were working on this. It was noted that not all patients would have a risk assessment. **Falls** There has been an increase in unobserved falls. The Matrons and Heads of Nursing are completing a review of falls with Birch and Cedar Ward being the main focus. The Director of Nursing is satisfied with the work on falls with the falls risks assessment compliance being satisfactory. **Primary PCI** The Primary protocol has been rewritten by the lead Consultant Cardiologist . Moving forward, the patients will be discussed in detail to determine if being transferred to the Trust is the appropriate choice.	**None**	A request has been made to the informatics team to ensure that the dashboard is updated across all indicators for the April meeting.

		Radiological Alerts Weekly report was discussed at Executive Group Meeting, the percentage rate for November was recorded at 73%, MIAA have examined this to determine how the response could be improved. The Associate Medical Directors were monitoring this with reminders being sent out on a twice weekly basis. Work was ongoing with the Radiology department to ensure the data was handled correctly.		
6.3	**RP/SP**	**QSEC Key Assurances Report – 3rd December 2021** **Fasting** – in both Surgery and Medicine, work has been ongoing to improve this over the last number of years. Sips to send has been introduced whereby patients can have sips of water right up to their procedure – this was being monitored through QSEC. **Acute Kidney Injury** (AK) – a report was discussed at the last QSEC, concerns were raised that Insufficient progress had been made in driving this work forward. There had been a change in leadership medically. The audit data was from pre-pandemic and was yet to be repeated. This will be included within the Clinical Quality Dashboard, the Director of Nursing will discuss this with the Informatics Team.	**None**	
6.5	**RP**	**Stroke Service Update** An E-Learning package has been developed with this to be discussed at People Delivery Group with a view of making the training mandatory for certain members of staff who were caring for stroke patients, this should be resolved by the end of January. The Trust have met with the Liverpool University Hospitals (LUFT) with regards to the SLA, the main concern was medical cover since losing one of the consultants to promotion, there has been some disparity on when LUFT should attend and when they attend. This was driven by the Stroke Therapists. A further meeting was to be held imminently. The Director of nursing suggested medical staff to be involved for the SLA meeting with LUFT. The SLA was to be firmed up with	**None**	

		immediate effect. The In-Hospital Therapy Lead to provide feedback to the Director of Nursing when the meeting has been arranged. EPR training was to also be on the agenda when meeting with LUFT.		
6.2	**RP**	**A Quality Impact Assessments (CIPs) & Update Report** Assurance was accepted of the rigorous process for the CIPs being identified. The financial risk was being managed and planning for next year is to commence.	**None**	
6.4	**RP**	**Dr Foster Dashboard** The Board presentation was useful on Mortality and Dr Foster, good to see new mortality improvement group being formed. The MD shared the Dr Foster Dashboard with the Committee. This was an encouraging and interesting development; this gives the Committee a better insight into what is happening within the organisation.	**None**	

minutes

Item 6.1.2a*

Quality Committee

Minutes of the Quality Committee Meeting held on Tuesday 19th October 2021

Present:	
Nick Brooks (Chair)	Non-Executive Director
Karen O'Hagan	Non-Executive Director
Julian Farmer	Non-Executive Director
Sue Pemberton	Director of Nursing, Quality & Safety
Raph Perry	Medical Director
In Attendance:	
Megan Underwood	Personal Assistant (Minutes)
Anna Rogers	Senior Consultant, Telstra Health UK (item 6.6.1 only)
Mike Filek	Head of Improvement & Transformation (item 6.4 only)
Helen Martin	Risk & Safety Lead (item 8.2 only)

1. Apologies for Absence

There were no apologies to record.

The Chair formally welcomed Julian Farmer to the Committee.

2. Declarations of Interest

There were no declarations of interest to record.

3. Minutes of e-meeting held on: 20th July 2021

It was agreed that the minutes were a true and accurate record.

4. Patient Story

The Director of Nursing, Quality and Safety read the patient story.

5. Action Log

Item 1 – Stroke update – A verbal report was to be given as part of the main agenda. This item was completed and removed from the action log.

Item 2 – Sepsis Annual Report – This was to be discussed as part of the main agenda. This item was completed and removed from the action log.

Item 3 – GIRFT update Critical Care – This was discussed at July's Committee. It was agreed that updates would be provided on a six-monthly basis. The item was to be added to January's agenda.

6. Quality

6.1 Stroke Service Update

The Medical Director informed the Committee that there were no significant developments to report since the July meeting. Progress would be reviewed in January 2022. **RP**

6.2 Quality Strategy

Members of the Committee commended the ambitious and far-sighted proposals in the document which had previously been discussed at the Board of Directors.

Discussion took place on how the Committee should obtain assurance on implementation of the proposals. The DoNQS explained that, together with the leads for each of the objectives, progress towards achievement of the targets will be reviewed at three-monthly intervals and it was agreed that updates would be reviewed by the Committee in April and July 2022, culminating in an annual report prior to the Board of Directors in October 2022.

The Committee noted the personal commitment of the DoNQS to leading on development of the roles of a safety ambassador and patients as safety partners.

Update to be provided in 12 months' time. **MU**

6.3 Clinical Quality Report

Members of the Committee suggested that the new dashboard, which had been approved at the July 2021 meeting, would be more useful if accompanied by additional narrative alongside areas of performance that had fallen below target. The DoNQS explained that the document is still a work in progress and that further modifications would be discussed with the information team in conjunction with the Board of Directors. Among other issues, the R/G rating of indicators involving low numbers, for example C.*Diff*; SSA; clinical claims; falls and pressure ulcers would be reassessed.

Dementia

The Committee questioned a dip from 100% to 67% for the 'dementia-find' category in September. The DoNQS explained that this was attributable to the omission of just two emergency patients for whom it had not been feasible to carry out the assessment on admission, and who were still on critical care at the time of the 72-hour cut-off point for assessment.

C.*Diff*

Single cases of *C.Diff* occurring in each of the last eight months have resulted in the total number exceeding the annual target of six. Nevertheless, the MD pointed out that the number of cases is exceptionally low, and the Trust has achieved the 2021/22 target in the new National Infection Prevention Guidance which had been published in July.

The Committee was assured that the new guidance was being implemented by the infection prevention team and that a mini-RCA had been carried out for every documented case.

MSSA Bacteraemias

It was noted that the upward trend in instances of MSSA bacteraemia in November 2020 had not been sustained since measures adopted by the IV-line subgroup of the surgical site infection group had been implemented.

Gram Negative Bacteraemias

The data for Gram negative bacteraemia were incorrect; a total of 13, not 16, have occurred in-year.

Medication Errors

Work continues on the documentation of medication errors. The Committee noted with approval the inclusion of errors that were potentially serious despite no harm having actually occurred.

Radiological Alerts

A reported fall in responses to radiological alerts since May 2020 was questioned by the MD as being possibly incorrect, since the numbers are higher than in the weekly safety reports. The inconsistency would be investigated.

A draft of the MIAA report on the process has been received and a management plan has been developed. The MD would bring the report to the committee in due course. **RP**

Primary PCI

Despite the on-going problem of pre-hospital delays, as discussed at previous meetings of the Committee, assurance over the in-hospital management of patients undergoing primary PCI has been derived

consistently from the monthly statistics. The recent fall in the percentage of patients treated within 90 minutes of arrival in the Trust was, accordingly, noted with some concern. The MD explained that this had not registered as an alert because the percentage of patients revascularised within 90 minutes still exceeded the Trust target of 90%, but the data would continue to be monitored to ensure that the trend of the last three months does not further deteriorate.

Nutrition

The DoNQS questioned the validity of the information on screening and care planning for malnutrition. A meeting is to be held with the Informatics Team to determine if in the information is being derived from the correct place in EPR. **SP**

Discharge Summaries on day of discharge

The apparent 20% drop during the last six months in the number of patients receiving their discharge summary could not be explained satisfactorily, though it was most likely to have been failure to document rather than failure to give it to the patients. The data would be reviewed with the informatics team. **SP**

6.4 Quality Impact Assessments (CIPs) & Update Report

As of 6th October, 19 of the 29 schemes have been signed-off by the MD and DoNQS. Fifteen of the 19 have been submitted to the new Finance and Performance Group (FPG) which has now replaced FISG. The terms of reference of the new group are yet to be finalised but will be shared with the Committee when finally approved. The Committee was assured that the rigorous oversight of the QIA, EIA and CIP processes, as presented to the Committee at the April 2021 meeting, is unchanged.

The Committee having accepted assurance that assessment of CIPs for quality (and equality) is robust, discussion took place on the desirability of some form of post-hoc audit/assessment for unforeseen impacts on patient care or failures to achieve anticipated savings. It was explained that a post-project evaluation of selected under-performing schemes for the previous year had been undertaken and discussed at the FPG. A report was to be submitted to the Audit Committee.

6.5 QSEC Key Assurances / Risks Report
10th September 2021

Members of the Committee noted that the summary document referred to a number of proposed actions but no timeframe for completion; and most were reported as ongoing.

The Committee focussed discussion on the exceptions.

Delirium Risk Assessments **SP**

See item 6.3. The Committee received assurance that work is ongoing to improve compliance with delirium risk assessment. Progress will be reviewed at the January 2022 meeting.

Incidents not closed within 28 days

The number of incidents not closed within 28 days was relatively low. A reminder is sent out at 21 days. Generally, those that have not been closed are linked to incidents in another trust. Nevertheless, SP has identified areas for improvement.

Resuscitation Report

The main concern for the resuscitation service is the poor training facilities which cannot be accommodated within the Highfield House development. Planning for improved training provision in the resus room is ongoing.

Diabetes Steering Group Annual Report

The DoNQS informed the Committee that, though rated green, a combination of staffing challenges and an ever-growing number of referrals was imposing increasing pressure on the service. At any one time about 25% of in-patients have diabetes; this includes those with cystic fibrosis, most of whom have diabetes and are cared for by an Advanced Nurse Practitioner who specialises in diabetes.

6.6 Dr Foster Dashboard

The MD informed the Committee that regular meetings with a member of the Dr Foster team have proved helpful in understanding the Trust's HSMR being consistently greater than 100, though there have been no recent alerts of mortality exceeding the 'within expected' range. Explanations and future actions were discussed by the Committee after the presentation by Anna Rogers (item 6.6.1)

6.6.1 Dr Foster Consultant Focus & Functionality

Anna Rogers, Senior Consultant with Dr Foster (now Telstra Health UK) presented a review on measuring mortality. After an outline of the processes involved in deriving the HSMI (and SMI), there followed an analysis of the Trust's results. The presentation highlighted the following issues:

- The vital importance of accurate coding and completeness of input data
- The direct and indirect impact of Covid-19, which the model is unable to calculate
- Outlier diagnoses driving the higher-than-expected relative risks for the 56 diagnoses in the HSMR at LHCH from July 2020 to June 2021: acute myocardial infarction (RR 193.1; expected deaths 52.8; observed 102) and syncope (relative risk 2470.5; expected deaths 0.1; observed deaths 2).
- The SMR (all diagnoses) analysis identified in addition nonspecific chest pain (RR 903.9; expected deaths 0.6; observed 5).

The Committee discussed the factors underlying the overall risk adjusted mortality rate in LHCH which has remained consistently greater than 100.

Previous analyses presented to the Committee by the Medical Director have highlighted the impact of the management of unselected patients with out of hospital cardiac arrest as the main driver of the high mortality among patients with acute myocardial infarction. Moreover, the difficulty in identifying and recording risk-modifiers, including the Charlson and Carstairs indices, in patients admitted *in extremis* could have resulted in underestimation of their expected risk. Anomalous coding is the most likely explanation for the high RRs among patients with syncope and nonspecific chest pain; it was noted that the 2470.5 RR for syncope was derived from the deaths of just two patients out of 112, whereas the expected mortality in this group was one in a thousand.

AR explained that if a review of the coding issues confirmed the existence of anomalies and missing data, the analyses and published results could be amended.

The Committee acknowledged the difficulty in addressing these issues in the short-term pending the appointment of a successor to the Director of Research and Innovation, but the MD undertook to ensure further exploration of the data, to the introduction of measures to ensure its completeness and accuracy, and to report back to the Committee in due course.

RP

6.7 Sepsis Improvement Plan & Data Review

The MD presented the sepsis improvement plan, an earlier version of which had been submitted to the Commissioners. The main current challenge relates to screening. MEWS screening on the wards works reasonably well, but the different system – SOFA – on critical care has been more problematic because of the rapidly changing score in the early post-operative period. Other challenges relate to the regular rotation of junior medical staff, the time lag in availability of validated compliance data and the low priority given to monitoring by junior staff on critical care due to the regular presence of senior medical and nursing staff. The report describes further educational, monitoring and reporting initiatives that have been put into place together with the secondment of a specialist nurse to infection prevention.

The Committee was informed that Dr Omar Al Rawi, who has been the Sepsis Lead for several years, has stepped down to become Clinical Lead for Anaesthesia; his successor will be Dr Ben Murray. It is hoped that it will be possible to establish the Infection Prevention Specialist Nurse post which is currently a temporary appointment.

The Committee acknowledged the significant work and effort that has been devoted to sepsis management.

7. Clinical Effectiveness

7.1 GIRFT update Medicine

Many of the GIRFT recommendations for cardiology require a system approach and the consequent need for engagement with other Trusts has constrained the rate of progress. It is expected that compliance will advance more rapidly with formation of the cardiac network, and it was noted that Dr Joe Mills is leading four of the mandated workstreams. The gap analysis and action plan showed that good progress is being made on recommendations within the control of LHCH.

7.2 GIRFT update Surgery

The Committee noted the continuing progress towards adoption of the GIRFT recommendations for surgery, with demonstrable improvements in outcomes despite the inevitable interruptions – for example with DOSA (day of surgery admissions) - imposed by the Covid-19 pandemic. Most notable has been the progressive fall in reoperations for bleeding after cardiac and aortic surgery, observed since June 2019.

The Committee recorded their thanks to the team members involved in the work.

7.3 Mortality Review Annual Report

The report covered the year to December 2020 and the main issues have been discussed in previous meetings, and in association with previous GIRFT reports and item 6.6.1 of the current agenda.

High unadjusted mortality rates were attributable to Covid patients transferred to LHCH critical care combined with a consequent reduction in the number of elective patients who would have been at low risk.

A new mortality improvement plan will be presented at November Board of Directors.

8. Compliance and Regulation

8.1 Quality Risks

The new report format, which is still work in progress and includes all the corporate risks together with more detailed narrative, was welcomed by the Committee as a helpful improvement.

The report identified two risks with increasing scores, three with decreasing scores and 13 that were unchanged. The Committee received assurance that the risk registers are reviewed monthly, and individual risks scoring15 and over more frequently.

8.2 SUIs

All the open incidents identified in the report have already been discussed at the BOD. The most recent: incident 3.5, iatrogenic lung injury during surgery, remains under investigation.

Although it was noted that all RCAs are accessible within the organisational learning database, members felt that it would be helpful to their assurance role if summaries could be made available to the

Committee once incidents have been closed. This suggestion will be reconsidered in the light of the serious incident summary report which is scheduled for presentation to the November BOD.

9. Date and Time of Next Meeting:
Tuesday 4th January 2022, 11.00am-1.00pm, Research Meeting Room / Microsoft Teams

Board of Directors (in Public)
Item 6.1.4

Subject: **People Committee BAF Key Issues Report**
Date of Meeting: **Tuesday 25th January 2022**
Prepared by: **Karen Nightingall, Chief People Officer**
Presented by: **Margaret Carney, Chair of People Committee**
Meeting Held: **8th December 2021 (E-Meeting)**

Agenda Item	Lead Exec	Assurance Received	New/ Emerging Risks	Actions/Comments
5.1	KN	National workforce update	None	Guidance for Mandatory vaccine has been released, which will be embedded into regulation from April 2022 onwards. Unvaccinated Trust staff would need to have their first vaccination by 3rd February to enable second doses to be given in April and remain in line with regulation. Colleagues were informed that a small project group has been set up within the Trust with assessments carried out to understand the total number of staff that still require first doses. It was understood that 132 staff had been identified and it was anticipated that a small number would be clinically exempt. Colleagues were informed that by 14th December 2021, the Trust would have a full clear position with dates for staff to have had their vaccination or provide exempt proof. CCG's have requested a return of complete status by 7th December. The HR team are looking at developing a Policy as part of the VCOD Programme. It was anticipated that despite compliance, some staff may continue to

Agenda Item	Lead Exec	Assurance Received	New/ Emerging Risks	Actions/Comments
				refuse the vaccine and therefore potentially risk their jobs. It was stated that there are few reasons for exception such as a severe allergic reaction to previous vaccines or first dose vaccine, therefore those staff who may think they would be exempt may now. It was reported that staff retention remained a challenge with staff departing the Trust between year and year two of employment; a meeting took place on 22nd November 2021 with L&D and senior nurse teams which resulted in a number of actions with the aim to improve retention. The Chair acknowledged risks and requested that colleagues remain close to the subject matter going forward.
5.2	KN	Junior Doctor Engagement and Action Plan	None	Medical Director & Deputy CEO, Dr Raphael Perry (RAP) provided a paper and presentation which informed colleagues of the results of the GMC Trainee Doctor Survey and subsequent actions. Colleagues were reminded that the 2021 GMC survey results were released in August which demonstrated a decline for LHCH trainees since 2019; there had been no survey in 2020 due to COVID 19. Specific areas showed a poor trainee experience which were presented at the previous People Committee. Colleagues were informed that the Director of Medical Education has been working with the divisions to address the gaps and improve overall training. An extensive action plan has been developed and significant progress has been made in addressing the areas of concern identified by the Survey. The Plan also contains measures to assess trainee satisfaction and experience at regular intervals during their placements.

Agenda Item	Lead Exec	Assurance Received	New/ Emerging Risks	Actions/Comments
				Director of Medical Education had held drop-in sessions in conjunction with junior doctor forum and medical education group. Feedback received was positive; still issues with departmental induction and planning in relation to out of hours admissions across the specialties. The next local survey would be mid-January 2022 and the next drop-in scheduled to be held before the Christmas break. The national training survey from November would report in January 2022 which involved all trainees. It was recognised that the status had changed from partial to assured which was welcomed by the Committee as were the actions in place. It was expected that future surveys remain of high importance to drive improvement. A further update was requested 6 months before the next GMC survey.
5.3	KN	NW BAME Assembly Annual Report and Anti-Racist Framework	None	It was stated that Organisations should have a statement and commitment to become an anti-racist organisation, and the Committee were invited to discuss the proposed statement outlined within appendix 3 with the aim to ratify. The Committee was directed to Appendix 3 in relation to the endorsement of Trust's position to enable the Trust to move forward with the network event. Colleagues were informed that strong language had been used which aligned with other organisations. The Committee were happy with the content and endorsement was provided.
5.6	KN	People Plan Delivery Update	None	HR & OD Manager, Beth Williams-Lally (BW-L) provided a paper which outlined the key priorities in relation to People Plan delivery. The delivery plan sets out the key actions and timescales for delivery of the people plan objectives. Key highlights from Q3, together with key

Agenda Item	Lead Exec	Assurance Received	New/ Emerging Risks	Actions/Comments
				actions for the upcoming quarter were provided within the paper. The Chair acknowledged the activity and expressed concern in relation to the Trust's capacity to deliver against the plan and assurance was sought. It was questioned whether actions were on track or any areas of concern. Assurance was given that actions were on track The Committee noted the contents of the report.

Item 6.1.4a *

minutes

E- Meeting of the People Committee

Minutes of the People Committee Meeting scheduled on Tuesday 7th September 2021

Meeting Participants:	**N/A**	
Committee Members:	**Mark Jones (Chair)**	**Non-Executive Director-Chair**
	Bob Burgoyne (BB)	**Non-Executive Director**
	Sue Pemberton (SP)	**Director of Nursing, Quality and Safety**
	Karen Nightingall (KN)	**Chief People Officer**
	Dr Raphael Perry (RAP)	**Deputy CEO and Medical Director**
	Ruth Dawson (RD)	**Head of Learning, Education & OD**
	Sarah Smith (SS)	**Temporary Head of HR Operations**
Committee Attendees:	**Laura Williamson (LW)**	**Executive Assistant (Minutes)**
	Beth Williams-Lally (BW-L)	**HR & OD Manager**
	Margaret Carney (MC)	**Non-Executive Director**
Apologies:	**Nicholas Brooks**	**Non-Executive Director**

In accordance with the Trust's response to Covid-19, it was decided that face to face meetings were to be limited and therefore a system to enable business to be conducted by remote working was devised. The papers were produced as usual and in accordance with the business cycle and distributed on 26th August 2021 by e-mail. A template was produced for each meeting participant to complete individually if they wished to make any comments following the review of papers.

A two-hour Microsoft Teams meeting was convened on 7th September 2021 between Committee members to discuss the comments and questions presented by e-mail. A summary of key issues raised, and decisions made are documented below as minutes of the meeting, and individual participant's comments have been retained on file in support of the minutes.

The Chair opened the meeting by welcoming members and attendees to the Trust's People Committee meeting and informed colleagues that this would be the last meeting as PC Chair and introduced Margaret Carney, Non-executive Director, who would be taking over as Chair and invited Margaret to provide a brief introduction.

1. Apologies for Absence
All meeting participants were included in the e–meeting and in attendance at the Microsoft Teams meeting.
Nicholas Brooks apologies were noted.

2. Declarations of Interest
All meeting participants had been asked to declare any interests in respect of items listed on the agenda. No participants declared that they had any interests.

3. Minutes of the Meeting held on 8th June 2021
The minutes were approved as a true and accurate record of the meeting.

4. Action Log
All items listed on the Action Log were marked as agenda items, no individual updates were required and therefore not provided.

5. Strategy
5.1 National Workforce Update
The Chief People Officer, Karen Nightingall (KN) provided the Committee with a verbal update which informed colleagues of the following areas of focus: -

Sickness figures were reported: -

- Nationally - 5.3% (1.2% Covid related).
- Cheshire and Mersey 6.5% (1.4% Covid related)
- Trust 4.5% (1.3% Covid related)

It was reported that lots of conversation and discussion had taken place around isolation, and the change in rules had contributed to an improvement in absence across the NHS.

Action

Recent significant headline has been in relation to NHS 3% pay increase, and there did not appear to be much push back from Unions.

It was stated that wellbeing was still an area of concern with lots of conversation in relation to burnout and stress nationally and guidance provided on how to combat with wellbeing initiatives and wellbeing guardian roles being promoted throughout all of the NHS.

Discussions have been taking place around vaccination of children and young people

Lots going on with NHS Leadership Academy in terms of promoting leaders for the future.

Colleagues were informed that there has been an ongoing project over the past 12 months, which is the future of HR and OD within the NHS which has focussed on how to improve and get to where they want; led on a national agenda.

Projects

- Flowers and flowers case still ongoing which would be discussed later on in the agenda.

- Scope for growth – talent management approach and succession planning developed by the wider NHS and it was reported that Liverpool, heart and chest are looking to be an early adopter of that, with two pilots already running. LHCH intends to be one of the forerunners in terms of promoting that.

The Pulse Survey re-launched in July nationally for the NHS and LHCH has its survey results which will be shared later in the agenda. Colleagues were informed that work is being undertaken around incentives, bonus, waiting list initiatives and self-isolation information which is being collated for CEO's upon request nationally.

The WRES and DES again on the agenda was submitted on time on the 31st of August.

The Director of Nursing, Quality and Safety was invited to comment in relation to burnout and stress: -
It was reported that there is a shortage of nursing on a national level, particularly registered nurses and as a result of that, the Trust has been involved in the big collaborative across Cheshire and Mersey for the overseas nurses of which LHCH has requested 50 initially, and have requested an extra 20 to help fill some vacancy gaps; 17 nurses currently appointed and the remainder scheduled to arrive throughout the rest of the year with 12 left to fill.
In relation to well-being and general fatigue the Trust has experienced some pressures in areas across the Trust. It was reported that the Trust is doing everything it can to support staff and a Quality and Safety Strategy is due to be launched, with some measures relating to Staff Survey questions.

The Chair acknowledged the comments and noted that the Committee would be hearing the divisional response to the previous staff survey and the feedback, along with the civility data.

The Chair raised concerns in relation to staff across the NHS system.

The Chair sought clarification in relation to the review of HR & OD and the papers that refer to a centralised HR approach and queried whether it would it affect LHCH in any way. It was stated that the encouragement was more so in relation to collaboration.

5.2 Be Civil, Be Kind Campaign Update
HR & OD Manager, Beth Williams-Lally (BW-L) presented a paper which informed colleagues of the progress to date in relation to the work that has been taking place to address negative behaviours within the Trust.

Colleagues were informed there has been lots of engagement with the Culture Club The focus groups have provided rich data which has gone well in terms of expectations with good progress made. Colleagues were invited to ask questions in relation to the paper shared.

A question was raised as to how much had been implemented so far; colleagues were informed that the Trust has implemented the following: -

- Formed the Culture Club group
- Finalising the Civility Charter which will be released in September 2021.
- Working closely with Education in relation to the rollout of change in behaviours to have a meaningful impact.

Further to the incidents that had been reported to the Board, clarification was sought in relation to status of the situation and whether it had continued. It was confirmed that the Trust had seen a reduction of incidents and the Trust plans to link culture changes into appraisals and recruitment; a long-term project but there had been improvements.

It was reported that the Trust has been receiving speak outs which is seen as a positive in that people feel able to. Discussion took place in relation to the terminology ‘be civil, be kind’ and ‘call it out’ under review; some Trusts feel ‘call it out’ has a positive impact and good practice.

Assurance was sought in relation to the monitoring and success of the implementation in terms of the cultural element. It was stated that culture survey’s take place every three years and 2021 results of that have been included in the Quality and Safety Strategy. It was also noted that there were relative questions within the Staff Survey, triangulated with Freedom to Speak Up (FTSU). Measurements were acknowledged and it was agreed that those measures could be consolidated into a culture focused dashboard. It was accepted that cultural change takes longer.

Concerns were expressed in relation to time with pending winter pressures. Discussion took place in relation to training and colleagues were informed that various methods would be made available to accommodate different staff needs within the organisation, such as 20-

minute bite sized and e-learning. It was therefore acknowledged that training would be economic in time.

5.3 Equality, Diversity & Inclusion, WRES data, ethnic minority group data, and Inclusion Networks Update
Senior Business Partner, Rachael McDonald (RMc) prepared a paper which was presented by the Chief People Officer.

It was acknowledged that a full report was due to be presented at Board of Directors and therefore the report presented to People Committee was not in full.

Colleagues were directed to the trend in relation to the white workforce and invited to comment. It was noted that People Committee had rightfully addressed issues amongst BAME staff, however, were now faced with an increase of bullying and harassment of white staff. It was noted that survey completion percentage had risen slightly which may have impacted the increase in relation to white staff.

Discussion took place in relation to statistics and denominators and it was queried whether all questions had been answered to form a fair comparison. It was acknowledged that analysing data would be difficult from a statistical point of view as the number of people completing the survey each year is different and not all questions answered.

It was suggested that data be triangulated to offer consistency and drive improvements.

ACTION: Feedback Committee Comments for the Board meeting. **KN**

5.4 HR, OD & Education Quarterly Assurance Report
The Head of Learning, Education & OD, Ruth Dawson (RD) presented a paper which outlined the Trust's position in relation to targets and invited feedback and questions from colleagues.

In addition to the report provided, it was highlighted that a new national model for Talent Management and succession planning is being launched. The Trust has been in touch with NHS E&I to request authorisation to be an early adopter of the programme which would provide access to national resources and offer the resources to identify talent pipeline and potential gaps in the future to ensure succession planning can be carried out appropriately.

It was noted that the Education Centre opening had experienced a delay due to water supply, which was anticipated to be resolved within the next 24 hours.

Clarification was sough in relation to International Nurses and banding. It was stated that nurses would be appointed at Band 4 initially and upon successful completion of training would move up to Band 5. Appointed across the whole of the Trust with a rotation plan between wards and critical care to ensure skills can be utilised and assist with retention.

It was reported that a strategic model for the HR Business Partners had been agreed to be implemented within the Trust which outlines the

business-critical role HRBP's provide to the Trust. As part of measuring the success of the implementation of this model, a survey has been sent to all Heads of Departments to ascertain their views and opinions of the current HR service. The survey will be repeated following implementation of the model.

The Chair sought clarity as to whom was involved in the development of the plan and was informed that the review had taken place with the HR team, then shared and discussed with Triumvirates and Execs. It was stated that feedback had been positive, and the aim of the survey would be to measure where they are now and then against the Strategic Business Partner model.

It was further explained that the purpose of the survey was to gain intelligence as to the perception of the current HR service from Heads of Departments and Key Stakeholders across the organisation, and plan to hold key stakeholder sessions to address the results and provide clarity on the role of the HRBP where needed.

5.5 People Plan Delivery Update

HR & OD Manager, Beth Williams-Lally (BW-L) provided a paper which outlined the key priorities in relation to People Plan delivery. Colleagues were informed that the People Plan has taken the four pillars from the NHS agenda and has good progress has already been made in those areas.

The Chair referred to the section on greater flexibility that staff are seeking and sought clarity as to how realistic it would be with winter nearing and anticipated to be more challenging than previous. The challenge in reaching a balance was recognised.

Discussion took place and it was acknowledged that it is important to have a balanced approach to flexibility and be mindful of staff without children with other responsibilities. Although there are many flexibility options for nursing staff, the option to work less hours per shift is being reviewed.

It was recognised that a high percentage of people seek flexible working arrangements which presents more of a challenge when faced with retention and attraction difficulties. It was suggested that engaging with staff as to what flexible working means to each individual would be helpful to understand as it can be different for everybody.

Clarification was sought in relation to the 12-month timeline of the People Plan. It was stated that the Trust implements a 12-month plan in conjunction with the NHS People Plan which would be in place up to March 2022, after which a People Strategy would be launched.

The Chair summarised discussions and noted that flexibility would be addressed though increased numbers, managed ward by ward and challenges were recognised by different needs with engagement to take place with staff to understand differences.

5.6 Staff Survey Divisional Action Plans
HR & OD Manager, Beth Williams-Lally (BW-L) presented a report which provided assurance to the People Committee of the actions the Trust and the HR, Education & OD Teams have and will be undertaking in support of the NHS Staff Survey 2020 results.

Concerns were expressed in relation to the staff belief that the Trust has not taken enough action on health and wellbeing; clarification was sought as to whether that was due to lack of publication, and therefore staff were not aware of the many actions that have been put in place, or whether the investment has been spent in the wrong areas. It was recognised that the Trust has invested significantly in health and wellbeing, promoted via corporate comms. It was suggested that perhaps the staff response had been of a resilience point of view. It was highlighted that the survey results were from 2020 and lots more has been introduced since and anticipate seeing an improvement in the 2021 survey results.

It was stated that key issues such as lack of involvement in decision making and time pressures may have speared due to the Covid situation; the outcomes from the next staff survey would be important to monitor perceptions.

The Chair expressed the importance of taking action to drive improvements and positively acknowledged the actions put in place and addressed.

5.7 Education Strategy
The Head of Learning, Education & OD, Ruth Dawson (RD) presented a paper which detailed the Trust's Education Strategy.

Colleagues were impressed with the document, in particular the vision and objectives outlined. Clarification was sought in relation to criteria, other than process, can be used to assess the impact; it was recognised that would be via Staff Surveys and FTSU.

It was expressed that recruiting Allied Health Professionals through Apprenticeships rather than the degree programme would be desirable and financially viable. It was stated the Trust would continue to explore other ways to help AHP's access support and education that meets their needs; Physio, Occupational Therapy and exercise physiologists has already engaged with different ways of learning.

Clarification was sough in relation to who has engaged with the development of the strategy. It was noted that the Triumvirates, senior nurses, therapy staff and Health Care Scientists have had an input across the organisation. Small focus groups have also taken place with engagement from support and corporate staff.

The Chair felt the Education Strategy was an excellent achievement on many levels:

- LHCH now has a holistic view of the Educational and Organisational offerings to staff in the Trust.

- The clarity provided on the strategy facilitates a wider understanding of how we are building the LHCH team to create an organisation that is fit for the future.
- It opens the staff's eyes to what is on offer for them to help with their own development and to seek more information on specific offerings.
- A very informative, readable and useful document.

5.8 Recruitment - Challenges
The Chief People Officer, Karen Nightingall (KN), and Temporary Head of HR Operations, Sarah Smith (SS) provided the Committee with a presentation which explained the challenges the Trust is faced with in terms of Recruitment.

The Chair was pleased to see a joined-up plan and it was acknowledged that competition isn't isolated to the NHS.

Discussion took place and it was noted that lots of support is available for International and Student nurses; following feedback and questions at induction, it was highlighted that more support may be required for newly qualified nurses on the wards.

Whilst the Committee recognised and welcomed the structured approach to recruitment and retention, ongoing, it was acknowledged that some of the measures in terms of support and education may require a review to gain full assurance; to be revisited at December's People Committee.

ACTION: Revisit in December. **KN/SS**

5.9 Trainee Doctor Action Plan Update
Medical Director & Deputy CEO, Dr Raphael Perry (RAP) provided a verbal update to inform colleagues of the results of the GMC Trainee Doctor Survey; it was explained that the survey takes place annually between April and May, which asks a number of questions in relation to training and support and there must be at least three responses from trainees within a specialty in order for data to be generated.

The results of the GMC Trainee Doctor survey results were shared which highlighted poor performance within specific sub-specialties. The Committee were surprised with the information shared as positive results had been anticipated.

Concerns were expressed, especially as the Trust had previously made improvements, particularly in Surgery, and it was suggested that meetings with junior doctors take place in a formal capacity to monitor conversations and support. It was also suggested that support from Practice Educators may be beneficial in scoping support Framework.

The Committee were informed that an action plan had been implemented with some already addressed.

Although a full report would be presented at September's Board of Director's meeting, the Chair requested this be addressed again at December's People Committee meeting.

5.10 Variable Pay Audit
Temporary Head of HR Operations, Sarah Smith (SS) provided the Committee with an update in relation to the MIAA Variable Pay Audit.

Colleagues were reminded that a variable pay audit was carried out in relation to shift pay and bank pay which was centred around six areas: -

- Policy non-compliance - sickness
- Policy non-compliance – requested to work bank annual hours approval
- Bank and agency shift requests and KPI reporting
- Working time directive opt-out forms
- Temporary staff policy
- Annual leave - working bank shifts whilst on annual leave

At the last meeting it was reported that the HR and Rostering team had commenced a great piece of work in following up on actions and that actions found by MIAA had been completed or part completed; the remaining actions were: -

- Non-compliance - sickness
- Bank agency shift request
- Annual Leave

The Committee welcomed the clear report which provided assurance that the risks identified and documents within the paper had been addressed.

The Committee noted the contents of the report.

5.11 Disciplinary, Policies & Procedures
HR Business Partner, Rachael McDonald (RMc) presented a paper which sighted the People Committee on the ongoing Disciplinary activity within the Trust and the actions taken to ensure that the pastoral care is strengthened for any employees that are subject to a formal process.

The report highlighted that in line with Improving People Practice recommendations, mechanisms had been established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level.

Concerns were raised in relation to identification of individuals upon reporting; discussion took place and the Committee agreed that the information provided to the Board should be on an anonymous basis as a consensus report.

The Committee were pleased to see the emphasis on Pastoral Care.

The Committee noted the contents of the report.

5.12 Pulse Survey Summary
The Chief People Officer, Karen Nightingall (KN) presented a paper which outlined the results.

It was highlighted that the number of staff responses were quite low in terms of percentage of the total workforce; clarification was sought as to

whether the responses were from a particular group or spread across different parts of the organisation. It was stated that the Pulse Survey provides a temperature check and employee voice

256 responses were received, which was low in comparison to 1800 employees, however, it was noted that the response was considerably more than peer Trusts.

Colleagues were informed that the Pulse Survey has replaced the Family and Friend questionnaire. It was highlighted that the benefit of the Pulse Surveys was that results are feedback within 4 days which is helpful in addressing real time issues, and each quarter address different topics such as winter pressures. It was anticipated that the completion rate for the next survey would be greater than the last survey.

It was recognised that the Trust would do all it can to increase responses to enable a more robust analysis.

6. Dashboards – Workforce Intelligence
6.1 HR/Team LHCH Dashboard
Temporary Head of HR Operations, Sarah Smith (SS) presented the Dashboard and highlighted the following

The Chair expressed appreciation and gave praise in relation to the new format of the Dashboard.

Clarification was sought in relation to the increase in voluntary leavers and it was reported that there were factors that had contributed.

It was noted that lots of work will be taking place in relation to retention of nurses.

The People Committee were assured that measures were being put in place to tackle retention and recruitment.

Colleagues were informed that work had been taking place in relation to exit interviews to ensure they take place going forward.

7. Workforce Risks
7.1 Board Assurance Framework (BAF) 2021/22
The Chief People Officer, Karen Nightingall presented the Board Assurance Framework which highlighted risks 4,5 and 6.

The Chair highlighted that BAF 4 was due for review in December and should be included as an agenda item.

BAF 5 – the Committee were pleased to see contributions in relation to Education Strategy and the Talent Management pilot.

BAF 6 – it was noted that value based, and international recruitment was proceeding well.

ACTION: BAF 4 was due for review in December and should be included as an agenda item. **KN**

The Committee were assured that items highlighted within the BAF report were being addressed and moving in the right direction, particularly with BAF 4 and 6 and therefore recognised the actions in place to provide assurance.

8. Evaluation of Meeting
It was stated that the meeting was effective with timely updates and discussion.

Non-Executive Director, Margaret Carney was impressed with agenda and meeting pack and noted that information was very clear and concise with points clearly articulated, and particularly liked the Chair summary.

9. Date and Time of Next Meeting:
Tuesday 7th December 2021, 12.00 – 14.00, MS Teams

Board of Directors (in Public)
Item 7

minutes

Minutes of the Meeting of the Board of Directors held on 30th November 2021

Present:	**Neil Large**	**Chair**
	Jane Tomkinson	**Chief Executive**
	Nick Brooks	**Non-Executive Director**
	Bob Burgoyne	**Non-Executive Director**
	Margaret Carney	**Non-Executive Director**
	Karen Edge	**Chief Finance Officer**
	Julian Farmer	**Non-Executive Director / Deputy Chair**
	Mark Jones	**Non-Executive Director**
	Hayley Kendall	**Chief Operating Officer**
	Karen O'Hagan	**Non-Executive Director**
	Sue Pemberton	**Director of Nursing, Quality & Safety**
In Attendance:	**Jenny Crooks**	**Associate Director of Research & Innovation**
	Jonathan Develing	**Director of Strategic Partnerships**
	Karen Nightingall	**Chief People Officer**
	Tim Ridgway	**Clinical Lead for Organ Donation (Item 1.6 only)**
	Kate Warriner	**Chief Digital & Information Officer**
	Karan Wheatcroft	**Interim Chief Governance Officer**
	Peris Widdows	**FTSU Guardian (Item 5.4 only)**
	Jennifer O'Brien	**Senior Executive Assistant (minutes)**
Observers- Governors/ Staff/ Members of the Public:	**Dorothy Burgess**	**Public Governor-Merseyside**
	Roy Page	**Public Governor-Cheshire**
	Allan Pemberton	**Public Governor- Cheshire**
	Dusty Rhodes	**Public Governor-North Wales**
	Trevor Wooding	**Senior Governor (Public -Merseyside)**
	Tracey Cooper	**Sr Accounts Sales Manager-Nuance**
	Raj Purewal	**Director of Healthcare-Netcall**
Apologies for absence:	**Lucy Lavan**	**Director of Corporate Affairs**
	Jay Wright	**Interim Director of Research**

Action

Chair's Initials

1 Opening Matters

1.1 Apologies for Absence

Apologies for absence were received Lucy Lavan and Jay Wright.

1.2 Declaration of interests relating to agenda items

All meeting participants were asked to declare any interests in respect of items listed on the agenda. All participants declared that they had no interests.

1.3 Chair's Briefing

The Chair updated the Board on the recent opening of the Sir Ken Dodd Knowledge & Education Centre and informed colleagues that a recommendation would be made to the Council of Governors on the 7th December 2021 relating to the new LHCH Chair.

The Chair acknowledged Chief Operating Officer, Hayley Kendall's final Board of Directors meeting, thanked her for her hard work and service during her time at LHCH and commented that she would be greatly missed.

The Chair highlighted the relentless pressure faced by staff as the effects of Coronavirus continued, together with the major changes around the ICS and various significant policy changes coming into effect. The Executive Team and entire cohort of LHCH staff were thanked for their hard work and dedication they demonstrate on a daily basis together with planning for the changes and challenges in the future.

1.4 Patient Story

The Director of Nursing, Quality & Safety shared a story from a patient from Leeds who underwent an aneurysm repair procedure at LHCH as it was not available locally. The letter expressed the patients gratitude to all staff at LHCH for their incredible compassion and emotional support which was fundamental to their recovery and wellbeing.

1.5 Staff Story

The Chief People Officer provided a staff story from the Trust's Security Manager which detailed his journey to working at LHCH and the various challenges he and his team had faced, from historical staffing issues, the impact of the Coronavirus pandemic and the most recent failed terrorist attack on a local hospital and the impact that had on the Trust.

The colleague spoke of building a team that reflected the values and behaviours of LHCH, motivating the security staff, encouraging empowerment and showing the team support and trust. It was noted that the investment in staff resource had allowed the team to grow and ensured further security support could be provided to all Trust colleagues.

Chair's Initials

1.6 Organ Donation and Transplantation

The Clinical Lead for Organ Donation set out the history of organ donation in the UK, highlighting the publication of 'Organs for Transplant' in 2008 which detailed the requirement for all hospitals to have a Clinical Lead for Organ Donation. The report also suggested that Trusts recruited a Specialist Nurse for Organ Donation, however, due to the size of the service at LHCH, it was noted that the Specialist Nurse at the Trust was a shared position. The development of an Organ Donation Committee and appropriate policies also resulted from the 2008 publication.

Historically, the Trust had not seen a significant number of patients suitable for transplants, however a steady increase had been seen since 2016, and in particular the last three years with 18 lives transformed by the gift of organ donation from LHCH patients.

The Trust had recently received its latest organ donation report which set out referrals, any missed referrals, the figures relating to Specialist Nurse present for organ donation discussions and the data relating to neurological death testing. The outcomes in the report provided a strong picture across many areas although it was noted that some anomalies in the figures had been identified, which had since been explored to ensure there weren't any gaps or areas for improvement.

There were a number of actions and next steps required to ensure the Trust continued to deliver the best possible service to patients and their families, with it noted that the Trust was planning to develop a small memorial to recognise donors and the lives that they had saved.

Questions were asked and responded to in terms of those who patients and/or families didn't consent, as well as the importance of maximising donation opportunities to accommodate the ever-increasing national organ transplant waiting list.

The Chief Executive recognised the excellent work carried out by the service under the guidance of the Clinical Lead for Organ Donation and wanted to ensure that the Board were regularly sighted on the work through future updates.

2 Patient Safety and Quality

2.1 Infection Prevention and Control:

2.1.1 IPC BAF

The Medical Director provided an update in terms of the IPC assurance report, informing colleagues that further to the major update to infection prevention measures in July 2021, additional guidance relating to infection prevention controls had been issued the previous week. It was noted that infection prevention

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colleagues were currently reviewing the new guidance and would embed the recommendations throughout the Trust. It was stated that the updated guidance was aimed at attempting to produce a safe environment in which elective restoration could be carried out. Any further changes in IPC guidance as a result of the recently discovered new variant of Coronavirus would be monitored closely.

The Board of Directors (Board) were informed about a regional issue with the microbiology workforce, although it was noted that improvements were being seen. The Trust had implemented some mitigations with an IPC Specialist Nurse located on Critical Care and would aim to expand the IPC service further once Consultant microbiology cover had been secured.

Whilst it had been hoped that there could have been a relax of some IPC measures seen throughout the Trust, colleagues did not see that happening now due to the new variant.

It was confirmed that the Trust would be utilising the flexibilities in the guidance in order to ensure LHCH were able to safely offer mutual aid going into the winter months. Considerable work had been done on closed beds, four of which would be opened up immediately, with an additional four planned by the end of March 2022. It was recognised that some work was needed regarding the early transfer of ACS patients. The situation would be continually monitored, and risk assessing would take place regularly.

The Board were informed that 111 LHCH staff remained unvaccinated, however work was on-going to encourage those staff to take the opportunity to receive their vaccination. The Executive Directors reviewed the data regularly and would understand the reasoning behind those decisions of unvaccinated colleagues in the coming weeks. It was noted that there had been a significant improvement since the vaccine had been mandated. It was confirmed to the Board that under the proposed guidance any staff member unvaccinated by the 1st February 2022 would no longer be able to work at the Trust.

The Board **noted** the report.

2.1.2

New IPC Strategy

The Medical Director introduced the new IPC Strategy to the Board informing colleagues that the Trust had been very effective with IPC measures, low infection rates were seen and there was a robust system in place to manage any lapses. The three year strategy included a practical set of action plans for specific areas which included MSSA numbers, surgical site infection due to intravenous cannulas and UTIs. IPC colleagues were currently reviewing the audit data and would apply the latest guidance from NICE on UTI management.

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The Medical Director confirmed that benchmarking was carried out against other organisations and as a result the Trust recognised the improvements required regarding surgical site infection and there was now a Surgical Site Infection (SSI) Group in place to monitor any issues and track progress with actions.

In response to questions raised about infections seen at the Trust despite the level of controls in place, the Medical Director confirmed that there would always be some level as there were varying reasons for the existence of infections such as anti-biotic management and patient self-cleaning pre-admission. The Trust would continue to ensure the effective management of outbreaks.

The Director of Nursing informed the Board that the latest guidance also included the need to carry out risk assessments on patients that staff were concerned about rather than the amber, red and green system currently in place. Senior colleagues would be assessing the placement of patients, as there would always be a need for an area for COVID positive patients, however, changes would be needed in order to move forward with treating patients quickly enough to reduce backlogs.

The Board noted the report and acknowledged that the strategy optimised the use of the Trusts resources whilst ensuring effective IPC.

2.1.3 DIPC Quarterly Report

This paper provided information and an update on infection prevention and control issues for the second quarter of this financial year, 1st July until 30th September 2021.

The Board noted the contents of this report and progress against the annual plan.

2.2 Learning from Deaths Quarterly Update

The Board were informed that there had been forty-two deaths in the Trust between July and September 2021. Thirty-nine of the deaths had been through the mortality review process. There had been no deaths in patients with an identified learning disability.

A full organisation learning report relating to learning from deaths would be discussed in depth during part two of the Board in private.

The Medical Director explained that all avoidable deaths were not automatically classed as a serious incident (SI). Whilst every death was reviewed by the Mortality Review Group (MRG), there was very clear guidance/criteria to what met a SI and what didn't.

The Board noted the report.

Chair's Initials

2.3 Patient Survey Results

The Director of Nursing, Safety & Quality presented the very positive survey results. Whilst recognising the outstanding results from the survey, there is always the desire to learn and the three key areas highlighted were:

1. Explaining the reasons for changing wards during the night
2. Getting enough help from staff to wash or keep yourself clean
3. Getting enough help from staff to eat your meals

Whilst it was noted that the medicine division performed much better compared to other hospitals, the surgery division was noted as performing at the same level and therefore the Trust would focus improvement work in that area. The Board were informed that patients who were in hospital now and throughout December would be the cohort questioned for next year's survey and who was questioned was random with no input from LHCH.

It was confirmed that there wasn't much insight available as to what other organisations were doing better, however colleagues would attempt to benchmark.

The Board acknowledged the excellent results and recognised the continued hard work and focus on improvement.

2.4* LHCH Monthly Nurse Staffing Report for September and October 2021

The Board **noted** the report and acknowledged the challenges faced with bank staff and how the Trust relied on current staff working additional hours and the movement of colleagues between various areas.

2.5* Deprivation of Liberty and Safeguarding (DoLS)

The Board was updated on the number of applications made for Quarter 2 of 2021/22 in relation to the Deprivation of Liberty Safeguards (DoLS). Whilst a slight increase had been seen, colleagues did not attach this to the impact of the no visitor's policy in place as a result of the global pandemic, as the increase had been seen from late 2019.

It was confirmed that the Trust always informed the local authority on the number of applications, however feedback was rarely received. It was noted that as of next year it would be the responsibility of organisations to lead on this.

The Board **noted** the numbers of applications made and assessments undertaken.

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2.6* ***Guardian of Safeworking (GoSW) Exception Report***

The Board **noted** the report.

3 Strategy and Development

3.1 Green Plan Update

The comprehensive report demonstrated progress made against the Trusts Green Plan and savings; both environmental and financial, and in particular those that had been realised through the October Green Month Initiative. The Board were informed that a formal green plan would be submitted to NHSE/I by January 2022.

It was noted that 1,073,217 kg CO2e was being saved from being released into the atmosphere every year, and LHCH was saving £163,710 recurrently per annum due to the range of sustainability initiatives outlined in the paper.

The Director of Strategic Partnerships opinion was that the Trust's implementation of green initiatives was well in advance of fellow organisations, however further work would be done on promoting the work undertaken at the Trust in this area. It was noted that as capital projects were agreed, colleagues would be asked to be aware of environmentally smart ideas.

It was explained that the environmental performance of the Cath Lab development would not be available until the entire project had been completed, however the Trust were aiming to offset any increased carbon omissions in the future. Work would also be on-going in other areas such as disposable gowns, with Board colleagues acknowledging that it was difficult to calculate indirect costs.

The Board **noted** the progress and success of the Green Plan to date.

3.2 Strategic Objectives Update

The paper described the output from the work completed at the Board of Directors strategy day on 2nd November 2021 where an update on each objective was developed with an aim for delivery for the remainder of 2021 and into 2022. Each objective had been allocated to a lead Director and would be monitored regularly. A progress update against objectives would be reported to the Board in January 2022 as planned.

The Board **approved** the refresh of the strategic objectives.

3.3 Digital Excellence Report

The report provided the Board with a digital update including the national direction of travel and local Digital Excellence progress.

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Key headlines included:

- National digital developments
- Engagement with new regional ICS digital lead
- Submission of initiatives for national Unified Tech Fund resources
- Good progress with Digital Excellence delivery
- Good progress with digital clinical and safety developments
- High levels of operational performance against agreed key performance indicators
- Developments with the iDigital service

The Chief Information Officer (CIO) informed Board colleagues that an announcement had been made regarding NHS X and NHS Digital, with the teams being integrated within NHSE/I. Whilst the full impact of the changes was not clear, colleagues predicted that processes should be simplified and streamlined as a result.

Work was on-going with the initiatives put in place by the NHS X CIO and the new Chief Digital and Information Officer for Cheshire & Merseyside (C&M) and further updates would be provided as the new strategy took shape.

It was noted that good progress had been made in all areas of the digital strategy with the Trusts Digital Excellence Committee (DEC). Arrangements were well embedded and monitoring in place across all areas including data warehouse and business intelligence transformation. The HIMSS level 6 assessment was scheduled for week commencing 6th December 2021, the results of which would be feedback to the Board.

The iDigital service continued to perform well and colleagues would be celebrating the talent of the workforce at an upcoming staff away day.

The Board acknowledged the excellent report which ensured alignment with national requirements and the Chair thanked the digital team for their work.

4 Targets and Financial Performance

4.1 Board Dashboard period Ended 31st October 2021

The Chief Operating Officer (COO) presented the high level messages within the Board dashboard.

In terms of the Trust's statutory performance the following exceptions were noted:

- Six week diagnostic performance had narrowly

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underperformed in month with a position of 97.55% against a target of 99%. This was due to specific challenges on staffing additional sessions, significant work had gone into planning for the rest of the year and the forecast was that of a compliant position.

- Referral to treatment waiting times remained below target as expected due to the significant backlog accumulated during the Coronavirus surge. Performance in month stood at 79.21% for English commissioned activity and 82.32% for Welsh commissioners, a slightly improved position compared to the previous month. This performance was in line with the Trust recovery trajectories.
- There were 54 patients waiting longer than 52 weeks at the end of October 2021, an improved position compared to previous months. Several challenges were forecast for November in relation to critical care staffing that may impact on performance against the trajectory for December 2021.
- Sickness absence had increased slightly to 5.5% in month, 0.6% higher compared to the same period last year. The teams were focused on clear and early intervention to avoid long term sickness absence where possible.

Additional performance exceptions to note were summarised within page two of the report.

It was agreed that the KPIs reported on would be reviewed and agreed for 2022/23. **HK**

The Board **noted** the contents of the paper and the associated actions.

4.2 Phase 4 Recovery

The Chief Operating officer set out the performance against the trajectories.

At present there were only 12 breached patients in the P2 category, the divisions were well sighted on the capacity required, and it was reviewed weekly with the Executive team.

It was confirmed that the Elective Recover Fund (ERF) was now going to be based on clock stops, this was a new currency and the Trust were showing a very strong performance. The C&M system were forecasting an overall achievement of ERF, notwithstanding the risks of COVID and winter pressures.

It was confirmed that it was expected to be at least the next financial year before the Trusts waiting lists were at pre COVID

levels. Significant numbers were seen due to the cohort of patients treated at LHCH, which consisted of a high number of P2 category patients. There continued to be strong clinical engagement and colleagues were well sighted on the patients on the waiting list with patients risk assessed, proactively managed and fully supported by staff. It was noted that increased waiting list was a common position across all NHS organisations.

The Board **noted** the strong performance and risks highlighted within the paper.

5 Governance and Assurance

5.1 Consultant Appointments

The Board **ratified** the following consultant appointments:

- Dr Emma Houston-Consultant Anaesthetist
- Dr Melissa Evans-Consultant Anaesthetist

5.2 Ratification of Use of Trust Seal

The Board ratified the application of the Trust's seal to documentation relating to the following:

- Replacement of Lifts 8 and 9 – Birch Ward, Liverpool Heart and Chest Hospital **JCT DB 2021 Contract Documents**

5.3 SORD: Liverpool Health Partner Updates

Liverpool Health Partners (LHP) had requested a change to the expenditure approval limits in the Scheme of Reservation and Delegation (SoRD).

The existing LHP approval limits contained some ambiguity and were not consistent with the desired working practices in place at LHP. The proposed revisions clarified what could be approved and would allow each LHP Executive Director the ability to approve expenditure up to £25,000. Approvals were made within the overall funding available and the expenditure plan agreed at the beginning of each financial year. The proposed expenditure limits were shown in appendix 1 of the report and an extract from the existing SoRD was detailed within appendix 2.

The Board noted that the LHCH Audit Committee had reviewed the requested change and recommended approval and adoption.

The Board **approved** the changes and adoption requested.

5.4 Report of Freedom to Speak Up Guardian

The paper provided the Board with an update on the work of the Freedom to Speak Up (FTSU) Guardian and Champions in supporting the safety culture within the Trust. It also provided an overview of issues and concerns raised in the quarter and

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contained updates from the National Guardians Office (NGO) of FTSU, with the aim of giving assurance that the local arrangements in place continued to meet best practice and support staff to raise concerns.
The paper provided a reflection on the progress made by the FTSU Network in empowering staff to speak up freely and encourage ongoing positive cultural change.

The Board were informed that the NGO had published a case review of Blackpool Teaching Hospitals in October 2021, which looked at the speak-up culture, the Freedom to Speak Up Guardian and the leadership in the organisation. The majority of the recommendations were already embedded at LHCH, however, a detailed analysis of the key recommendations would be undertaken to ensure inclusion at the Trust's Team Brief and the SOLE bulletin.

Another case report produced by the NGO from the100 Voices campaign, "Speaking up about burnout - improving worker experience" echoed some of the worker concerns raised at LHCH in this quarter. Learning from this case study would be extracted and shared to facilitate the listening processes.

The Freedom to Speak Up Guardian confirmed that closed concerns were followed up one to two months following closure and that the FTSU process at the Trust was inclusive with several avenues available for staff to raise concerns. It was noted that the Be Civil, Be Kind campaign had made a positive impact as had the co-created Civility Charter.

The Board **noted** the quarter 2 2021/22 report, the NGO guidance for the FTSU Champion's role description and NGO recommendations from the Blackpool case review and accepted assurance that local FTSU arrangements were in place and met best practice guidance.

5.5* ***Communications Report Q2***

The Board **noted** the good work set out within the report.

6 Board Assurance

6.1 BAF Key Issues Reports and Approved Minutes of Assurance Committee Meetings

6.1.1 Audit Committee: BAF Key Issues and Approved Minutes for Meeting held on 6th July 2021

The Board **noted** the BAF key issues report (October 2021) which included details on the mid-year review of assurance committee's and updates from cyber security and data quality assurance.

It was highlighted that the survey regarding Trust's internal auditors, MIAA, had received a resoundingly positive response to

the service they provided and that the LHCH internal audit arrangements were working well.

The Board received and **noted** the approved minutes of the Audit Committee meeting held on the 6th July 2021.

6.1.2 Quality Committee: BAF Key Issues and Approved Minutes for Meeting held on 20th July 2021

The Board **noted** the BAF key issues report (October 2021) which showed that the Quality Committee had discussed the new Quality Strategy in depth and agreed processes for monitoring its implementation. Comments were included relating to ongoing quality report accounting for exceptions and the new NHS UTI management guidance adopted by the IPC team.

An amendment was stated that there had been 13 cases of Septicemia, not 16, as previously reported, and therefore the Trust lay in the green category.

There had been a slight concern in response documents regarding a radiology alert and the response to the MIAA audit, however, it was thought that the data may not be accurate and therefore this would be reviewed as would the screening for malnutrition data.

The Quality Committee had also acknowledged the implementation of a Sepsis screening improvement plan and the development of the Mortality Improvement Group.

The Board received and **noted** the approved minutes of the Quality Committee meeting held on the 20th July 2021.

6.1.3 Integrated Performance Committee: Approved Minutes for Meeting held on 26th July 2021

The Board **noted** the BAF key issues report (October 2021) with the Chair of the Integrated Performance Committee thanking the finance team for their excellent efforts at mitigating risks during the current, ever changing climate.

It was noted that the Improvement Steering Group was actively managing CIPs and progress was strong.

The COO was thanked for the clear and concise reports presented to the Committee and the positive impact that regularly reviewing the trajectories had.

The Board received and **noted** the approved minutes of the Integrated Performance Committee meeting held on the 26th July 2021.

Chair's Initials

7 **Minutes of the Board of Directors Meeting held (in public) on 28th September 2021**

The minutes of the meeting of the Board of Directors held on 28th September 2021 (in public) were reviewed for accuracy and **approved** by the Board.

8 **Action Log (Public) from Previous Meeting**

The action log was reviewed and updated as follows:

Item 1-Presented at agenda item 3.2. This item would be marked as complete and removed from the action log.

Item 2-Mortality Improvement Plan would be presented at the Board of Directors (in private). This item would be marked as complete and removed from the action log.

Item 3- Presented at agenda item 4.2. This item would be marked as complete and removed from the action log.

Item 4- Presented at agenda item 5.4. This item would be marked as complete and removed from the action log.

Item 6- Presented at agenda item 2.1.2. This item would be marked as complete and removed from the action log.

Item 8- Refresher training for the Board in use of SPC methodology had been delivered. This item would be marked as complete and removed from the action log.

All other actions remained on the action log.

9 **Legality of Board Documentation and Decisions**

Board members confirmed that the conduct of the meeting and decisions made by the Board, to the best of their knowledge, complied with the law. Board members confirmed they were satisfied with the format of the meeting.

10 **Date and Time of Next Meeting:**

Tuesday 25th January 2022 10.00 hours

11 **Resolution to exclude the Public**

The Board resolved to exclude the public at this point by reason of the private nature of the business to follow.

The Chair thanked Board colleagues and Governors / members of the public (observing), for their attendance, comments and feedback.

Chair's Initials

Board of Directors (in Public)
Item 8

Action log

Updated 30.11.21

No.	Agenda Item	Action	By Whom	Progress	Board review	Note
November 2021						
1.	4.1 Board Dashboard period ended 31st October 2021	KPIs reported on to be reviewed and agreed for 2022/23.	HK		Jan 22	Agenda Item
July 2021						
2.	5.7 Premises Assurance Model	Develop an Estates Strategy	HK		TBD	
April 2020						
3.	3.1 Strategic objective – quarterly update	Present new R&I strategy	JT/JW	An update was provided on the development of the strategy at the Sept BoD	TBD	
November 2019						
4.	5.3 Freedom to Speak Up Review of New Guidance	Self-reflection exercise to be repeated every 2 years	LL		Nov 21	