Meeting of the Board of Directors

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

Tuesday 26th July 2022
MS Teams/Conference Room, 9.30-12.30

Agenda

Time	No.	Item	Owner	Purpose	Paper
	1	Welcome and Opening Matters			
9.30	1.1	Apologies for Absence Andrew Lang	Chair		Oral
9.31	1.2	Declaration of Interests Relating to Agenda Items	Chair	To Note	Oral
9.32	1.3	Minutes of Previous BoD (in public) Meeting on 31st May 2022	Chair	To Approve	Item 1.3
9.34	1.4	Action Log from Previous Meeting	Chair	To Note	Item 1.4
9.36	1.5	Patient Story	Director of Nursing, Quality & Safety	To Note	Oral
9.40	1.6	Staff Story	Chief People Officer	To Note	Oral
9.45	1.7	EECS Overview	Joan Mathews/ Angela McKenna	To Note	Presentation
10.15	1.8	Chair's Briefing	Chair	To Note	Oral
10.20	1.9	CEO Report	Chief Executive	To Note	Item 1.9
	2	Safety And Quality			
10.30	2.1	IPC BAF Update	Medical Director	For Assurance	Item 2.1
10.33	2.2*	*LHCH Monthly Ward Staffing Report for Period: June 2022*	Director of Nursing, Quality & Safety	For Assurance	Item 2.2
10.34	2.3*	*Safeguarding Annual Report*	Director of Nursing, Quality & Safety	For Assurance	Item 2.3
10.36	2.4*	*Guardian of Safe Working-Quarterly Exception Report*	Medical Director	For Assurance	Item 2.4
10.38	2.5*	*Deprivation of Liberty and Safeguarding (DoLS)*	Medical Director	For Assurance	Item 2.5

10.40	2.6*	*DIPC Quarterly Report*	Medical Director	For Assurance	Item 2.6
	3	Strategy and Development			
10.42	3.1	Strategic Objective KPIs Quarterly Update	Director of Strategic Partnerships	To Note	Item 3.1
11.12	3.2	Prevention update: Liverpool Schools program pilot	Director of Strategic Partnerships	To Note	Item 3.2
11.16	3.3	People Plan Update	Chief People Officer	For Assurance	Item 3.3
11.20	3.4	Digital Excellence Report	Chief Digital & Information Officer	For Assurance	Item 3.4
11.28	3.5	System update	Director of Strategic Partnerships	To Note	Item 3.5
	4	Targets and Financial Performance			
11.37	4.1	Board Dashboards: SOF, Operational and Exception Reports	Chief Operating Officer	For Assurance	Item 4.1
	5	Governance and Assurance			
11.47	5.1	Governance Manual Annual Review	Director of Risk and Improvement	To Approve	Item 5.1
11.52	5.2	Mock CQC/EECS Report	Director of Nursing, Quality & Safety	For Assurance	*Item 5.2*
12.11	5.3	Report of Freedom to Speak Up Guardian	Peris Widdows, FTSU Guardian	To Note	Item 5.3
12.26	5.4*	*Emergency Preparedness and Business Continuity Annual Report*	Director of Risk and Improvement	To Approve	*Item 5.4*
12.27	5.5*	*Health & Safety Annual Assurance Report*	Chief Finance Officer	To Approve	Item 5.5
12.28	5.6*	*Complaints Process Annual Review*	Director of Nursing, Quality & Safety	To Approve	*Item 5.6*
12.29	5.7*	*Communications Report Q1*	Chief People Officer	To Note	*Item 5.7*
	6	Board Assurance			
12.30	6.1	BAF Key Issues Reports and Approved Minutes*			
12.31	6.1.1	Quality Committee: • BAF Key issues for meeting held on 12th July 2022 • Approved minutes of meeting held on 12th	Chair of Quality *Committee*	To Note For Assurance	Verbal Item 6.1.1

		April 2022*			
12.37	**6.1.2**	**People Committee:** • **BAF Key issues for meeting held on 7th June 2022** • **Approved minutes for meeting held on 8th March 2022***	**Chair of People Committee**	**To Note** **For Assurance**	**Item 6.1.2a** **Item 6.1.2b**
	6.1.3	**Audit Committee:** • **Approved minutes for meeting held on 22nd March and 17th June 2022***	**Chair of Audit Committee**		
12.39	**7**	**Legality of Board Documentation and Decisions**	**Chair**	**-**	**Verbal**
12.40	**8**	**Date and Time of Next Meeting:** Tuesday 27th September 2022	**Chair**	**-**	**Verbal**
12.40	**9**	**Resolution:** To exclude the public from the meeting at this point by reason of the private nature of business to follow.		**-**	**Verbal**

Papers are 'for information' unless any Board member requests a discussion

Board of Directors (in Public)
Item 1.3

minutes

Minutes of the Meeting of the Board of Directors held on 31st May 2022

Present:	**Val Davies**	**Chair**
	Jane Tomkinson	**Chief Executive**
	Bob Burgoyne	**Non-Executive Director**
	Margaret Carney	**Non-Executive Director**
	Jonathan Mathews	**Chief Operating Officer**
	Sue Pemberton	**Director of Nursing, Quality & Safety**
	Kate Warriner	**Chief Digital & Information Officer**
	Jonathan Develing	**Director of Strategic Partnerships**
	Karen Nightingall	**Chief People Officer**
	Karan Wheatcroft	**Director of Risk and Improvement**
	Raphael Perry	**Medical Director**
	Karen Edge	**Chief Finance Officer**
	Julian Farmer	**Non-Executive Director / Deputy Chair**
	Andrew Lang	**Non-Executive Director**
	Louise Robson	**Non-Executive Director**
	Jay Wright	**Director of Research**
In Attendance:	**Nusaiba Hannan**	**Executive Office Manager &Governance Lead**
Observers-Governors/ Staff/ Members of the Public:	**Allan Pemberton**	**Public Governor- Cheshire**
	Trevor Wooding	**Senior Public Governor- Merseyside**
	Dorothy Burgess	**Public Governor - Merseyside**
	Sharon Faulkner	**Staff Governor**
	Princey Santosh	**Staff Governor**
Apologies for absence:	**Nick Brooks**	**Non-Executive Director**

Action

1 Opening Matters

1.1 Apologies for Absence

Apologies for absence were received from Nick Brooks.

Chair's
Initials

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.

LR declared her ongoing consultancy role with a number of provider collaboratives. It was important that this declaration was noted but agreed that this did not preclude LR from discussions on the CMAST update as her insights would be helpful in understanding the national picture.

Other participants confirmed that they had no interests to declare.

1.3 Minutes of the Board of Directors Meeting held (in public) on 26th April 2022 – for approval

The minutes of the meeting of the Board of Directors held on the 26th April 2022 (in public) were reviewed for accuracy and **approved** by the Board.

1.4 Action Log (Public) from Previous Meeting

The action log was reviewed, with confirmation that the following actions had been completed and could be removed:

- Gender pay gap disclosures
- Mortuary update
- Phase 4 recovery
- Board Dashboard period ended 31st October 2021
- Freedom to Speak Up Review of New Guidance

The remaining actions were in progress and the strategic objectives quarterly update board review date was to be confirmed.

1.5 Patient Story

A patient story shared via video was deferred to the Private section (due to technical issues).

1.6 Staff Story

The Chief People Officer shared a staff story from Yasser Yusuf a Senior Respiratory Clinical Physiologist from the respiratory team. He expressed his admiration for the exceptional respiratory facilities and dedicated team at LHCH. He expressed his pride in being part of the team and was excited to continue to contribute to the innovation of this department. He thanked LHCH for taking care of their staff and the small gestures provided by the Trust to express their gratitude.

The Board expressed their pleasure in hearing staff stories and suggested potentially relaying these stories via video or in person in future if possible.

Chair's
Initials

1.7 Cystic Fibrosis Services

Professor Martin Walshaw and Clare Sumner shared a presentation to The Board providing an update on the adult cystic fibrosis services at LHCH. Innovations, objectives, and outcomes were discussed in depth.

The Board thanked them for their ongoing work and the detailed update.

1.8 Chair's Briefing

The Chair shared that the Health and Care bill had been passed into law which in turn removed a lot of barriers for Trusts and Systems working together in a more collaborative way. She highlighted the ongoing work behind existing and ongoing collaborative projects. This would be discussed further in subsequent agenda items.

The Chair shared that she was continuing to tour various wards and departments in the hospital and introducing herself to relevant internal and external stakeholders.

The Chair introduced the two new Non-Executive Directors to their first Board meeting. Andrew Lang and Louise Robson provided a brief introduction on themselves.

VD expressed her thanks to KWh, NH and Gill Donnelly for their support and thanked everyone for making the time for introductions.

1.9 CEO's Report

The CEO report provided an update on a range of issues. The report was taken as read and the following points were highlighted.

The NHSEI Board had reclassified the pandemic from an incident Level 4 to Level 3, moving the onus of decision making to a regional level. LHCH recovery planning focused on implementing the changed guidelines which allowed flexibility on how services are delivered. It was noted that there were still 21 covid positive staff at LHCH at that point. The CEO reiterated that IPC measures are still relevant and in full force included mandated staff testing. Allocations have also been adjusted to assume less spending on COVID 19 response.

LHCH had recently received a letter from NHSEI on options and opportunities to support the organization in workforce recovery. The CEO confirmed that majority of these were already in place but was pleased this consolidated LHCH's plan for recovery.

In June 2021, LHCH were awarded the contract to be the primary sole provider to deliver the Targeted Lung Health Check programme for NHS Halton, NHS Knowsley and NHS Liverpool CCGs. NHS Sefton and NHS St Helens CCG have been awarded funding to the value of £9,582,000 from the national cancer team to deliver a TLHC

Chair's
Initials

programme over the next four years (1st April 2022 to 31st March 2026). Following an expression of interest exercise led by the Midlands and Lancashire Commissioning Support Unit, LHCH have been informed of the intention to direct award the service subject to completion of procurement processes.

Discussion took place regarding the intricacies of extending the targeted lung health service and the impact it would have on the existing service. The COO provided reassurance that a full business case would be developed to address the details of the transition. He highlighted that there would be a big focus on recruitment and retention.

The CEO provided an update on LHCH's response regarding mortuary services following the Maidstone and Tunbridge Wells review. A comprehensive action plan has been developed based on learning from this. The action plan is now complete. LHCH will maintain rigorous monitoring and are assured that the security and safety of mortuary is robust. Discussion took place regarding lessons learned from the review.

The Board **noted** the contents of the report.

2 Safety and Quality

2.1 IPC BAF and Update

The Medical Director provided a summary of the purpose of the IPC BAF for the new members of The Board.

The Medical Director confirmed that there had been no changes since the IPC BAF update presented at the March 2022 Board meeting. LHCH are to carry out risk assessments on how IPC guidance is to be continued to be implemented.

It was confirmed that IPC measures currently implemented will remain in place. There is ongoing work in risk assessing non-clinical areas across the organization.

It was noted that the microbiology services remain under significant strain. There will be new microbiology appointments by September 2022.

The Board **noted** the report and IPC BAF.

2.2* *LHCH Monthly Nurse Staffing Report for Period: April 2022*

The Director of Nursing, Quality and Safety shared the monthly staffing report and the paper was taken as read. SP provided The Board with clarity on some of the abbreviations in the paper and the associated processes.

DR

The paper detailed the current vacancies and internal improvements. SP expressed her satisfaction with the outcome of the international recruitment drive so far and that an internal recruitment event would take place in June 2022.

Discussion took place regarding roster efficiency, triangulation between nurse staffing level, incidents and quality and safety. EECS (Excellent, Efficient, Compassionate and Safe) is a tool used to quality assess every area and a paper would return to Board in July to provide assurance. **SP**

The Board **noted** the report.

3 Strategy and Development

3.1 Equality, Diversity, Inclusion and Belong Strategy

The Chief People Officer set out the context of the paper.

The Trust has refreshed its EDIB Strategy which sets out the Trusts ambition to have a culture of belonging and trust, and to understand, encourage and celebrate diversity in all its forms. The strategy is underpinned by an operational action plan and work streams with a discussion scheduled for the next EDIB Steering Group.

The paper provided the annual EDI update, noting the progress and achievements to date. The commencement of LHCH Belong Inclusions Network virtual events was highlighted, along with the increased focus on supporting staff from ethnic minorities, an overhaul on recruitment and flexible working practices and noting that LHCH had successfully been accredited as ‘Veteran Aware’.

WRES and WDES highlights were shared against KPIs. It was noted that some assumptions could be made about the impact the pandemic had on achieving certain KPIs. Actions were being developed which will be included in the operational EDIB action plan.

The trust will undertake the EDS in line with the new statutory requirements as part of EDS3 planned in 22/23

An analysis of the gender pay gap data in relation to the Clinical Excellence Awards was shared as requested by The Board.

The Chief People Officer addressed comments with regards to the extensive focus on the workforce and provided reassurance that patients were included in the action plan. It was felt that there could be more focus on this in the strategy.

Discussion took place regarding digital exclusion. The Chief Digital recognized that digital resources are not available for every patient. A range of measures are in place to provide less digitally mature

DRAFT

individuals with support, appropriate technological tools and continued face to face appointment were needed. It was noted that this would also be high on the ICS agenda.

The work LHCH was doing to support patients with complex care needs and provide mental health support was highlighted. It was also noted that communication presented a major barrier to accessing healthcare and therefore LHCH is working collaboratively to pursue a city-wide framework for translation and interpretation services.

Further discussion took place regarding the use of reverse mentoring and the reporting of discriminatory incidents. It was agreed that an increased focus on reverse mentoring would be beneficial in the future, but the Trust was currently formalising a mentoring programme. It was confirmed that incidents were reported via Datix and were also reported verbally via a daily Safety Huddle. Staff are also actively encouraged to report via the Trust's Freedom to Speak Up Guardians.

The CEO discussed having an integrated approach to better understand the population to better enable Trust's to minimise any form of exclusion and inequality of access.

The Board **approved** the report.

3.2 Prevention Pledge

The Director of Strategic Partnerships explained that the Cheshire & Merseyside Prevention Pledge consists of 14 core predetermined commitments aimed at encouraging Trusts to adopt a disease prevention approach rather than just focussing on treatment. JD shared an overview on LHCH's progress and actions taken in accordance with these commitments. LHCH's key priority is reducing the incidence of cardiovascular disease (CVD).

LHCH has been actively engaged with the prevention pledge since December 2021 and is currently in phase two of five. The Trust has agreed to 8 commitments with a view to committing to all 14 commitments by March 2023.

JD introduced the concept of an 'Anchor Institution' which recognised scale and contribution of NHS organisations on their local populations. This consisted of the following key components:

- Social Value
- Prevention Pledge
- Green Plan
- Ability to collaborate with other parts of the system

It was noted that LHCH has recently been awarded a Social Value Award. JD explained that the prevention pledge is a key element in being an 'Anchor Institution' and that LHCH are proud to be leading

DR

the way on this piece of work. LHCH has also been officially awarded a certificate of recognition as one of the Trusts implementing the pledge. The report also shared the work that LHCH was leading, orchestrating and delivering on to support the prevention pledge.

JD highlighted work being done with a school in Fazakerley in conjunction with Heart Research UK and Liverpool Football Club. Progress reports on these projects would return to Board at a later stage. **JD**

Discussion took place regarding population needs and obtaining data to help support the prevention pledge. It was recognised that there currently is no dashboard for health inequalities, but that it would be essential to establish strong relationships with primary care services to use local data to support the regional agenda. However, the Board also recognised there are limitations as not all of the population are registered with a local GP. It was noted that Social Media campaigns would be a tool used to target specific areas to raise awareness and extrapolate relevant data.

The CEO commented on the importance of the prevention pledge and how this would link into LHCH's work on the Cardiac Board. She also shared the relevance of using the data from the Health & Inequality Strategy to drive this agenda.

The Board **noted** the report.

3.3 Systems Update

The Director of Strategic Partnerships shared the key points of the paper. The ICB appointments were noted.

With regards to Place, it was shared that the One Liverpool Partnership systems delivery group had developed a governance structure against a workplan reflective of local needs. LHCH are playing an active role in this. The workplan focusses on:

- Heathy Children and Families
- Complex Lives
- Long Term Conditions (including Cardiovascular and Respiratory Care)
- Frailty and Dementia
- Disabilities

The Cheshire & Merseyside ICS on behalf of NHS England, has commissioned an independent review of the model of care within Liverpool. This review is about the opportunity to learn messages from COVID 19, improving quality and efficiency and working in collaboration. The Board were asked to note that the review is taking place.

Discussion took place regarding any potential mergers. The Board were reassured that there were currently no plans for merging of

Chair's Initials

Trusts and that the focus was on care models and how this would be delivered.

The Board **noted** the report.

3.4 **Recruitment and Retention Strategy**

The Chief People Officer shared that the Recruitment Strategy had now been developed with a dedicated action plan in place.

The six key ambitions are:

- Align our recruitment activity to our workforce plans
- Brand LHCH as an employer of choice
- Optimise technology to improve our recruitment processes
- Recruit the best candidates with the correct values and skills
- For the candidate to have a positive recruitment experience
- Improve employee retention

Discussion took place about the focus on retention and the reasons for staff leaving. The Board were reassured that the main reasons for leaving were due to relocation or promotion. The Chief People Officer described some of the recruitment campaigns taking place and addressed comments on how the learning and development strategies would link in and support the Recruitment & Retention Strategy.

The Board **approved** the report with the comment to provide more focus on retention.

4 Targets and Financial Performance

4.1 **Board Dashboard 2022/23-KPI Definitions and Performance Assignment Thresholds**

The Chief Operating Officer set out the context of the paper which proposed the approach to monitoring the Trust's operational performance for 2022-23. The Single Oversight Framework (SOF) sets out statutory targets that the Trust is responsible for monitoring performance against. It was noted that the SOF document for 2022-23 is yet to be published but guidance has been shared through annual planning.

The oversight is characterised by the following key principles:

1. working with and through ICSs, wherever possible, to tackle problems
2. a greater emphasis on system performance and quality of care outcomes, alongside the contributions of individual healthcare providers and commissioners to system goals
3. matching accountability for results with improvement support, as appropriate
4. greater autonomy for ICSs and NHS organisations with evidence of collective working and a track record of

successful delivery of NHS priorities, including tackling inequality, health outcomes and access
5. compassionate leadership behaviours that underpin all oversight interactions.

It was noted that in 2020-21, performance reporting had been updated to utilise run charts as opposed to a written report. This had allowed the Board to easily identify trends associated with KPIs. This change had been well received and proven to be a strong tool in monitoring KPIs across the Trust. Minor changes to existing KPIs and additional indicators were highlighted in the report for the Board's approval.

Discussion took place on how performance of major capital programmes were being monitored. It was shared that a separate Major Capital Project report was sighted to the Board to provide assurance and a more in-depth overview of performance both from an operational and financial perspective. There was also discussion about how local targets were set in accordance with national targets and ensuring that they were challenging but realistic.

Further discussion occurred regarding the RAG rating system and that the report would benefit from providing assurance and a narrative for cause for concern' items. The COO confirmed that the report and appendix for item 4.1 had been amended for May Board to provide clarity and that a narrative could be implemented for future reports. **JM**

There was an exchange regarding uptake of additional lists to support recovery and it was confirmed that there had been a positive uptake.

The Board **approved** the KPIs set out in the report.

4.2 **Board Dashboards: SOF, Operational and Exception Reports**

The Chief Operating Officer presented a report detailing the Trusts performance for the period ending 30th April 2022.

Exceptions were shared under the categories of operational performance, workforce and quality as detailed in the report. JM highlighted the potential impact of the Admin restructure on service delivery and that the achievement of the Faster Diagnosis would impact on the 62 day cancer performance. It was noted that Omicron continued to have an impact on staff sickness levels. Specific action plans are being developed by the Divisions to address workforce and Faster Diagnosis targets.

Assurance was provided to The Board with regards to actions being taken to recover all the exceptions. The Trust's focus remains of safely restoring maximum levels of elective activity post pandemic whilst maintaining COVID system support. Monthly updates will continue to be provided to the Board.

DRAFT

The financial performance for the period ending 30th April 2022 is a £77k deficit against a breakeven plan. Income and expenditure is broadly in line with plan. Private patient income is lower than the plan with the target to increase the activity back to pre-pandemic levels in line with National assumptions. It was noted that there were some pressures in medical and nursing pay relating to vacancies, but this was offset by underspend in other staff groups. It was also noted that high staff sickness levels were a contributing factor. There is an under-delivery of CIP as the financial year has just commenced but this has been offset by an underspend on clinical supplies. CIP targets have been allocated to Divisions and Departments and work is progressing in identifying and progressing schemes. There was Capital expenditure of £0.3m in month. The Trust is awaiting confirmation of the ICB capital allocation before concluding the composition of the capital programme for the year.

Discussion took place regarding CIP targets and the Board were also informed that the main focus is on recurrent CIP schemes.

The Board **noted** the paper and associated actions detailed.

5 Governance and Assurance

5.1 Consultant Appointments (none to record)

The Board **noted** that there were no consultant appointments to report.

5.2 Review of CQC Insight

The Director of Risk and Improvement shared a report detailing the Trusts performance against a wife range of measures. The paper was taken as read.

BB commented that the report may benefit from being shared in a presentation format to present the key issues as it was quite lengthy and complex. It was noted that the report received from the CQC is extensive and the purpose of this paper is to provide assurance to the Board that the data is being monitored. The Director of Risk and Improvement will consider how to present the data in a more digestible format in future. It was also noted that some indicators will be out of date as the report is received on a bi-annual basis.

The Board **noted** the report.

5.3 Comms Report Q4

The Chief People Officer shared a report providing a high level update on Trust communications activities during quarter 4 (2021/22).

DR

AL concurred that Trusts communication is regular and detailed. Discussion took place regarding evidence of staff absorbing and reading the information.

It was noted that communications were reinforced through a monthly team brief and daily safety huddle. There was further discussion on ways ensure and encourage staff to engage with comms. It was also shared that a Comms strategy is being developed.

The Chair passed on thanks to the small Comms Team on behalf of the Board for their consistent and excellent work.

The Board **noted** the report.

5.4 NHS Constitution Compliance Report

The report confirmed the Trusts compliance with the NHS Constitution with the exception of the rights for access to services as a result of the Covid 19 pandemic.

The Board **noted** the report.

5.5 Ratification of Trust seal

The Director of Risk and Improvement shared a report requesting retrospective ratification of the use of the Trust's seal on the following document:

- Deed of Surrender between Community Health Partnerships Limited and Liverpool Heart and Chest Hospital NHS Foundation Trust relating to premises at Speke Neighbourhood Health Centre, 75 South Parade, Liverpool, Merseyside, L24 2SF

It was noted that high risk items would be presented to the Board in advance of use. Discussion took place regarding which cases would warrant prospective or retrospective approval.

The Board **ratified** the use of the Trust seal.

5.6 FTSU Arrangements

The Director of Risk and Improvement set out the context of the paper. It was noted there are well established FTSU arrangements at LHCH.

The Board were informed that The Director of Risk and Improvement will take over as the Director Lead for FTSU with ongoing strong involvement from the CEO. The Trust also looked at ways to improve and enhance the service and appointed a 2nd guardian to provide resilience and cover.

NHSEI recommend that Trusts complete a self-assessment every 2 years at Board level. The last self-assessment was completed in November 2019 and was paused during the pandemic. The FTSU self assessment exercise has been undertaken by the Executive and Non Executive leads for FTSU on behalf of the Board and the paper set out how the Trust demonstrates compliance.

Discussion took place regarding data received from leavers and if this corroborated with feedback from retained staff. It was noted that HR were not directly involved with FTSU arrangements (unless a grievance was raised), however feedback from exit interviews were analysed to identify any themes and triangulated with the FTSU team.

The Board **noted** the update to FTSU arrangements and **approved** the Board self-assessment.

6 Board Assurance

6.1 BAF Key Issues Reports and Approved Minutes of Assurance Committee Meetings

6.1.1 ***Quality Committee Key Issues for meeting held on 25th April 2022 and Approved Minutes for meeting held on 28th January 2022.***

It was noted that a verbal update had been provided at the May Board and that a written paper had now been circulated.

The Board **noted** the BAF Key issues from the meeting held on 25th April 2022 and minutes from the meeting held on 28th January 2022.

6.1.2 ***Integrated Performance Committee: BAF Key Issues for meeting held on 25th April 2022 and Approved Minutes for meeting held on 28th January 2022***

LR confirmed that the Committee received key assurances of the risk and actions set out in the report. The Committee noted the changes in the annual plan and annual planning cycle and adjustments made to financial regime. There was good discussion on risk and CIP. The issue of workforce and impact on delivery was highlighted and discussed across previous agenda items.

The Chair highlighted the new format of the BAF key issues providing a succinct presentation of outcomes from the assurance committees.

The Board **noted** the BAF key issues report from 25th April 2022 meeting and minutes from the meeting held on 28th January 2022.

DR

7 **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.

8 **Date and Time of Next Meeting**

Tuesday 14th June 2022 (Strategy Day)
Tuesday 26th July 2022

9 **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.

DR

Chair's
Initials

action log

Board of Directors (in Private)
Item 1.4
Updated 31.05.22

No.	Agenda Item	Action	By Whom	Progress	Board review	Note
31st May 2022						
	3.1 Major capital projects update	The Board would receive a further update on Cath lab once the survey for phase 3 was complete.	KE			
	3.3 Planning update	To provide an update on the outcome from the ICB peer review process including any changes to the Trust's approved financial plan.	KE			
	3.4 CMAST	The Chief Executive Officer would raise the importance of communication regarding the review of acute and specialist services in Liverpool with the Managing Director for CMAST and also work closely with LHCH Chief People Officer to establish the internal communications requirements with a focus on improving patient pathways	JT/KN			
	3.5 Liverpool Cardiology Collaborative	Liverpool cardiology collaborative highlight reports to be regularly reported to the Board.	JM			
26th April 2022						
	2.2 Single Cardiology Services	Draft LUHFT/LHCH Board Partnership Agreement	JM	**In progress**	June 22	
29th March 2022						
	4.5 BAF	BAF session to take place at the June Board Strategy day	KWh	Included on June Board strategy day agenda.	June 22	
27th April 2021						

	4.5 Evaluation of BoD	Consider again the timing of the next independent review per NHSI well led framework	NL	Included on June Board strategy day agenda.	TBD	Last review reported March 17. Paused due to pandemic and planned Board leadership changes / system reform
17th December 2020						
	4 Highfield House business case	Scoping exercise – 'The Institute'	JD	Deferred	Oct 22	

Board of Directors (In Public)

Item 1.9

Subject: Chief Executive's Report
Date of Meeting: Tuesday 26th July 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.

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. Changes in the Role of NHS England

NHS England, Health Education England, and NHS Digital have announced the merger of the three arm's-length bodies into NHSE.

There will be a new operating model for NHSE following the establishment of Integrated Care Systems, creating space to lead locally, working alongside the NHSE seven regions.

The size of NHS England will be reduced by up to 30-40%, with its scope changing to only undertake activity at national and regional level, where it is necessary to do so, with more functions delegated to ICSs', including further delegation of direct commissioning functions.

The restructure and post reductions will take place by April 2024, although NHSE, HEE and NHSD are due to merge legally in April next year. These changes will impact on the Liverpool system, in part due to our concentration of directly commissioned specialist.

2. Messenger report

The Messenger Report was published on 8th June 2022 following a national review of the state of leadership and management in the health and social care sector. The report includes 7 recommendations. Many of these recommendations require a national and/or

regional response. The table below provides a summary of the recommendations and the Trust position against these.

Report Recommendation	LHCH Position
1. Targeted interventions on collaborative leadership and organisational values A new, national entry-level induction for all who join health and social care. A new, national mid-career programme for managers across health and social care	The Trust has local leadership programmes in place and awaits the national response to this recommendation.
2. Positive equality, diversity and inclusion (EDI) action Embed inclusive leadership practice as the responsibility of all leaders. Commit to promoting equal opportunity and fairness standards. More stringently enforce existing measures to improve equal opportunities and fairness. Enhance CQC role in ensuring improvement in EDI outcomes.	The Trust has recently published a new Equality, Diversity, Inclusion and Belong Strategy. This reflects our continued commitment to EDIB and the actions within the strategy are being progressed.
3. Consistent management standards delivered through accredited training A single set of unified, core leadership and management standards for managers. Training and development bundles to meet these standards.	The Trust has local leadership programmes in place and awaits the national response to this recommendation.
4. A simplified, standard appraisal system for the NHS A more effective, consistent and behaviour-based appraisal system, of value to both the individual and the system.	The Trust has a well embedded approach to appraisals including reflection on Trust values and behaviours and more recently the Be Civil Be Kind principles and wellbeing conversations. Training is in place for appraisers. The Trust awaits any further national response to this recommendation.
5. A new career and talent management function for managers Creation of a new career and talent management function at regional level, which oversees and provides structure to NHS management careers.	The Trust continues to enhance career pathways and talent management. This recommendation is clearly aimed at a National response which we would also welcome.
6. More effective recruitment and development of non-executive directors Establishment of an expanded, specialist non-executive talent and appointments team.	We recognise the findings of the report and the development of central support (Regional or National) would be welcomed.

Report Recommendation	LHCH Position
	We will continue to work closely in our networks to support this.
7. Encouraging top talent into challenged parts of the system Improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles.	This is again aimed at National and Regional parts of the system.

3. CQC relationship meeting

A CQC relationship meeting was held on Monday 11th July 2022. The CQC reviewed the Clinical Services Division in addition to conducting a review of the Trust. There were no issues flagged and no actions identified.

4. External Stakeholder comments on Quality Account

The Trust has received feedback from our Commissioners and HealthWatch Liverpool on our Quality Account. This provides excellent external stakeholder feedback to support our Quality Account.

Refer ***Appendix A*** for the full statements.

5. Changes in the Role of NHS England

NHS England, Health Education England, and NHS Digital have announced the merger of the three arm's-length bodies into NHSE.

There will be a new operating model for NHSE following the establishment of Integrated Care Systems, creating space to lead locally, working alongside the NHSE seven regions.

The size of NHS England will be reduced by up to 30-40%, with its scope changing to only undertake activity at national and regional level, where it is necessary to do so, with more functions delegated to ICSs', including further delegation of direct commissioning functions.

The restructure and post reductions will take place by April 2024, although NHSE, HEE and NHSD are due to merge legally in April next year. These changes will impact on the Liverpool system, in part due to our concentration of directly commissioned specialist services.

6. EPRR

NHSEI have released an updated National EPRR Framework. The updated framework reflect the establishment of the ICB and therefore the delegated roles and responsibilities. We attend both the Strategic and Operational EPRR meetings and as required will reflect any changes in our local Major Incident Plans.

7. Major incident table top exercise

The Trust undertook a major incident table top exercise on the 28th June 2022 to test our new mass evacuation plan. This involved a wide range of colleagues including Executive Directors, Triumvirates, ward manager, clinical teams, IT, estates and other areas. This was a successful exercise to work through a scenario which enable clarification of roles and responsibilities, as well as practical steps. The learning has been captured to enable further updates to the policy and where appropriate the major incident plan.

A further exercise is being diarised and this will be observed by NHSEI for their sign off.

8. Staff Awards

The staff awards 2022 will be presented as part of a virtual event on 13th October 6pm, along with our Long Service Awards winners. This year's award categories include:

- Compassion in Care Award
- Quality Improvement Award
- Outstanding Service Delivery Award
- Outstanding Contribution Award
- Significant Impact to Patient Safety Award
- Non Clinical Team of the Year
- Unsung Heroes Awards
- IMPACT Award
- Enhancing Patient Experience Award
- Caring For Those Who Care Award
- Working Together Award
- Employee of the Year Award (selected from Employee of the Month Winners May 2021-August 2022)

9. Roadmap to delegation of specialised services

As part of the policy to delegate more commissioning function to ICBs, a roadmap has been issued setting out those specialised services that will transition to ICB commissioning from April 2023. The majority of LHCH services commissioning will transfer to the ICB under the aegis of Liverpool Place. Work is ongoing via the federation of specialist hospitals to ensure that any transfer is managed effectively with the right capacity and capability. LHCH is fully represented at national level and a meeting held on 19th July with the National Director, John Stewart set out 5 key proposals to facilitate continued excellence in specialised services. Further updates will be brough to the Board as appropriate.

10. Recommendations

The Board of Directors are asked to review the content of this report.

Appendix A – Full Quality Account Comments

NHS Liverpool Clinical Commissioning Group
NHS Knowsley Clinical Commissioning Group
NHS Sefton Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
NHS Halton and Warrington Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group
NHS England and Improvement Specialised Commissioning

Quality Account Statement 2021-22
Liverpool Heart & Chest Hospital NHS Foundation Trust

NHS Liverpool, Sefton, Southport & Formby, Knowsley, Halton and Warrington and St Helens CCG's along with NHSE/I Specialist Commissioning welcome the opportunity to jointly comment on the Liverpool Heart & Chest Hospital NHS Foundation Trust Draft Quality Account for 2021-22.The report was an excellent insight into the challenges, achievements, and improvements that the Trust has dealt with in the last twelve months. It was clear, honest, and transparent.

It is also acknowledged that the Trust has had a challenging year with the ongoing COVID-19 pandemic, and the impact on service delivery, patients, and staff. We would like to take this opportunity to thank the Trust and its staff for the work it has undertaken through this period of time, including adapting service delivery to ensure the patient is supported and the mutual aid it has offered to other partners in the health care economy.

We have worked closely with the Trust throughout 2020-21, at Contract & Quality Review Meeting (CQRM) and other forums to gain assurances that the services they delivered were safe, effective, and personalised to service users. The CCGs share the same fundamental aims as the Trust in delivering high quality, harm free care.

Commissioners noted the quality priorities for 2021-22, were achieved, for which we commend the Trust. Commissioners also noted that CQC performed their relationship reviews on the 29th November 2021 and 21st March 2022 with no actions for improvement identified following each event and that the Trusts overall rating is 'Outstanding' which the Trust should take pride in.

Primary Percutaneous Coronary Intervention (PPCI) remains a challenge regionally and nationally, (65% this year compared to 73% last year), with delays in ambulance times transferring the patient to the door being the main issue impacting on delays. The Trust is proactive in their approach, rewriting the PPCI policy to emphasise discussion with LHCH for all patients identified as STEMI at a peripheral hospital and re-emphasising the consideration of thrombolysis as an alternative to delayed transfer.

Through this Quality Account, and on-going quality assurance processes, the Trust clearly demonstrates their commitment and ambition to improve the quality of care and safety of services delivered. The Trust has made significant inroads with Clinical Harm Reviews/Long Waiters including reporting themes and trends and identifying harm on a quarterly basis.

Throughout 2021-22 there has been continued achievement in excellence reflected in the following work streams which are of particular note, for which we commend the Trust:

- LHCH was rated as one of the best hospitals in the country and the best in the North West according to the NHS Inpatient Survey, published in October 2021.
- LHCH was rated the top Trust in the country for 'care is our organisation's top priority' and 'staff engagement' in the NHS Staff Survey 2021, published in March 2021.

- LHCH successfully achieved the HIMSS Analytics Electronic Medical Record Adoption Model (EMRAM) Stage 6 rating in December 2021.
- LHCH became the first heart centre in the UK and EU to acquire the world's first and only fully autonomous artificial intelligence (AI) driven robotic transcranial doppler (TCD) ultrasound system for use in open aortic arch surgery, in December 2021.
- LHCH won the NHS England-sponsored Commitment to Carers category of the RCN Nursing Awards 2021, for establishing a support group for colleagues who are unpaid carers outside work.
- LHCH played a pivotal role as part of the collaborative Cheshire and Merseyside Covid-19 vaccination programme, helping to deliver more than 51,000 vaccinations.
- All minimum standards of care met or exceeded as defined by the Department of Health.

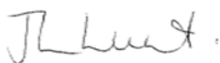
The CCGs acknowledge the Trust's work with commissioners and the continued involvement of patients and carers in developing options for the future, based on strong clinical evidence, quality assurance and the most rigorous standards of quality. This is particularly evident in the thorough review and associated workplan from the recommendations of the Ockenden Report.

As we move into 2022-23, we welcome the Trust being a key partner to help optimise the further opportunities that the Integrated Care System (ICS) and Provider Collaboratives will bring. We commend the Trust on its commitment to working with the CCGs in a collaborative and transparent manner in 2021/22, and we look forward to continuing to work in collaboration and partnership over the coming year as we transition to the Integrated Care Board (ICB).

NHS Liverpool CCG

Jane Lunt

Director of Quality, Outcomes & Improvement (Chief Nurse)



Signed on behalf of the Chief Nurses for NHS Liverpool, South Sefton, Southport & Formby and Knowsley Halton and Warrington and St Helens CCG's CCGs

---

Healthwatch Liverpool Comment LHCH Quality Account

Healthwatch Liverpool welcomes the opportunity to comment on this 2021-2022 Quality Account for the Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH).

We base our commentary on feedback and enquiries that we receive throughout the year, as well as our annual Listening Events that we carry out at each Trust. Healthwatch Liverpool have not carried out a Listening Event at LHCH since 2019, due to various restrictions and measures taken in healthcare settings to reduce the spread of Covid-19. When we visited the Liverpool Heart and Chest Hospital in June 2019, we spoke to 63 patients and visitors. People we spoke to rated the hospital highly at 4.85 out of 5 stars, and we received many positive comments about the staff and the care provided. We have since resumed engagement within Trusts and therefore are looking forward to being able to visit LHCH again to gather feedback and speak with their patients.

The 2021-2022 Quality Account this year, again, highlights many of LHCH's successes despite it being a tough year for many staff working in the NHS. It is especially reassuring to see the Trust has maintained its rating as one of the best hospitals in the country and the best in the Northwest according to the NHS Inpatient Survey 2021. In addition, we are reassured to see that the Trust is also highly rated according to the NHS Staff Survey 2021, in the category 'care is our organisation's top priority'.

LHCH have made good progress this year on their priorities in many areas. Healthwatch Liverpool particularly welcome the appointment of a mental health liaison nurse to improve outcomes for patients who may experience delirium. Although this was carried over from the previous year, the Trust's priority around delirium training to screen all patients for delirium within 8 hours of admission is welcomed as an important development to ensure patient safety and experience.

Despite many Trusts struggling with returning to normal wait times for elective care, LHCH has focused on restoring safe levels of elective activity over the past year and has managed to minimise growth in waiting lists and times to the lowest it could be. As a national issue that will continue long after the pandemic, Healthwatch Liverpool hope that LHCH will continue to develop elective recovery plans into the next year to increase capacity and reduce wait times further.

The Trust has improved and progressed on many, but not all, of its priorities from previous years. It is encouraging to hear that specific training opportunities are being offered for staff, however, the staff survey highlighted areas where staff would like more training to aid confidence. It is good to see a slight improvement regarding incidents involving injectable medications from 67 to 54. However, the Trust has acknowledged it still needs to improve in relation to ensuring the right drug and amounts are being prescribed to patients, particularly in relation to insulin. Still, the Trust's improvements around outpatient satisfaction with medicines information are reassuring, with patients welcoming the new courier service, along with the Trust aiming to ensure that patients receive adequate information on the potential side effects of their medication and advising where patients can seek more help/ information if needed.

The Trust has consistently proven their commitment to support their staff as well as patients. Healthwatch Liverpool would congratulate LHCH on winning the NHS England-sponsored Commitment to Carers category of the RCN Nursing Awards 2021, for establishing a support group for colleagues who are unpaid carers outside work. This, along with the adherence to their Freedom To Speak Up policy (FTSU), shows a good commitment to creating a culture of speaking up and supporting staff with their concerns. It is reassuring to hear that the Trust also receives high levels of advocacy from their own staff. The FTSU policy is essential not only for staff, but also has a knock-on effect on patient care and experience and contributes to future learning from errors. Therefore, we welcome the fact that it is explicitly referred to in the Trust's values.

The Trust has shown its efforts this year regarding patients with information and emphasising effective communication pre and post care. We are pleased to see that the Trust is regularly carrying out post discharge phone calls to patients within 10 days of discharge to home and ensuring that any patients with accessibility needs are catered to effectively when receiving these calls. We attend regular Equality, Diversity, Inclusion & Belonging (EDIB) Steering Group Meetings and the Trust has shown an excellent commitment to these values and we hope to see this continued into the future.

Due to the pandemic, we could not visit Trust sites and meet patients and visitors face to face to capture their feedback. We are hoping to carry out a face to face listening event during 2022-23, and look forward to working with the Liverpool Heart and Chest Hospital, helping to ensure that patients' voices continue to be central in celebrating good practice, and in feeding back if and where improvements could be made.

Board of Directors (in Public)

Item 2.1

Subject: IPC BAF
Date of Meeting: Tuesday 26th July 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	Assurance regarding Infection prevention control measures and 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 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 were no 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.

There have been various revisions and updates with 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 was first presented at the Board of Directors in January 2022.

The fourth peak of the coronavirus pandemic began to surge in November 2021 due to the Omicron variants. The infection levels are now low with a continued fall in hospitalisation, no pressure on critical care and law mortality. The government has relaxed all restrictions for the general population and there is a slight increase in hospitalisation but little impact on critical care.

A further wave of covid infections has grown through the spring due to a new variant of Omicron B (4,5). There has been a steady increase in hospitalisations, out breaks and in staff sickness. There is little pressure on critical care and deaths remain low. The majority of cases in hospital

The vaccination program has offered vaccines to cohorts down to the age of 5 -11 and the booster program has been delivered at pace. The over 75s and vulnerable subgroups have also been offered a spring booster. The focus of hospitals has been to maintain as much normal activity while managing any increase in Covid admissions. The government issued living with Covid guidance and visiting was re-introduced to LHCH with a step wise plan. This a had to be restricted again as community numbers are so high but has now relaxed.

Mask wearing was relaxed in non-clinical areas but has now been reinstated due to the increase in infections in staff. Mask wearing continued in all clinical areas.

The meticulous processes in place to keep patients and staff safe and prevent cross infection continue. There have been no further outbreaks. The numbers of cases are now low and almost exclusively detected by pre-admission or on admission positive tests in asymptomatic patients.

All IPC precautions continue for all staff. Staff are mandated to test regularly every week. Staff testing is now by LFT twice weekly. All staff, clinical front facing, and back office must adhere to this regime. Mandatory staff vaccination is no longer a condition of deployment

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.

The latest version, V1.8, is attached with the version 1.8 updates highlighted. The actions are now all complete apart from full support from microbiology.

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.

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: ○ 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 ○ to enable appropriate segregation of cases depending on the pathogen. ○ plan for and manage increasing case numbers where they occur. ○ 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. • 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: ○ 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. ○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ○ communicated to staff. • 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.	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 Clinical areas risk assessment reviewed by IPT based on hierarchy of controls. Communicated via Command structure Non – clinical areas have been assessed previously	Policy ratified at Emergency Planning 09/03/2022	Non -clinical areas to be reassessed in accordance with hierarchy of controls submitted to H&S committee **Complete**

• 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.	Implementation group in place including IPNs, Hygiene services and Matrons		
• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	Areas/rooms have been assessed by Cleaning group		
• cleaning standards and frequencies are monitored in clinical and non- clinical areas with actions in place to resolve issues in maintaining a clean environment.	Cleaning schedules in place		
• increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	Included in cleaning schedules		
• 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.	1000ppm chlorine disinfectant product (actichlor) used for terminal and deep clean and high risk respiratory virus areas Disinfectant wipes used for equipment.		
• 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.	Virusolve solution used for bathrooms.		
• 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	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		The placement of high-risk respiratory virus patients is in line with guidance. A full assessment of side rooms has been undertaken. Portable ventilation units are in place in appropriate areas **Complete**

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:
  ○ to reduce inappropriate prescribing.
  ○ 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 to 50% previous service level 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.
			A new microbiologist has been appointed with a September start date.

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.	Visiting re-introduced February 2022 and initially limited to one visitor for one hour daily. Plan to increase visiting in a stepwise manner in place. Visiting advice available on intranet. Information boards and posters in all areas across the trust		

• 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)](C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf)	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 responsibilit ies 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 screening team and IP team available for advice and queries, including bank and locum 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	Protocol and risk assessments in place		
• 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.	Education and training in place. Fit testing programme for all staff – records available		
• 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	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.		
• 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	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. • 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.	Robust staff welfare systems in place including at risk groups Risk assessments have been undertaken by departmental heads 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.		

Board of Directors (in Public)

Item 2.4*

Subject: Guardian of Safe Working Q1 Report 22/23
Date of Meeting: 26th July 2022
Prepared by: Lauren Murphy, Medical Staffing Officer
Presented by: Dr Raphael Perry, Medical Director
Purpose of Report: To Note

BAF Reference	Impact on BAF
BAF 1	Trust compliant with exception reporting.

<table>
<tr><td colspan="6">Level of assurance (please tick one)
To be used when the content of the report provides evidence of assurance</td></tr>
<tr><td>✓</td><td>Acceptable assurance
Controls are suitably designed, with evidence of them being consistently applied and effective in practice</td><td>☐</td><td>Partial assurance
Controls are still maturing – evidence shows that further action is required to improve their effectiveness</td><td>☐</td><td>Low assurance
Evidence indicates poor effectiveness of controls</td></tr>
</table>

1. Executive Summary

This is the 22/23 Q1 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):	58
Number of Doctors / Dentists in training on 2016 TCS (total):	58
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. Main Body of Report.

a) Exception Reports (regarding working hours)

There have been no exception reports in Q1. Only one exception has been received since August 2016.

b) Issues Arising

- Current gaps in Tier One rota for both Surgery and Cardiology are causing problems with on call cover.
- Lead Employer are sending the information for the rotating documents late or incorrect causing problems with work schedules and rotas.
- Trust Drs for surgery leaving the trust leaving empty slots.

c) 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.
- Successfully recruited 2 new Trust Drs who are going through recruitment checks.

4. Junior Doctor Forum

The last forum was on 23rd December 2021. Currently in the process of organising another forum with Dr Holemans.

5. GSW Annual meeting

Dr Holemans attended the 2021 GSW Annual conference organised by NHS employers on 9th December.

6. Recommendations

The Board of Directors are asked to note the report.

Board of Directors
Item 2.3

Subject:	**Safeguarding Annual Report 2021/2022**
Date of Meeting:	**Tuesday 26th July 2022**
Prepared by:	**Joanne Shaw Safeguarding Lead**
	Angela McKenna Operational Lead, Safeguarding
Presented by:	**Sue Pemberton, Director of Nursing, Safety and Quality**

BAF Reference	**Impact on BAF**
BAF 1	To provide assurance regarding the Trust's safeguarding arrangements.

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

Liverpool Heart and Chest Hospital (LHCH) has a statutory responsibility for ensuring that the services provided have safe and effective systems in place which safeguard adults, children, and young people at risk of abuse, neglect and harm. We follow the six safeguarding principles, which are: Empowerment; Protection; Proportionality; Prevention; Partnership; and Accountability.

The 2021-22 annual report provides the Trust Board with:

- An overview of the local, regional and national context of safeguarding
- An overview of safeguarding practice within the Trust
- The Safeguarding and Mental Health Teams activity, achievements and progress during 2021-22 to develop a culture that puts safeguarding at the centre of all care delivery
- Assurance that the Trust is meeting its statutory obligations and the required national standards regarding safeguarding and mental health

- 2021-2022 challenges, current priorities and work plans for the safeguarding and mental health teams to demonstrate continuous improvement, on the arrangements currently in place

2. Background

Safeguarding children, young people and adults cannot be done in isolation; it is only truly effective when we work collaboratively and restoratively with our partner agencies to protect all those at risk of harm, abuse or neglect.

This collaborative approach is embedded across the Trust in safeguarding practice that balances the rights and choices of an individual, with the Trust duties to act in their best interest to protect the patient, the public and the organisation from harm in line with:

- Liverpool Safeguarding Adult Board (LSAB),
- Liverpool Safeguarding Children reporting
- National/Legal requirements e.g., Care Act 2014, Children Act 1989/2004

LHCH has a duty to ensure robust systems are in place to appropriately safeguard those who require it. This includes adults, children and young adults who may be at risk from abuse.

3. National and Local Context

Self-Neglect & hoarding

Throughout 2021-2022 there has been a small increase in referrals for self-neglect and hoarding. The safeguarding team work closely with our social worker colleagues using a multi-disciplinary approach utilising the Merseyside Safeguarding Adults Board Self-neglect toolkit (April 2019) to underpin the assessments undertaken, for those patients referred. The Trust works closely with Merseyside council services, to ensure patients receive the best support available.

Managing Disclosures/Concerns and Information Sharing

The safeguarding team are confident we have the right processes in place to manage disclosures and safeguarding concerns sensitively and effectively in the trust. This forms part of all training delivered within the Trust with emphasis on sharing as a 'need to know' basis and confidentiality. Staff are encouraged to use their professional curiosity and escalate any concerns. The team respond to external requests for information into the Trust, with the safeguarding administrator monitoring any request, ensuring a response is given within the requested timeframes via our secure account.

Responding to the need of Looked after Children (LAC) and Children in Care (CIC)

There have been minimal children safeguarding escalations during the past year. The safeguarding team has a clear framework of external escalation and referral. The Early Help Assessment is the agreed framework that supports partnerships/joint working and multi-agency interventions which are recorded on the Early Help Assessment Tool documentation (EHAT) (July 2016). This ensures the appropriate level of support is put in place at the point of referral.

The Trust has led one child death overview case, a young male age 14 who was in care and sadly died here at LHCH, following transfer directly to theatre as a critically ill child. The review into this case was supported by the Liverpool Clinical Commissioning Group (LCCG) colleagues covering three local authorities. The Trust was highly commended for its work on the case.

Due to the changes within the Safeguarding Intercollegic document – "Looked after Children": roles and competencies for healthcare staff required changes to our e-learning packages. Due to the Trust using skills for health e-learning packages for level 1 & 2 children's safeguarding training we are unable to edit and update these packages at Trust level currently. There has been ongoing communications with skills for health who are reviewing all their e-learning packages and the Trust is expecting an update in quarter 2.

Domestic Violence/Abuse

The Safeguarding team continues to strengthen its approach to supporting staff and patients that are affected by domestic abuse. The aim is to encourage all staff and managers seeking support for their health and wellbeing in domestic violence situations. These referrals are very low in number for LHCH for 2021-2022. The safeguarding team continue to signpost staff to services and support.

Harmful Practices

Within the Trust harmful practice education is delivered at Level 3 Safeguarding ambassador training, face to face sessions for Preceptorship, and Care Certificate training to increase staff awareness, of this subject. There will be a continued focus on staff understanding and responding to any concerns or disclosures.

Child Sexual Exploitation (CSE) and Child Criminal Exploitation (CCE)

The Safeguarding team continue to raise awareness and prevention strategies of CSE through corporate communications and the Safeguarding Steering group. CSE awareness training is delivered for level 2 and level 3 training programs

Mental Capacity Act

The Mental Capacity Act (MCA) is designed to protect and empower people who may lack mental capacity to make their own decisions about their care or treatment. This act applies to people aged 16 and over. Examples of people who may lack capacity include those with: dementia, a severe learning disability, a brain injury, a mental health illness, a stroke or unconsciousness caused by an anaesthetic or sudden accident.

The Safeguarding team have put increased emphasis in empowering and educating staff to complete mental capacity assessments for inpatient and outpatient settings. Staff feel confident to undertake these assessments and they are embedded in most areas with some new staff still requiring some education and support. The safeguarding team facilitate these meetings by using a multi-disciplinary approach, which includes patients' family members and next of kin.

Deprivation of Liberty Safeguards (DoLs) Liberty Protection Safeguards (LPS)

The Liberty Protection Safeguards (LPS) will replace the Deprivation of Liberty Safeguards (DoLS). Implementation is expected from October 2023-April 2024. This was announced in a Mental Capacity (Amendment) Bill which passed into law in May 2019. There will be many changes to the process that will have an impact on resources for the responsible bodies i.e. hospitals and care homes. A Consultation exercise has been undertaken regarding the LPS draft Code of Practice and completed 7th July 2022. The Safeguarding team will work alongside the senior nursing team to ensure any changes to policy and practice are identified following release of the consultation outcomes.

Clinical Health Psychology

The psychology service support both our inpatient and outpatients. The team focus is on planning and delivering interventions for individuals and groups of staff and patients. The aim is to support positive change and improved coping, in relation to physical health problems or illness. The psychology team work collaboratively with the safeguarding and mental health liaison team.

Mental Health Liaison Service

Both the safeguarding and mental health liaison team work very closely with the clinical lead for delirium. The mental health liaison team are developing their workplan for the next 18 months which incorporates assessment, referral to mental health services and education for all staff. The aim of the team is assessment at the earliest opportunity (pre procedure) to follow up clinics.

Safeguarding Team Structure

The Safeguarding Team is fully established, comprising of:

- Named Doctor for Safeguarding Adults and Children - Dr Petra Jenkins
- Head of Nursing, Quality and Safeguarding Adults and Children - Joanne Shaw
- Operational Nurse Lead for Safeguarding Adults and Children – Angela McKenna
- Safeguarding Administrator – Kimberley Baker.

Governance Structure

The Head of Nursing, Quality and Safeguarding represents the Trust at local Safeguarding Adult and Children's health subgroups for Liverpool and Knowsley, and the policies and procedures working group.

The Safeguarding Steering Group meets bi–monthly and is chaired by the Trust's Operational lead nurse. The Safeguarding Annual Key Performance Indicators (KPI's) for 2021/2022 were developed by the Liverpool Clinical Commissioning Group, to identify the key priorities and actions for the safeguarding team. The progress of the work plan is reviewed at quarterly meetings. The key priorities are on target for delivering against the KPI objectives for the year, except for the Children in care additions required by skills for health in level 1 and 2 e-learning modules, which commissioners are aware of.

Safeguarding – Policies

All 17 Safeguarding policies have been updated and ratified via the Safeguarding Steering group during 2021-2022. These include-

- Deprivation of liberty safeguards policy was updated in 2021 to include an update to the DoLs code of practice.
- Domestic Abuse policy was updated in 2021. There were many updates to this policy which reflect current practice and guidance post covid.
- Ligature and Suicide Risk: Risk Assessment and Management guidelines was updated in 2021 to include more factual evidence-based practice.
- Safeguarding Adults policy was updated with minor changes to reflect current practice and strengthen our approach to protecting adults at risk of harm abuse or neglect.

Safeguarding Audit Plan

To ensure best practice in its Safeguarding processes, LCCG require submission of a Safeguarding audit plan (Table 1) to enable achievement of quarterly KPI's. The team have begun the yearly audit plan, with the support of the audit team and have submitted Q3 & Q4 audits for 2021/2022. The audit paper and results are presented at Safeguarding Steering group and action plans are agreed. Progress is monitored through this group until all actions are complete.

Table 1

Safeguarding Audit Annual Plan 2021/2022

Audit Topic	Trust Lead (s)	Internal or External Audit	Division /Trust Wide	Reporting to Assurance Committee / Providing data for	Timescale			
					Q1	Q2	Q3	Q4
Admission for Children/Young Adults Requiring Treatment	Operational lead For safeguarding and Safeguarding Administrator	Internal	Trust Wide	Safeguarding Steering Group				√
Quality checks of Mental Capacity assessment documentation.	Operational lead For safeguarding and Safeguarding Administrator	Internal	Trust Wide	Safeguarding Steering Group		√		
Quality checks of Deprivation of Liberties documentation.	Operational lead For safeguarding and Safeguarding Administrator	Internal	Trust Wide	Safeguarding Steering Group	√			
Compliance with use of hand control mittens policy/procedure	Operational lead For safeguarding and Safeguarding Administrator	Internal	Trust Wide	Safeguarding Steering Group				√
Mental Capacity Assessments and Consent	Operational lead For safeguarding and Safeguarding Administrator	Internal	Trust Wide	Safeguarding Steering Group	√			
Review the quality of Safeguarding referrals in EPR	Operational lead For safeguarding and Safeguarding Administrator	Internal	Trust Wide	Safeguarding Steering Group			√	
Compliance with Deprivation of Liberty Safeguarding Legislation	Operational lead For safeguarding and Safeguarding Administrator	Internal	Trust Wide	Safeguarding Steering Group		√		

4. Training and Education

Training figures for 2021/2022

During the reporting period LHCH worked towards achieving compliance for all levels of Safeguarding Children's and Adults training. We have a Safeguarding Training needs analysis (TNA) which is submitted as part of LHCH LCCG KPI's.

Each Division is responsible for monitoring and maintaining training compliance for their staff groups. Training compliance is readily accessible for individual staff and managers to view by the electronic reporting system. LHCH compliance for April 2021- March 2022 is outlined in table 2.

Table 2

			Percentage YTD
STA_1	Level 1 Adult Safeguarding Training for all staff (Intercollegiate document Adult Safeguarding: Roles and Competencies for Health Care Staff 2018)	Percentage of staff who have had training within the past year in line with Trust TNA	96.2%
STA_2	Level 2 Adult Safeguarding Training - eligible cohort of staff (Intercollegiate document Adult Safeguarding: Roles and Competencies for Health Care Staff 2018)	Percentage of staff requiring training who have completed training within the past year in line with Trust TNA	95.6%
STA_3	Level 3 Adult Safeguarding Training - eligible cohort of staff (Intercollegiate document Adult Safeguarding: Roles and Competencies for Health Care Staff 2018)	Percentage of staff requiring training who have completed training within the past year in line with Trust TNA	100%
STA_4	Level 4 Adult Safeguarding Training - for all relevant staff (Intercollegiate document Adult Safeguarding: Roles and Competencies for Health Care Staff 2018)	Percentage of overall identified cohort of staff who have had training within the past year.	100%
SCT_1	Level 1 Children Training for all staff (Intercollegiate document Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019) (Intercollegiate document Looked after Children: roles and competencies of healthcare staff 2020)	Percentage of staff who have had training within the past year in line with Trust TNA	95.8%

STC_2	Level 2 Children Training for all relevant staff (Intercollegiate document Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019) (Intercollegiate document Looked after Children: roles and competencies of healthcare staff 2020)	Percentage of staff requiring training who have completed the training within the past year in line with Trust TNA	94.4%
STC_3	Level 3 children Training for all relevant staff (Intercollegiate document Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019)	Percentage of staff requiring training who have completed the training within the last year in line with Trust TNA	100%
STC_4	Level 4 Children Training for all relevant staff (Intercollegiate document Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019)	Percentage of Staff requiring training who have completed the training within the last year in line with Trust TNA	100%

Prevent training

NHS organisations are required to provide awareness raising sessions for staff about PREVENT which aims to stop terrorism or support terrorist acts from people who have been radicalised. It is recognised that vulnerable individuals may be targeted for recruitment into violent extremism, and this is therefore a safeguarding issue in the context of the wider responsibility of all agencies to safeguard and promote welfare.

The training target set by NHS England re: Workshop to Raise Awareness of Prevent (WRAP) is 85% which is a national target for WRAP (level 3) training. LCCG have set a target of 90%.

The Trust remains compliant with delivery of this training.

STS_1	Prevent Strategy/Awareness Training	Percentage of overall Staff who have received Prevent Awareness training in the last year	94.9%
STS_2	Prevent Strategy/Health Wrap Training	Percentage of overall identified cohort of staff who have received Prevent Wrap training in the last year	95.2%

To ensure maximum coverage with face to face training, sessions are continuing for the foreseeable future. Communications continue to raise awareness of the requirement for eligible staff to complete the training.

Monitoring & Analysis of Safeguarding Data

During 1st April 2021 - 31st March 2022 there were a total of 760 safeguarding contacts made to the team via EPR. The most common referrals are for mental health, confusion/delirium and mental capacity assessments.

Priorities for 2022/23

The priority for the Trust is to create a culture of continuous improvement in Safeguarding, with empowerment of staff, that is both patient and family centred and safety focused. The safeguarding team will continue to:

- Listen to patients, their families, and staff using a 'Making Safeguarding Personal' approach which ensures all people have a voice and we represent their wishes and beliefs in their best interests.
- Work with our stakeholders, working collaboratively with LHCH teams and external providers to provide timely effective interventions to adults and children, who may be at risk of harm, abuse, or neglect.
- Develop our strategy for the introduction of LPS
- Focus on safety, prevention and education– and how we deliver Safeguarding care within our teams.

5. Conclusion

Whilst Safeguarding, Prevent, Mental Capacity and Mental Health agendas continue to be a challenging area for all health agencies and multi-agency partners, the Trust continues to actively respond and contribute to regional and national developments. This annual report demonstrates that safeguarding vulnerable people remains a significant priority for the Trust and offers assurance that the annual work programme has been delivered. The Trust continues to meet its statutory duties as well as proactively developing safeguarding provision and implementing learning from adverse events, into frontline practice.

6. Recommendations

The Board of Directors is to receive assurance that appropriate safeguards are in place to protect adults and children in LHCH in line with national and local directives, and legislation related to safeguarding adults and children at risk.

Associated Reading Materials

- Clinical Governance and Adult Safeguarding - An Integrated Process (2010) Department of Health http://www.gov.uk
- Deprivation of Liberty Safeguards (2009) http://www.gov.uk
- Essential Standards of Quality and Safety (2015) Care Quality Commission http://www.cqc
- Looked after Children: roles and competencies of healthcare staff, Intercollegiate Document (Dec 2020)
- Mental Capacity Act (2005) http://www.legislation.gov.uk/uk
- Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2013/14 (2015) Care Quality Commission http://www.cqc
- NHS London UK Core Skills Training Framework (2013) Subject 9 Safeguarding Adults http://www.skillsforhealth.org.uk/developing-your-organisations-talent/uk-wide-core-skills-training--framework/
- "No Secrets" (2000) Guidance Department of Health and Home Office
- Safeguarding Vulnerable Groups Act (2006) www.legislation.gov.uk/ukpga/2006
- Responding to Need Guidance and Levels of Need Framework, Early help Assessment Tool, Liverpool Safeguarding Children's Board (July 2016)
- The Care Act (2014) http://www.dh.gov.uk
- The Ombudsman Report, Six Lives" (2009) http://www.dh.gov.uk
- The National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010) National Patient Safety Agency http://www.npsa.nhs.uk
- The Short Guide to Working with People in Circumstances of Complex Self-Neglect - Self-Neglect Toolkit – Merseyside Safeguarding Adults Board (April 2019)
- The Safeguarding Adults: A National Framework of Standards for Good Practice and Outcomes in Adult Protection Work (2005). The Association of Directors of Adult Social Services http://www.adass.org.uk
- Domestic Violence and abuse: how health services, social care and the organisations they work with can respond effectively" NICE PH 50 (February 2014)
- "Safeguarding Children and Young People Roles and Competencies for Health Care Staff" Intercollegiate Document 3rd Edition (March 2014)

Board of Directors (in Public)

Item 2.4*

Subject: Guardian of Safe Working Q1 Report 22/23
Date of Meeting: 26th July 2022
Prepared by: Lauren Murphy, Medical Staffing Officer
Presented by: Dr Raphael Perry, Medical Director
Purpose of Report: To Note

BAF Reference	Impact on BAF
BAF 1	Trust compliant with exception 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 22/23 Q1 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):	58
Number of Doctors / Dentists in training on 2016 TCS (total):	58
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. Main Body of Report.

a) Exception Reports (regarding working hours)

There have been no exception reports in Q1. Only one exception has been received since August 2016.

b) Issues Arising

- Current gaps in Tier One rota for both Surgery and Cardiology are causing problems with on call cover.
- Lead Employer are sending the information for the rotating documents late or incorrect causing problems with work schedules and rotas.
- Trust Drs for surgery leaving the trust leaving empty slots.

c) 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.
- Successfully recruited 2 new Trust Drs who are going through recruitment checks.

4. Junior Doctor Forum

The last forum was on 23rd December 2021. Currently in the process of organising another forum with Dr Holemans.

5. GSW Annual meeting

Dr Holemans attended the 2021 GSW 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 2.5*

Subject: **Deprivation of Liberty Safeguards (DoLS) Update for Q1 22/23**
Date of Meeting: **Tuesday 26th July 2022**
Prepared by: **Terri Marshall, Risk Management Coordinator**
Kimberley Baker, Corporate Services PA
Presented by: **Sue Pemberton, Director of Nursing and Quality**
Purpose of Report: **For Note**

BAF Reference	Impact on BAF
BAF 1	Assurance regarding DoLs compliance

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

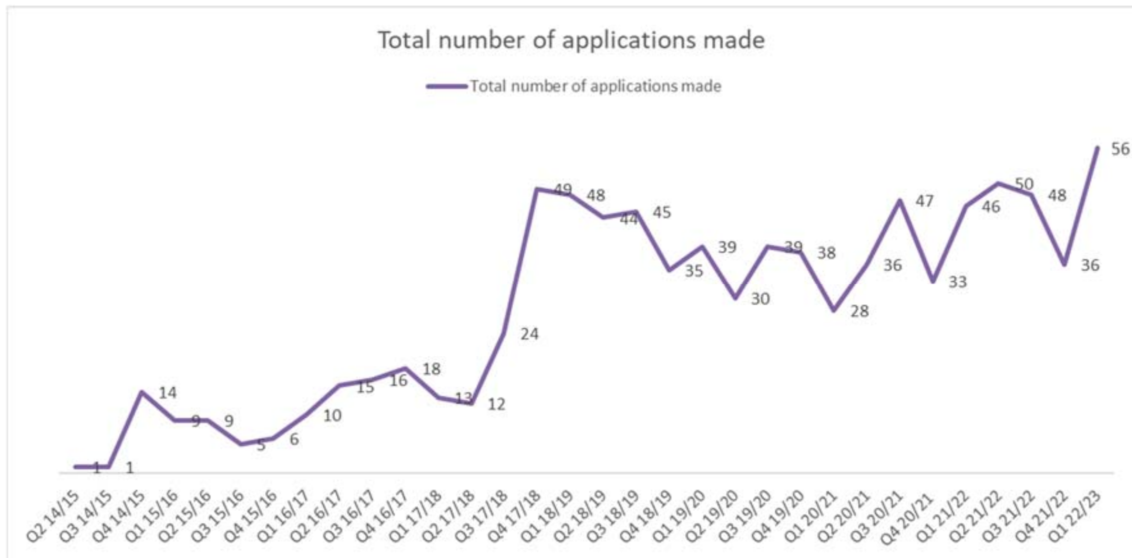
1. Executive Summary

The purpose of this paper is to update the Board of Directors on the number of applications made for quarter 1 – 2022/23 in relation to the Deprivation of Liberty Safeguards (DoLS). For Q1 a total of 56 Deprivation of Liberty Applications have been received by the Safeguarding Team for 13 different local authorities across the catchment area. This is a 36% increase in applications received since the previous quarter. The report confirms the completion of DoLs assessments.

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



<u>MCA Assessments and DoLS Applications – Q1 (2022/23)</u>

For Q1 a total of 56 Deprivation of Liberty Applications have been received.

Of the total 56 applications received by the team, all were standard and urgent applications.

- 6 urgent applications were issued, and the standards were not required as the patients were discharged/transferred within the 14-day urgent period or the patient's confusion had settled.
- In 2 cases no decision was received from the local authority however the patient was treated under best interest principles.
- 1 case remains ongoing as the patient remains an inpatient.
- In 47 cases, the applications were reviewed, and the patients were assessed by the safeguarding team, but the applications were not sent. In general this is due to the increase in delirium patients which once notified on the CAM tool automatically prompts the completion of a DoLs application. In many instances, the patient's confusion settles, and/or the patient meets the criteria for a critical care patient and were to be managed under the best interests principle and would not require the DoLs to be submitted. This will always be reviewed again once the patient is ready to be transferred to the ward or the patient was transferred or discharged.

MCA and DoLS Mandatory training is currently at 95.2% 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 2.6*

Subject: **Director of Infection Prevention and Control (DIPC) Quarterly Report Q1 22/23**
Date of Meeting: **Tuesday 26th July 2022**
Prepared by: **Nicola Best, Infection Prevention Nurse Specialist**
Presented by: **Dr Raphael Perry, Medical Director/DIPC**
Reason for Report: **To Note**

BAF Ref	Impact on BAF
BAF 1	Assurance regarding infection prevention control measures to prevent patient harm.

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

This paper provides an update on infection prevention and control issues for the 1st quarter of this financial year, 1st April until 30th June 2022. Previous reports have covered the period up to the end of March 2022.

This paper provides assurances that surveillance systems, audit and governance 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 process 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 UKHSA (UK Health and Security Agency) on a monthly basis. In addition, the infection prevention team continuously monitor other resistant organisms or organisms of concern.

Mandatory Reporting – Bacteraemias (Blood cultures)

	Attributable cases April – June 22 **(Year to Date-Trust attributable)**	Threshold 22/23
MRSA bacteraemias	0 **(0)**	0
MSSA bacteraemias	1 **(1)**	8
E coli	0 **(0)**	6
Klebsiella sp.	0 **(0)**	1
Pseudomonas aeruginosa	2 **(2)**	1

Post infection reviews have been undertaken for all these patients, in conjunction with Critical Care, the ward staff and theatres, to identify the probable source of the infection and also any learning and actions required. These reviews will be discussed at the relevant divisional governance meetings (see below for summary).

Additional actions have also been taken because of the Pseudomonas bacteraemias on Critical Care:

(1) Additional sampling and testing of the water on Critical Care has been undertaken although no increase in bacterial load was found.

(2) Patient cleansing products were reviewed due to an alert issued because of contamination of products (during manufacture or production) by Pseudomonas aeruginosa, no issues were identified at LHCH.

Summary of patient reviews following reportable bacteraemia				
Month	**Bacteraemia**	**Area**	**Summary**	**Learning Points**
April	Pseudomonas aeruginosa	CCA	Emergency admission as ACS transfer. CABG x3. Post -operative complications and prolonged stay on Critical care. Probable source was Ventilator associated pneumonia	None identified
May	Staphylococcus aureus	Cedar	Elective admission for repair of aortic dissection, repair of hernia and oophorectomy. Complex surgery performed in	Issues with documentation related to wounds noted. Issues related to supply of consumables/equipment required by visiting surgeons

			conjunction with visiting surgeons. Unable to close surgical incisional site on the day of surgery. Source of bacteraemia was surgical site infection.	is currently being reviewed by Theatres. Some doses of antibiotics apparently missed. Actions have been noted in the patient review
June	Pseudomonas aeruginosa	CCA	Emergency admission for PPCI. Emergency CABG and insertion of IABP for cardiovascular support. No definitive source identified but possibly associated with IABP	Issues with documentation and care of IABP noted, to be addressed in action plan in the patient review.

CPE (Carbapenemase producing Enterobacteriaceae) cases

There were 3 new patients with CPE within this time period. 2 were not attributable to the Trust, 1 was attributable. They were all screening samples (rectal swabs). There was an overlap of 2 days between 2 of the patients on the same unit but they had been nursed in separate isolation rooms. Audits have not identified any specific issues

All MRSA cases (non-bloodstream)

A number of patients were identified as MRSA positive in this time period. 1 appeared to be Trust acquired. This was a patient who was transferred from another Trust for (failed) management of pneumothorax and had had repeat chest drains inserted. The patient was not known to be MRSA positive however the admission swabs were discarded by the lab as there was insufficient data on the request form. The positive isolate was obtained after the patient underwent surgery for exploration and debridement and an early empyema was identified. Correct procedure for screening patients has been fedback to the wards.

C. difficile Infection

	Attributable cases April -June 22 **(Year to Date)**		Threshold for 22/23
Clostridium difficile infection (C. difficile **toxin** positive)	0 **(0)**		9

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. Ongoing surveillance and reporting to the national system is performed by the Infection Prevention nurses.

COVID 19 Patients April- June 22	Numbers of Patients
Community-Onset – First positive specimen date <=2 days after admission to trust.	68
Hospital-Onset Indeterminate Healthcare-Associated – First positive specimen date 3-7 days after admission to trust.	5
Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission to trust.	3

Hospital-Onset Definite Healthcare-Associated – First positive specimen date 15 or more days after admission to trust.	4

There were no outbreaks identified.

All actions related to the prevention and control of SARSCoV2 are regularly discussed in the Gold, Silver and Bronze command meetings and are reviewed in line with UKHSA and NHS guidelines, as they are released.

3.2 Audits

An annual audit programme has been developed and audits have been performed by the Infection prevention team within this quarter including:

- COVID- 19 swabbing compliance
- Critical Care screening compliance
- CPE screening compliance
- Compliance with MRSA policy and pathways
- PPE compliance

Audits have been performed by ward and Critical care staff assessing compliance with hand hygiene, Intravenous line care and care of urinary catheters.

Results and action plans have been feedback 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.

A Cleaning Group has been convened to oversee the audit programme and action plans, this is led by the Infection Prevention lead nurse and the Facilities manager.

Audits of all inpatient areas have been completed, some issues were identified (e.g., dust on equipment) which could be rectified immediately, other issues require additional input and have been highlighted to the Estates team and placed on an action log to be reviewed by the group on an ongoing basis.

3.4 Surgical Site Infection (SSI) Group

The SSI group has been re-established with multi-disciplinary membership. A report on SSI, including an annual audit plan has been compiled and submitted to the group and the Infection prevention committee. A software module to improve surveillance data collection has been developed and commenced on the 6th July.

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 of Directors is asked to note the contents of this report and request further updates on progress against the annual plan

Board of Directors (in Public)
Item 3.1

Subject: 2022/23 Strategic Objectives
Date of meeting: Tuesday 26th July 2022
Prepared by: Executive Directors
Presented by: Jonathan Develing, Director of Strategic Partnerships
Purpose of Report: To note

BAF Ref	Impact on BAF
ALL	Update of progress against the Strategic Objectives as at Q1 2022/23

1. Executive Summary

This paper provides an update on the progress against the strategic objectives as at Q1 2022/23.

2. Strategic Goals (High Level Ambitions)

The Trust Five Year Strategy, Patients, Partnership and Populations contains the following strategic goals:

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

3. Strategic Objectives

Each strategic goal has several objectives with an identified lead Director responsible for delivery as part of their personal objectives. Thus, providing a golden thread from the Trusts strategy into organisational and personal objectives.

Organisational objectives are reviewed on an annual basis by correlating key information and influences for example the Publication of the White paper, NHS Planning guidance, Development of Provider Collaboratives, etc.

Directors discuss and review objectives which are then considered within the appraisal process and personal objectives and leadership responsibilities agreed.

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

4. Strategic Objective Review

This review of strategic objectives for 2022/23 is being finalised with Directors in time for the Q2 report. In the interim Q1 appendices describe progress against existing objectives.

5. Recommendation

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

Appendix One

	A	B	WHO	2021/22		2022/23
World Class Care	Director Objective	Specific Deliverable Actions		Q3	Q4	Q1
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.	Good progress continues in the delivery and implementation of the objectives from the quality and safety strategy - a progress report is due to be presented at the quality committee in April 2022. The first modules for safety training have now been launched from the national team and are due to commence in the Trust imminently. Be civil be kind continues to embed across the Trust and managers are utilising the framework within their respective areas. The closed loop medicines improvement project is progressing well with implementation across all wards in relation to oral medications.	A progress report was presented to the quality committee in April 2022 which gave good assurance that delievry of the strategy is progressing well. A one year report will be presneted to the Board of Directors in October 2022.
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	Research Strategy near completion. Professor Wright to feedback to MD April 2022	Research Strategy presented for engagement purposes at Ops and Clinical Leaders 24th June.
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.	The clinical strategy draft document has been completed and circulated to the divisions for feedback. The document and strategy were discussed at the Ops Board Clinical Leaders day in March 2022 in conjunction with the divisional plans for partnership working. Final comments and additions to be submitted by end of April 2022	Engagement process on the development the draft clinical strategy now closed. Further iteration being developed for Q2
WCC4	Develop world class facilities	Cath Lab Refurbishment	Karen Edge	Phase 1 complete and Phase commenced	Phase 2 in progress	Phase 2 nearing completion - Phase 3 planning in place
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.	Tactical command established in Q4 to support flow pressures. Further work to be undertaken for next steps of Flow delivery group. Action plans for GIRFT continue to be reported through Operational Board. Cardiac Board continue to support regional improvement work driven by Model Hospital Data	Action plans for GIRFT continue to be reported through Operational Board. Cardiology Collaborative with LUFT in place to support Cardiology improvements. Flow work Governance and KPIs being revisted in Q2 to support current challenges. Model Hospital Data continues to be reviewed by the Divisions supported by QI.

Advancing Quality				2021/22		2022/23
	A Director Objective	B Specific Deliverable Actions	WHO	Q3	Q4	Q1
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	New objective for 2022/23	Mapping of educational offer in conjunction with academia and in house capacity being undertaken
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	Scoping yet to be completed due to capital financial restraints. Meetings have taken place with Merseycare with regards to Broad Oak site and layout of the unit.	Series of workshops with Clinical and Operational Leads, Education Leads, Research and Innovation. HR and Finance, Estates.
AQI 3	Implementation of the digital strategy	Establish Digital Excellence Committee Further develop the digital 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 digital aspirant programme have been achieved. LHCH achieved an international digital accreditation in December 2021 with the achievement of HIMSS Level 6.	Implementation of iDigital Excellence progresses well and at pace. External milestones continue to be met and associated funding received.	Implementation of iDigital Excellence strategy progresses well and at pace. A range of projects have gone live in the previous reporting period delivering benefits to staff and patients. Operational IT performance is good and cyber expectations have been met.
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	Innovation Portal developed and added to the staff app (07.02.2022). Team identified to triage innovation ideas. NHS x remote monitoring of cardiac elective waiting list is making good progress and on target to onboard first patient in March 2022.	Innovation portal now live. Innovation workshop held with Ops Board and Clinical Leaders. Draft Plan to come back to Board in Q3

Increasing Value				2021/22		2022/23
	A Director Objective	B Specific Deliverable Actions	WHO	Q3	Q4	Q1
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	Interim financial regime precludes medium term planning. Tactical approach to manage cost base and develop CIP in place	Financial Plan for 22/23 agreed internally and externally. Emerging system financial architecture will enable strategy development Q4 2022/23
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	During 2021/22 the improvement team has continued to support quality improvement as required. In setting the priorities for 2022/23 the team have engaged stakeholders and will be aligning quality improvement work programmes to the quality and safety strategy. Recruitment is in progress including a jointly funded post to provide some dedicated support to quality improvement.	Through the work with stakeholders we have now identified the quality imporvement work programmes aligned to both the quality and safety strategy and the Divisional needs. We have successfully recruited into a number of key posts which will enable these work programmes to be delivered. We are also aligning the benchmarking intelligence and expertise to help inform the quality improvement work for 2022/23.
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.	Tactical command established in Q4 to support flow pressures. Further work to be undertaken for next steps of Flow delivery group. Action plans for GIRFT continue to be reported through Operational Board. Cardiac Board continue to support regional improvement work driven by Model Hospital Data	Action plans for GIRFT continue to be reported through Operational Board. Cardiology Collaborative with LUFT in place to support Cardiology improvements. Flow work Governance and KPIs being revisted in Q2 to support current challenges. Model Hospital Data continues to be reviewed by the Divisions supported by QI.
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	Green repository created. Green plan has been submitted 14/01/22 and green champions identified. Social Value award submitted - awaiting outcome. Monthly green champion meetings are in place. OKTA submission for Q4 complete.	Trust has been nominated by the ICS to develop a benchmark model with the Carbon Neutral Group (consultancy)

Developing People	A	B		2021/22		2022/23
	Director Objective	Specific Deliverable Actions	WHO	Q3	Q4	Q1
DP 1	Development of a recruitment and retention strategy	Development of a recruitment and retention strategy	Karen Nightingall	The framework for the recruitment and retention strategy went to People Delivery Group for discussion and feedback. The strategy overview was presented at People Committee at the beginning of Q3.	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 EDIB strategies, the recruitment strategy targets this. The delivery timeframe for this has been extended due to the significant resources required to manage VCOD.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 action plan that will deliver an inclusive recruitment process reflective of the communities we serve. The EDIB strategy will also further enhance this work so that we are making continuous improvements.	The recruitment and retention strategy was approved by the Board in June 22. This is supported by a robust action plan for 22/23
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 comprehensive action plan has been developed for 2022.	Comprehensive action plans are underway for Clinical and medical education and OD. Trackers have been developed as the action plans and proposed delivery stretches into 2022/23 year.	There is a new OD team in place which has continued to lay foundations for the OD offer, including leadership training for new, experienced and aspiring managers/leaders. A training catalogue has been launched for the function and Sir Ken Dodd knowledge hub is now fully up and running (it will need to close for 5 weeks in Q2 for pipework replacement).
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	EDIB draft strategy created, think tank was held in March 2022. Feedback received will influence final EDIB strategy to be presented at Board April 2022.	The EDIB strategy was approved by the Board in June 22. This is a new 3 year strategy and action plan. The LHCH Belong (inclusion group) which was launched in November 21 has continued to gain momentum and the team has signed up to its first Pride event in Liverpool on 30th July 22.

Leading Collaborations				2021/22		2022/23
	A Director Objective	B Specific Deliverable Actions	WHO	Q3	Q4	Q1
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	Tracker developed for collaborative projects by way of monitoring. Leading the specialised provider alliance, CVD prevention subgroup, cardiac board.	The Trust leadership is at the fore of the Cardiac Program and CVD Prevention Group. Workplans are reported to the ICS via the Transformation Board/ All programs and budget expenditure are on track for delivery
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	Active role in CMAST, LSSCOG. Commenced LUFT/LHCH single cardiology service work.	Liverpool Cardiology Group established and an inaugural meeting held in June. The One Liverpool Cardiac Group (LSSCOG) will mature to become a system wide group looking at Long Term Conditions with LHCH leadership
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	LHCH presence at newly formed CAG meeting, HF take 2 event organised, Inspira PCHF service engagement, regular updates provided via network and Cardiac board re NPI work	Case for change of the current network model accountable to NHSE has been submitted via the Federation of Specialist Providers.
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	Inspira PCHF service, LFC, PHE outreach model under development	Program of engagement with suppliers / Boston / Medtronic / Siemens / Philips / General Electric / Pfizer / AZ / BSM / Heart Research Uk / BHF

Improving Population Health

	A	B	WHO	2021/22		2022/23
	Director Objective	**Specific Deliverable Actions**		**Q3**	**Q4**	**Q1**
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	Novartis health inequality tool reviewed and feedback, AZ inequality tool reviewed , working with network to review NW Coast Cardiac dashboard, regular updates re CIPHA dashboard. Internally looking at what inequality LHCH has e.g. referrals by post code etc to inform a targeted approach to prevention and early detection.	Approach to health inequalities has been developed for Board od Directors. BOD agenda July 2022.
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	Liverpool Healthy Hearts Project - plan drafted, awaiting IG approval, Inspira Health partnership, engagement with LNA has taken place (primary care), mutual aid provision for secondary care providers as and went needed, LUFT/LHCH integration work has commenced	The Trust has attainted level One for its Prevention Pledge Leadership
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	Social value ward for Kite mark submitted - awaiting outcome.	The combination of our Green Plan / Social Value Award and Prevention Pledge supports our Anchor Institution application

Board of Directors in Public
Item 3.2

Subject: Liverpool Healthy Families Heart and Lung Pilot
Date of Meeting: 26th July 2022
Prepared by: Katie Fitzsimmons, Associate Director of Strategic Partnerships
Presented by: Jonathan Develing, Director of Strategic Partnerships
Purpose: To Note

BAF Ref	Impact on BAF
BAF 9, BAF 10	Example pilot project to support population health and systems Leadership and Collaborations.

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 Liverpool Healthy Families Heart and Lung Pilot was developed to support the realisation of one of Liverpool Heart and Chest Hospitals (LHCH) key ambitions, improving population health with a focus on reducing the incidence of cardiovascular disease (CVD) beyond the hospital setting, reaching out to the local population.

The Pilot saw multiple partnership working between: LHCH, Heart Research UK (HRUK), Liverpool Football Club (LFC) Foundation and Aintree Primary Care Network (PCN), taking a whole family approach to deliver Education, Physical Activity (PA) and Primary Prevention over the course of a week (6th – 10th June 2022).

The paper herein looks to provide an evaluation of the Pilot, highlighting strengths and areas for

improvement and will detail a series of recommendations to support future roll out of the Pilot to continue to improve population health using an outreach model of care. The Board are asked to note recommendations.

2. Background

CVD is attributable for a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. However, it has been identified as the single biggest area where the NHS can save lives over the next ten years and is therefore a key healthcare objective as described in the NHS long term plan (NHS LTP), national CVD ambitions and LHCH strategic plan, Patients, Partnerships and Populations. The pilot aimed to support CVD prevention efforts through a vehicle of Primary Prevention, Education and PA, involving multiple partners to facilitate its delivery. The Pilot adopted a whole family approach and consisted of two core elements that focused on child CVD prevention and adult CVD prevention. Following COVID-19 there has been significant impact on many long-term conditions and access to healthcare, this approach will help towards find the missing millions of undiagnosed CVD conditions.

3. Overview of the Pilot

In terms of the focus on children:

- **Fazakerley Primary School -** The pilot was hosted by Fazakerley Primary School, selected due to its locality as an area of deprivation within Liverpool, Index Multiple Deprivation (IMD) % ranking of 6-10%. There is a strong link between deprivation and increased incidence of CVD with Liverpool ranked as the nineth most deprived Integrated Care System (ICS) out of the 42 ICS in England.
- **HRUK -** Year six pupils (two classes) engaged in an educational programme developed by HRUK, consisting of four lessons covering heart and circulatory system specification points on Key Stage 2 (KS2) national school's curriculum. The lessons involved virtual reality (VR) headsets and computer games to reinforce learning and were delivered throughout the week. Children were assessed for basic knowledge of the heart pre and post lessons so to evaluate attainment.
- **LFC Foundation –** The LFC Foundation supported the Pilot as part of their Health and Wellbeing agenda, delivering two afterschool physical activity sessions led by a health coordinator on the 8th and 10th of June. The sessions were delivered to each of the two Year six classes participating in the pilot.

In terms of the focus on adults:

- **LHCH -** As a catalyst on the final day LHCH provided an American style school bus to launch the Healthy Heart and Lung event. It was a great opportunity to raise awareness and the use of an American style bus brought great attention to all. Positioning the bus on the school playground supported delivery of an opportunistic diagnostic session, led by Cardiac Rehabilitation Matron for LHCH and her team. Blood Pressure (BP) and manual pulse checks were provided coupled with advice and support regarding healthy lifestyles to teachers, parents and carers at the school. Members of the local community, drawn by the bus, also attended as did local builders working in the street.

- **Aintree Primary Care Network (PCN) -** As the pilot had potential to detect new patients the Trust liaised with Aintree PCN which covers four general practices in the Fazakerley location. The PCN provided support of Healthcare Coordinator able to:
    - Register those bus attendees who were **<u>not</u>** registered with a GP to a practice that was readily accessible to them.
    - Input vital signs of bus attenders direct into their EMIS patient records and arranging follow-up appointments if required.
    - Support the LHCH team with lifestyle advice and guidance provision to bus attendees.

3. Pilot Evaluation

To support the evaluation of the pilot the following elements have been reviewed:

- Bus attendee survey
- HRUK post-test quiz, completed by participating children and teachers.
- Information collection on the day by LHCH Cardiac Rehabilitation team.
- Feedback from staff involved in the pilot

Refer Appendix 1 for evaluation detail.

Strengths and areas for improvement

The evaluation and debrief sessions identified what went well and what could be done to improve future outreach sessions, as shown in the table below:

Strengths	Areas for improvement
Right number of trained staff taking BP and pulse readings.	Change location – away from school setting and into a more accessible location e.g. supermarket setting.
PCN healthcare coordinator was an excellent idea – inputting attender information, registering attenders with GPs and making follow-up appointments.	Potentially bring VR headsets outside of the school to show parents what the children had been participating in.
Goodies – water bottles, pens, heart stress balls etc were a great added benefit.	Consent forms in this case were not fit for purpose and should be revised to include; gender, ethnicity, age etc.
School had effectively promoted the pilot in the local area via twitter, facebook, school social media platform.	Extend the range of diagnostics provided to include; Spirometry, cholesterol checks, BMI, waist circumference.
Successful in identifying several health issues on the day including chest infections for which GP appointments were made.	Larger marquee to be used in future events and more tables to improve attender confidentiality.
	Social Prescribers needed – improving health and wellbeing in the community.
	Clipboards needed for attendees to complete

Strengths	Areas for improvement
	forms.
Identifying raised BP and irregular pulse could mean early treatment and reduced risk.	Post-event follow up videos from attendees if possible.

4. Conclusion

Following the evaluation of the Liverpool Healthy Families Heart and Lung Pilot and despite the event taking place in a small school setting, evidence suggests it had a big impact in the community both in terms of raising awareness of CVD but also identifying some individuals potentially at risk of developing CVD.

A key success factor associated with the Pilot was that of partnership working in which a range of different knowledge and skills were brought together to improve local population health in the Fazakerley community. This approach will be adopted for future outreach events.

5. Recommendations

Building on the success of the Liverpool Healthy Families Heart and Lung Pilot, LHCH plans to run another event, early September 2022, to coincide with ‘Know your numbers week’.

During this week LHCH will look to adopt a Core20Plus5 focus, identifying hypertension in deprived areas of Liverpool potentially adopting the bus outreach model in a community setting as opposed to a school setting. A partnership approach will again be taken, and a working group will be established to support the planning phase.

A key recommendation from this evaluation includes incorporating the areas identified as requiring improvement into account during the planning of the next event.

The Board of Directors is asked to **note** the report.

Appendix 1 – Detailed evaluation of the Pilot

Bus attendee survey findings

A total of 20 surveys were completed on the day with bus attendees responding to five questions shown in the table below:

Question	Feedback	Response
On a scale of 1-10 how would you rate the drop-in session (0=very poor, 10=excellent)	**Q1 (10)**	100%
Did staff treat you with courtesy and respect?	**Q2 (YES)**	100%
Were you provided with enough information?	**Q3 (YES)**	100%
Do you understand the importance of maintaining a healthy lifestyle to improve heart health?	**Q4 (YES)**	100%
Do you think today's event was useful?	**Q5 (YES)**	100%

The overall findings from the surveys completed was that attendees felt the opportunistic diagnostic session was both informative and useful, raising awareness of the importance of healthy lifestyle on maintaining heart health. Some comments received from attendees included: ***'very useful', 'provided with so much useful information', 'thank you', 'Sarah went above and beyond'.***

Matron Faulkner further described the story of an LHCH patient who saw the Pilot on facebook and came along for a BP check. On attendance the patient noted he felt unwell and presented with swollen ankles, stating he was under the care of Dr J. Wright from LHCH. He had a cardiac device and his BP was elevated coupled with shortness of breath. The rehab team reassured the patient and booked him into see one of LHCH's heart failure nurses the following week where the patient expressed his gratitude and gave positive feedback thanking staff for the opportunity to come along and be checked in the community; ***'cannot believe how lucky it was attending that day, staff were marvellous and really helpful'.***

HRUK post-test quiz findings

Average findings have been provided across the two participating classes, 30 pupils in each who completed the four lessons.

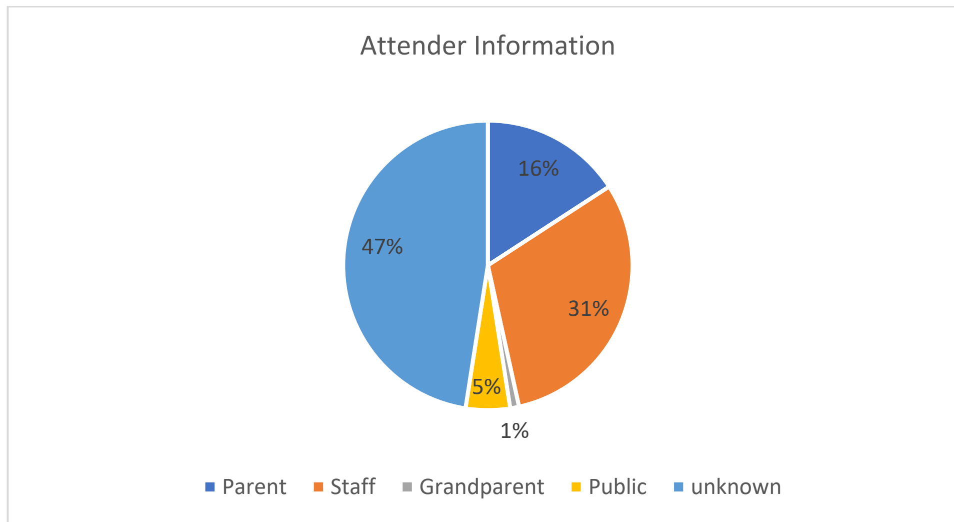
The children improved their pre-test score by 22.2%. Pre assessments scored 4/10 compared to a post assessment score 6.2/10. This suggests the lessons were of benefit in terms of educating the pupils regarding heart health.

Information collected by LHCH Cardiac Rehabilitation team on 10th June 2022

The following information was collected by the team on the day:

- **Number of bus attendees**

  There was a total of 101 bus attendees on the day shown below:



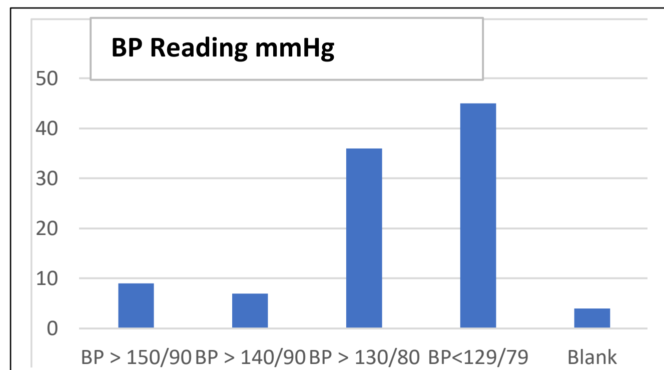
Each member of the Cardiac Rehab team delivered dedicated screening sessions reviewing approximately 20 attenders each.

- **BP readings**

National Institute for Health and Care Excellence (NICE) (2019) Hypertension in adults: diagnosis and management guidelines set out the parameters for identifying people with high BP.

We identified 16% of attendees who has raised BPs > 140/90mmHg, and although a single reading is not a diagnosis, for some this will be the first important step on the pathway to confirm high BP and management to reduce heart attack and stroke.

BP Reading mmHg	
BP > 150/90	9
BP ≥ 140/90	7
BP > 130/80	36
BP<129/79	45
Blank	4
Total	**101**



There are over 416,000 known hypertensive patients (patients with high BP) across Cheshire & Merseyside (CHAMPS 2021)[2] but many cases remain undiagnosed, and many known patients' BP is not controlled to target.

Recent data suggests that in order to achieve the national BP ambitions of 80% detection by 2029, it is estimated that more than 69,000 additional people with high BP need to be diagnosed across C&M, and more than 41,000 additional known BP patients need improved BP control.

- **Pulse Checks**

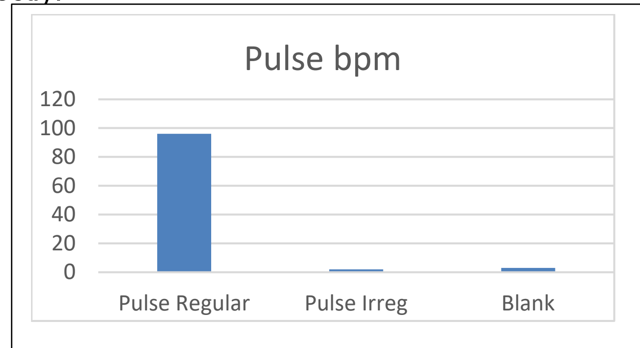
Normal pulse rate is 60-80 beats per minute (bpm), 21 people had pulse rates greater than

81bpm.

Atrial Fibrillation (AF) is an irregular heart rhythm, particularly older people, and often there are no symptoms. By taking a manual pulse check can indicate that there is a potential irregularity which may be undiagnosed AF, one of the major factors for stroke.

On the day there were **2 people** with irregular pulse rates were advised to see their GP and 1 person advised to attend A&E directly.

Pulse bpm	
Pulse Regular	96
Pulse Irreg	2
Blank	3
Total	101



From information gathered on the day 21 people stated that there was a family history of cardiovascular disease and 3 where already known to have high BP and were on medication. **45 people** were advised to make contact with their GP for a variety of health reasons which included BP check, pulse check, smoking cessation referral and other reasons.

Appendix 2 – Overview of the sessions

HRUK VR lessons

LFC Foundation PA session

Appendix three: LHCH opportunistic diagnostic session

Appendix three: LHCH opportunistic diagnostic session

(Please note that consent has been given by Fazakerley Primary School and Parents to use the photographs shown within the evaluation).

Board of Directors (in Public)
Item 3.3

Subject: People Plan Update
Date of Meeting: 26 July 2022
Prepared by: Beth Williams-Lally, HR & OD Manager
Presented by: Karen Nightingall, Chief People Officer
Purpose of Report: For Note

BAF Reference	Impact on BAF
BAF4, BAF5, BAF6.	The delivery of LHCH People Plan 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	☐	Partial assurance	☐	Low assurance
	Controls are suitably designed, with evidence of them being consistently applied and effective in practice		Controls are still maturing – evidence shows that further action is required to improve their effectiveness		Evidence indicates poor effectiveness of controls

1. Executive Summary

The purpose of this paper is to provide assurance to the Board of Directors on the delivery of the LHCH People Plan, directly contributing to the Trust's strategic workforce objectives.

2. Background:

The Trust launched its People Plan in January 2021 following publication of the national 'NHS People Plan - action for us all' by NHS England, NHS Improvement (NHSEI) and Health Education England (HEE) in July 2020. That specific strategy was successfully concluded at LHCH in March 2022.

Moving forward, we are continuing with the people plan pillars listed below as they are still very much relevant and a key focus for LHCH. Please note, there is a slight name change from the 'LHCH People Plan' to 'LHCH People Strategy 2022-2025'.

- **Looking after our people**, with quality health and wellbeing support for everyone
- **Belonging in the NHS**, with a particular focus on tackling the discrimination that some staff face
- **New ways of working and delivering care**, making effective use of the full range of our people's skills and experience
- **Growing for the future,** how we recruit and keep our people, and welcome back colleagues who want to return.

3. Progress update and highlights:

The LHCH People Strategy 2022-2025 is progressing well in alignment with the trust's strategic workforce objectives, the NHS people promise and the annual staff survey results. The overall strategy has now been drafted and will be ready to launch by the end of September 2022.

Please note a name change to the department name 'HR, Education & OD' who are now 'HR, Learning and Development', to signify the trust's passion and dedication to it's learning and development culture.

Below are progress highlights for the 4 key areas of 'The LHCH People Strategy 2022-2025'.

3.1 Recruitment & Retention

The Recruitment and Retention Strategy has now been launched.

We have started new ways of promoting our job vacancies to attract new talent through the LHCH Twitter account and recognising that NHS jobs online has been a deterrent for some prospective talent due to the lengthy application process. To combat this, we have facilitated several in-person recruitment fairs that have been very successful.

Meetings are being arranged with managers to discuss the Strategy and Recruitment in general. We will be surveying new starters and recruitment managers moving forward from August 2022 to gather data on what is going well and what we can improve during the recruitment process.

Due to the success of the trust's International Nurses recruitment, a review is currently underway whether to participate in the coming year.

Retention remains a key focus for us, Anna York has been appointed as a dedicated resource for the trust to support nurse recruitment and retention.

3.2 Learning & Development

The Education & OD strategy has now been launched. This strategy will be renamed 'Learning & Development' strategy to align with the change of department name. Below are some key projects we are currently working on.

Building leadership capability

- One of the identified requirements following the Ockenden Report is to develop and launch a support program whereby all newly appointed band 7 and 8 clinical staff are to be allocated a named and experienced 'mentor' to support their transition into leadership and management roles. This proposed support program is to be used in conjunction with the Clinical Supervision Policies and is NOT a replacement or change to those policies which link to the technical OTJ support requirements.

Talent management

- Aspiring Clinical Skills Program to commence September 2022.
- Support continues for apprenticeships and widening access programs.
- Graduate management trainee scheme, 3 appointments made in HR, Finance & General
- Automisation improvements to be made, particularly around mandatory training
- Scope for growth project in development, to better enable 'high potentials' to be identified and supported to progress.
- Career pathways have been created and launched
- 2021/22 appraisals have been launched, complete with training to encourage meaningful and valuable conversations as this was raised as an area of improvement in the 2021 staff survey results. The wellbeing conversation continues to be a focus area and new this year is an alignment to 'Be Civil Be Kind' requesting employees demonstrate how

they positively contribute to our culture.

Increase learning opportunities and accessibility for all

- Launch learning & development opportunities catalogue
- Improve communications by sharing what's 'coming soon'
- Build an interactive platform on SharePoint to share learning opportunities
- Provide e-learning and virtual replays where possible to enhance accessibility and address some of the 'time out to train' challenges

3.3 Culture & Wellbeing

Initially, culture and wellbeing were going to feature in this strategy as the golden thread throughout all the above. However, following the recent People Committee meeting it was agreed that employee wellbeing is such a key area of focus that it should also be supported by a dedicated strategy. This work is now to commence. We will continue to support the HWB of our people by:

- Constantly reviewing the needs and wants of our people in the ever-changing world we live in. Currently we are supporting financial wellbeing for colleagues facing challenges with the cost-of-living increase, by providing resources available and implementing 'ask Freddie' hampers. A comprehensive offer is in development, to be launched August 2022.
- Team building, social styles, and effective communication engagement roadshow trust wide
- Completing the NHSE HWB diagnostic tool to assist with future planning of required focus areas and meaningful and valuable interventions.
- Schwartz rounds in situ to provide support and learnings
- Enhancing our mental health offer to now include CBT where appropriate and have partnered with Rugby League Cares to deliver stress & coping and self-confidence and belief sessions.
- Support staff survey results communication and creation of action plans for 2021.
- Partnered with a workforce menopause consultant to support colleagues.
- Encourage 'employee voice' and actively engage with our people via quarterly people pulse surveys and annual staff survey 2022, commencing in September.

We would like to inform the Board of Directors that trusts culture campaign 'Be civil be kind' has been shortlisted as a finalist for the HPMA awards for excellence in employee engagement.

3.4 Equality, Diversity, Inclusion & Belonging Strategy (EDIB)

The EDIB strategy was reviewed at Board on 31st May 2022 and ratified by the People Committee on 4th June following feedback from the Board. The paper included a detailed of summary of all EDIB activity and key achievements over the last 12 months from both a workforce and patient perspective.

The pledges and equality objectives within the new EDIB strategy are set out below:

- Enhance the visibility of all EDIB activity across the organisation, engage and encourage our employee voice and build and grow our LHCH Belong Inclusion Network
- Overhaul our recruitment, promotion and flexible working practices, increase leadership diversity across the organisation and widen employment opportunities to support our community
- Improve experiences for our ethnic minority and disabled workforce as outlined in the Workforce Race / Disability Equality Standard (WRES/WDES) and Anti-Racist Framework
- Create a compassionate and inclusive culture through a review and refresh of our leadership training and development programme and EDIB training offer

- Improve the quality of our equality information to facilitate better decision making and ensure compliance with the Public Sector Equality Duty (PSED) and other national equality requirements
- Reduce the barriers experienced by patients, individuals and specific groups who engage with LHCH and identify how to address issues in relation to health inequalities to support better outcomes for all
- Improve patient access and experience to reduce the inequality gap, ensuring patients with learning difficulties and/or language needs are able to access our services

To celebrate and support diversity, inclusion and the belonging of our people and build an inclusive culture we have created a staff inclusion network and held a number of successful events and also shared a powerful staff story around the inclusion of Ramadan provided by Yasser Yousif, Senior Clinical Respiratory Physiologist working in the Pulmonary Function department.

Our next belong event to take place is Pride, which is extra special this year to celebrate it being 50yrs old. LHCH are participating in Liverpool Pride on Saturday 30 July 2022.

4. Conclusion

In conclusion, we look forward to providing the Board of Directors with regular updates and further assurance regarding the strategy and the supportive initiatives that will help the trust achieve its workforce objectives.

5. Recommendations

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

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Board of Directors
Item 3.4

Subject: **Digital Excellence**
Date of Meeting: **26th July 2022**
Prepared by: **Kate Warriner, Executive CDIO, Ian Gilbertson – Deputy CDIO**
Presented by: **Kate Warriner, Executive CDIO**
Purpose: **To Note**

BAF Reference	**Impact on BAF**
BAF 11	The paper provides assurance in respect of digital transformation and operational IT delivery.

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 purpose of this report is to provide the Board of Directors with a digital update including national direction of travel and local Digital Excellence progress.

Key headlines include:

- Good progress with Digital Excellence delivery
- Good progress with digital clinical improvements
- Significant progress with digital safety improvements – Closed Loop deployed to Critical Care
- Digital Health and Care Plan published by NHS England
- Progress on remote monitoring/virtual wards

The Board of Directors is asked to receive the report and note good progress to date.

2. National & Regional Digital Update – Digital Health and Care Plan

In June, NHS England published the Digital Health and Care Plan which is aiming to 'lay the foundations of a brighter digital future by 2025 and beyond. The plan comprises of 4 major goals:

1. Prevent people's health and social care needs from escalating
2. Personalise health and social care and reduce health disparities
3. Improve the experience and impact of people providing services
4. Transform performance

Top line headings form the plan include:

1. Equipping the system digitally for better care (digitising records, EPRs, shared records across systems including social care, diagnostics including clinical decision support based on AI)
2. Supporting independent healthy lives (including NHS App expansion/'NHS services in people's pockets', digital self help and therapies)
3. Accelerating adoption of proven tech (tech R&D partnerships, buying better tech across health and social care)
4. Aligning oversight with accelerating digital transformation (using regulatory levers with NHSE and CQC, enforcing standards, supporting social care)

The plan has strong links to other national digital strategies, including 'What Good Look Likes Like, Data Strategy and the Year of the Digital Profession. Finally, there is a strong focus throughout on remote monitoring and virtual expansion alongside population health and reducing health inequalities.

LHCH currently perform well against a number of the goals set out in the above strategies, this includes having a well embedded EPR which has facilitated the digitisation of the patient record. Digital Excellence, aims to build on this, in line with the above themes, by "*harnessing our digital capabilities and putting information, easily accessible in the hands of our patients".*

Compounding this will be a huge focus on Population Health and how we utilise data in line with other providers for the benefit of the population, through the strategy '*We will enable our clinical analytical ambitions and role in the wider system as set out in People, Partnerships and Populations to support predictive and personalised care for our patients and families.'*

3. Digital Excellence Update

3.1 Digital Excellence / Digital Aspirant Programme Progress

The Digital Excellence programme is on largely on track and progressing well. Digital Excellence Committee (DEC), which governs the Programme, continues to meet on a regular basis with good attendance from its members.

A review of the Digital Excellence deliverables for 22/23 was completed in April by key stakeholders. No major changes to the original plans were highlighted and there is no further investment required. Alongside this, the Terms of Reference for the group were reviewed and approved for the year ahead.

The plans for 22/23 include the delivery of the following solutions, pending Business Case approval:

- Strategic Review of Core Digital Systems

- Patient Portal
- EPR Mobile
- Critical Care of the Future

All Business cases will be submitted and ratified through the relevant committees in line with the Trusts governance structure. DEC will receive oversight of each case and subsequently oversee the delivery and benefits realisation.

3.2 Digital Excellence Finances

Overall, the Programme remains in budget and is forecast to achieve this by the end of the financial year. From an external funding perspective, the Digital Aspirant Programme remains on track and the Trust have successfully received and invested the scheduled £3million to date.

The Trust are also on target to meet the agreed deliverables and receive the final round of external funding in September 22, which amounts to circa £3 million.

3.3 Core Digital Systems – Strategic Review

A draft Terms of Reference, outlining the proposed scope, membership and objectives of the review, was presented to DEC in May. There was strong support for the overall proposal and some further additions identified by the group.

The discussion resulted in the following scope and objectives proposed:

Systems In Scope

- Electronic Patient Record – AllScripts
- Patient Administration System – Silverlink
- EMIS – Community EPR
- Cath Lab Scheduling System – CareCube

Objectives

- Review the EPR and wider digital systems functionality required for the Trust
- Consider the developing national and ICS position e.g., the guidance on convergence
- Ensure a comprehensive and effective approach to stakeholder participation, involvement and communications
- Complete an in-depth review of the current supplier and the wider market
- Conduct a benchmarking exercise, assessing similar hospitals in the region and their current platforms and contracts
- Ensure that the review stays strategically aligned to the aims of the overall Trust's strategic objectives
- Ensure strong alignment to Trusts Procurement Team throughout the process
- Provide recommendation and proposed plan for the long-term future of LHCH Core Digital Systems

3.4 Back to Basics Workstream

The 'back to basics' workstream has delivered some key solutions in the last couple of months and aims to improve the experience of our staff by ensuring they have the best, up to date digital technology to complete their jobs efficiently.

Having identified a further 390 devices that require replacing across the Trust, the team have successfully deployed 242 to date. The team are aiming to have all 390 devices deployed by August 22. Alongside this the team are working with the Administration Service to refresh and upgrade their PC monitors and phones following a request from the Division.

3.5 Clinical and Nursing Digital Developments

Good progress continues to be made with the transformation element of the Digital Excellence Programme.

The Critical Care of the Future project will now enter Business Case stage now a chosen supplier has been selected. This was supported by a site visit to Alder Hey to review their Electronic Anaesthetic Record, which is provided by the same supplier. Feedback from the visit was really positive.

The Digital Team continue to work with clinical and operational teams to optimise the existing digital platforms and have delivered solutions for over 250 requests in the last reporting period. The highlights include enhancements to the Nursing Documentation which were approved by the relevant stakeholders in the Nursing Team. Concurrently, the development team have been working with the Cath Lab to deliver solution enabling them to document medication, improving patient safety.

A visit was held on the 6th July 2022 where the NW Regional Chief Nursing Information Officer visited LHCH to see nursing developments and progress with 'What Good Looks Like' for nursing. The visit was extremely successful with LHCH held up as an exemplar organisation for others to learn from.

3.6 Digital Safety Programmes

Compliance remains at an average of 80% across all wards for Closed Loop Medication. The solution has now also been implemented in the Critical Care wards, with really positive feedback. In terms of Closed Loop technology for Blood Products, pilots for Specimen Collection and Transfusion are due to progress further in August again aiming to reduce administration and collection errors.

From a surgical perspective, the Electronic Consent project is progressing and is scheduled to deliver implementation from August. A review session with the Trust solicitors has been completed to ensure the form complies with all legal requirements. To compliment the process, the Trust have invested in 'Explain My Procedure'. An online platform for clinicians to create and upload short, simple videos describing procedures to patients. This will help make the process more meaningful and reduce risk.

3.7 Remote Monitoring/Virtual Wards

The remote monitoring solution pilot, financially supported by NHS Digital, went live on 30th March with 1 patient as a 'soft launch' and the initial feedback has been really positive. Following the initial pilot, 4 further patients have been onboarded successfully. Patients are completing ongoing pre and post questionnaires and the data collated will be used to measure the qualitative impact of the solution. Once completed the pilot and its benefits will be evaluated before the Trust decide whether to continue with the solution on a permanent basis.

The Knowsley Community Respiratory Service have been working collaboratively with Whiston Hospital to deliver a Virtual Ward solution to reduce the pressures on patient flow within the hospital. Since March 20, when COVID first hit, the collaboration has seen over 200 patients cared for safely via a daily calls and remote monitoring technology. There are now plans to develop and build on this great work across the ICS with each region expected to be delivering at least 40-50 virtual beds, per every 100,000 population by December 2023.

3.8 Patient Interactions

Work is going to digitise the Trusts communication with patients. The first phase is complete with all the hospitals SMS activity transitioning to the new platform. As part of Phase 2 which is already underway, digital letters will now be sent to patients for appointment notifications, reminders and clinic summaries improving their experience and reducing the Trust's carbon footprint.

The Targeted Lung Health Check service are the first to embrace this solution and went live in June with Digital Communications to their patients. This includes invitations and appointment letters. Acute and Radiology will be the next services to go live in August, followed by Community in September.

3.9 Digital Innovations

Some of the highlights from the Digital Innovation space include the Digital Human Resources platform, which completed in May 2022. This has modernised the various HR processes, improved workflows for staff across the hospital and reduced the time taken in each individual area.

3.10 Data and Analytics

There has been significant progress made in redeveloping the Trusts Corporate Performance report in conjunction with senior operational leads. This will be in iterative process but initial feedback on approach and design has been positive.

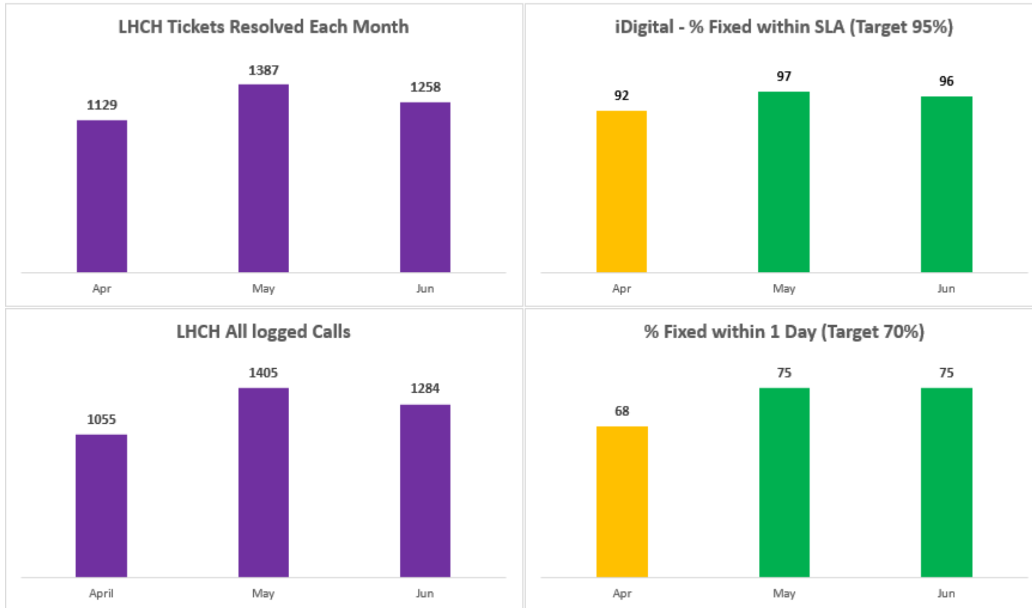
A new Bed management dashboard has also been developed and is currently under review with the Hospital Coordinators. It is planned to go live in May and will dual run alongside the current process for a specific period of time to ensure a smooth transition.

4.0 Operational Performance

There has been further improvement in 'Fixed within SLA%' over the last couple of months. A combination of ticket management focus, proactive ward checks and hardware updates have contributed to this success. June has been a challenging month with a number of computer and project updates such as installing Credential Manager (Smart Card users), G2 software upgrade, Internet explorer end of support and Windows 10 feature updates.

In terms of recruitment, a full-time technician for both the desktop and technical services teams is underway to help further bolster the technical support service at LHCH.

The below gives a view of the performance over previous months:



5.0 Summary and Recommendations

Since the previous reporting period, there have been lots of developments and progress delivered at pace. Progress against plans is excellent. Our national and external reputation and profile is high and internal feedback from colleagues is positive.

The Board of Directors is asked to receive the report and note good progress to date.

Board of Directors (In Public)
Item 3.5

Subject: Systems Update
Date of Meeting: Tuesday, 26th July 2022
Prepared by: Jonathan Develing, Director of Strategic Partnerships
Presented by: Jonathan Develing, Director of Strategic Partnerships
Purpose: To Note

BAF Ref	Impact on BAF
BAF 10	Demonstration of Systems Leadership 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. Executive Summary

The purpose of this report is to ensure the Board of Directors are apprised of the various activities taking place across Cheshire and Merseyside in respect of the developing systems management.

2. Cheshire and Merseyside Integrated Care Board (ICB)

Clinical Commissioning Groups have been formally dissolved as Thursday 30th June 2022 with most statutory functions aligned with the new ICB. NHS Cheshire and Merseyside ICB became a statutory organisation on Friday 1st July 2022.

The ICB will be responsible for NHS strategic planning and allocation decisions. Within these new arrangements, activity to integrate care and improve population health will be driven by commissioners and providers collaborating over smaller geographies within Integrated Care

Systems (ICSs), referred to as 'Places', and through teams delivering services working together in neighborhoods.

The first meeting of the Cheshire and Merseyside ICB took place on 1st July 2022 with confirmation of the following:

- Board appointments
- Adopt the ICB Constitution, Scheme of Delegation and Reservation
- Approve the establishment of ICB Committees
- Approve ICB policies
- Approve an ICB public engagement and involvement framework

3. Place

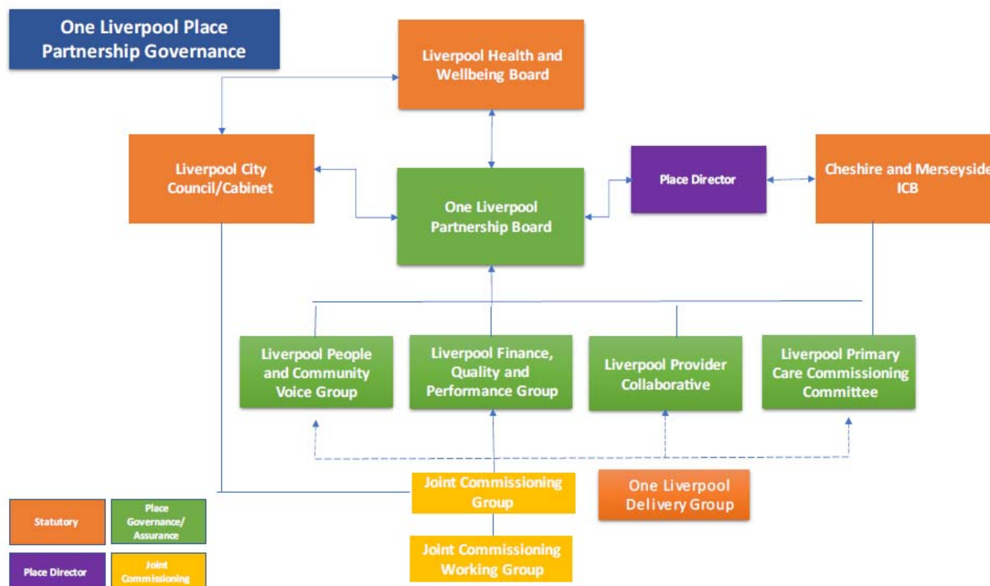
The Trust continues to establish relationships and partnership with Place, with One Liverpool being the most advanced.

3.1 One Liverpool Place Development

Following the formal establishment of the ICB, Liverpool Place Partnership development is moving forward.

The ICB Place Partnership senior structure for Liverpool has been confirmed and appointments have been made to the structure,

The Liverpool Place governance structure, which has been in shadow form, will now be implemented, with new Terms of Reference, membership and details of alignment and reporting to the ICB. Objectives will be agreed between Place and the ICB and agreed through the One Liverpool Partnership Group.



3.2 The One Liverpool Partnership Board

The partnership board has identified the development and implementation of a population health management approach across the life course as its main priority for 2022/23, with a focus on preventing ill health and address health inequalities.

This approach will use data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities. Targeting interventions at those groups most at risk, with focus on prevention and early intervention as well as treatment and care support.

The safe and effective use of patient data is key to this. Liverpool is leading on a Cheshire and Merseyside-wide programme, System P[1], to have in place the technical capability required for population health management, with longitudinal linked data available to enable population segmentation and risk stratification, using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.

Liverpool has identified five population segments:

- Healthy Children and Families
- Complex Lives
- Long Term Conditions
- Frailty and Dementia
- Disabilities

These groups and wider system working will be further supported by the Prevention and Health Inequalities Assurance Group.

LHCH will be taking a leadership role in the Long-Term Conditions segment and supporting the prevention and Health Inequalities Group.

3.3 Liverpool Model of Care Review

Cheshire and Merseyside ICB have been asked by NHSE/I to commission an independent review of the current acute care model within Liverpool, with a view to identify opportunities that will improve clinical hospital-based services. The improvements will be realised in terms of clinical quality, efficiency, and effectiveness.

The review aims to address the longstanding issue and position of Liverpool Women's Hospital NHS Trust, which has been subject to clinical review. There are areas across the ICB of outstanding practice which need to be identified and built upon.

The procurement process has been managed by NHS Shared Business Services (NHS SBS) on behalf of the Contracting Authority (ICB). The outcome of this procurement exercise is imminent.

3.4 Liverpool Providers

Within Liverpool a new Provider collaborative involving all trusts and the care sector will be developed to maximise the potential of greater partnership working for the local health and care system to reduce unwarranted variation, address health inequalities, tackle care back logs, deliver more efficient and sustainable services.

The Provider Collaborative will be responsible for implementation of major system configurations and improvement work.

A major clinical service review is currently underway in partnership with Liverpool University Hospitals NHS Foundation Trust (LUHFT). A public consultation has recently been launched about proposals for five services – breast surgery, general surgery, nephrology, urology, and vascular surgery.

The consultation is part of a wider plan to better organise where care happens across Aintree, the Royal Liverpool, and Broadgreen hospitals. Bringing clinical teams together and reducing duplication across Liverpool's main adult hospitals, will help make the most of specialist staff and resources, and ensure that all patients receive the same, high-quality treatment.

4. Provider Alliances

4.1 Cheshire and Merseyside Acute and Specialist Trust Alliance (CMAST)

CMAST have been considering the publication of the new Guidance on Good Governance and Collaboration which describes how NHSE will oversee providers' collaboration under the NHS System Oversight Framework.

The guidance sets clear expectations of collaboration by NHS trusts and foundation trusts and the governance characteristics that trusts must have in place to support this.

The success of individual NHS trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver safe, effective care, and effective use of resources.

This guidance sets expectations of providers in terms of collaboration in respect of three key areas –

- engaging consistently in shared planning and decision-making
- consistently take collective responsibility with partners for delivery of services across various footprints including system and place
- consistently taking responsibility for delivery of agreed system improvements and decisions.

In addition to their existing duties to deliver safe, effective care, and effective use of resources, the success of individual trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS

At the heart of effective collaboration is the expectation that providers will work effectively on all issues, including those which may be contentious for the organisation and system partners, rather than focusing only on those issues for which there is already a clear way forward or which are perceived to benefit their organisation

A framework to support and drive this collegiate working through a 'committees in common' model is under development for review at the CMAST Leadership Board on 25th July and for subsequent review by individual Boards by September. This will, facilitated by Hill Dickinson and advised by the Trust Secretaries aims to drive system wide delivery with clarity on roles and responsibilities set out in a joint working agreement. In parallel a set of principles to

support investment decisions will be developed by the CMAS CEOs to align with the 2023/24 planning round.

4.2 Workstreams

The core workstreams are progressing and moving to a more structured PMO focus, an update on the workstreams as at the end of June is attached at Appendix A.

4.3 Pan C&M Collaboration

The learning disabilities, mental health and community collaborative continues to drive system wide data systems as a key facilitator of improvement including health inequalities. LHCH and Merseycare are leading the C&M response to developing virtual wards in support of capacity and improved patient experience. The core workstreams of People and Finance / Collaboration at Scale must be driven as a Pan C&M initiative to maximise opportunity and impact.

5. Recommendation

The Board of Directors is asked to note the content of this briefing.

CMAST
Cheshire and Merseyside Acute and Specialist Trusts

Cheshire and Merseyside
Health and Care Partnership

CMAST Briefing

June 2022

NHS Cheshire and Merseyside Becomes a Statutory Organisation

NHS Cheshire and Merseyside has passed the significant milestone of becoming a statutory organisation on 1st July - a development which sees it become integral to the health and care for all of its 2.7 million residents.

Cheshire and Merseyside become one of 42 Integrated Care Systems (ICS) in the country, which are now on a legal footing. It also signals the closure of all nine Clinical Commissioning Groups (CCG) in Cheshire and Merseyside.

This marks a significant development in the way health and care needs for the population will be met; by reducing inequality in health and care provision and improving services and outcomes for people.

The creation of NHS Cheshire and Merseyside and a new statutory Integrated Care Partnership means that considerations and decisions can be made with partners, including Local Authorities, while retaining local influence and decision making within the nine "Places" of Cheshire and Merseyside, which cover the Local Authority boroughs. Unlike previous NHS re-organisations, this marks a fundamental shift in the alignment and work of health and care services across the region and is the single largest change to health and care in decades. Integrated care is designed to improve patient experience and outcomes by bringing services closer together and reducing unfair differences in availability and outcomes for people across Cheshire and Merseyside – thereby helping reduce health inequalities.

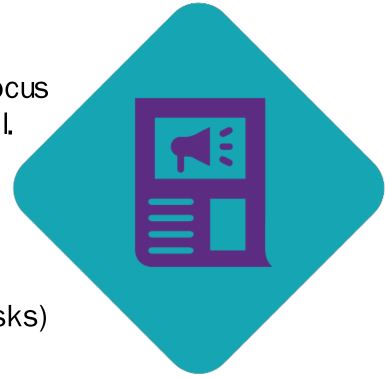
CMAST Development

Further to the last update on the CEO and Chairs' development session, which took place on 6th May, engagement has taken place with CMAST governance leads and company secretaries on the emerging proposals to formalise the CMAST Leadership Board. This will take shape through development of a Joint Working Agreement and establishing a Committee in Common which can be used to develop and underpin shared decision making when and as appropriate.

Proposals are expected to be reviewed by the CMAST Leadership Board at the end of July following further engagement with CMAST's governance leads. The summer will then be used to brief and orientate boards through CEOs, Chairs and your local teams, with a view to securing agreement on these important foundations during September.

Planning is currently underway to host a briefing session and workshop, for non-executive directors of boards across both collaboratives and the ICB in early August focused on system working, shared challenges and government changes to the way in which trust boards are expected to work and be accountable going forward. We recognise August can be a tricky time, however, the timeliness of this discussion with the recently established ICB and the live consultations affecting boards feels appropriate.

Elective Recovery and Transformation Programme



Long Waits:

The trusts have been working incredibly hard to clear the long waits, with a key focus on the 104 weeks. At the end of July, the C&M system declared 34 breaches in total.

- 77 P6's (patients who have opted to wait longer for their treatment)
- The end of July position risks equates to 33 patients, (although not all trusts have confirmed their position)
- Plans are in place to treat the majority of the long wait patients in July..
- All Trusts aim to maintain a zero 104-week position in July (aside from P6 risks)

Theatre Productivity:

- The theatre productivity dashboard has now been commissioned to be updated on a monthly basis, providing 3 views
    - In-session productivity (a list was run and staffed)
    - Fallow theatre session opportunities
    - OPCS* level benchmarking marking, linked to high volume low complexity (HVLC) procedures
- Sessions have been arranged with every trust to review opportunities and data
- HVLC opportunities pack has been developed for every trust, to be circulated w/c 4th July
- Ongoing virtual training sessions are still available
- May performance saw a 2% increase in utilisation and average cases per 4-hour session increase by 0.1 (across the whole systems for largest surgical specialities)

Outpatient Transformation:

The programme is gaining pace, with the development of a formal oversight group and the ability to monitor activity through the new transformation dashboard. Key highlights include:

- Patient Initiated Follow Up (PIFU) activity is rising steadily, up to 1.4% of all outpatient attendances and doubling from 0.7% in the previous month. Specialty mapping has been undertaken to further inform scale up, sharing of best practice and gap analysis.
- The next C&M wide Outpatient Transformation Network meeting is planned for 7th July and will focus on plans for the new Personalised Follow Up ambitions. A case study will be shared by LUFT, who have demonstrated a successful model of digital PIFU.

Other Project Highlights:

- Gastroenterology referral pathways piloted in North Mersey will be rolled out across C&M, and a joint project with the endoscopy programme is currently being established. The work seeks to standardise pathways, improve processes for patients, and support GPs in managing diagnostics.
- A joint undertaking with the C&M Cardiac Network has seen the formation of a NW Cardiology PIFU Special Interest Group, chaired by LHCH. This group will look to offer direction and implementation guidance for clinicians and trusts who are rolling out PIFU in a cardiac sub-specialty.
    - Specialist advice has been incorporated into the C&M tele-dermatology roll out, support is currently being offered to ensure that it is also part of the new electronic eye care referral system to further enhance the offer into primary care.
    - Work is also underway with the personalised care programme and digital programme to ensure that transformational changes are sustainable and result in measurable benefits for patients.

*The Office of Population Censuses and Surveys Classification of Interventions and Procedures

Clinical Pathways Programme

The Clinical Pathways Programme was launched in April 2022. The programme brings a structured and methodical process to review specialties and develop improvement plans at a whole pathway level.

Simon Constable is the programme SRO and Sir David Henshaw is the Chair sponsor.

A formal governance structure has been established with a leadership team – reporting into the Elective Recovery and Transformation Programme Board. Clinical leads for each of the prioritised specialties are working with the dedicated project team, through the clinical networks, to build on existing work, and identify, prioritise, and implement opportunities for improvement to support longer term transformation.

Programme Highlights

Work is underway in **orthopaedics,** with engagement of trust level clinical and operational leads, along with other key stakeholders across the Cheshire and Merseyside system. A current state analysis has been developed to support the first workshop, held on 15th June, with the aims of:

- Gaining consensus on the current challenges facing orthopaedics across Cheshire and Merseyside
- Agreeing what good looks like for orthopaedics and establishing principles to adhere to going forward
- Defining how to work practically together as a system – establishing short term commitments and a structure for decision making.

Further engagement is taking place with trust clinical and operational leads and system key stakeholders to discuss the outputs from the workshop and take forward key actions and next steps.

Diagnostics Programme

Community Diagnostics Centres (CDCs)

- C&M CDCs are delivering a run rate of 110,000 tests per year, which is the highest level in the Northwest.
- We have 5 CDCs operational, with plans submitted for an additional 4 CDCs, regional approvals have been received.

Performance

A monthly diagnostic performance report has been developed. We ask that all trusts review this data at board level. The report will be shared with Chief Operating Officers and Chief Executives and others who would find it useful.

March Performance Headlines:

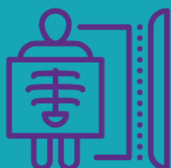
- C&M ICS is ranked 16th out of 42 ICSs for diagnostic waiting time performance.
- C&M ICS is delivering the 3rd highest levels of diagnostic activity, as the ICS with the 4th largest population, this is excellent and we are aiming for more!
- C&M diagnostic activity levels have increased each month since Jan 2022.
- 75,685 C&M patients are waiting for a diagnostic test, 1/3 of these patients have been referred for non-obstetric ultrasound.
- C&M MRI activity levels are now greater than pre-pandemic levels. 88% of MRI patients were seen within 6 weeks.

This data allows us to identify issues, opportunities, and review health inequalities such as the rates of activity and waiting times between places. Among a range of plans to help address inequalities, we are working to facilitate mutual aid, a number of our trusts have provided support including:

- Alder Hey have agreed to provide mutual aid for paediatric patients who are waiting for CT, MRI and ultrasound.
- Liverpool Heart and Chest agreed to support organisations with MRI capacity.
- The Walton Centre agreed to provide mutual aid with imaging capacity.
- East Cheshire Trust is supporting neighbouring trusts with endoscopy capacity.
- C&M performance will be monitored at an aggregate level, as such we will be increasingly seeking collaboration, to ensure we achieve the highest standards.

Endoscopy

- Broadgreen have launched a service for patients to receive a transnasal gastroscopy, this regional service is helping to reduce waiting times and patients are reporting that this new method for scoping is less uncomfortable than traditional methods.



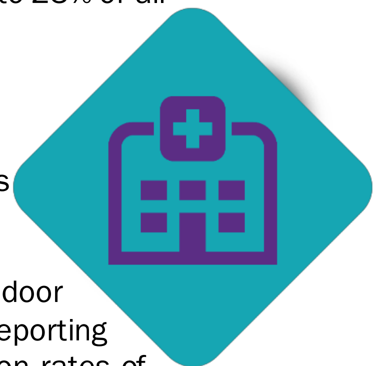
Workforce

- Business case to establish a C&M system wide bank for the diagnostic workforce is in final stages subject to agreement by organisations. Implementation is planned from November 2022 onwards.

Echocardiography

- All trusts have been asked to ensure that appointment slots are in line with the British Society of Echocardiography Guidelines which recommends an echo should take 40-45 minutes. C&M activity levels have increased month on month since Dec 2021.

Urgent and Emergency Care – Gold Command



- Overall COVID occupancy and COVID G&A occupancy continues to increase across Trusts, COVID occupancy is at 12% for C&M. New COVID admissions and inpatient diagnoses have risen significantly in recent weeks.

- C&M Acute Trust COVID related staff absence has increased from previous weeks to 23% of all sickness absences.

- G&A bed occupancy remains very high; on average 96% or greater for C&M.

- Trusts continue to report high numbers of long lengths of stay patients and patients no longer meeting the criteria to reside.

- All Acute Trusts remain pressured in terms of continued high occupancy and front door demand impacting on flow from Emergency Departments. Trusts additionally reporting large numbers of A&E attendances, high patient acuity leading to high conversion rates of admissions from A&Es; some admissions exceeding discharges and discharges coming up late in days, impacting further on existing UEC pressures. Crowding in Emergency Departments leading to episodes of corridor care. Trusts are additionally reporting staffing gaps and challenges and high agency staff usage.

- Weekly monitoring of UEC pressures continues to take place through the Chief Operating Officers' Group and led by the ICB Designate Director of Performance & Planning.

Finance and Collaboration at Scale

After numerous iterations a C&M financial plan was submitted on 20th June with a deficit of £30m; this figure is linked to costs associated with the opening of the new Royal Hospital. The financial plan contains significant levels of risk and financial performance at month 2 is a higher risk than planned deficit, this is linked to delays in delivering efficiency plans and costs of recovery.

Peer Scrutiny Process

Deficit organisations are subject to extensive and robust review, these meetings are in progress with themes and learning collected.

Aligning Incentives and Delivery

An agreement has now been made to cap the loss of income linked to elective underperformance at the level of total ERF. This will manage risk, the impact on over performance will need to be modelled and reviewed.

Capital Prioritisation

Organisations have been notified of their backlog maintenance and capital priorities funding. C&M retains a risk reserve for in year issues.

Impact of specialised commissioning roadmap

C&M strategy directors are reviewing the impact of the transition to delegation, Jon Develing is leading this work. The initial focus is on:

- Transfer of specialised expertise from NHSE to the ICB
- Alignment with networks
- Alignment with pathway development work
- Mapping whole pathway's funds, flow, and readiness to amend pathways
- Impact of PPI

The majority of local specialised services are referred to in the delegation schedule and this is being worked through locally and through the Federation of Specialist Hospitals.

Collaboration at Scale

MIAA will report back this month on the major opportunities for C&M based on benchmarking, Model Hospital, ERIC returns and GIRFT. This will inform the prioritisation of the workstreams.

Principles and Rules of Engagement

It is important that Providers sign up to an underlying set of principles about how we operate as a collaborative. This work focussing on Boards' and governance is being supported by Hill Dickinson and from this a more detailed set of principles will need to be developed. Jane Tomkinson is the SRO for this work, Jane is seeking volunteer CEOs to join a task and finish group to progress this in advance of key decision points, e.g., investment priorities and CoS schemes.

Other Workstreams

Now that the C&M financial plan has been established, other workstreams will commence via Claire Wilson, ICB CFO and CFO community, with oversight from CMAST board and workstream SROs.

Chair Sponsorship

A meeting was held on 21st June with Ian Haythorn-Thwaite, Chair Sponsor, who is currently reviewing the workplans, briefings and ToRs. A follow up session with Kathy Doran and Karen Bliss will be set up in late July/August. Thanks to all for the offers of help.

Cheshire & Merseyside Hospital Cell Activity and Recovery Summary

Wednesday 6th July

NHS England and NHS Improvement

Summary

UEC

- Emergency admissions at **85.2%** of historic 19/20 levels, compared to **93.5%** across the NW
- Emergency admissions via A&E at **87.3%** of historic 19/20 levels, compared to **94.8%** across the NW
- A&E performance at **69.3%** (Cat 1 at **53.5%). ** A&E attendances increased by 220 to **27,678**

Electives

- DC rates at **94%** of 19/20 levels, compared to **90%** in NW
- Ordinary Electives at **105%** of 19/20 levels, compared to **97%** in NW
- Cancelled operations **283,** increase of **30** from previous week
- 1st Outpatients at **109%** of 19/20 levels, compared to **102%** in NW
- FU outpatients at **115%** of 19/20 levels, compared to **107%** in NW
- 52+ week waits **21,997** (increase of **138,** of which Admitted **12**, Non-admitted **126)**
- 78-103 week waits **2,873** (decrease of **-79)**
- 104+ week waits **199** (decrease of **-33,** of which Admitted **-24**, Non-admitted **-9)**
- **3,373** P2 patients (decrease of -**43**) P2 patients waiting longer than 1 month **1,580** (increase of **31**)

Imaging

- CT at **132%** of 19/20 levels, compared to **124%** in NW
- MRI at **116%** of historic 19/20 levels. compared to **110%** in NW

Endoscopy

- Colonoscopy at **127%** of 19/20 levels, compared to **126%** in NW
- Flexi-Sig at **62%** of 19/20 levels, compared to **69%** in the NW
- Gastroscopy at **104%** of 19/20 levels, compared to **103%** in NW

Cancer

- 62 day treatments at **98%** of 19/20 levels, compared to **105%** in NW
- 63+ day backlogs at **297%** of 19/20 levels, compared to **326%** in NW
- 104+ day backlogs at **405%** of 19/20 levels, compared to **537%** in NW

Adult G&A Bed Occupancy – 05/07/22

Adult G&A beds occupied by confirmed COVID-19 cases

638

(increase of 5 from 04/07/22)

Acute Provider Confirmed COVID-19 Occupancy

12.4%

Acute Provider Unoccupied Capacity

4.1%

	Adult G&A Beds (Covid SitRep) 05/07/2022									Covid Weekly Acute Discharge SitRep & COVID-19 SitRep 03/07/2022		Covid Weekly Acute Discharge SitRep w/e 03/07/2022	Weekly COVID-19 SitRep 03/07/2022	Covid Weekly Acute Discharge SitRep 03/07/2022		Covid Weekly Acute Discharge SitRep w/e 03/07/2022
	Occupied Covid	Occupied Suspected Covid	Covid % Occupancy	Suspected Covid % Occupancy	Occupied Non-Covid	Total Occupied G&A Beds	Unoccupied G&A Beds	Total G&A Beds	Adult G&A % Occupancy	% of patients who do not meet the criteria to reside / G&A Total Beds Occupied	% Total patients > 21 days / G&A Total Beds Occupied	% patients > 14 days who meet the criteria to be discharged discharged but who continue to reside in hospital (weekly average) / G&A Total Beds Occupied	Total G&A occupied beds	Number of patients who do not meet the criteria to reside	Total patients > 21 days	Number of patients > 14 days who meet the criteria to be discharged discharged but who continue to reside in hospital (weekly average)
Countess of Chester	47	0	12%	0%	343	390	7	397	98%	11%	6%	14%	447	49	26	63
East Cheshire	21	0	6%	0%	306	327	10	337	97%	30%	21%	23%	328	100	70	74
Liverpool University	212	61	14%	4%	1169	1442	101	1543	93%	23%	28%	16%	1,444	330	408	230
Mid Cheshire	61	23	12%	5%	406	490	15	505	97%	25%	27%	18%	502	125	134	91
Southport and Ormskirk	43	0	12%	0%	317	360	4	364	99%	11%	0%	7%	352	40	-	26
St Helens and Knowsley	99	0	14%	0%	575	674	16	690	98%	26%	19%	13%	680	175	127	90
Warrington & Halton	79	0	15%	0%	419	498	16	514	97%	28%	25%	21%	485	137	121	104
Wirral University	68	0	9%	0%	644	712	39	751	95%	38%	37%	35%	591	227	218	207
C&M Acute Provider Totals	**630**	**84**	**12%**	**2%**	**4179**	**4893**	**208**	**5101**	**96%**	**24%**	**23%**	**18%**	**4,829**	**1,183**	**1,104**	**885**
Liverpool Heart and Chest	4	0	3%	0%	131	135	5	140	96%							
Liverpool Women's	0	0	0%	0%	16	16	8	24	67%							
The Clatterbridge Cancer Centre	3	0	3%	0%	73	76	14	90	84%							
The Walton Centre	1	0	1%	0%	132	133	10	143	93%							
C&M Total (All Providers)	**638**	**84**	**12%**	**2%**	**4531**	**5253**	**245**	**5498**	**96%**							

Please Note: **The daily COVID-19 Discharge SitRep has been refreshed but not validated. Unfortunately this part will not be validated against the National dashboard until the 18th July when the National dashboard will be updated**

Data Sources:
Daily COVID-19 Acute SitRep
Daily Discharge SitRep

C&M Bed Occupancy LOS

Daily Number of Occupied Beds by Adult Long Stay Patients

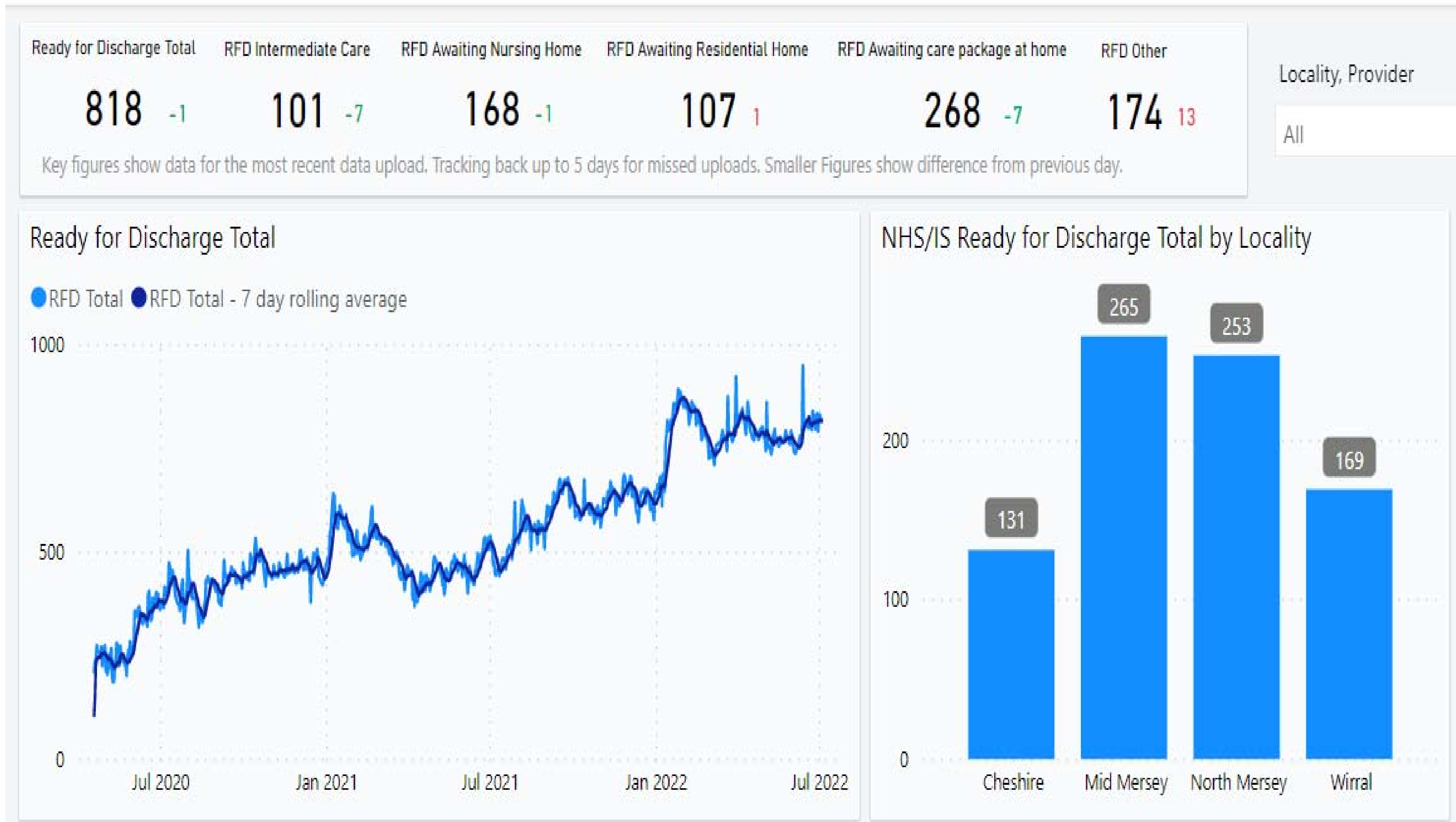
LOS	Patients	Previous Day	Previous Week	% of Occ Beds
7+ Days	2894	▲ 86	▲ 10	57.7%
14+ Days	1837	▲ 44	▼ -36	36.6%
21+ Days	1280	▲ 18	▼ -22	25.5%
Bed Occupancy	95.1%	▲ 0.2%	▼ -0.3%	

Trust Level Comparison of Long Stay Patients Against Local Trajectory

Trust	14+ Days			21+ Days		
	Target	Actual	Variance	Target	Actual	Variance
Countess of Chester Hospital NHS Foundation Trust	76	110	+ 34	54	72	+ 18
East Cheshire NHS Trust	58	106	+ 48	39	73	+ 34
Liverpool University Hospitals NHS Foundation Trust	268	624	+ 356	179	446	+ 267
Mid Cheshire Hospitals NHS Foundation Trust	91	194	+ 103	61	135	+ 74
Southport and Ormskirk Hospital NHS Trust	56	121	+ 65	40	82	+ 42
St Helens and Knowsley Teaching Hospitals NHS Trust	121	214	+ 93	81	132	+ 51
Warrington and Halton Teaching Hospitals NHS Foundation Trust	88	183	+ 95	59	125	+ 66
Wirral University Teaching Hospital NHS Foundation Trust	118	285	+ 167	79	215	+ 136
Total	**876**	**1837**	**+ 961**	**592**	**1280**	**+ 688**

Data Source: C&M Long Stay Report
Data period: 03/07/2022

Ready for Discharge



Data Source: CIPHA OOH Capacity & Demand Tracker
Data period: 05/07/2022

Elective: North West STP Analysis - Electives

4 week average as a percent of 2019/20:
England: 96% (DC), 93% (Ord)

	Daycases						Ordinary Electives					
	4 Week Average (Final data)			Latest Week (Provisional)			4 Week Average (Final data)			Latest Week (Provisional)		
STP	Same weeks in 2019/20	Week Ending: 19 Jun 2022	as a % of 2019/20	Same week 19/20	Week Ending: 26 Jun 2022	as a % of 2019/20	Same weeks in 2019/20	Week Ending: 19 Jun 2022	as a % of 2019/20	Same week 19/20	Week Ending: 26 Jun 2022	as a % of 2019/20
Cheshire and Merseyside STP	7,042	6,639	94%	6,941	6,344	91%	1,076	1,133	105%	1,115	1,109	99%
Greater Manchester Health and Social Care Partnership (STP)	7,748	6,464	83%	7,924	6,840	86%	1,466	1,239	85%	1,455	1,331	91%
Healthier Lancashire and South Cumbria STP	4,064	3,957	97%	4,093	3,762	92%	647	737	114%	633	743	117%
North West	**18,854**	**17,059**	**90%**	**18,958**	**16,946**	**89%**	**3,188**	**3,108**	**97%**	**3,203**	**3,183**	**99%**

Data Source: Weekly Activity Report – Adjusted – Week Ending 26/06/2022
Available at: https://future.nhs.uk/OIforC/view?objectId=25715696

Elective: North West STP Analysis - Outpatients

4 week average as a percent of 2019/20:
England: 99% (1st OP), 100% (FU OP)
Virtual OP: 19%

	First Outpatients						Follow-Up Outpatients					
	4 Week Average (Final data)			Latest Week (Provisional)			4 Week Average (Final data)			Latest Week (Provisional)		
STP	Same weeks in 2019/20	Week Ending: 19 Jun 2022	as a % of 2019/20	Same week 19/20	Week Ending: 26 Jun 2022	as a % of 2019/20	Same weeks in 2019/20	Week Ending: 19 Jun 2022	as a % of 2019/20	Same week 19/20	Week Ending: 26 Jun 2022	as a % of 2019/20
Cheshire and Merseyside STP	20,254	22,019	109%	20,197	20,089	99%	49,252	56,843	115%	49,630	50,591	102%
Greater Manchester Health and Social Care Partnership (STP)	21,377	20,341	95%	22,345	21,773	97%	52,204	52,132	100%	53,239	52,345	98%
Healthier Lancashire and South Cumbria STP	10,173	10,579	104%	9,995	10,367	104%	20,861	21,708	104%	21,043	20,569	98%
North West	**51,803**	**52,939**	**102%**	**52,537**	**52,229**	**99%**	**122,317**	**130,683**	**107%**	**123,912**	**123,505**	**100%**

Data Source: Weekly Activity Report – Adjusted – Week Ending 26/06/2022
Available at: https://future.nhs.uk/OIforC/view?objectId=25715696

52ww Restoration admitted pathway

52ww (admitted patients)

Org Name	w/e 29-May	w/e 05-Jun	w/e 12-Jun	w/e 19-Jun	w/e 26-Jun	Change from previous week	Average volume change per week (based on latest 4 weeks)	Difference from weekly change to 4 week ave
Alder Hey	216	215	213	215	**207**	-8	-2	-6
Countess of Chester	689	682	639	623	**600**	-23	-22	-1
East Cheshire	195	195	191	183	**178**	-5	-4	-1
Liverpool Heart & Chest	5	5	47	48	**43**	-5	10	-15
Liverpool University	1,910	1,922	1,968	1,955	**1,941**	-14	8	-22
Liverpool Women's	277	285	280	281	**281**	0	1	-1
Mid Cheshire	331	344	373	387	**415**	28	21	7
Southport and Ormskirk	242	234	227	212	**215**	3	-7	10
St Helens and Knowsley	1,681	1,696	1,716	1,720	**1,735**	15	14	2
The Clatterbridge	0	0	0	0	**0**	0	0	0
The Walton Centre	82	82	84	74	**80**	6	-1	7
Warrington and Halton	765	786	794	802	**813**	11	12	-1
Wirral University	579	594	590	599	**603**	4	6	-2
C&M Total	**6,972**	**7,040**	**7,122**	**7,099**	**7,111**	12	35	-23
GM Total	**10,489**	**12,506**	**12,200**	**12,246**	**12,055**	-191	392	-583
L&SC Total	**3,762**	**3,756**	**3,721**	**3,689**	**3,677**	-12	-21	9

52ww Restoration non-admitted pathway

52ww (non-admitted patients)

Org Name	w/e 29-May	w/e 05-Jun	w/e 12-Jun	w/e 19-Jun	w/e 26-Jun	Change from previous week	Average volume change per week (based on latest 4 weeks)	Difference from weekly change to 4 week ave
Alder Hey	72	78	91	101	**104**	3	8	-5
Countess of Chester	4,213	4,304	4,399	4,496	**4,522**	26	77	-51
East Cheshire	135	135	142	148	**149**	1	4	-3
Liverpool Heart & Chest	0	0	14	15	**14**	-1	4	-5
Liverpool University	6,335	6,510	6,684	6,793	**6,854**	61	130	-69
Liverpool Women's	704	858	982	1,105	**1,205**	100	125	-25
Mid Cheshire	838	859	905	914	**863**	-51	6	-57
Southport and Ormskirk	70	64	72	102	**84**	-18	4	-22
St Helens and Knowsley	74	78	85	98	**95**	-3	5	-8
The Clatterbridge	0	0	0	0	**0**	0	0	0
The Walton Centre	95	93	100	104	**76**	-28	-5	-23
Warrington and Halton	433	447	470	501	**498**	-3	16	-19
Wirral University	280	309	353	383	**422**	39	36	4
C&M Total	**13,249**	**13,735**	**14,297**	**14,760**	**14,886**	126	409	-283
GM Total	**14,196**	**23,789**	**24,946**	**26,340**	**26,675**	335	3,120	-2,785
L&SC Total	**6,545**	**6,501**	**6,632**	**6,658**	**6,661**	3	29	-26

 Data Source: Weekly RTT PTL data collection

Total Waiting List by Trust & Wait Bands
Admitted & Non Admitted 78 -103ww

78-103ww (admitted and non-admitted patients)

Org Name	w/e 29-May	w/e 05-Jun	w/e 12-Jun	w/e 19-Jun	w/e 26-Jun	May-22 Trajectory	Jun-22 Trajectory	Change from previous week	Average volume change per week (based on latest 4 weeks)	Difference from weekly change to 4 week ave
Alder Hey	17	16	16	14	**14**	**22**	**16**	0	-1	1
Countess of Chester	680	673	698	718	**688**	**830**	**457**	-30	2	-32
East Cheshire	56	56	67	59	**52**	**115**	**95**	-7	-1	-6
Liverpool Heart & Chest	0	0	10	12	**11**	**14**	**13**	-1	3	-4
Liverpool University	1,203	1,247	1,310	1,340	**1,312**	**1,177**	**941**	-28	27	-55
Liverpool Women's	26	27	28	32	**36**	**8**	**4**	4	3	2
Mid Cheshire	66	77	79	84	**89**	**85**	**68**	5	6	-1
Southport and Ormskirk	48	45	42	42	**34**	**0**	**0**	-8	-4	-5
St Helens and Knowsley	303	309	299	295	**304**	**233**	**186**	9	0	9
The Clatterbridge	0	0	0	0	**0**	**0**	**0**	0	0	0
The Walton Centre	45	45	45	27	**13**	**26**	**33**	-14	-8	-6
Warrington and Halton	221	234	241	239	**232**	**219**	**187**	-7	3	-10
Wirral University	71	76	84	90	**88**	**64**	**52**	-2	4	-6
C&M Total	**2,736**	**2,749**	**2,919**	**2,952**	**2,873**	**2,793**	**2,052**	-79	34	-113
GM Total	**3,740**	**4,798**	**4,888**	**5,164**	**4,953**			-211	303	-514
L&SC Total	**2,045**	**2,036**	**2,009**	**1,977**	**1,914**			-63	-33	-30

 Data Source: Weekly RTT data collection

104+ww Restoration admitted and non-admitted pathways

104+ww (admitted and non-admitted patients)

Org Name	w/e 29-May	w/e 05-Jun	w/e 12-Jun	w/e 19-Jun	w/e 26-Jun	May-22 Trajectory	Jun-22 Trajectory	Change from previous week	Average volume change per week (based on latest 4 weeks)	Difference from weekly change to 4 week ave
Alder Hey	0	0	1	1	0	0	0	-1	0	-1
Countess of Chester	199	172	157	119	103	200	0	-16	-24	8
East Cheshire	24	24	22	22	21	20	0	-1	-1	-0
Liverpool Heart & Chest	0	0	2	2	3	5	0	1	1	0
Liverpool University	76	71	63	51	43	92	0	-8	-8	0
Liverpool Women's	0	0	0	0	0	0	0	0	0	0
Mid Cheshire	2	1	1	0	0	8	0	0	-1	1
Southport and Ormskirk	0	0	0	0	0	0	0	0	0	0
St Helens and Knowsley	6	6	6	4	4	12	0	0	-1	1
The Clatterbridge	0	0	0	0	0	0	0	0	0	0
The Walton Centre	0	0	0	13	5	5	0	-8	1	-9
Warrington and Halton	20	24	23	20	20	16	0	0	0	0
Wirral University	0	0	0	0	0	4	0	0	0	0
C&M Total	**327**	**298**	**275**	**232**	**199**	**362**	**0**	-33	-32	-1
GM Total	**782**	**827**	**661**	**569**	**351**			-218	-108	-110
L&SC Total	**476**	**444**	**383**	**310**	**238**			-72	-60	-13
England Average	**197**	**189**	**167**	**136**	**112**			-24	-21	-3

 Data Source: Weekly RTT PTL data collection

Patients waiting 104+ weeks

104+ww (admitted patients)

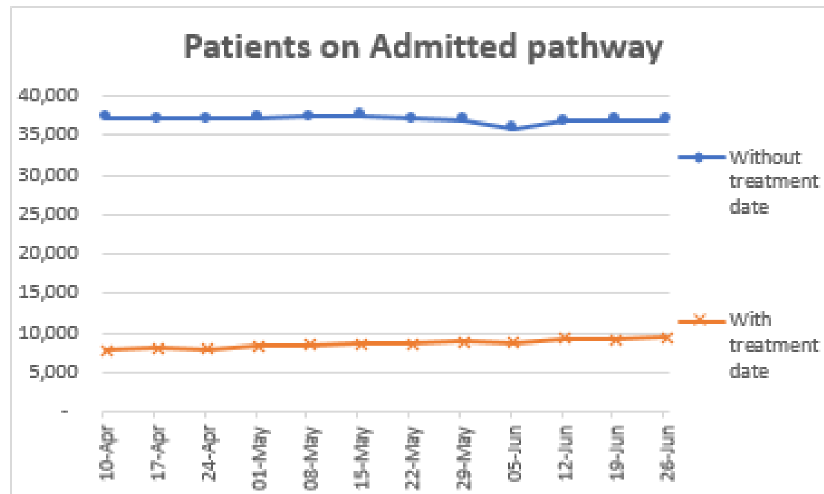
Org Name	w/e 29-May	w/e 05-Jun	w/e 12-Jun	w/e 19-Jun	w/e 26-Jun	Change from previous week	Average volume change per week (based on latest 4 weeks)	Difference from weekly change to 4 week ave
Alder Hey	0	0	1	1	**0**	-1	0	-1
Countess of Chester	93	80	67	51	**33**	-18	-15	-3
East Cheshire	24	24	22	21	**21**	0	-1	1
Liverpool Heart & Chest	0	0	1	1	**2**	1	1	1
Liverpool University	50	47	44	40	**36**	-4	-4	-1
Liverpool Women's	0	0	0	0	**0**	0	0	0
Mid Cheshire	2	1	1	0	**0**	0	-1	1
Southport and Ormskirk	0	0	0	0	**0**	0	0	0
St Helens and Knowsley	5	5	4	3	**2**	-1	-1	-0
The Clatterbridge	0	0	0	0	**0**	0	0	0
The Walton Centre	0	0	0	0	**0**	0	0	0
Warrington and Halton	17	20	21	17	**16**	-1	-0	-1
Wirral University	0	0	0	0	**0**	0	0	0
C&M Total	**191**	**177**	**161**	**134**	**110**	-24	-20	-4
GM Total	**682**	**708**	**570**	**465**	**299**	-166	-96	-70
L&SC Total	**314**	**297**	**259**	**220**	**169**	-51	-36	-15
England Total	**6,749**	**6,467**	**5,746**	**4,641**	**3,907**	-734	-711	-24
England Average	**161**	**154**	**137**	**111**	**93**	-17	-17	-1

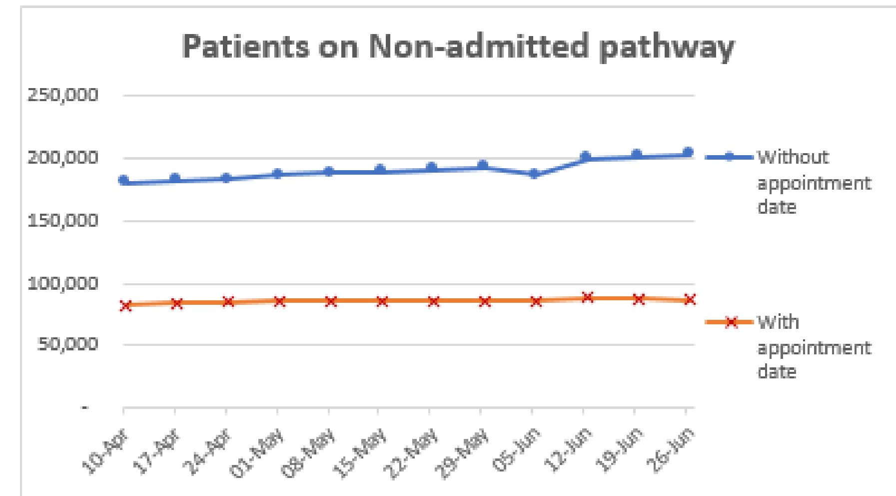
104+ww (non-admitted patients)

Org Name	w/e 29-May	w/e 05-Jun	w/e 12-Jun	w/e 19-Jun	w/e 26-Jun	Change from previous week	Average volume change per week (based on latest 4 weeks)	Difference from weekly change to 4 week ave
Alder Hey	0	0	0	0	**0**	0	0	0
Countess of Chester	106	92	90	68	**70**	2	-9	11
East Cheshire	0	0	0	1	**0**	-1	0	-1
Liverpool Heart & Chest	0	0	1	1	**1**	0	0	-0
Liverpool University	26	24	19	11	**7**	-4	-5	1
Liverpool Women's	0	0	0	0	**0**	0	0	0
Mid Cheshire	0	0	0	0	**0**	0	0	0
Southport and Ormskirk	0	0	0	0	**0**	0	0	0
St Helens and Knowsley	1	1	2	1	**2**	1	0	1
The Clatterbridge	0	0	0	0	**0**	0	0	0
The Walton Centre	0	0	0	13	**5**	-8	1	-9
Warrington and Halton	3	4	2	3	**4**	1	0	1
Wirral University	0	0	0	0	**0**	0	0	0
C&M Total	**136**	**121**	**114**	**98**	**89**	-9	-12	3
GM Total	**100**	**119**	**91**	**104**	**52**	-52	-12	-40
L&SC Total	**162**	**147**	**124**	**90**	**69**	-21	-23	2
England Total	**1,533**	**1,450**	**1,275**	**1,081**	**806**	-275	-182	-93
England Average	**37**	**35**	**30**	**26**	**19**	-7	-4	-2

 Data Source: Weekly RTT PTL data collection

Total waiting list: C&M





Admitted Pathway	10-Apr	17-Apr	24-Apr	01-May	08-May	15-May	22-May	29-May	05-Jun	12-Jun	19-Jun	26-Jun
Without treatment date	37,227	37,119	37,131	37,213	37,412	37,451	37,139	36,980	35,849	36,849	36,913	36,954
With treatment date	7,714	8,023	7,941	8,343	8,525	8,558	8,566	8,910	8,743	9,334	9,162	9,359

Non-Admitted Pathway	10-Apr	17-Apr	24-Apr	01-May	08-May	15-May	22-May	29-May	05-Jun	12-Jun	19-Jun	26-Jun
Without appointment date	180,496	182,071	182,830	186,252	188,319	189,293	190,638	192,383	186,933	199,627	201,138	203,154
With appointment date	82,216	83,791	84,577	85,703	85,900	86,160	85,852	86,122	85,773	88,035	87,140	86,456

Pathway Totals	10-Apr	17-Apr	24-Apr	01-May	08-May	15-May	22-May	29-May	05-Jun	12-Jun	19-Jun	26-Jun
Without treatment/appointment date	217,723	219,190	219,961	223,465	225,731	226,744	227,777	229,363	222,782	236,476	238,051	240,108
With treatment/appointment date	89,930	91,814	92,518	94,046	94,425	94,718	94,418	95,032	94,516	97,369	96,302	95,815

From w/c 19-Jun to w/c 26-Jun:
- for patients on the admitted pathway there has been a 0.1% increase in patients without a treatment date and a 2.2% increase in patients with a treatment date.
- for patients on the non-admitted pathway there has been a 1% increase in patients without a treatment date and a 0.8% decrease in patients with a treatment date.

19-Jun	26-Jun		Absolute value	in or decreas	19-Jun	26-Jun		Absolute value	in or decreas
36,913	36,954	0%	0.001111	increase	201,138	203,154	1%	0.010023	increase
9,162	9,359	2%	0.021502	increase	87,140	86,456	-1%	0.007849	decrease

 Data Source: Weekly RTT data collection

NHS

Diagnostics: C&M Analysis - Imaging

4 week average as a percent of 2019/20
England: 123% (CT), 109% (MRI), North West: 124% (CT), 110% (MRI)

	CT Scans						MRI Scans					
	4 Week Average (Final data)			Latest Week (Provisional)			4 Week Average (Final data)			Latest Week (Provisional)		
Provider	Same weeks in 2019/20	Week Ending: 19 Jun 2022	as a % of 2019/20	Same week 19/20	Week Ending: 26 Jun 2022	as a % of 2019/20	Same weeks in 2019/20	Week Ending: 19 Jun 2022	as a % of 2019/20	Same week 19/20	Week Ending: 26 Jun 2022	as a % of 2019/20
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	57	64	113%	58	60	103%	154	148	96%	152	156	103%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	607	803	132%	601	738	123%	282	362	128%	289	308	107%
EAST CHESHIRE NHS TRUST	212	258	122%	213	217	102%	179	101	56%	186	92	49%
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	211	267	126%	212	255	120%	96	148	154%	100	142	142%
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1,882	2,389	127%	1,888	2,050	109%	562	665	118%	558	566	101%
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0		0	0		0	0		0	0	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	450	871	194%	456	852	187%	244	457	187%	247	439	178%
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	394	517	131%	395	498	126%	189	184	98%	188	201	107%
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	1,144	1,346	118%	1,138	1,274	112%	578	612	106%	597	632	106%
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	126	351	278%	126	383	304%	98	164	167%	97	116	120%
THE WALTON CENTRE NHS FOUNDATION TRUST	93	91	97%	92	82	89%	286	335	117%	282	276	98%
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	583	726	124%	590	599	102%	402	418	104%	401	458	114%
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	765	962	126%	764	867	113%	325	360	111%	325	328	101%
CHESHIRE & MERSEYSIDE STP	**6,523**	**8,643**	**132%**	**6,533**	**7,875**	**121%**	**3,397**	**3,955**	**116%**	**3,422**	**3,714**	**109%**

Data Source: Weekly Activity Report – Adjusted – Week Ending 26/06/2022
Available at: https://future.nhs.uk/OIforC/view?objectId=25715696

Diagnostics: Imaging ISP

NHS

Source: SUS, Monthly Diagnostics (DM01) and Weekly Activity Return (WAR) Data in this table has not been adjusted. Any site that has submitted data in the last 5 weeks is included in the table, noting they have not all submitted data for all weeks or PODs	**Diagnostics**			**Diagnostics**		
	CT			**MRI**		
ISP.site	4 Week Average Activity	4 Week Average Baseline 19/20	% Difference	4 Week Average Activity	4 Week Average Baseline 19/20	% Difference
CHESHIRE & MERSEYSIDE TREATMENT CENTRE						
FAIRFIELD HOSPITAL	19	20	95%	14	21	67%
HCA - 52 ALDERLEY ROAD						
HOUGH GREEN HEALTH PARK						
NUFFIELD HEALTH, THE GROSVENOR HOSPITAL, CHESTER				10	4	250%
SPAMEDICA (WIRRAL)						
SPAMEDICA LIVERPOOL						
SPAMEDICA WIDNES						
SPIRE CHESHIRE HOSPITAL	4	12	33%	4	9	44%
SPIRE LIVERPOOL HOSPITAL	9	23	39%	20	27	74%
SPIRE MURRAYFIELD HOSPITAL	2	4	50%	9	7	129%
SPIRE REGENCY HOSPITAL	5	7	71%	17	23	74%
RENACRES HOSPITAL	5	18	28%	26	25	104%

Data Source: Weekly Activity Report – Raw WAR Data – Week Ending 19/06/2022
Available at: https://future.nhs.uk/OIforC/view?objectId=20423184

Diagnostics: C&M Analysis - Scopes

4 week average as a percent of last year:

England: 118% (Colonoscopies), 67% (Flexi-Sig), 104% (Gastroscopies)

North West: 126% (Colonoscopies), 66% (Flexi-Sig), 103% (Gastroscopies)

	Colonoscopies						Flexi-Sigmoidoscopies						Gastroscopies					
	4 Week Average (Final data)			Latest Week (Provisional)			4 Week Average (Final data)			Latest Week (Provisional)			4 Week Average (Final data)			Latest Week (Provisional)		
Provider	Same weeks in 2019/20	Week Ending: 19 Jun 2022	as a % of 2019/20	Same week 19/20	Week Ending: 26 Jun 2022	as a % of 2019/20	Same weeks in 2019/20	Week Ending: 19 Jun 2022	as a % of 2019/20	Same week 19/20	Week Ending: 26 Jun 2022	as a % of 2019/20	Same weeks in 2019/20	Week Ending: 19 Jun 2022	as a % of 2019/20	Same week 19/20	Week Ending: 26 Jun 2022	as a % of 2019/20
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4	6	137%	4	5	125%	0	0		0	0		8	4	43%	7	3	43%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	42	49	118%	42	54	129%	33	12	35%	34	17	50%	37	58	155%	38	74	195%
EAST CHESHIRE NHS TRUST	39	65	167%	41	71	173%	14	11	80%	14	10	71%	53	39	74%	51	27	53%
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	0	0		0	0		0	0		0	0		0	0		0	0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	210	299	142%	215	166	77%	126	52	41%	130	45	35%	232	248	107%	238	151	63%
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0		0	0		0	0		0	0		0	0		0	0	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	77	74	96%	78	76	97%	82	38	46%	82	42	51%	79	55	69%	78	23	29%
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	21	39	183%	20	22	110%	19	27	138%	20	23	115%	49	67	135%	49	64	131%
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	62	64	104%	60	56	93%	57	71	125%	57	56	98%	138	177	128%	141	134	95%
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	0	0		0	0		0	0		0	0		0	0		0	0	
THE WALTON CENTRE NHS FOUNDATION TRUST	0	0		0	0		0	0		0	0		0	0		0	0	
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	35	6	17%	34	5	15%	48	3	7%	50	2	4%	93	21	23%	93	17	18%
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	91	135	149%	94	96	102%	26	37	140%	26	41	158%	144	197	137%	148	178	120%
CHESHIRE & MERSEYSIDE STP	**581**	**737**	**127%**	**588**	**551**	**94%**	**405**	**250**	**62%**	**413**	**236**	**57%**	**834**	**865**	**104%**	**843**	**671**	**80%**

Data Source: Weekly Activity Report – Adjusted – Week Ending 26/06/2022

Available at: https://future.nhs.uk/OIforC/view?objectId=25715696

Diagnostics: - Scopes ISP

Source: SUS, Monthly Diagnostics (DM01) and Weekly Activity Return (WAR) *Data in this table has not been adjusted.* *Any site that has submitted data in the last 5 weeks is included in the table, noting they have not all submitted data for all weeks or PODs*	**Diagnostics**			**Diagnostics**			**Diagnostics**		
	Colonoscopies			**Flexible-sigmoidoscopies**			**Gastroscopies**		
ISP.site	4 Week Average Activity	4 Week Average Baseline 19/20	% Difference	4 Week Average Activity	4 Week Average Baseline 19/20	% Difference	4 Week Average Activity	4 Week Average Baseline 19/20	% Difference
CHESHIRE & MERSEYSIDE TREATMENT CENTRE									
FAIRFIELD HOSPITAL	6	5	120%	2	22	9%	3	7	43%
HCA - 52 ALDERLEY ROAD									
HOUGH GREEN HEALTH PARK									
NUFFIELD HEALTH, THE GROSVENOR HOSPITAL, CHESTER							5	0	
SPAMEDICA (WIRRAL)									
SPAMEDICA LIVERPOOL									
SPAMEDICA WIDNES									
SPIRE CHESHIRE HOSPITAL				3	0		1	0	
SPIRE LIVERPOOL HOSPITAL	4	0		5	0		17	0	
SPIRE MURRAYFIELD HOSPITAL	2	0		1	0				
SPIRE REGENCY HOSPITAL	2	0		3	0		2	0	
RENACRES HOSPITAL	2	9	22%	3	5	60%	3	16	19%

Data Source: Weekly Activity Report – Raw WAR Data – Week Ending 19/06/2022
Available at: https://future.nhs.uk/OIforC/view?objectId=20423184

Endoscopy Summary – C&M

For w/e 26 June 2022: (Countess of Chester new additions same as previous week)

WL increased (+625 patients) on previous week to 13,426 patients

- LUFT Aintree (+609 patients) added their overdue surveillance patients as <6 weeks waiting patients
- Increases at LUFT Royal (179 patients) and Warrington and Halton (118 patients) in last 4 weeks

13+ week waiting patients increased (+43 patients) to 3,993 patients

- Patients waiting <6 weeks increased due to LUFT Aintree adding overdue surveillance patients
- Wirral (19%) decreased in last 4 weeks
- East Cheshire have fewer than 35 patients waiting 13+ weeks (and fewer than 60 waiting 6+ weeks)

Activity (2,102 patients) decreased by 10% from previous week

- Activity decreased at LUFT Royal and St Helens and Knowsley
- New additions increased as LUFT Aintree added overdue surveillance patients; other units decreased new additions by 87 patients

Future capacity estimates for June around 4,500 BSG points on average

- Future capacity decreasing at Countess of Chester, LUFT Aintree and Mid Cheshire

Endoscopy recovery goals to focus on WL decrease and increased productivity

- East Cheshire, Mid Cheshire and Wirral have less than 15% of patients on waiting list waiting more than 13 weeks
- Countess of Chester have increasing % patients waiting more than 13 weeks; LUFT Aintree decreased due to addition of overdue surveillance patients as <6 week waiters
- Increased in booked points at Southport and Ormskirk

Data Quality issues

Activity comparison to previous year will be affected by the following changes:

- Clatterbridge Cancer Centre - A change in coding of some systemic anti-cancer treatments (SACT) from day case to outpatient with procedure
- East Cheshire - Activity that has shifted out to another system, Significant coding or counting change & Activity has shifted to a provider that does not submit to SUS
- Liverpool Women's – Termination of Pregnancy changed from day case to outpatient
- The Walton Centre – PMP (Pain Management Programme) activity historically coded as regular day and night attenders, but will be coded as day case from 1st October
- MCHT – A change in Day Case to out patients. Bowel Scopes have been replaced by Bowel Screening. Orthopaedic injections will now be carried out as a out patient procedure rather than day case.

Board of Directors (in Public)
Item 4.2

Subject: Month 3 SOF Performance Report
Date of Meeting: Tuesday 26th July 2022
Prepared by: Executive Directors
Presented by: Jonathan Mathews, Chief Operating Officer
Purpose of Report: For information

BAF Reference	Impact on BAF
BAF2	The paper provides assurance that performance against the statutory indicators remain in line with plan.

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 30th June 2022 and should be read in conjunction with the performance dashboard that is attached as Appendix 1.

The Trust continues to operate in an environment that is focused on safely restoring high levels of elective activity as an output of the COVID-19 pandemic. In terms of the Trust's statutory performance the following exceptions should be noted:

Operational performance:

- Referral to treatment waiting times remain below target as expected due to the significant backlog accumulated during COVID. Performance in month stands at 81.44% for English commissioned activity and 84.34% for Welsh commissioners.
- There were 58 patients waiting longer than 52 weeks at the end of June. Staff sickness, urgent demand and dropped anesthetic sessions have impacted our Q1 trajectory, IPC (integrated performance committee) have been evaluated of the key areas of concern

within the Surgical waiting list.

- The overall waiting list size has been added to the POF this month and shows that we are currently higher than the forecast trajectory. This is currently under review and is being managed through weekly performance.
- Three Cancer targets remain an active concern for performance: Faster Diagnosis at 55.6%, the 62-day position at 75% and the 62-day consultant upgrade position at 84%. An action plan for Cancer performance has been jointly developed by the Divisions, however capacity constraints for diagnostics (EBUS & CT guided biopsy) remain a continued risk.

Workforce:

- Sickness remained above the 3.4% target in June at 5.19% however is an improving position month on month . The teams are focused on clear and early intervention to avoid long term sickness where appropriate. COVID sickness for July has shown an increase and is expected to impact on the Q2 position.
- Staff turnover continues above 10% and a Trust wide retention action plan has been developed to improve retention rates.
- Executive turnover remains below the target as it is a 12 month rolling average and is impacted by previous months.
- Staff survey figures were shared with the Board April and the divisions have developed their own specific action plans for 2022.

Quality:

- HSMR data is still highlighted as non-compliant, however the data is currently only available up until Mar 22.
- Dementia Find has been missed in June and is showing at 87.5%. One patient not assessed as admitted as an emergency transfer direct to Oak from Whiston 17/6 and went to theatre the same day.

Safely restoring maximum levels of elective activity amongst COVID system support remains the focus for the operational teams, and updates will continue to be provided to Operational Board monthly.

2. Financial Position

The financial performance for the period ending 30th June 2022 is a £586k surplus against a £581k surplus plan. The plan has been updated following discussions with the ICB and the full year target is £2,328k surplus as a result of additional national funding and CIP.

Income is broadly in line with plan with the majority of patient related income remaining on block contracts. Elective Recovery Funding (ERF) which is variable in nature has been assumed in line with plan whilst we await the national baseline analysis to support reconciliation. Private patient income is lower than plan with the target increasing back to the pre-pandemic level in line with national planning assumptions; Isle of Man income has been particularly strong in

month 3 and has offset. Recovery of private patient income is a workstream that is being progressed operationally.

Expenditure is broadly in line with plan. There are some pressures in medical and nursing pay related to covering vacancies offset by underspends in other staff groups. Non-pay pressures include unidentified CIP offset by underspends in clinical supplies.

CIP targets have been allocated to Divisions and Departments and work is progressing in identifying and progressing schemes.

Capital expenditure was £1,697k year to date related to the ongoing progress on the catheter labs refurbishment and small values associated with completing schemes rolled forward. The Trust is received confirmation of the ICB capital allocation and has now concluded the capital programme for the year. Those schemes not supported by the ICB will roll forward to next year and mitigations have been put in place to address any risks.

The Trust retains a strong cash balance.

3. Conclusion

The Trust has continued to have staffing challenges in Q1 but have been able to deliver improved performance in several indicators. The Trust continues to monitor issues with COVID sickness as well as staffing pressures across Anesthetics and Radiology. However, these are being mitigated as far as possible. The clinical and operational teams are well sighted on the required performance and targets for 22/23 which will be managed through 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.

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

LIVERPOOL HEART AND CHEST HOSPITAL PERFORMANCE REPORT

Operational Performance

measure	target		in month	variation
RTT 18 weeks in aggregate - Incomplete Pathways	92.0%		81.44%	
Welsh Patients: 26 weeks Referral To Treatment waiting times - Incomplete	95.0%		84.34%	
Referral to treatment - Incomplete Pathways 52+ weeks	48		58	
Overall Size of Waiting List	4,522		5,777	
Outpatient activity delivered remotely via telephone or video consultation	25.0%		32.9%	
PIFU Pathway	113		172	
Elective Activity Levels	100.0%		113.0%	
Cancelled Operations for non-clinical reasons	2.0%		1.5%	
Patients not booked in within 28 days (non clinical cancellations)	0		0	
Maximum 6-week wait for diagnostic procedures	99.0%		99.14%	
Bed Occupancy	80.0%		81.96%	

Operational Performance and Quality of Care

measure	target		in month	variation
National patient safety alerts not completed by deadline	0		0	
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%		96.9%	
Cancer: 31 day Second or subsequent treatment (surgery & drug)	94.0%		100.0%	
All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85.0%		75.0%	
Cancer: 62 day Consultant Upgrade	85.0%		84.0%	
Cancer Patients meeting the Faster Diagnosis Target (FDT)	75.0%		55.6%	
Quantity of complaints	6		3	
Occurrence of any Never Events	0		0	
Mixed sex accommodation breaches	0		0	
Venous thromboembolism (VTE) risk assessment	95.0%		95.58%	
Clostridium Difficile	0		0	

Quality of Care

measure	target		in month	variation
MRSA Bacteraemias	0		0	
MSSA Bacteraemias	0		0	
Gram Negative Bacteraemias	0		1	
Hospital Standardised Mortality Ratio (HSMR) - basket diagnoses	101		61	
Hospital Standardised Mortality Ratio (HSMR) - all diagnoses	101		126	
Dementia - Find	90.0%		87.5%	
Dementia - Assess	90.0%		100.0%	
Dementia - Refer	90.0%		100.0%	
Delayed Transfers of care	5.0%		1.73%	
In-Hospital mortality	17		15	
Incidents - Serious incidents, Never Events, Adverse Events (Red)	1		1	
Clostridium difficile – infection rate	0		0	

Organisational Health

measure	target		in month	variation
Staff Sickness (All Staff)	3.4%		5.19%	
Staff Turnover	10.0%		11.15%	
Executive Team Turnover	25.0%		38.79%	
Mandatory Training Compliance	95.0%		95.5%	
Appraisals Compliance	90.0%		74.2%	
Recurrent CIP identified	100.0%		65.44%	
Liquidity (days)	0		28	
I & E distance from target (cumulative) - £,000	0		5	
Better Payment Practice Code	95.0%		99.0%	
Inpatient scores from Friends & Family Test - % positive	95.0%		99.6%	
NHS Staff Survey - Staff recommendation of the organisation as a place to work	76.0%		74.0%	
NHS Staff Survey - Staff recommendation of the organisation as a place of treatment	96.0%		91.6%	

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Board of Directors (Public)
Item 5.1

Subject: Annual Review of Corporate Governance Manual
Date of meeting: Tuesday 26th July 2022
Prepared by: Nusaiba Hannan, Executive Office Manager & Corporate Governance Lead
Presented by: Karan Wheatcroft, Director of Risk & Improvement
Purpose of Report: To Note

BAF Ref	Impact on BAF
BAF 7	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. Executive Summary

Mersey Internal Audit Agency has supported the Trust in the annual review of the Corporate Governance Manual in order to provide assurance that it is comprehensive and consistent with best practice.

he Audit Committee met on 19th July 2022 and considered and supported the proposed updates. The Audit Committee recommended that these are now approved by the Board of Directors and the revised Corporate Governance Manual adopted.

2. Key Updates

The ‘Contents’ page of the revised Manual is attached at Appendix 1. A copy of the manual can be circulated on request in full in order to view the changes, although a summary of the key changes made during the review is attached at Appendix 2 with many being minor amendments.

The significant changes that have been made are:

- The Risk Management Policy has been updated in terms of the Board risk appetite statement (this is provided to the Board of Directors as a separate paper for approval).
- The Organisation Learning Policy has been completely updated to reflect all aspects of organisational learning (this was circulated to the Audit Committee in full)
- The establishment of Health Procure Liverpool (HPL) needs to be reflected within the relevant aspects of the CGM. We have received the key documents setting out the proposed waiver processes and once approved these will be reflected in the CGM (these papers were circulated to the Audit Committee in full).

Other key updates reflect changes to terms of reference or policies that have been made during the year.

This update is provided in the context that there are a number of key publications currently being developed nationally to reflect the new Health and Social Care Act and establishment of the Integrated Care Boards, with a revised Code of Governance of particular note. A further review of the CGM will be needed as these revisions are published in full.

3. Recommendations

Following a review of the changes made to the Corporate Governance Manual by the Audit Committee it is recommended that the Board of Directors approve the changes and adopt the revised Corporate Governance Manual including the HPL Waiver processes. The revised Corporate Governance Manual will then be uploaded onto the staff intranet, in accordance with the Trust's document control procedure.

Appendix 1

Corporate Governance Manual

Table of Contents

1. **Foreword**

2. **Provider Licence**
   2.1 Monitor Provider Licence

3. **Constitution of the Foundation Trust**

4. **Standing Financial Instructions & Tendering Procedure**
   4.1 Tendering Procedure
   4.2 Standing Financial Instructions

5. **Scheme of Reservation and Delegation (SORD)**

APPENDICES

A. Conduct and Probity

A1 NHS Constitution for England

A2 Code of Conduct for NHS Boards

A3 Code of Conduct for Council of Governors

A4 Code of Conduct for NHS Managers

A5 Standards of Business and Personal Conduct Policy

A6 Payment by Results Code of Conduct

B. Key Corporate Arrangements and Policies

B1 NHS Foundation Trust Accounting Officer Memorandum

B2 Board Assurance Framework (BAF) Policy

B3 Risk Management Policy

B4 Internal Audit Charter

B5 Capital Investment Policy

B6 Treasury Management Policy

B7 Anti-Fraud, Bribery & Corruption Policy and Response Plan

B8 Managing Conflicts of Interests Policy

B9 Freedom to Speak Up Policy

B10 Information Disclosure Policy

B11 Fit and Proper Person Policy

B12 Organisational Learning

B13 Government Procurement Credit Card Policy

B14 Data Quality Strategy

C. Terms of Reference – Assurance Committees

C1 Board Committee Structure

C2 Audit

C3 Charitable Funds

C4 Quality

C5 Integrated Performance

C6 People

C7 Nominations & Remuneration - Executives

C8 Operational Board

C9 Committee of Board: Hosted Organisations

D. Council of Governors

D1 Statement of Roles and Responsibilities of the Council of Governors

D2 Policy for Raising Serious Concerns that are critical to the overall performance and welfare of the Foundation Trust

D3 Engaging the External Auditor to supply additional (non-audit) services

D4 Terms of Reference - Nominations & Remuneration (Non-Executives)

D5 Composition of Non-Executive Directors

Appendix 2 - Proposed Key Updates to the Corporate Governance Manual – July 2022

A review of the Corporate Governance Manual is undertaken on an annual basis. The latest review has been undertaken with support from MIAA. The key changes made to the document are summarised below.

Document	Ref	Update – Main Changes
1.Foreword		Updated to add that the Code of Governance sets out best practice principles and processes to help organisations maintain good corporate governance.
2. Monitor Provider Licence	2.1 Monitor Provider Licence	No changes.
3. Constitution		No changes.
4. Standing Financial Instructions and Tendering	4.1 Tendering Procedure	Will be updated to make reference to Health Procurement Liverpool *(waiver process documentation provided to Audit Committee).*
	4.2 SFI	No changes.
5. Scheme of Reservation and Delegation (SORD)		Updated the virement section to be in line with comments under B15 below. Also made a clear reference to Liverpool Network Alliance (LNA) approval limits to state that they are consistent with the Trust approval limits (this was a recommendation from the internal audit Hosted Services review).
APPENDICES		
A. Conduct and Probity	A1 – NHS Constitution	No changes.
	A2 – Code of Conduct for NHS Boards	No changes.
	A3 – Code of Conduct for Council of Governors	Update to note that the Code of Governance now relates to NHSEI rather than Monitor. Corporate Vision and Values updated. Director of Corporate Affairs duties re-assigned.
	A4 – Code of Conduct for NHS Managers	No changes.
	A5.1 – Standards of Business and Personal Conduct Policy	No changes.
	A6 – Payment by Results Code of Conduct	This was an external Department of Health document and it is no longer relevant. It can be removed.
B. Key Corporate Arrangements and Policies	B1 – NHS Foundation Trust Accounting Officer Memorandum	No changes.
	B2 – Board Assurance Framework (BAF) Policy	Executive Lead name change. Update of Executive Team responsibilities re BAF.
	B3 – Risk Management Policy	Executive Lead changed from Director of Corporate Affairs to Director of Risk & Improvement. Values and behaviours updated. Risk register updates to Divisional meetings changed from a frequency of quarterly to twice a year. Risks with a score of 12 and over to be reviewed monthly. Committees of the Board to receive assurances against risks in their remit.

Document	Ref	Update – Main Changes
		Director of Risk & Improvement responsibility around risk registers added. Risk Appetite Statement updated to reflect the Board risk appetite refresh session. Risk Appetite levels wording changed for Open risk category.
	B4 – Internal Audit Charter	Date change only.
	B5 – Capital Investment Policy	Reference made to the reduction in autonomy for Foundation Trusts in capital decision making. Reference also made to the ICS and role in prioritisation and approval.
	B6 – Treasury Management Policy	No changes.
	B7 – Anti – Fraud, Bribery & Corruption and Response Plan	No changes.
	B8 – Conflict of Interest Policy	No changes.
	B9- Freedom to Speak up (FTSU) Policy	Author amendment. Executive Lead changed from Director of Corporate Affairs to Director of Risk & Improvement throughout the document. Added Chief Executive personal pledge. Additional FTSU Guardian added. NHS Whistleblowing Helpline noted. Added that wherever possible, the investigation report arising would be shared with those raising the concern. Annual report on FTSU to be submitted to Board rather than Audit Committee. Outside Body contacts for those raising concerns updated. Separate section added on the National Guardian's Office.
	B10 – Information Disclosure Policy	Author's job title amended. Information Governance Team replaced with IG Team, LHCH replaced with the Trust. Digital Healthcare Committee amended to Digital Excellence Committee (DEC). National data opt out updated with new compliance deadline and Trust status. Urgent COH requests reworded. Timings for email requests. IG training amended to IG/data security and protection. FOI exemptions reworded with additional guidance. FOI process updated and presented in table format.
	B11 – Fit and Proper Person Policy	Author amendment. Executive Lead changed from Director of Corporate Affairs to Director of Risk & Improvement throughout the document. New 2022 Health and Social Care Act regulations referenced.
	B12 – Organisational Learning	Full refresh of the policy including the appendices which are all new and the general content has been updated to reflect all aspects of organisation learning. *(full policy provided to Audit Committee).*
	B13 – Government Procurement Credit Card Policy	No changes.
	B14 – Data Quality Strategy	Author amendment. Additional action added to link in Strategy with Alder Hey Children's NHS Foundation Trust and combined service.
	B15 – Budget Virement Policy	Amended to include a distinction between recurrent and non-recurrent virements.

Document	Ref	Update – Main Changes
C. TOR – Assurance Committees	C1 – Board Committee Structure	Hosted Organisations Board added to Main Board Sub-Committees. Executive Committees analysis updated to include: Research & Innovation; Capital Programme Board; Infection Prevention; Strategic Accommodation; and Safety Surveillance.
	C2 – TOR Audit Committee	No changes.
	C3 – TOR – Charitable Funds	Executive Lead name change to Chief Finance Officer.
	C4 – Quality Committee TOR	No changes.
	C5 – Integrated Performance TOR	No changes.
	C6 – People Committee ToR	No changes.
	C7 – Nominations & Remuneration - Executives	Author amendment. Executive Lead change to Director of Risk & Improvement throughout the document.
	C8 – Operational Board ToR	Author amendment. Additional objective/duty added: Review the wider system developments and collaborations in respect of positioning, influence and impact for the Trust. Added additional sub-committees of the Operational Board: Outpatient Transformation; Research and Innovation; Health Procurement Liverpool; and Strategic Accommodation Group. Added Director of Medical Education to the Membership.
	C9 – Committee of the Board Hosted Organisations	No changes.
D. Council of Governors	D1 – Statement of Roles and Responsibilities	Note that Monitor replaced by NHSEI.
	D2 – Policy for Raising Serious Concerns	Author amendment. Executive Lead changed to Director of Risk & Improvement throughout the document.
	D3 – Engaging the External Auditor	Author amendment. Executive Lead changed to Director of Risk & Improvement throughout the document.
	D4 – TOR – Nominations and Remuneration (Non-Executives)	Note that Monitor replaced by NHSEI. Author amendment. Executive Lead changed from Director of Corporate Affairs to Director of Risk & Improvement throughout the document.
	D5 – Composition of Non-Executive Directors	No changes.

Board of Directors (In public)

Item 5.2

Subject: EECS and CQC Quality Assessments Surgical Division
Date of Meeting: Tuesday 26th July 2022
Prepared by: Angela McKenna, Safeguarding and EECS Lead
Presented by: Sue Pemberton, Director of Nursing, Quality & Safety
Purpose: To Note

BAF Reference	Impact on BAF
BAF 1	To provide assurance on CQC and quality standards within the surgical 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 Tendable, 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 is 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.

DRAFT

The Surgical division has been assessed in its entirety throughout quarter four 2021/2022 and completed in March 2022. The assessments were conducted within Cedar ward, Maple Suite, Oak Ward, Rowan Suite and Theatres. 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 Tendable app at LHCH (Previously named Perfect ward) a review was conducted in April 2021 of the Trusts' EECS assessment process and together with our approach to CQC mock inspections. Tendable 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, Quality and Safety.

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

The areas within the Surgical division are listed below with the outcome of the EECS or service review.

Section	Area	Outcome	Key Themes	Improvements Required
1.	Cedar Ward	93.6%	• The ward was extremely clean and tidy on each visit. • Although the ward was busy, there was a calm atmosphere. • There were plenty of staff in bays and staff were observing patients that require observation. • Staff were knowledgeable. • 4 out of 5 staff questioned were confident they could raise concerns or use HALT. 1 HCA said they would feel uncomfortable to use HALT with a member of the medical team.	• Some patients didn't know about HALT. • Some 'What matters to me' boards had not been completed. • There was only 1 patient who knew what medications they were taking, other patients were unsure, although 1 patient had asked not to be informed and acknowledged that he would receive this information on discharge. • Majority of patients felt they hadn't been given health promotion advice whilst in hospital. • Some staff felt there was not always

				enough staff rostered on shift, however upon asking what they would do, they knew how to escalate appropriately if they felt there were safety issues. • General lack of awareness around LocSSIPs and NatSSIPs amongst all staff spoken to. • General lack of knowledge around finance, however Ward Manager adds this information into the ward meeting minutes.
	Maple Suite	90.56%	• Response from staff on the ward was extremely welcoming, they showed an interest in the assessment. • Training records were immaculate. • Support of complex patients has been good; patients are well supported. • Patient feedback was outstanding. • Leadership was outstanding and staff praised their Ward Manager and Matron. • New staff and junior staff are fully supported.	• Cleaning of the echo room was a challenge on the day. • Junior Doctor was unaware of HALT.
	Oak Ward	93.76%	• First impression, staff very welcoming, all friendly and engaging. • The ward was clean, tidy, and bright with a relaxed environment. • 'What matters to me' boards all present and complete. • HALT signs were visible behind bed spaces. • Comfort checks completed hourly. • Good teamwork demonstrated. • Equipment competency folders for all staff.	• Staff uniform non-compliance observed, nail polish and fake lashes were observed. • Suction on resuscitation trolley did not have the suction attached, however there was a portable suction which was attached. When checking the following day, this had been rectified. • Some Mindray equipment not tagged. Health care

DRAFT

			• Staff meetings take place led by Ward Manager and Band 6's. • Daily safety huddles take place with a Multi-disciplinary approach. • Staff felt proud to work for LHCH. • Excellent feedback received from patients regarding staff. • Patients felt the ward was like a hotel regarding food and care. • Staff aware of most recent complaints together with learnings. • Staff aware of evacuation policy procedure, Business continuity plans and how to report an incident, safeguarding team, clinical lead, policies, end of life, tissue viability. • Aware of budgets and CIP's. • Senior staff visible. • Excellent leadership.	assistant confirmed that they are normally cleaned and tagged following each patient. • One new member of staff did not know how to use the McKinley syringe driver. • Improvement required around knowledge of Safety 7. • NatSSIPs and LocSSIPs – staff unaware how to pinpoint particular procedures.
	Rowan Suite	90.7%	• Welcoming ward with friendly staff. • Staff willing to engage with assessors. • Clean ward. • Patients had all met and spoken to the ward manager. • Staff member providing meals was appropriately dressed in correct apron. • Kitchen was immaculate. • Ward manager holds competency files for each member of staff to include review dates. • Good number of mentors available on the ward. • Staff are happy that they receive timely rosters. • Staff felt that the ward manager is approachable. • Good compliance for mandatory training. • Excellent patient feedback, patients	• All staff bare below elbow, although one doctor was observed with three quarter length shirt. • One Advanced Nurse Practitioner was observed non-compliant with uniform policy, although she was compliant when going in to see the patient. • No Safety 7 poster on display, however this had been removed by the ward manager to discuss with the team and has now been redisplayed. • Lack of HALT posters visible in patients' rooms, however HALT posters were visible around the ward. • No 'What matters to me' boards, however

DRAFT

			explained that staff were fantastic and named Health care assistants and staff nurses who had been helpful. • Patients all had access to phones to call relatives. • Good newsletter to include the ward financial position.	new boards have been delivered and are currently waiting for estates to display. • One observation machine untagged. • Two storage rooms dusty and utilisation of the rooms may be improved. • Several side rooms set up with suction liners however it was unclear whether every room should be set up in case of emergency. • New staff unaware of the safeguarding lead nurse and contact for end-of-life advice. However new staff explained that they would escalate to the nurse in charge and will ensure they are aware of contacts going forward. • One patient noticed overflowing bins outside his room in the courtyard. This area belongs to Elm ward where scaffolding is currently in place. Ward manager has addressed this.
	Theatres	94.32%	• Good mandatory training compliance. • All staff received appraisals with objectives set. • Staff knew where to access policies. • All staff are aware of the be civil, be kind board • Staff and students felt supported. • Local inductions recorded appropriately. • All staff provided with an opportunity to be involved in complex cases. • Excellent education and training. Supportive mentors allocated.	• All staff knew where the safety 7 poster was located. Some ongoing safety work taking place by Matron. • New member of staff was unsure where to print a business continuity plan, however they would ask the band 7 for help. • Staff unsure of safeguarding leads and doctors, 3 new members of staff stated that they would ask their manager for guidance

DRAFT

			• Professionally presented staff all complying with the uniform policy. • All areas clean and tidy. • Patients treated with care and compassion. • Patients complimentary of staff and how they were treated, they felt well informed. • Staff aware of complaints procedure. Good evidence of complaints being discussed. • Staff aware of the processes around escalating concerns. • Staff confident in calling a HALT. • Good understanding of the financial position and targets. cost improvement sessions with staff have taken place.	• There are ongoing challenges with items out of stock, however all issues and concerns are escalated appropriately. • New staff had limited understanding around Trust CIP's and financial position.
2. Governance Review		Good	Positive feedback regarding the governance meeting observed by the Deputy Director of Nursing.	• Actions could be seen being rolled over from meeting to meeting (this appeared to be due to non-attendance of the action owner) • The minutes show the Head of Nursing chairs the meeting whereby in Terms of reference this should be the Associate Medical Director (AMD) this was due to absence of AMD. This is in place now the AMD is back from leave. • Observation: colleagues with camera off during the meeting - Added to action plan • There was lots of reading from risk registers etc whereas the expectation is colleagues would have read all papers etc. – added to action plan

DRAFT

			• Suggestion – Could Matrons meet their ward managers and provide one report on risk register – incidents – MEWS and operational matters in one report for the Committee to consider – this should reduce the onus on all registers and documents being presented. • Previous request has been to have individual risk registers for each area. This is currently being reviewed.
3. Surgery Staff Group Discussions 22/3/22 – x12 staff attended- included ward managers, Registered HCA staff, a Matron, and a service line manager. 23/3/22 – x1 staff attended- included a ward manager.	Good	**CQC domains from a patient's perspective** Safe – Staff were able to name safety huddle, learning and sharing, sharing from incidents and complaints Effective – Staff thought services/processes were effective for patients Caring – All agreed LHCH staff overall are very caring Responsive- nil to report. Well led- stated patients didn't always comment on who was in charge or who the managers were. **CQC domains from Staff perspective** Safe – spoke about Delirium and how it can be unpredictable, did agree it seems to be improving Effective – Staff spoke about taking their job home with them, because they want to do such a good job, sometimes they are tired, exhausted. They discussed unprecedented covid times and the stress attached to that. Staff said they don't always get the basics, such as toilet breaks, food, drinks, sometimes because they feel like they won't get their work done if they take a	• When nursing patients 1:1 Health care staff often did this for a whole shift or long day – need to consider it would be beneficial for staff experience to rotate this throughout a day. • Some staff were not receiving appropriate breaks due to choice and workload on occasion.

DRAFT

		break and they won't leave shift on time. Some had never been to the staff hub or knew what was is in there. Caring – They felt all staff are treated with compassion and kindness from management. Responsive – Short staffing can sometimes be an issue, especially if a 1:1 is required, staff felt they do have support and spoke about positive appraisals. Well-led staff felt everybody has really tried their best in their role, they felt managers were supportive. Staff were able to recall the Trusts values and behaviours and knew about FTSU.	
4. Well-Led Interview and CQC Self-Assessment	Good	A well led interview was conducted on 25th April 2022 with the Triumvirate ad the Director of Nursing and Quality. A self-assessment had been completed by the division prior to the interview. The interview outcomes included: • Asked regarding knowledge of each other objectives – Divisional Head of operations aware of Head of nursing but not of Associate Medical Director. Divisions to review. The triumvirate were clear they meet weekly and review their key areas of focus. There is healthy challenge between all members. • Feedback regarding oversight of governance on Friday 22nd April. Overall, positive. Chair led the meeting well and challenge observed between attendees. Meeting was held on teams and some members of the committee did not have cameras on and were not	

DRAFT

		as engaging as would be expected. Noted that this is an area for improvement across the Trust also. Discussed the need to involve ACHD and vascular teams in governance within the division and that ACHD recently attended a meeting. Work in progress. • Asked about plans for day of surgery and utilisation of Aspen Suite. Update from divisions is that they are up to 25%-day surgery in thoracic. They are planning to look at how Rowan and Aspen can be used as a unit for day of Surgery. Discussed succession planning and time planned to develop others. Recognition that Head of Nursing should meet more formally with the matron to discuss development. Also, discussion on clinical leadership and the importance of succession planning for the future within the medical team. • Discussed reporting culture across the division and recognition that cedar and theatres are top 2 reporting areas trust wide. Also acknowledged that the medical staff are reporting and escalating more over past few months. Discussed mandatory training for medical staff. Assurance received that this being addressed with individuals who are non-compliant. • Discussed high number of falls particularly in cedar ward noting that there had been a reduction over the last 4 months following some	

DRAFT

		improvement work on the ward. • Discussed medicines E learning and 67% compliance on Rowan ward for practical assessment – this is being addressed within the division.	

5. Summary and Conclusion

The new focus of the EECS/CQC plan ensures we gain a divisional overview of care delivery and services. The Surgical division has been assessed and has achieved good and outstanding ratings in most areas, with a small number of areas identified as requires improvement. The Surgical 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 Surgical Division.

DRAFT

Board of Directors (in Public)
Item 5.3

Subject: Freedom to Speak Up (FTSU) Q1-2022 /23
Date of Meeting: 26th July 2022
Prepared by: Peris Widdows, FTSU Guardian
Presented by: Peris Widdows, FTSU Guardian
Purpose of Report: To Note

BAF Ref	Impact on BAF
ALL	The report provides assurance on the arrangements in place to support staff to speak up and to ensure learning from staff concerns is identified and embedded.

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 purpose of this paper is to provide the Trust Board with an update of the work of the Freedom to Speak Up (FTSU) Guardian and Champions in supporting the safety culture within the Trust, reflect on the progress made by the FTSU Network in empowering staff to speak up freely and encouraging ongoing positive cultural change. The paper provides an overview of issues and concerns raised over the last 12 months and updates from the National Guardians Office of Freedom to Speak Up, with the aim of giving assurance that the local arrangements in place continue to meet best practice and support staff to raise concerns.

This is done in the context of an evolving and maturing national agenda, that is learning from the collective experiences of FTSU Guardians, their champion networks and those at the National Guardian Office.

The Board is asked to review the quarterly report and receive assurance that the FTSU arrangements in place continue to meet best practice.

2. Background

The Freedom to Speak Up (FTSU) policy continues to be integrated at Liverpool Heart and Chest Hospital alongside the Trusts other forms of Speak-Up Safely channels. In line with the national guidelines, the trust has appointed Freedom to Speak Up Guardians, whose role is to provide of an alternative channel for workers to raise concerns, ensuring that concerns received are escalated, investigated, and followed up to enhance patient safety and worker experiences.

The FTSU Guardians continue to maintain engagement and communication with the National Guardian's Office and the Northwest Regional Network of FTSU Guardians for regular updates, continued learning and support. The FTSUG continue to work closely with the FTSU Executive Director, champions and senior leaders to enable effective escalation, review and triangulation of safety and welfare concerns. A standard operating procedure within the governance process ensures that all concerns, especially any patient safety or serious issues are escalated immediately to the Chief Executive, investigated, and followed up.

Through a personal speak-up safety pledge, the Trust's Chief Executive encourages all staff to speak up and gives assurance that any concerns raised will be investigated, and the staff will be protected from any detriment after speaking up.

The FTSU Structure

The FTSU network comprises of the FTSU Executive Director, Non-Executive Director Lead, two Freedom to Speak Up Guardians, Deputy Guardian, and a network of multi-disciplinary FTSU Champions.

During recent discussions and as part of the ongoing completion of the Board self-assessment it was agreed to review the FTSU capacity and structure and a decision made to appoint a second FTSU Guardian to enhance capacity, visibility, and continuity for the role. The second FTSUG has been in post for two months.

3 Assessment of FTSU concerns Quarter 1, 2022/23

The trust has several safety reporting channels such as speaking directly to line managers, the HALT process, incident reporting and team and trust Safety Huddles. Issues raised in other channels are not logged as FTSU unless referred to or raised directly to the FTSU Guardian or champions. A total of 10 concerns were raised through the FTSU policy and network in the first quarter 2022/23. Of note, there were no anonymous or detriment cases raised in this quarter. A summary of concerns raised in this quarter is provided in the tables below with further details of action plans and outcomes provided in appendix one.

The themes of the FTSU concerns raised in Q1 2022/23 as categorized by the NGO guidelines and outcomes are detailed in the table below.

Table 3.1: Themes of FTSU concerns (categorised by the NGO guidelines and outcomes)

Themes of concerns as categorised by the NGO	**No. of concerns (Q1 22/23)**	**Outcome**
Element of Patient Safety / Quality (professional conduct)	1	Investigations in progress
Worker Safety: Changes to Trust Covid PPE requirements	1	Continued PPE policy review + regular updates.
Element of Bullying and Harassment: Team and colleague behaviours	2	One resolved informally. One filed formal grievance - investigations in progress.
Detriment from speaking-up	0	
Other Category: • Remuneration • Training and progression • Policy • Guidance and support	6	• Guidance offered as needed. • Actions in place to review related policy. • Triangulation with HR and Education Team. • Shared learning.
No. of Speak-ups in Quarter one 2022/23	**10**	**7 closed** **3 in progress**
Concerns raised anonymously	**0**	

Comparative numbers and themes to previously reported quarters are set out below.

Table 3.2: Comparative themes

Themes of concerns as categorised by the NGO	**Q1 2022/23**	**Q4 2021/22**	**Q3 2021/22**	**Q2 2021/22**
Element of Patient Safety or Quality	**1**	0	2	1
Worker safety	**1**	0	0	2
Bullying and Harassment	**2**	1	0	1
Detriment / demeaning treatment from speaking up	**0**	1	1	1
Other**:**	**6**	3	2	4
Total	**10**	5	5	9
Concerns raised anonymously	**0**	0	0	1

In line with the NGO guidance, comparative views of concerns raised over the In Q1-2022/23 and the previous three quarters, per professional groups are provided the below.

Table 3.3: Comparisons of staff groups raising concerns

Concerns raised by staff bands	**Worker**	**Senior Manager**	**Senior Leader**	**Unknown/ Undisclosed**	**Total**
Q1 2022 / 23	**8**	**0**	**0**	**2**	**10**
Q4 2021/22	5	0	0	0	5
Q3 2021/22	5	0	0	0	5
Q2 2021/22	6	0	0	3	9

The table below reflects comparative data of concerns raised different professional groups for the current and previous 3 quarters, as per the National Guardian Office guidelines.

Table 3.4: Comparison of concerns raised by different professional groups

Concerns raised by professional groups	**Q1 2022/23**	Q4 2021/22	Q3 2021/22	Q2 2021/22
Medics	**0**	2	0	0
RGN/ Midwives/ ANPs	**1**	1	3	1
Nursing Assistants & HCA	**0**	0	0	0
Allied Health Practitioners	**1**	1	2	2
Admin, Clerical	**3**	0	0	3
Maintenance/Ancillary/Cleaning/ Catering/ Porters	**1**	0	0	0
Corporate Service Staff	**0**	1	0	0
Undisclosed	**4**	0	0	3
Total number of speak-ups	**10**	5	5	9

In terms of analysis of FTSU concerns and actions:

- There was one patient safety concern related to clinical practice which has been escalated through appropriate channels and actions implemented. Follow up discussion will be taken to confirm outcomes
- In the staff safety category, changes to Trust Covid PPE requirements have been continuously reviewed. Learning identified around provision of clearer understanding of national policy, the local risk assessments and the decision-making processes followed. Guidance was issued with local communications ongoing. DIPC perspective and involvement in response.
- Team and colleague behaviours were actioned by encouraging discussion with line manager, signposting to Trust HR policy and processes and offer to re-connect with FTSU.
- In the other category around remuneration, training and progression, facts gathered on through engagement with Human Resources and Education managers and cascaded.
- There were no specific trends identified.

The following areas for wider organisational learning areas were identified:

- The need to raise awareness of the training offer
- Manager support and consistency
- Clarity of roles and responsibilities
- Triangulation with HR processes
- FTSU Guardians and Champions often provide support through signposting colleagues and/ or factfinding/ information gathering
- Listening can help individuals to determine the action they want to take
- Triangulation is important

4. Update on previous ongoing cases

Two Bullying and Harassment / detriment concerns were carried forward from quarter 4, 2021/22, with

formal grievances raised through Human Resource processes. Of these:

- One case has since been completed. Colleague feedback awaited before closure.
- Investigations still in progress for the second case and outcome awaited.

In both cases there was an open door for FTSU support to colleagues as needed.

5. Progress on Internal assessments and Governance

MIAA commenced an internal audit of FTSU arrangements in June 2022. The audit is progressing and the report is expected for the October 2022 Audit Committee meeting.

The Board Self-Assessment Review which had been put on hold due to the Covid-19 pandemic since 2020 was completed and approved by the Board in quarter 1 2022/23.

The FTSU Policy was reviewed and updated in June 2022, and is awaiting final approval in July 2022.

Engagement with the FTSU champions for support and updates continues through regular correspondence and quarterly FTSU workshops. These create opportunity for champions to learn and share / showcase their experiences. The latest workshop was held on the 14th of July, attended by the FTSU Non-Executive Director, the Executive Director, the two Guardians and a group of champions. Slides have been circulated to all champions.

6. Updates from the National Guardian Office

NHS England has published an updated national Freedom to Speak Up Policy and Guidance (June 2022).

- The **Freedom to speak up policy** (e-book) includes:
  - ➢ References the People Promises and ED&I
  - ➢ Summarises the routes to speak up and how
  - ➢ Signposts national organisations for support and advice

- **The guide for leaders** in the NHS and organizations delivering NHS services is aimed at Senior Leaders and Boards. The guide provides ideas about how FTSU principles can be developed and embedded

These resources are being reviewed alongside the NGO FTSU reflection and planning tool (published June 2022) to ensure our arrangements continue to reflect best practice.

7. Conclusion

The FTSU compliments existing speak-up safely policies and processes within the trust, providing an alternative channel for staff to speak confidentially or anonymously. The policy provides assurance that concerns will be escalated, and workers are supported during the process and investigations.

The FTSU Guardians supported by the network of champions continue to maintain engagement with

the staff to raise the FTSU profile, support staff who have raised concerns, record and follow-up cases raised. The FTSU Guardians will continue to provide quarterly and annual reports on the number of concerns raised through the FTSU Network and any common themes to the Board of Directors and the National Guardian's Office. Learning from cases will continue to be reviewed and shared appropriately. The FTSU guardians will continue to maintain engagement with the National Office and regional networks to ensure that national updates are cascaded and implemented.

8. Recommendations

The Board of Directors is asked to:

i) note the Q1 2022/23 report.

ii) receive assurance that local FTSU arrangements are in place and continue to meet best practice.

Appendix 1: Concerns raised in Q1 2022/23, Action Plans and Outcomes

Concern	Actions	Outcomes
1. Recruitment and induction policy	Escalated and fully reviewed by Critical Care Manager, Head of Recruitment, Lead Recruitment Nurse. Review of international recruitment process. Changes to recruitment agencies in place to improve new starter experiences. Work in progress for continued feedback requests and anonymous data capture for continued improvement.	Concerns have been addressed and Learning extracted and shared. **Closed**
2. Training, and Career Development pathways, perception of exclusion, role management and organization.	Escalated to Ward Manager, Head of Education and HR Manager	Specific staff group currently undergoing organizational change to be placed under a directorate. Available learning pathways identified through HR and Education Team. Need for inclusion of all staff to ward meetings, career progression discussions and regular check-ins for support identified and cascaded for sharing with ward managers. **Closed**
3. Role banding and remuneration	Discussions underway as linking to above admin speak-up.	Await outcome to ongoing meetings and organizational change. **Open**
4. Patient safety / colleague's professional conduct	Case being formally investigated by professional body. Anonymous statement provided.	Formal professional investigation in progress. FTSU closed as escalated to appropriate channels. Open door to FTSUG for support as required. **Closed**
5. Discrimination / Bullying and Harassment (Team and colleague behaviours)	Signposted to line manager and HR Business Partner.	Formal grievance raised at HR. Investigations in progress **Open**
6. Discrimination / harassment (Team and colleague behaviours)	Listening and guidance and options. Colleague happy escalate directly to ward manager.	Colleague spoke to deputy manager. Issues addressed informally, locally. **Closed**
7. Remuneration	Concerns already raised to the manager and escalated to finance department at the point of the speak-up.	Await outcome to current review process and receive guidance re-appeal process if dissatisfied with the outcome. No FTSU input at this point. Open door to FTSU if new concerns arise in the

Concern	Actions	Outcomes
		meantime. Follow-up in 4-6 weeks for further action plan. **Open**
8. Changes to Trust Covid PPE requirements	Escalated to Head of Risk Management and DIPC. Colleague updated on guidance assessed and utilized prior to implementing current changes and ongoing review processes. Issues already under review by trust leadership.	Update on current processes provided. **Closed**
9. Size and numbers of patient property brought in (Other category)	Already discussed previously with risk assessment team. Raised at safety huddle.	Patient Property Policy updated. **Closed**
10. Guidance and support requested – on dealing with investigations in department and related stress (Other category).	Signposted to staff welfare support team and union representative.	ongoing peer support provided. Regular check-ins and open door to FTSU if needed. **Closed**

Board of Directors (in public)
Item 5.4

Subject:	**Emergency Preparedness and Business Continuity Assurance Report**
Date of meeting:	**26th July 2022**
Prepared by:	**Helen Martin, Head of Risk Management**
Presented by:	**Karan Wheatcroft, Director of Risk and Improvement**
Purpose of Report:	**To Note**

BAF Ref	Impact on BAF
N/A	N/A

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

In line with the Civil Contingencies Act 2004, LHCH has in place a Major Incident Plan, a Business Continuity Strategy and Business Continuity Plans. Testing of the plans takes place throughout the year, which includes a tabletop exercise each year. Training is conducted by way of business continuity testing in the areas, tabletop exercises and attendance at regional sessions held in year.

The Emergency Planning Group is attended by the multi-disciplinary team and is responsible for monitoring actions from RCA's into business continuity events and oversight of the work carried out as per emergency planning and business continuity.

The Emergency Planning Group reports to the Risk Management Committee and this report has been approved by the Committee.

Each year, LHCH makes a self-assessment against the Emergency Planning resilience Response (EPRR) standards and to date is compliant with the core standard.

2. Background

Liverpool Heart and Chest Hospital (LHCH) has a Major Incident Plan in place, a Business Continuity Strategy and business continuity plans for each area of the organisation which conforms with the Civil Contingencies Act (CCA 2004).

LHCH has constructed its Major Incident Plan on the requirements as stipulated in the Civil Contingencies Act (CCA 2004) (See appendix 1).

The purpose of the Plan is to ensure that all relevant staff are aware of the co-ordinated action and emergency management procedures that need to be implemented in the event of a Major Incident affecting any part of LHCH.

It is emphasised this plan will only be triggered on the declaration of a Major Incident by the appropriately authorised person and will not be stood down until that person or their successor at an equal or higher level in the Trust Management Structure declares it to be over.

Responsibilities are set out in The CCA (2004), which defines an emergency as:

- An event or a situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK.

This Act is supplemented by specific guidance to the NHS from the Department of Health. This defines major incidents for the NHS as being:

- Any occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations.

Additionally, and conforming to best practice, the Trust has an overarching Business Continuity Strategy accompanied by local business continuity plans in all areas.

3. Statutory requirements

3.1 Major Incident Plan

Definitions for what is considered a major incident are clearly represented as part of the Major Incident Plan, which includes descriptions of an external and internal event. This is intended to provide those senior staff who may be required to declare and coordinate in the event of a major incident, with

detailed information as to what is required within that role.

An external major incident will require a multi-agency response, which could include involvement of sectors outside of the NHS, such as police, fire and rescue services or the military. Requirements for mutual aid are described within the plan as is the agreement for information sharing. Leadership in the event of a declaration of a major incident is defined in the roles and responsibilities section.

In the event of a major incident being declared internally, the major incident plan will be required to be activated which includes making a declaration to Northwest Ambulance Service (NWAS). In this event the coordinator of the incident will be considered strategic command (Gold). If, however, the event is regional/national, LHCH will be notified and will assume the role of operational command (Bronze) and will await instructions from command centre. Competent advice regarding the requirement to establish an incident control team and utilise the major incident room is fully described with the plan.

Other considerations including but not limited to vulnerable persons, mass casualties, contaminated causalities and health and safety welfare are also included. Action cards for each of the specified roles required within a major incident are supplied within the document. These offer a description of the exigent tasks to be undertaken throughout the period of the event.

At the commencement of the Covid 19 outbreak and on the instruction of NHSE/I, a command-and-control structure was put in place at LHCH. This allowed for allocation of specific duties to leaders around the development of action cards which among other things, detailed staffing levels that would be required in order to manage the potential intake of patients for the duration of the outbreak.

For the duration of the pandemic, LHCH has flexed arrangements for managing the outbreak. This has included keeping a watchful eye on staffing and ensuring all areas are supported as required while returning to a recovery and business as usual model of work. This is achieved by having in place a rigorous communication strategy and strong leadership.

3.2 Business Continuity

An overarching Business Continuity Strategy is available which provides the leadership and structure for the contingent local business continuity plans. The local plans are split into mission critical services (clinical areas) and supportive functions (non-clinical services).

Each local plan differs slightly depending on the speciality of the area. Within all plans, the most likely business disruption events are described, with actions to be taken at specific time points for example 24hour, 48hour etc. Risks to the service are identified with probability and impact scoring highlighting the degree of severity should a business disruption occur. Crucially, all plans contain business recovery requirements for the disruptive events identified. Review and update of the plans takes place once a year or

in the event of an incident occurring. To date 87% have been reviewed, updated and approved via Divisional Governance Committees. A robust plan is in place to ensure the rest of the BCP's are updated and approved.

3.3 Exercises and Training

Emergency planning and business continuity are communicated via induction training and Divisional Governance meetings.

With regards to business continuity, a schedule of area scenario testing is in place, ensuring that all areas receive a test at least once per year. This is monitored at the Emergency Planning Group. A random member of staff is chosen, and a continuity event is discussed with them. They are asked what they would do to ensure the safety of patients and staff and the return to normal functioning. Feedback of what went well and what requires improvement is discussed at the time and feedback is given to the ward/department manager for further dissemination in the team.

The Emergency Planning Lead Nurse and the Fire/Health and Safety Advisor/Security Manager have been working together to develop larger area scenario tests for CCA and theatre. These exercises will include fire drills and will be conducted on audit days.

Exercises are largely dictated by the EPRR standards.

In February 2020, a cyber tabletop exercise took place which was led by the Head of IT. A number of actions were identified where improvements could be made to existing processes. The action plan is being monitored by the Emergency Planning Group.

In July 2021, the table top exercise topic was dedicated to power outage and lockdown. Several actions were identified and actioned as part of the exercise.

In July 2022, following instruction from NHSE/I, a tabletop exercise was undetaken to test the Mass Evacuation Policy for the organisation. This instruction follows a series of high-profile fires in hospitals across Britain which necessitated the mass evacuation of patients and staff. As with other exercises, the actions that are identified as a result of the exercise will be monitored via the Emergency Planning group.

The CCA (2004) recommends that tabletop exercises are conducted annually; a live exercise every three years (in the absence of a live event) and communications exercises at least six monthly. Since 2015, tabletop exercises have included dealing with Pandemic flu, major power outage for the site, power outage specific to critical care, lockdown, cyber-attack and flooding on site This has resulted in raised awareness of the issues encountered in this scenarios and minor policy changes.

Live continuity events have included EPR downtime, power outage disrupting non-clinical services, power surge affecting critical care, switchboard downtime affecting communications and a significant IT downtime event in February 2019. While these were not declared as major incidents, they did result in minor disruption to services, with subsequent learning being shared

at the Emergency Planning Group. In each case an RCA is undertaken and reported through the Emergency Planning Group with actions monitored by the group.

In November 2021, a bomb was detonated outside the Liverpool Women's Hospital. As a result of this, each hospital was asked to review their communication and lockdown policies. LHCH had reviewed and tested the Lockdown Policy earlier in the year with good results. Communication testing takes place on a monthly basis with results being reported to the Emergency Planning Group.

LHCH has attended and been involved in regional multi agency exercises in successive years since 2016 and has recently contributed to the development of the Regional Emergency Planning Risk Register being led by NHSE. In addition, an 'E' learning package has been developed. This is a basic introduction to business continuity and acts as a refresher to managers and an introduction to the speciality for other staff.

3.4 Emergency Planning group (EPG)

The EPG is chaired by the Head of Risk Management and is attended by the multi-disciplinary members of staff. The groups remit is to discuss recent past business continuity events, receive RCA reports and monitor actions from said events, training, regional news in relation to emergency and business continuity planning and review and discuss business continuity plans. The group meets quarterly and is a forum for providing an oversight of the work carried out as per emergency planning and business continuity. The work of the EPG is monitored by the Risk Management Committee with an assurance report being reviewed in Quality and Safety Experience Committee.

4. Assurances

4.1 Proactive

Along with tabletop exercises, business continuity testing has been carried out across all areas of the organisation on a monthly basis. This involves mainly frontline staff being tested in the areas in which they work, of their preparedness and knowledge of given scenarios and how to manage and recover from them. Feedback is given at the time to the member of staff and written feedback is provided to the manager for onward sharing with the rest of the team. During the pandemic, testing in this way was suspended however, this has now been re-established. The results will be reported to EPG.

Covid testing for staff has been established for the majority of the pandemic and continues to provide a vital service to ensure staff who test positive for Covid are not mixing with colleagues for the duration of their infection. Risk assessments and advice are provided by specialist members of the Risk Team.

A PPE subgroup of the EPG has been established in order to monitor PPE requirements and changes to legislation with regarding to the wearing of

protective equipment. Fit testing will also be monitored via this group to ensure all areas maintain adequate levels of staff who have been fit tested.

Each year the Trust delivers the Flu campaign, deploying a variety of methods to ensure as many staff within the organisation receive the flu vaccination as possible. The 2021 flu campaign achieved 67% of staff choosing to receive the vaccination. This was not as successful as the previous year when 88% was achieved.

Anecdotally, the low uptake was reported by many hospital trusts across the region, with vaccine fatigue being cited as one of the reasons staff chose not to be vaccinated.

The covid vaccination campaign proved successful with 90% of LHCH staff receiving the Covid 1st, 2nd and booster vaccinations.

The campaign was opened up to other health professionals and patients and LHCH vaccinated in the region of 51,000 people.

The Trust has an active membership of Local Health Resilience Partnership (LHRP) strategic and LHRP practitioner groups which meet quarterly. The groups offer a valuable network with other health and social care providers and emergency planning professionals and are a consistently good forum to discuss ideas and share learning from a variety of events.

The Trust has an active page on Resilience Direct which is a secure online portal specifically used by multi-agency partners for emergency planning purposes.

4.2 Reactive

As previously stated, all business continuity events are subject to an investigation with subsequent actions plans being monitored until completion. Key learning includes policy changes and heightened awareness for staff.

4.3 External Assurance

Each year the Emergency Preparedness and Resilience Response (EPRR) core standards are published, and Trusts are expected to self-assess against the standards. LHCH is committed to this process and has successfully achieved substantial compliance against the core standards set in 2021.

The EPRR core standards are released in August with submission required by October 2022.

5. Summary

LHCH has well established business continuity processes across the entire establishment which are underpinned by a strategy and local plans of which all managers are aware. The Major Incident Plan is a comprehensive and detailed document providing leadership and guidance in the event of a major incident. It is aligned to the CCA (2004). Training in business continuity and

emergency planning continues to be provided with scenario testing and tabletop exercises.

LHCH is part of a wider network for EPRR with subsequent learning and sharing capabilities that is able to provide rounded and expert advice on a variety of given situations.

6. Recommendations

The Board of Directors is asked to note the annual report, as approved by the Risk Management Committee.

Appendix 1 - The Civil Contingencies Act

The Civil Contingencies Act (CCA 2004), and accompanying non-legislative measures, delivers a single framework for civil protection in the UK. The Act is separated into 2 substantive parts: local arrangements for civil protection (Part 1); and emergency powers (Part 2).

Part 1

Part 1 of the Act and supporting Regulations and statutory guidance 'Emergency preparedness' establish a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level. The Act divides local responders into 2 categories, imposing a different set of duties on each.

Those in Category 1 are organisations at the core of the response to most emergencies (the emergency services, local authorities, NHS bodies).

Category 2 organisations (the Health and Safety Executive, transport and utility companies) are 'co-operating bodies. They are less likely to be involved in the heart of planning work but will be heavily involved in incidents that affect their own sector. Category 2 responders have a lesser set of duties - co-operating and sharing relevant information with other Category 1 and 2 responders.

Liverpool Heart and Chest Hospital (LHCH) is classed as a category 2 responder as there is no A&E however the organisation would be expected to support Category 1 responders in the event of a Major Incident, depending upon the nature of the incident.

Category 1 and 2 organisations come together to form 'local resilience forums' (based on police areas) which will help co-ordination and co-operation between responders at the local level.

Part 2

Part 2 of the Act updates the 1920 Emergency Powers Act to reflect the developments in the intervening years and the current and future risk profile. It allows for the making of temporary special legislation (emergency regulations) to help deal with the most serious of emergencies. The use of emergency powers is a last resort option and planning arrangements at the local level should not assume that emergency powers will be made available. Their use is subject to a robust set of safeguards - they can only be deployed in exceptional circumstances.

Board of Directors (in Public)
Item 5.5

Subject: **Annual Report of Health and Safety Committee**
Date of meeting: **26th June 2022**
Prepared by: **Adam Hope, Head of Estates Liam Telford, Fire and Safety Lead**
Presented by: **Karen Edge, Chief Finance Officer**

1. Executive Summary

This is annual report on effectiveness of H&S Committee during 2021-22 in terms of delivery of objectives set by BoD (per ToRs) and effectiveness of operation of Committee.

The objectives within the committees Terms of Reference were to monitor performance of health and safety management within the Divisions and provide assurance to the Health and Safety committee and the Risk Management and Corporate Governance Committee as to the effective management of health and safety across the Trust. Some of the objectives target specific needs while others are long term and will roll over from one year to another as they relate to the continual development of health and safety management within the Trust. The objectives are as below.

All members of the committee have attended in line with requirements set out in the Terms of Reference. The Chairman of the committee has reviewed the membership to ensure that it remains appropriate and relevant.

There has been significant progress noted across the Health & Safety function, with areas of improvement such as revising the health and safety assessment, increased control of contractors, permits to work, improved DSE service and compliance, and addition of new evacuation chairs across the trust.

An MIAA audit is scheduled for Q2 of 2022, this will further inform the team of key areas of focus.

2. Delivery of Objectives set by the Board of Directors

ToR Ref	Objective	Evidence to Support Delivery	Outstanding Issues / Action Plan
3.1	Approve the Trust's Health and Safety Policy and monitor	Health and Safety Policy reviewed and ratified at Health & Safety	No Outstanding actions

	adherence to it and take assurance that the Trust operates in a way that meets all regulatory requirements.	Committee on 1st April 2021. The policy has a review date of April 2024. The health and safety committee is well established and meets on a quarterly basis to review and monitor Health and safety arrangements set out by the trusts H&S policy. Risk Registers are reviewed by Divisional Governance Committee's twice yearly and in the Risk Management and Corporate Governance Committee	
3.2	Continue to improve Health & Safety culture for the Trust by effective management of Health & Safety risks throughout the Trust and the monitoring of Ward / Department Health & Safety annual assessments	The 2021 H&S assessment schedule commenced in January 2021. All areas of the trust received a detailed H&S risk assessment in 2021. All significant risks are added onto department risk registers, these risks are reviewed regularly by local managers.	No Outstanding actions
3.3	To review data on incidents to staff, patients and visitors, identifying trends and ensuring appropriate action is taken.	Staff, patient and visitor incidents are reported as a standing agenda item. RIDDOR, Occupational reports and violence and aggression incidents are presented at each meeting. These detail any harm obtained as a result and actions of mitigation taken	No Outstanding actions

3.4	To consider reports and other information provided by the Health and Safety Executive and other external bodies and recommend appropriate action.	Covid Regulations set by NHS England have been adhered too throughout the year, as restrictions have been altered the health and safety team has assisted in the trusts review process.	Support the MIAA audit process and compile an updated action list, and present findings of audit to the relevant channels.
		There have been no visits during this reporting period from external agencies, spot checks last conducted in March 2021. There is an MIAA audit have scheduled a trust wide Health & Safety audit for Q2 2022.	
3.5	Monitor the Trust's performance in relation to H&S KPIs.	Health and Safety dashboard data now presented at every H&S committee meeting and issues relating to staff absence are reviewed at each committee meeting. It has been noted from review of this data, that stress related staff sickness and Display screen Equipment DSE requests spiked significantly in the reporting period of 2021.	As numbers remained low in 2020, no KPI's were set. As the numbers have now spiked, this is cause for concern and KPI's need to be introduced for monitoring.

3.6	To monitor compliance of H&S policies, fire safety and produce an annual report.	Policies are reviewed and approved as per work plan. A 'Smoke Free Policy' has been added as an additional policy to the workplan. Security Annual report – The report detailed that the security team was in a good position to significantly improve its service, and several new initiatives had been introduced. There had been a decrease in all security incidents noted across the period. The Fire Safety Annual report was received by the H&S committee in September 2021. Significant progress has been noted within Fire Safety at LHCH with this confirmed via an external audit in May 2021.	No Outstanding Actions
3.7	To review, consult and ratify policies pertaining to H&S.	Workplan reviewed and all H&S pertaining policies are detailed as part of the work plan which is ratified through the H&S committee.	No Outstanding Actions
3.8	Quarterly updates for key workstreams in safety areas (Fire, Security and Decontamination) by relevant lead	Regular quarterly updates brought to the committee meetings by key stakeholders in decontamination, security, and fire.	No Outstanding Actions

3. Membership and Attendance

The membership composition is made up of senior managers and leaders from multidisciplinary backgrounds across the Trust. The Chairmanship of the committee is performed by the Head of Estates, Health & Safety and Security.

Union H&S rep attends the committee from CSP. There are no other union reps that attend the H&S committee at this time.

All members of the committee have attended in line with requirements set out in the Terms of Reference. The Chairman of the committee has reviewed the membership to ensure that it remains appropriate and relevant.

All meetings in 2021 have been quorate.

4. Sub Committees

The committee receives minutes from the Local Water and Ventilation Safety group, Electrical Safety Group, the Radiation Safety Group, and the Medical Gas Committee.

5. Conduct of Meetings

The work plan is presented at the beginning of the year and is sent out with papers for each meeting. Papers and reports are sent out at least 5 working days ahead of the committee meeting.

The minutes are of a consistently high quality and are sent out one week following the meeting.

Action logging is robust and maintained at each meeting with follow on actions taken to each meeting. Responsibilities for completing actions are clear.

Reporting to the Board is via risk escalation reports reporting to Risk Management and Corporate Governance Committee.

Updated ToR was agreed when the committee met in September 2021. The ToR is due to be reviewed again and presented at the September 2022 meeting.

6. Relevant Health & Safety Updates

The trust's Health and safety risk assessment has been revised to ensure it is suitable and sufficient and incorporates all the recommendations set by the relevant regulatory organisations such as the Health & Safety Executive (HSE)

Contractor control safety and control measures have been reviewed, more stringent control measures have been introduced to improve the safety of contractors, staff patients and visitors. Examples of the systems improved/introduced are as follows; modernised permits to work, improved sign in/out process, more frequent on the job spot checks to ensure all workers and hospital users are as safe as possible.

Additional emergency evacuation equipment has been installed to assist all clinical areas were located on upper floors and may have to use stairs to safely evacuate. Emergency evacuation chairs have been installed, this equipment ensures the trust has the most updated industry leading equipment, this ensures compliance is met and provides reassurance to staff and patients that a safe exit can be achieved in the event of an emergency.

During this reporting period, Display Screen Equipment (DSE) and intimate load assessments, have been inherited by the Health & Safety Team. Significant work has been put into developing this service, with a lot of non-compliant items noted on handover. For example, the team have developed a refreshed risk assessment, an initial DSE policy has been drafted and is due to be ratified at the H&S committee in June 2022. Additional

resource has been allocated to the H&S team to ensure adequate management of this and other H&S services moving forward.

7. Conclusion

The H&S Committee is an established committee of the Trust. It has shown effective and robust leadership for H&S in the organisation. Members of the committee are fully apprised of their responsibilities, are engaged and committed to communicating the importance of H&S to their teams and the wider Trust community.

Appendix 1

Attendance at H&S committee in 2021

Member	June 2021	September 2021	December 2021	March 2022	% Attended
Head of Estates	Yes	Yes	Yes	Yes	100%
Health and Safety Lead	Yes	Yes	Yes	Yes	100%
Chief Pharmacist	Apologies	Yes	Yes	Yes	75%
Divisional Representation	Yes	Yes	Yes	Yes	100%
Risk Lead	Yes	Yes	Yes	Yes	100%
Head of HR or Head of Education	Yes – Nominated deputy	Yes – nominated deputy	Yes – nominated deputy	Yes – nominated deputy	100%

Occupational Health Advisor	Yes	Apologies	Yes	Yes	75%
Infection Prevention and Control Nurse	Yes	Yes	Yes	Yes	100%
Radiology Manager	Yes	Yes	Yes	Yes	100%
Manual Handling Co-ordinator	Yes	Yes	Yes	Yes	100%
Trade Union Rep	Yes	Apologies	Yes	Yes	75%
Security Manager	Yes	Yes	Yes	Yes	100%
Support Services Manager	Yes	Yes	Yes	Yes	100%
Decontamination Lead (Head of Capital Projects)	Yes	Yes	Yes	Yes	100%
Medical Engineering	Yes	Yes	Yes	Yes	100%

Board of Directors

Item 5.6

Subject: **Complaints Process Annual Review – 2021/22**
Date of Meeting: **Tuesday 26th July 2022**
Prepared by: **Laura Allwood, Patient & Family Support Manager**
Presented by: **Sue Pemberton, Director of Nursing, Quality and Safety**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
BAF 1	Assurance regarding the Trust's complaints process.

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 purpose of this paper is to provide assurance that the raising of concerns and complaints, through the Trusts complaint process, is monitored for its effectiveness and efficiency, and is in line with, Making Experiences Count – the NHS adult social care complaints process. All complaints/concerns raised are managed with the upmost in compassion and understanding to those raising a complaint/concern.

The Trust is committed to resolving any concerns at the earliest opportunity. This is often achieved through the patient, relative or carer, discussing their concerns directly with the Patient and Family Support Team in the first instance. In 2021-22 the Trust received thirty-eight formal complaints. This number has remained static in relation to pre covid total number of yearly complaints received. This, in the main, is due to engaging with the complainant, at the earliest opportunity, to review and resolve the concerns they have raised.

Of the thirty-eight complaints received, all were acknowledged within three working days via telephone/ email with a formal acknowledgement letter being sent. Nineteen complaints were responded to within the negotiated timeframe, with the remaining nineteen complaints re-negotiated with the complainant - most delays were due to awaiting responses to the complaint from other Trusts. Of the thirty-eight complaints investigated, two were fully upheld, twelve were partially upheld and twenty-three not upheld, and did not require any action to be taken or identified learning considered. One complaint remains outstanding due to awaiting a response from another trust. Feedback from complainants regarding our processes in answering their complaint is important. How we will get this feedback is in development and will be reported in the next annual complaints report.

2. Background

The Trust has a Complaints Policy which is in in line with the NHS Adult Social Care Complaints Process & Regulations. The Trust's complaint process remains in line with guidance. All complaints received are reviewed by the Chief Executive, the Director of Nursing and the Deputy Director of Nursing and shared with the relevant Divisional Triumvirate for investigation. The Patient & Family Support Manager is the Trust's designated complaints manager and coordinator of responses to complaints/concerns raised.

3. Parliamentary Health Service Ombudsman Referrals (PHSO)

The Trust has received two PHSO referrals.

In February 2022, information was requested from the Trust for a complaint that was replied to in 2020. This request was regarding a patient whose daughter had claimed that the Trust incorrectly discharged her father and ignored her request for a larger pair of stockings for her father to wear. Nursing records and discharge summary has been supplied; we are awaiting the PHSO provisional report.

In March 2022 the Trust received the provisional report, from the PHSO in relation to a complaint made to them regarding a pacemaker insertion which the complainant alleges was not properly inserted. The Trust has responded to the PHSO we await their final report.

3.1 Learning from complaints that were upheld/partially upheld – requiring action

Fourteen complaints were considered upheld or partially upheld, this meant actions were required, or the investigation process had identified learning from the complaint raised. Those complaints not considered to be upheld were offered apologies in the complaint response.

All action plans identified through the investigatory process are presented in the relevant divisional governance meetings. Any cross divisional actions or learning are detailed in the report; this enables each division to identify any recurrent themes arising from complaints received. All learning that can be shared corporately forms part of the organisational learning processes. Complaints' learning is shared via the learning and sharing forums to learning is cascaded widely across the organisation.

3.2 Complaints Management – Quarterly Complaints Panels

To provide assurance of the Trust's robust complaints management process panel meetings with named Non-Executive Directors, have occurred on three occasions during 2021/2022. The purpose of this panel is to provide assurance that complaints are being managed robustly and effectively. This also demonstrates that lessons are being shared widely and embedded across the organisation.

4. Recommendations

The Board of Directors is asked to receive assurance that the complaints process is robust and monitored for effectiveness and is in line with the Trust's Complaints Policy.

Board of Directors (in Public)
Item 5.7*

Subject: Communications Report Q1
Date of Meeting: 26th July 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 1 (April-June 2022).

2. Background

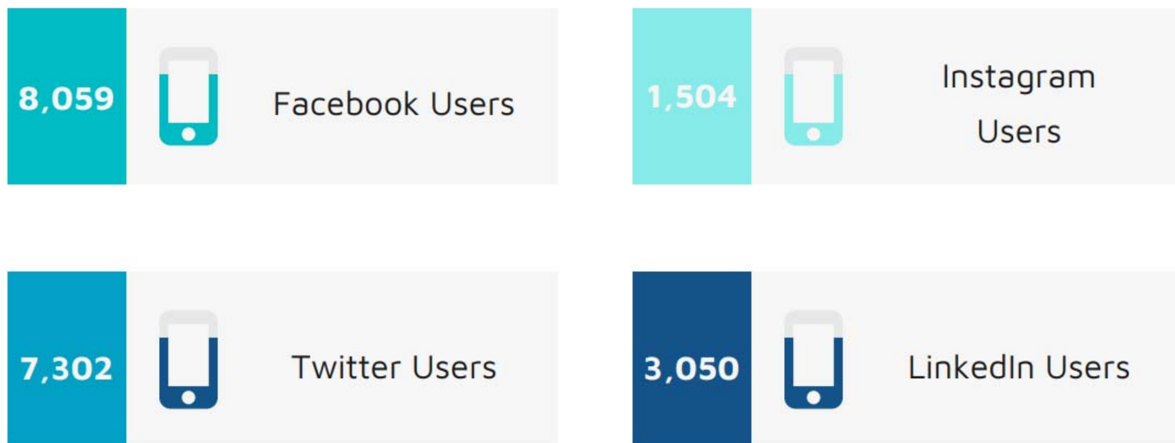
This is the fifth quarterly communications update provided to the Board of Directors.

3. Highlights During Quarter 1 (April-June 2022):

- Produced first draft of new communications strategy
- Completed the Annual Report & Accounts 2021/22
- Interviewed and appointed a new Digital Communications Officer on a 12month fixed term contract to support LHCH and LHCH Charity – started in post 1st June.
- Coordinated VIP visit with Innovation Agency and NHS England in June
- Supported a new community heart health initiative with Heart Valve Voice, a local primary school and other NHS partners.

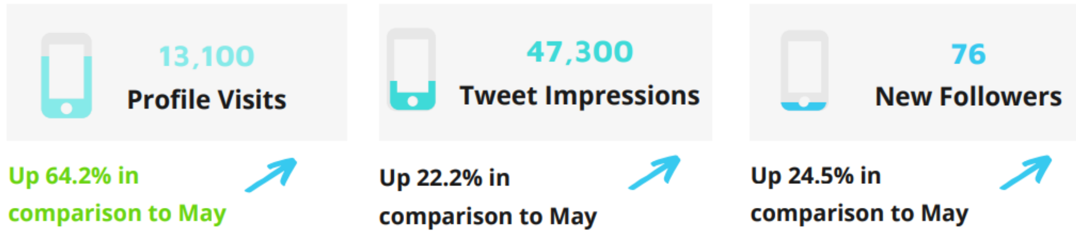
- Agreed plans for 2022 staff recognition virtual awards – launched 1st July.
- Quarterly Members Matters newsletter produced and distributed May/June.
- Provided comms support for Nurses' Day, International Clinical Trials Day, CF Awareness Day, Dying Matters, and other staff wellbeing initiatives
- Started developing monthly patient experience videos – identifying participants, filming and sharing with Executive Team
- Produced a mouthcare training video for surgical division
- Atrial fibrillation awareness event for members and staff in June
- Jubilee event comms and ice cream van organisation and managed 'Party at the Palace' prize draw for staff and associated comms
- Staff governor election campaign developed
- Implemented membership engagement plans for 2022/23 in conjunction with Chair and governors
- Developed new internal campaign to increase nominations for employee of the month
- Received positive media coverage.
- Supported comms for multiple vacancies and collaborated with HR Team.
- Supported Schwartz rounds for staff
- Continued providing regular covid briefings for staff
- 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. Instagram audience continues to grow fastest.
- A sample of social media insights are shown below.

SOCIAL MEDIA ACTIVITY HIGHLIGHTS



Q1 Top Twitter Insights *(June 2022)*

INSIGHTS



TOP POST - 24 LIKES

Top Tweet earned 5,574 impressions

Today we're teaming up with @heartresearchuk to perform free blood pressure checks for parents and teachers @fazakprimary.
The blood pressure checks will be conducted from our unconventional, yet, brilliant 'Heart Health' Bus! 🚌❤️
pic.twitter.com/FpE4lELyeZ

1 7 24

TOP POST PERFORMANCE

Impressions	5,635
Total engagements	80
Likes	24
Detail expands	17
Profile clicks	15
Media engagements	13
Retweets	10
Replies	1

Top mention earned 524 engagements

jane tomkinson @janetomkinson07 · Jun 26

Dinner in Liverpool with the rock stars of the aortic world. @LHCHFT leading this stellar global event with 3 years of learning , research and education squashed into 48 hours. Riding high on excellence #outstanding pic.twitter.com/GFMSHDvZzl

4 3 78

Top media Tweet earned 3,217 impressions

Today we look forward to welcoming @AmandaPritchard @mgwhitty and colleagues from @NHSEngland to LHCH to hear about our role in delivering complex respiratory and cardiac care and our partnership with @innovationnwc to implement innovations.
pic.twitter.com/2BOhGZyjGi

3 30

Q1 Top Facebook Insights *(June 2022)*

INSIGHTS

TOP POST - 435 REACTIONS

Reach

Total
4,408 Worst — Best

This post reached more people than 90% of your 50 most recent Facebook posts and stories.

Reach	4,408

Reactions, comments and sha...

Total
502 Worst — Best

This post received more reactions, comments and shares than 100% of your 50 most recent Facebook posts and stories.

Reactions	435
Comments	61
Shares	6

Q1 Top Instagram Insights *(June 2022)*

INSIGHTS

431 Profile Visits	2,135 Post Reach	35 New Followers
Up 30.2% in comparison to May	Up 75.9% in comparison to May	Up 25% in comparison to May

TOP POST - 170 LIKES

Reach

Total
1,178 Worst Best

This post reached more people than 100% of your 50 most recent Instagram posts and stories.

Reach	1,178

Likes, comments and shares

Total
178 Worst Best

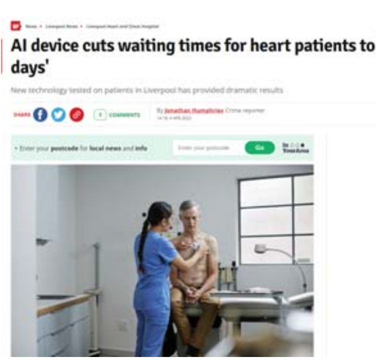
This post received more likes, comments and shares than 100% of your 50 most recent Instagram posts and stories.

Likes	170
Comments	8
Shares	0

MEDIA COVERAGE

- A total of 28 pieces of positive media coverage were picked up in quarter 1 with no negative coverage including LHCH's partnership with ZIO technology, charity support, patient care, mobile spirometry and new services (virtual wards/Dr Sibley)

Charity feature: Hospital that looks after lots of people from the Isle of Man



AI device cuts waiting times for heart patients to 'days'

New technology tested on patients in Liverpool has provided dramatic results

PLANS FOR Q2 (2022/23)

- Organise Annual Members' Meeting
- Develop summary annual review document
- Complete laying before Parliament of Annual Report and Accounts
- Planning for health awareness events, including Pride (July) and World Heart Day in September.
- Planning for charitable funds bid for staff recognition vouchers for Christmas
- Planning for extensive LHCH Charity support – video production, Christmas campaign materials, event promotion and PR
- Finalise new communications strategy
- Develop and implement a more consistent and analytical approach to social media comms for LHCH and LHCH Charity
- Identify new podcast guests
- Continue membership events / governor elections and ongoing planning for 2023 events.

4. Conclusion

- Overall positive media coverage.
- Positive engagement and increases across social media channels in line with the appointment of new digital communications officer.
- Ongoing work to identify strong patient / staff stories, to deliver greatest reach.
- Extensive comms/membership planning ongoing

5. Recommendations

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

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

minutes

Quality Committee

Minutes of the Quality Committee Meeting held on Tuesday 12th April 2022

Present:	
Nicholas Brooks (Chair)	Non-Executive Director
Sue Pemberton	Director of Nursing, Quality & Safety
Raph Perry	Medical Director
Julian Farmer	Non-Executive Director
In Attendance:	
Megan Underwood	Senior Executive Assistant (Minutes)
Val Davies	Chair
Apologies:	
Karen O'Hagan	Non-Executive Director

1. Apologies for Absence

Apologies were noted as above.

2. Declarations of Interest

There were no declarations of interest to record.

3. Minutes of e-meeting held on: 4h January 2022

It was agreed that the e-minutes were accepted and recorded as a true and accurate record.

4. Patient Story

The Director of Nursing, Quality and Safety read the patient story.

5. Action Log

Item 1 – GIRFT update Critical Care – Update reports to be added to workplan. Removed from the action log.

Item 2 – Quality Strategy – Discussed under agenda item 6.1. Further 6-monthly updates and annual report in October to be included in workplan. Removed from the action log.

Item 3 – GIRFT project – Discussed under item 7.2. Further progress reports to be included in workplan. Removed from the action log.

Item 4 – Quality Dashboard –Completed and removed from the action log.

Item 5 – Responsiveness of BAF risk ratings to reports and briefing papers – Informal conversations held with the Chief Governance Officer have concluded that the issue will be addressed by inclusion of the BAF 1 (Quality and Safety) report on the agenda of every Quality Committee. Removed from action log.

Item 6 – QSEC Key Assurances Report/Acute kidney injury – 3rd December 2021 – Discussed under item 6.2 and removed from the action log.

Item 7 – Dr Foster Dashboard – Minutes from the newly established Mortality Improvement Group will be received by the Quality Committee as a starred standing agenda item. The item was completed and removed from the action log.

Item 8 – Stroke Service Update – To be discussed at July's Quality Committee.

Item 9 – Annual Report Clinical Effectiveness Strategy – The Director of Nursing, Quality and Safety (DoNQS) to liaise with the Clinical Audit and Effectiveness Manager to determine the feasibility of returning to the format of previous years, in which all internal and external audits and responses to national directives were tabulated, in readiness for next year's report. **SP**

Item 10 – Quality Risks – This item was completed (as in item 5 above) and removed from the action log.

6. Quality

6.1 6-monthly progress update Quality and Safety Strategy

Despite constraints imposed by the residual Covid-19 challenges which have resulted in slippage of the planned timelines and a lack of clarity over when some will be fully implemented (e.g., the medicines safety improvement plan), the report provided assurance on overall engagement in delivering the strategy. The process was being managed with regular meetings with the leads for each objective. A further progress report will be made to the Committee in July, and an annual report will be presented to the Committee and the Board of Directors in October 2022

6.2 QSEC Key Assurances / Risk Report – 4th March 2022

DoNQS highlighted the areas in red and amber, as follows:

Acute Kidney Injury – screening of cardiac surgical patients for risk of acute kidney injury remains low at 54%. A meeting is scheduled between Dr Al Rawi and the IT team to devise an IT solution to improving uptake of the tool and to include patients in the Medical Division undergoing contrast-based radiological procedures.

Radiology discrepancy reporting – key learning points are to be escalated from the radiology review meetings to the Ops Board

All other areas within the report were rated as green.

The DoNSQ informed the Committee of a notable improvement in dietician referrals in March, and of completion of work with the matrons and IT team to ensure accuracy of the data.

6.3 Clinical Quality Dashboard / Supporting paper

The DoNQS presented the new clinical quality dashboard to the Committee. The accompanying report provided assurance on progress with areas previously identified as requiring continuing focus or improvement: delirium assessment, medication incidents, screening for dementia, copies of discharge summaries to patients, nutrition, pressure ulcers, radiology alerts and serious incidents. In response to a question about a recent serious incident the DNoQS explained that this primarily involved a delayed referral from another trust, from which an investigation and report have been requested.

Members requested that for future meetings the dashboard be included with the briefing papers. **SP/MU**

6.4 Annual Assurance Report Quality Committee

The report has already been approved at the March Audit Committee. Tracked changes were approved and deleted.

The report was approved by the Quality Committee.

6.5 Quality Committee Terms of Reference – For Approval

The chair outlined the new NSHE recommendations for certain roles currently delegated to NED champions to be moved to the respective assurance committees. For the Quality Committee this includes the end of life and resuscitation services. It was agreed that reports from these services should be added to the TOR and workplan. NB would continue to attend the action group meetings whenever possible.

6.6 Quality Committee Workplan 2022/23 – For Approval

As discussed in action point 7, the annual report and minutes from the Mortality Improvement Group will be added to the workplan. **MU**

Aside from these amendments, the Quality Committee approved the workplan for 2022/23.

6.7 Quality Impact Assessments (CIPs) & Update Report

The closing report for the 2021/22 financial year cost improvement programmes QIAs and EIAs was presented by the Head of Improvement and Transformation.

Of the 32 schemes requiring assessment, 28 have been ratified (gateway 5) and those remaining are on course to be implemented within the next month. Preliminary evaluation in all schemes discounted the requirement full EIA.

Additional assurance activities in relation to the 2021/22 schemes to be undertaken in quarter 1 include:

- a lessons-learned review based on a sample of schemes for 2021/22
- review of a sample of QIA/EIA documents by the Trust's Equality Lead for an independent assessment of the equality impact assessments.

Planning for 2022/23 is in the early stages with no schemes currently ready for a QIA.

Members of the Committee agreed that the report provides acceptable assurance on the QIA/EIA process.

The Head of Improvement and Transformation left the meeting.

6.8 Dr Foster Dashboard

The Medical Director shared the Dr Foster Dashboard with the Quality Committee.

Members were satisfied with the dashboard which disclosed no unexpected new findings and had no specific comments or questions

6.9 Resuscitation Training

Current risks affecting the resuscitation service were outlined by the chair; in particular, the outstanding recommendations of the previous external review for a second resuscitation training officer (RTO), and for improved facilities for training. The situation is compounded by the current absence of the Resuscitation Lead, and compliance with mandatory training was below target at all levels in Q4.

The DoNSQ outlined the measures in progress or already adopted to mitigate the situation:

- appointment of an interim Resuscitation Training Officer
- support for the development of additional in-house instructors to provide appropriate training to specific areas of the Trust with greater flexibility in timing

- a new trajectory for training with 206 BLS, 60 recertification ILS and 48 full day ILS sessions available for Q1 and Q2. If all sessions are filled compliance should increase to 95%.
- the RTO to monitor mandatory training compliance, attend audit days and ensure that instructors maintain their skills and have completed their General Instructor Course
- the purchase of extra mannequins, facilitated by a recent large donation, which will be based on the wards, thereby mitigating the problem of not having a designated training room and reducing the need for staff to leave their departments for training.

Flyers have been circulated to all Heads of Departments with awareness being raised in both Gold and Silver Command

The Committee commended the commitment to these improvements.

7. Clinical Effectiveness

7.1 Mortality Review Annual Report and improvement plan

The Medical Director presented the mortality review covering the period December 2020 to November 2021 but with updated information covering the subsequent three months, together with details of the mortality improvement plan.

The key issues from the annual report:

- though persistently greater than 100 throughout the year, the risk adjusted (SMR and HSMR) mortality rate is declining
- the higher-than-expected mortality (both risk and-adjusted and in comparison, with peer group trusts) is being driven mainly by the unrestricted policy, unique to LHCH, of accepting direct admission of patients with out of hospital cardiac arrest (OOHCA). In these patients and others admitted acutely, there is inevitably incomplete collection – and consequently coding - of co-morbidities
- the mortality reduction strategy has been strengthened by the establishment of the mortality improvement group, set up in collaboration with Telestra Health (formerly Dr Foster), which meets monthly and reports to the Ops Board
- introduction of the Medical Examiner post
- progressive implementation of GIRFT recommendations
- use of the learning from deaths process to improve clinical systems
- rigorous performance management: notably use of CUSUM curves for individual cardiac surgeons, none of whom were outliers. The MD explained that a comparable analysis for device implantation would not be meaningful because of the rarity of deaths relating to these procedures
- Development of improvement plans for all three clinical divisions, though it was noted that whilst clear timelines were set out by clinical services these are less well, if at all, defined for medicine and surgery
- Appointment of a new VTE lead and continuing focus on application of care bundles across a range of interventions

Based on discussion of these issues, members of the Committee agreed that acceptable assurance was received in the following areas:

- The rigorous multi-layered processes involved in the scrutiny of and learning from deaths, the comprehensive measures to reduce mortality and the reliability of the data
- The higher-than-expected mortality is a reflection of causes other than from any deficiencies in the standards of care within the hospital.

7.2 Annual Report re GIRFT Report Actions and Progress Update

The MD presented an update on progress with the GIRFT programme and informed the Committee that with the addition of a litigation GIRFT there are now eight best practice reports applicable to LHCH from which assessment for gaps and action plans are developed. The report detailed excellent progress with deep dives and implementation of best practice reports. Feedback from the regional GIRFT implementation manager has been of exemplary practice. In certain areas, notably pathology, which is provided by Liverpool Clinical Laboratories, where there is reliance on external parties, it may not be possible to complete the gap analysis because of competing priorities. The Committee also noted reservations over the feasibility of participation in the recommended Infection in Critical Care Quality Improvement Programme because of the onerous requirement for data collection, though mitigations are being explored.

Members of the Committee noted the good progress with clear and appropriate actions.

7.3 Annual Report Medications Safety

The Chief Pharmacist was congratulated on their sustained commitment to medications safety, and members noted the excellent record and new initiatives in monitoring and learning from errors over the course of the year. The Chief Pharmacist explained how introduction of the closed loop system for drug dispensing and administration could be expected to eliminate common human errors in dispensing and administration.

Key to this continued progress is actual reporting of medication incidents. Identification of issues and corrective action plans to prevent harm/potential harm to patients can only be achieved if there was awareness of incidents and this, together with “safety through learning” has been a key component of the Trust’s new Quality and Safety Strategy.

In the last 12 months, out of 280 reported incidents, 273 resulted in no harm, six in minimal harm and one in moderate (short-term) harm. Two major safety concerns had been discussed at previous meetings of the Committee: a never event in which a patient was connected to medical air instead of oxygen and an incident involving a controlled drug. Both were followed with RCAs and prompt implementation of actions to prevent recurrence.

The report was reported as providing partial assurance, but the Quality Committee considered that it provided acceptable assurance and recommended the change.

The DoNQS thanked the Chief Pharmacist for his leadership.

The Chief Pharmacist left the meeting.

7.4 MIAA Secure Health Messaging – actions completed

Committee members were pleased to note the positive response to the MIAA audit. Measures in the action plan, which includes a detailed Standard Operating Procedure, and which should be implemented in full by the end of the month are considered to cover all possible eventualities. Retrospectively, outstanding alerts up to three years old have been identified, reviewed by the AMDs and the responsible clinicians, and urgent cases acted upon.

Rigorous assurance that secure health messages are being opened, actioned, and documented is to be provided to the Operational Board.

8. Compliance and Regulation

8.1 SUIs

There was nothing of significance to note; only a minor update on the actions of most recent incident (technical issues during and internally proctored case) since presented to Board of Directors in April.

8.2/8.3 Quality Risks and BAF 1 review

The most up to date BAF was discussed by the Committee. The DONQS considered that full implementation of the refreshed quality and safety strategy could be expected to bring all assurance levels to within the risk appetite.

9. Date and Time of Next Meeting
Tuesday 12th July 2022, 11.00am-1.00pm, Research Meeting Room/MS Teams

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Board of Directors (in Public)
Item 6.1.2a

Subject: People Committee BAF Key Issues Report
Date of Meeting: 26th July 2022
Prepared by: Karen Nightingall, Chief People Officer
Presented by: Margaret Carney, Chair of People Committee
Meeting Held: 7th June 2022 (E-Meeting)

This report sets out the key assurances, risks and actions from the recent People Committee meeting. Areas for escalation to the Board of Directors are included below as required.

Agenda Item	Lead Exec	Assurance Received	New/ Emerging Risks	Actions/Comments
5.1	KN	National workforce update including trade unions supporting staff in terms of cost of living, retention, wellbeing, ED&I, People promise and scope for growth.	None	Continue to support working in partnership with trade unions through the partnership forum. Delivery of the Trust EDIB strategy. Currently drafting a 5 year people strategy. LHCH is one of the early adopters of Scope for Growth.
5.2	KN	GMC Survey Progress against action plan and assurance from internal survey feedback (April 22).	None	GMC survey results and action plan to be presented to the committee when received.
5.4	KN	Staff Survey 2021 update regarding approach to developing department action plans.	None	
5.6	KN	Retention Plan update showed good progress. Recruitment challenges noted for occupational therapists and radiology staffing and admin staff being the	As well as nursing, there are also national shortages in Operation Department Practitioners (ODP’s).	Ongoing discussions taking place to address shortages of ODPs. Numbers of Tier 1 doctors will reduce and a plan to recruit more ANP’s will be presented at Ops Board next month. The retention group will be

Agenda Item	Lead Exec	Assurance Received	New/ Emerging Risks	Actions/Comments
		most recent group identified with a struggle to recruit good candidates.		focusing on the recruitment challenges.
5.7	KN	HR, OD & Education Quarterly Assurance Report included investment in OD team, development of the OD plan and the priorities for the team.	None	A national review of appraisal processes will take place next year.
6.1	KN	HR/Team LHCH Dashboard showed a reduction in sickness to under 5% from 7.07% (this was 3.4% when covid was removed). 39% of registered nurses and 33% of AHP's are leaving for pay and reward. Model Hospital provides data on how the Trust compares broadly across the NHS and the Trust is consistently better than peers and the national median for turnover of leavers less than 12 months.	None	

Item 3.0
E- Meeting of the People Committee

Minutes of the People Committee Meeting
scheduled on Wednesday 8th March 2022

Meeting Participants:	**N/A**	
Committee Members:	**Margaret Carney (Chair)**	**Non-Executive Director-Chair**
	Bob Burgoyne (BB)	**Non-Executive Director**
	Nicholas Brooks (NB)	**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)	**Head of HR Operations**
Committee Attendees:	**Laura Williamson (LW)**	**Senior Executive Assistant (Minutes)**
	Beth Williams-Lally (BW-L)	**HR & OD Manager**
	Rachael McDonald (RMc)	**Strategic HR Business Partner**
	James Greenwood (JG)	**Director of Medical Education**
	Val Davies (VD)	**Trust Chair (April 2022)**
Apologies:	**None**	

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 1st March 2022 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.

Action

A two-hour Microsoft Teams meeting was convened on 8th March 2022 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. It was assumed that all papers had been read with no further discussion required unless colleagues raised any queries.

1. Apologies for Absence

All meeting participants were included in the e–meeting and in attendance at the Microsoft Teams meeting; there were no apologies to note.

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 December 2021

The minutes were approved as a true and accurate record of the meeting.

4. Action Log

All two items listed on the Action Log remained outstanding to be brought to the June and August meetings as agenda items.

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: -

Reference was made to the time and efforts that went into (Vaccination as a Condition of Deployment (VCOD). Although Covid vaccines are no longer mandated, colleagues were informed that talks in relation to guidance had been taking place.

Absence – staff sickness had increased significantly in the last quarter due to the Covid Omicron variant and reached 10%, it was stated that some other Trust's within Cheshire & Merseyside had reached 15%.

It was stated that one of the Trust priorities was to focus on retention and wellbeing; colleagues were informed that £100k funding for wellbeing became available in Cheshire and Merseyside and that the HR & OD Manager (BW-L) placed a bid for funding and managed to secure £60k for the Trust.

In the last quarter it was reported that turnover stretched to over 11% within the Trust, with other Trusts having experienced similar numbers. Following analysis, it was understood that promotion and relocation were the most common reasons, and those leavers would recommend LHCH as a place to work.

It was reported that Nationally, the People Promise has been paused (effectively people plan 2); initially halted due to VCOD, and Prerana Issar has stood down as Chief People Officer for NHS E. The work underway in relation to annual planning has been significant, locally and nationally.

It was anticipated that the People Promise would gain momentum and dovetail into the People Strategy, with the ED& I Strategy on track to be refreshed in Q1 2022.

Nationally conversations have been taking place with regards to assessing the reintroduction of car parking charges, and the impact on workforce in relation to National Insurance (NI) increases due to commence.

The Chair acknowledged the volume of work going on and thanked the Chief People Officer for the update.

5.2 GMC Survey Progress

Consultant Respiratory and Critical Care Physician and Director of Medical Education, James Greenwood (JG) shared a presentation which informed colleagues of the results of the GMC Trainee Doctor Survey and subsequent actions.

Colleagues were reminded that following the GMC survey of 2021, which scored below standard, an extensive action plan had been introduced and presented by the Board of Directors and HEE Quality Committee in January 2022.

It was reported that good progress has been made against the action plan in relation most of the actions. Local surveys and feedback have been gathered recently from trainees, the results of which have been positive which indicated a significant improvement. There were however some areas of concern that remained, in relation to feedback obtained; it was felt focus was to improve survey results rather than improving the service.

Colleagues were informed of the following improvements so far:

- Handover processes
- Induction streamlined, made more relevant and consistent
- Induction Handbook updated and circulated
- All trainees have access to office and rest space
- Simulation case being worked up

Trust Wide challenges experienced were shared in detail, which included survey fatigue, on-call rotas, IT access, car parking and Tier 1 workforce.

Colleagues were informed that the following areas were being prioritised:

- Tier-1 medical workforce trainees vs Trust-grade appointments
  - APs, PAs, CNPs?
  - International medical graduate programme?
- Out-of-hours rota – drop to 1 doctor, increase / invest in APs?
- Professional development for non-medical workforce
- Where the DME's new office will be

The Committee were assured of the progress made and efforts in identifying issues and the transparency of such. The complexity of the work required was acknowledged.

Clarification was sought in relation to quality assurances (QA) and it was explained that the GMC was the responsible body for QA in relation to training programmes offered by HEE and governed by GMC, to monitor and quality assure training programmes on offer.

It was challenged whether there was confidence that there was sufficient support from Associate Medical Directors (AMD's), it was explained that there was support however some challenges in relation to having complete insight to enable support to address issues. It was suggested that regular feedback meetings within the Divisions and junior doctors take place to drive divisional engagement.

It was stated that there is a huge commitment from the AMD's in driving and sustaining improvements.

The importance of driving improvements with support from Divisional leads was acknowledged, the risk in relation to CQC was flagged.

The Chair acknowledged the risk discussed and suggested further updates would be beneficial for assurance purposes.

5.3 People Plan Annual Summary

HR & OD Manager, Beth Williams-Lally (BW-L) provided a paper which outlined progress made within 2021/22 against the People Plan objectives.

Clarification was sought in relation to specific steps taken or planned to improve leadership development within minority groups. It was stated that this had been explored and the feedback received didn't support the targeted approach. It was explained that with the development of the People Strategy, and Equality, Diversity, Inclusion and Belonging being one of the four pillars, it was stated that focus would be given to engagement sessions to gain feedback in relation to leadership development with the aim to close disparity gaps.

It was stated that engagement with the leadership programme had been low due to pressures within the Trust such as staffing and resources focussing on VCOD. Assurance was provided that full competency would be in place in April 2022 with an OD Practitioner and OD lead, which would enable further focus. Colleagues were informed that

attendance in March 2022 in respect of the leadership programme had increased.

Colleagues were informed that Health and Wellbeing counselling for staff would continue post Covid, funded from the £60k funding that was recently secured.

The Trust SCHWARTZ rounds are due to launch on 25th March 2022, it was reported that engagement do far has been high from both non-clinical and clinical staff; further information would be provided at the next People Committee meeting.

Clarification was sought in relation to the development of new roles and whether these were additional responsibilities for current staff. It was confirmed that the roles mentioned were new and some shaped differently; all had been through the agenda for change process.

The tremendous achievement of the whole team against the plan was acknowledged, especially given the challenging climate.

The Committee noted the contents of the report.

5.4 Staff Survey
HR & OD Manager, Beth Williams-Lally (BW-L) shared with the Committee a presentation which highlighted the results of the 2021 Staff Survey.

The Staff Survey closed on Friday 26th November 2021 with a final response rate of 62%; a 3% decrease in comparison to the previous year. It was reported that feedback gathered indicated that work pressures were the biggest factor of non-responses.

It was reported that the following questions remained high in terms of positive results:

- 74% - Would recommend the organisation as a place to work
- 91.6% - If a friend/relative needed treatment would be happy with the standard of care provided by the organisation
- 90% - Care of patients/service users is organisations top priority

The focus on the recruitment and retention, culture, wellbeing and Equality, Inclusion, Diversity and Belonging (EDIB) was highlighted and it was anticipated that the results above would improve next year.

The top 5 scores were shared, along with the most improved scores, which demonstrated that the Trust had scored higher than the picker average in relation to the top 5 scores, and the Trusts most improved scores had increased compared to the previous year.

In addition, the bottom 5 scores were shared, along with the most declined scores which showed the comparison versus the picker average and the previous year.

The declined response in relation to adequate disability adjustments was highlighted as a concern and it was stated that the Trust is in the process

of developing a reasonable adjustments policy, and as part of the EDIB strategy.

Reference was made to the decline in appraisal score, which was unexpected given the amount of effort that had been given. It was suggested that the structure of the appraisal may have contributed to the negative association and would be addressed in engagement sessions.

The Committee were pleased to see improvements, especially in relation to support, and credit was given to all involved. Overall, it was the positive results were recognised.

Colleagues were informed that the embargo would be lifted on 30th March 2022, which would allow results to be shared and undertake further analysis and action.

The seven People Promise elements were shared:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

It was reported that nationally there has been a big focus on WRES and WDES linked in with the EDIB strategy, which would drive changes to associated indicators – question 15.

Graph's in relation to LHCH overview and theme changes were shared; 2020 vs. 2021.

It was highlighted that LHCH scored the best in 'Compassionate Culture' and 'Place to Work' in comparison to other Trust's.

Next Steps were shared as follows:

Prior to publication date, 30 March 2022

- Share divisional breakdown with DHoO's (internal benchmarks)
- Acknowledge areas we are doing well
- Identify focus areas
- HRBP's to support DHoO's with the development of action plans to combat challenges faced
- Prepare high level public communication for sharing results

Post publication date, 30 March 2022

- Create meaningful, valuable and effective action plans to make positive change

The Chair expressed the importance of receiving rich information in building action plans.

5.5 Pulse Survey

HR & OD Manager, Beth Williams-Lally (BW-L) informed the Committee that the Pulse Survey was launched in December 2021. It was reported

that 160 responses were completed. It was recognised that the low response rate was felt across the whole NHS.

It was felt that survey fatigue was a factor in the low response rate due to being so close to the staff survey. It was also assumed that the low response rate was due to the Pulse Survey not generating email reminders.

The pulse survey considered 6 areas;
- Colleague feedback
- Colleague mood
- Colleague feelings
- Colleague feelings, why?
- Feedback to leaders
- Engagement
- Health & Wellbeing

A detailed breakdown was shared in a table within the presentation. It was anticipated that that the next survey in April would gain more engagement.

It was highlighted that the enhanced survey engagement is in alignment with 'Our NHS People Promise'.

5.6 Retention Plan and Update
Senior Business Partner, Rachael McDonald presented a paper which provided an update in relation to the retention plan.

It was highlighted that in relation to BAF impact, although good progress had been made, assurance was confirmed as partial.

It was reported that feedback sessions with new nurses had been taking place bi-monthly, and the work in relation to preceptorship was highlighted. Colleagues were informed of the work undertaken in relation to a retention summit; a comprehensive action plan has been introduced and lots of focus has been made with induction. It was stated that the Trust is focussed on induction with the view to improve retention.

It was queried why the number of leavers recommending LHCH as a place to work was higher in the Staff Survey. It was highlighted that the predominant reason for staff leaving was promotion, it was wondered whether this related to less opportunities within the Trust due to being a specialist Trust. It was recognised that career progression could be looked at as part of the retention plan and career pathway moving forward. Staff leaving within 1-2 years was a concern which needed to be addressed. It was recognised that more exposure was desired and work in relation to rotation would be beneficial in addressing retention.

It was explained that work is underway with development roles and rotation to give staff the opportunity to gain further experience.

It was highlighted that some leavers ticked no to returning to the Trust, whilst recommending LHCH as a place to work; the assumption made was that the reason was due to relocation. It was suggested that a sub-

question would be helpful to understand this reason in more detail rather than rely on assumption. It was also suggested that support in relation to relocation be looked at.

Discussion took place in relation to flexible working and it was recognised that further work was required to attract candidates with targeted adverts. The challenges in relation to ward managers managing flexible working was acknowledged. It was recognised that further work was required in relation to attraction and promoting flexible hours and part time nursing roles. It was reported that the flexible working policy has been changed whereby now staff from day one can request flexible working.

The Chair acknowledged that retention is a focus for the Committee which aligned to the Board Assurance Framework. Acknowledgement was given to the teams involved in relation to the progress made so far.

5.7 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 relation to data on retention for national recruits, it was reported that the Trust had retained all of the International Recruits from the latest cohort; a further 40 International Nurses were due over the next 6-9 months. It was thought that the first cohort of international recruits from 6 years ago were still employed by the Trust, it was explained that data be accessed and presented at the next meeting, if required.

It was highlighted that 65 of the 68 nurse recruits from last year passed training first time which was credit to the Trust's two PEF's.

It was reiterated that it has been an intense time for the Trust of late and as it moves into business as usual, great progress has been made such as the Digital HR project has been as a great success in streamlining HR process.

The Committee noted the contents of the report.

6. Dashboards – Workforce Intelligence
6.1 HR/Team LHCH Dashboard
Temporary Head of HR Operations, Sarah Smith (SS) provided the Dashboard.

Assurance was sought in relation to sickness levels and it was reported that the numbers were beginning to improve.

Sickness levels were reported at 3.6% (including Covid) against a target of 3.4%. It was highlighted that during the Omicron variant, focus had been given to long-term sickness absences to support staff returning to work or leaving the Trust in a dignified way.

The Chair highlighted the importance of maintaining a focus on red and amber areas.

The Committee noted the contents of the report.

7. Governance

7.1 People Committee Annual Report

The Chair presented the Annual report; no comments were received.

The Committee noted the contents of the report.

7.2 Terms of Reference (ToR) Annual Review

The Committee reviewed the Terms of Reference (ToR) as the date for reviewal was due in March 2022. There were no changes required, therefore, a new review date was set, and the Committee approved the ToR.

7.3 Business Cycle Annual Review

The Committee reviewed the Business Cycle for the year ahead 2022/23. There were no changes suggested and therefore the Business Cycle was approved.

7.4 Board Assurance Framework (BAF) 2021/22

The Chief People Officer, Karen Nightingall provided the Board Assurance Framework which highlighted risks 4,5 and 6 for Q4 2021/22.

The Committee noted the contents of the reports.

7.5 People Delivery Group Approved Minutes

The Committee were presented with approved minutes from the People Delivery Group for information purposes:

- *7.5a* 13th May 2021*
- *7.5b* 22nd June 2021*
- *7.5c* 5th August 2021*
- *7.5d* 11th November 2021*

The Committee noted the minutes.

8. Evaluation of Meeting

Feedback provided was that the meeting was good with focus on key areas of concern.

9. Date and Time of Next Meeting:

Tuesday 7th June 2022, 12.00 – 14.00, MS Teams.

E- Meeting of the Audit Committee
Item 6.1.3a

Minutes of the Audit Committee Meeting held on Friday 17th June 2022

Committee Members:	**Julian Farmer**	**Non-Executive Director-Chair**
	Nick Brooks	**Non-Executive Director**
	Margaret Carney	**Non-Executive Director**
	Bob Burgoyne	**Non-Executive Director**
	Andrew Lang	**Non-Executive Director**
	Louise Robson	**Non-Executive Director**
Committee Attendees:	**Karen Edge**	**Chief Finance Officer**
	Georgia Jones	**Key Audit Partner-Grant Thornton**
	Karan Wheatcroft	**Director of Risk & Improvement**
	Nigel Woodcock	**Senior Internal Audit Manager-MIAA**
	Jing Ma	**Head of Financial Services**
	Michelle Moss	**Anti-Fraud Specialist-MIAA**
	James Bradley	**Deputy Chief Finance Officer**
	Jane Tomkinson	**Chief Executive**
	Chris Whittingham	**Senior Manager-Grant Thornton**
	Megan Underwood	**Senior Executive Assistant (Minutes)**
Apologies:		

	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

There were no apologies to note.

2. Declarations of Interest

There were no declarations of interest.

3. Annual Accounts Review

3.1 Annual Governance Statement

The Director of Risk and Improvement presented the final version of the annual governance statement on behalf of the Chief Executive and confirmed that minor amendments had been made following March's

DRAFT

Audit Committee. The statement was thorough, with consideration of risks during 2021/22, and an overall conclusion that no significant control issues had been identified in 2021/22.

It was acknowledged that there was a strong process in place at the Trust with the Audit Committee monitoring AGS risks as a matter of routine throughout the year.

The Chief Executive, as accounting officer, had reviewed the statement in detail and fully supported it as her signature confirmed.

The Audit Committee **recommended** the final version of the annual governance statement for approval by the Board of Directors on 17th June 2022.

3.2 Review Audited Annual Report and Accounts 2021/22

The Chief Finance Officer (CFO) presented the previously seen annual report and accounts.

The accounts were submitted to NHS Improvement and to Grant Thornton UK LLP, the Trust's external auditors on 26th April 2022. Following the completion of the external audit, the final audited version of these documents is required to be submitted to NHS Improvement before 12.00 noon on 22nd June 2022.

The audited annual accounts for 2021/22 were contained within the annual report. Key points to note were as follows:

Financial performance
As the NHS continued to respond to Covid, the financial framework was revised for 2021/22. Trusts across the region continued to be paid on a block basis, with additional income available to incentivise elective recovery.

The Trust had a breakeven financial target. The Statement of Comprehensive Income (SoCI) reports a surplus for the year of £3.064m. In reporting to NHSE/I, impairments and any income / depreciation relating to donated assets are removed to present an adjusted financial performance. Once removed, the reported surplus is £0.33m, this was in line with the breakeven expectation for the year with a small surplus due to technical adjustments.

An informal session had been held with the Non-Executive Directors to discuss the accounts, where the Deputy Chief Finance Officer highlighted changes and key issues from the previous year.

It was noted that on page 30 of the annual report a small amendment was required regarding fraud investigations and the Deputy Chief Finance agreed to update the statement.

JB

Audit Committee members acknowledged that the reported figures aligned with what the Committee had been updated on throughout the year and **recommended** the accounts for approval by the Board of Directors on 17th June 2022.

DRAFT

3.3 Audit Findings Report 2021/22

The headlines of the report were provided on pages three and four of the report, Audit Committee members were informed that this reflects the position from earlier in the week with a small queries to be completed, this included typing errors. The final report willbe circulated week commencing 20th June 2022 but it is not envisaged that there will be any significant changes.

The Audit Committee noted that the audit work completed to date had not identified any audit adjustments, however, there had been several misclassifications and changes, these have been identified and actioned.

The Audit Findings Report presents the observations arising from the audit that were significant to the responsibility of those charged with governance to oversee the financial reporting process. Its contents have been discussed with management and are subsequently presented to the Audit Committee.

The audit approach was based on a thorough understanding of the Trust's business and was risk based, and it included:

- An evaluation of the Trust's internal controls environment, including its IT systems and controls
- Substantive testing on significant transactions and material account balances, including the procedures outlined within the report in relation to the key audit risks.

The Audit Plan presented to the Audit Committee on 22nd March 2022 had not been altered.

The auditors have substantially completed the audit of the Trust's financial statements and subject to outstanding queries being resolved, anticipate issuing an unqualified audit opinion. These outstanding items include:

- Response to a number of outstanding audit sample queries as well as queries relating to property valuations and assets under construction.
- Completion of the NAO specified procedures and the group consolidation schedules.
- Receipt of management letter of representation
- Review of the final sets of financial statements.

It was confirmed that the auditors were yet to complete the Value for Money (VFM) work, with full details on the reasons for the delay provided in the appendices to the report. It was expected that the auditors would issue the Auditor's Annual Report by the end of July 2022 ahead of and in line with the National Audit Office's revised deadline of 22nd September. Based on the detailed work on VFM that has been completed to date the auditors have not identified any significant weaknesses or issues that required attention from the Audit Committee.

The auditors noted the report was pleasing in terms of findings and thanked the Trust and officers involved.

DRAFT

The audit had gone well with good communication between the auditors and the Trust. Matters were to be concluded shortly with accounts being submitted week commencing 20th June 2022.

The Trust management letter of representation lwas a standard letter, most of which was modelled narrative. There were two specific assurances that the Trust had to provide which have been drawn out in the letter.

The Audit Committee **noted** the audit findings report and **recommended** the accounts for approval by the Board of Directors on 17th June 2022, including the Trust management letter of representation.

4. Internal Audit

4.1 Head of Internal Audit Opinion

One change had been made to the draft that was presented in March and this was the data security protection toolkit report, with substantial assurance received. The final Head of Internal Audit Opinion provided Substantial assurance overall.

The Audit Committee **noted** the Internal Audit Opinion.

4.2 Final Anti-Fraud Plan

The draft plan had been presented to the Audit Committee and this had now been updated to reflect agreement from the Chief Finance Officer and team.

The Audit Committee **approved** the final anti-fraud plan.

4.3 Final Anti-Fraud Annual Report

The draft report was presented in full to March's Audit Committee. One change has been made to the report, which was fraud prevention checks, at the time of writing the draft there were 30 and this has since increased to 33. There were no new referrals in the period.

The Audit Committee **noted** the final anti-fraud annual report.

5. Minutes of e-Meeting held on Tuesday 22nd March 2022

It was noted that the minutes of the Audit Committee meeting held on 22nd March 2022 had been reviewed for accuracy by all meeting participants and were **approved**.

6. Action Log

It was confirmed that all completed actions were to be removed following the meeting.

DRAFT

Item 2- Report was ready to be issued to the Chief Finance Officer and team, the report is to be discussed at the July 2022 Audit Committee meeting.

Item 7- Minor change has been made to the Terms of Reference, therefore this item was completed and removed from the action log.

7. Evaluation of Meeting

The Audit Committee was content with the mechanism in place for the e-meeting, given the on-going social distancing measures.

8. Date and Time of Next Meeting
Tuesday 19th July 2022, 8.30am-10.30am

DRAFT

E- Meeting of the Audit Committee
Item 6.1.3a

Minutes of the Audit Committee Meeting held on Tuesday 22nd March 2022

Committee Members:	**Julian Farmer**	**Non-Executive Director-Chair**
	Nick Brooks	**Non-Executive Director**
	Karen O'Hagan	**Non-Executive Director**
	Margaret Carney	**Non-Executive Director**
Committee Attendees:	**Karen Edge**	**Chief Finance Officer**
	Georgia Jones	**Engagement Lead, Grant Thornton**
	Karan Wheatcroft	**Interim Chief Governance Officer**
	Nigel Woodcock	**Senior Manager, MIAA**
	Val Davies	**(Incoming Chair – Observing)**
	Kate Warriner	**Chief Digital Information Officer (for items 3.11 and 3.12)**
	Michelle Moss	**Anti-Fraud Specialist, MIAA**
	James Bradley	**Deputy Chief Finance Officer**
	Megan Underwood	**Senior Executive Assistant (Minutes)**
Apologies:	**Lucy Lavan**	**Director of Corporate Affairs**
	Bob Burgoyne	**Non-Executive Director**

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

Apologies noted as above.

2. Declarations of Interest

Karan Wheatcroft declared herself as a senior member of MIAA until 25th April 2022. MIAA are the Trust's internal auditors, and KWh 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 Annual Report of Audit Committee

DRAFT

The Audit Committee annual report sets out clearly what has been completed. There were no further comments from the Audit Committee, this was noted for submission to the Board of Directors.

3.2 Draft Annual Governance Statement

KWh presented the draft AGS. The red text was used to indicate the areas where there is flexibility for local wording. The only change to national guidance was a slight wording change to net-zero and this has been reflected in the draft.

Overall, a strong annual governance statement with a wide range of governance assurance mechanisms in place and the transparency of risks and issues. Since drafting there has been one further serious incident and the numbers around serious incidents will be updated at the end of March to ensure the figures are reflective of the final figure. The Audit Committee were asked to consider the consistency of the AGS with the assurances received around the organisation and to approve the draft which will form part of the submission with the financial accounts.

A minor change to be made to the bottom of page three in relation to risk appetite wording. The Audit Committee approved the draft Annual Governance Statement.

KWh

3.3 Review of Assurance Committee Annual Reports:

The reports set out the work of the committees. As discussed at the Audit Committee effectiveness workshop there is an opportunity for more consistency in report formats for 22/23.

3.3.1 Integrated Performance Committee

Thorough report which covers the challenges and current situation. The team have done a good job this year and have kept the Board fully informed.

The NEDs referred to the discussions on performance indicators which had been considered at the various committee meetings, and it was noted that this work was in hand and wouldn't be added to a specific Assurance Committee Annual Reports. The Audit Committee Effectiveness report looking ahead points included the assurance processes to support data quality.

The expression of committee attendances was misleading, some were expressed as how many meetings were attended percentage of a whole complete attendance of meetings, for some attendees some were unable to attend when not appointed. For future reports, the percentage of potential attendants to be documented.

3.3.2 People Committee

The Annual Report confirmed compliance with terms of reference. The Audit Committee had no further comments to note.

3.3.3 Quality Committee

The report confirmed that the Workplan had been delivered, with major areas of activity and concern summarised.

The Audit Committee noted the Assurance Committee reports for submission to the Board of Directors.

3.4 Review of losses and special payments

The report covered the period September 2021 to February 2022, noting there have been no losses or special payments over £10,000 in the period. There have been low value payments which were set out in the appendix. Bed debt provision does cover 85% of non-NHS debt, the provision has been reduced as the Trust have utilised the provision against the long-standing private patient dispute, this has now been settled and closed. There was an error in one of the tables in terms of the count of invoices, the value of invoices was correct however the count of invoices was duplicated. This will be corrected for the final papers that are archived.

KE

In terms of the value of non-NHS debt, which was raised as a query, this has increased and was predominately around the Isle of Man. The Trust had taken a significant amount of work from the island since the latter end of 2021, there has been issues with local surgical capacity and this has resulted in the Trust receiving higher flows than usual, there were no concerns in relation to payment.

Request for write off for £2,000, technical issue with regards to the transaction. The Chief Finance Officer was to investigate and send the Chair the information.

KE

The Committee noted the report.

3.5 Review single supplier tender waivers

27 waivers were raised during the period totalling £1.3m. There were two over £100,000, one was in relation to specialist diagnostic equipment installation and the other being access control system that interfaces with fire alarm system both appropriate in terms of interdependencies.

The Committee noted the report.

3.6 Review register of interests (including details of breaches)

The report sets out the arrangements that were in place at the Trust, there was an additional step that any declarations of interest include a management step. This is reported annually to Audit Committee, currently in the process of continuing to follow up the decision makers who were yet to submit a nil-declaration – this to be closed off by March. This was statutory guidance in 2017 for CCGs this was then built into standard procedures and is mandatory to declare a nil declaration.

DRAFT

There were some gaps between the number of staff and those that have declared a declaration. An offline update is to be provided to Audit Committee members to provide assurance as at the end March 2022. **KWh**

The Committee noted the report.

3.7 Report on Audit Committee Annual Self-Assessment (incl. ToR review, skills review and self-assessment questionnaire)

This was a useful process with different ways of working being looked at, there were some good suggestions on how performance can be tweaked over the coming year.

Action plans has been formalised in section five.

The Audit Committee thanked NW and approved the report.

3.8 Annual review of Provider Licence

This has been consistent with the issues reported through the quarterly reviews received by the Audit Committee. The Committee confirmed they were happy with the process and the quarterly updates were useful to provide in year assurance.

The Audit Committee noted the report.

3.9 Review Audit Committee ToR

A minor change required on Page five, section 5.4.1, to replace the reference to NHS Protect with the NHS Counter Fraud Authority. **MU**

The Audit Committee approved the Terms of Reference for submission to the Board of Directors, subject to the amendment above.

3.10 Regulatory Action Plans

There was nothing to report, CQC engagement meetings were continuing and were going well.

3.11 The National Cyber Security Centre guidance checklist

The report was a general update on items relating to cyber security measures, specifically looking at work being done nationally. There was also an update on the Trust's responses to national priorities that have come out from NHSE/I, and the national cyber security centre guidance which has been published for Non-Executive Directors and Board of Directors.

KW confirmed that the Trusts prioritisation and efforts around cyber security continue as previously reported to Audit Committee. The global threat around cyber security has heightened given the situation across the world. The Trust were in a good position, there was one outstanding action in relation to further work on back-ups this was reported at the previous Audit Committee which was in relation to immutability. The Trust were expecting the hardware to be installed but due to global

DRAFT

hardware shortages there has been a delay – the Trust is managing the risks, and there are no concerns with several interim options being reviewed, a session with suppliers will be held on 24th March 2022.

General summary of cyber was that a significant amount of internal work had been completed with the Trust in a strong position in terms of resources and investments made.

As part of Digital Excellence Programme, there has been a programme of work around e-consent this was going through a business case and has been approved. This will be rolled out in Quarter 1 in the next financial year, this was a live programme of work which will be deployed shortly, this will come through the Operational Board updates and up to Board of Directors.

The Committee thanked KW and noted the report.

3.12 Log4Shell global cyber security vulnerability update

This paper was requested by JF to provide an update of the response to the Log4J issue. This was a global vulnerability notified in December 2021, which tested the on-call resilience and expertise within the Trust to respond quickly. The paper provided a high-level briefing and actions identified. There was assurance that the issue had largely been resolved with this continuing to be monitored.

The Committee thanked KW and team for the response and noted the report.

4. Internal Audit

4.1 Internal Audit Plan: 3-year and annual (draft & final)

There had been some good discussions and engagement in the planning process. There was good linkage with topical issues that MIAA noted, notably through the elective recovery theme, the audit universe topics, and the NHS Audit Committee handbook. There were some discussions around IT recovery, this was actively considered for inclusion in the plan and whilst it was not included within the 22/23 plan it was a priority for the following year.

The timing by quarter was indicative, there was flexibility within the Trust within moving quarters around, and the committee will be updated as appropriate.

The Audit Committee had no further comments and the Internal Audit Plan was approved.

4.2 Internal audit progress report

There were three audits that had been finalised since the previous meeting; patient consent where there was moderate assurance, budgetary control high assurance and the board assurance framework opinion. The patient consent audits, and budgetary control audits were both management requests. In terms of the patient consent review the

DRAFT

key issue was around legibility of staff names and signatures on consent forms this should be resolved by electronic process. The assurance level for budgetary control management was commended, as a significant amount of work had gone into this area. The outstanding area was the data security protection toolkit audit, with the final deadline for national submission being moved to the end of June. The internal audit review of the DSPT was now in the early stages, which was a positive position to be in.

The Chair thanked the Engagement Manager and team for the work that had so far been completed.

4.3 Head of Internal Audit Opinion (draft)

The overall head of internal audit opinion was Substantial assurance.

The report set out the basis of the opinion:

- Assurance framework – there was a positive view on the assurance framework.
- Results of individual audit reports – recognising that this includes areas proactively identified by Executive Directors for review, for example patient consent and secure health messaging. This demonstrated a good approach to risk based reviews.
- Audit recommendation follow up process – good strides have been made through the year with thanks to the Chief Finance Officer.

The Committee discussed the overall level of assurance and the importance of reflecting the management requests. It was agreed that the wording in the AGS would be reviewed to ensure this was explicit.

KWh

4.4 Anti-Fraud plan (draft & final)

This was an indicative plan for 2022/23 based on fraud risks. The guidance was yet to be published from NHS Counter Fraud Authority for the national exercise, however, the following is to be considered:

- Cyber fraud
- Bank mandate
- Covid fraud vaccinations
- Supply mandate fraud
- Recruitment fraud

The plan was based on the NHS counter fraud national standards and must comply against components 1 to 12.

The focus of the proactive work for 2022/23 financial year was yet to be set as the fraud risk assessment document was still in the process of being completed for the organisation.

The Audit Committee approved the plan.

DRAFT

4.5 BAF opinion

The report confirmed the Board Assurance Framework is structured to meet the NHS requirements, is visibly used by the organisation and clearly reflects the risks discussed by the Board.

The report noted the work undertaken on the BAF and reporting for 2021/22 including the ongoing roll out of the board assurance framework extracts to sub-committees.

The Committee noted the report.

4.6 Internal Audit Charter

There was no change from the prior year, in summary the document confirms how MIAA operate in relation to the public sector internal audit standards.

The Audit Committee approved the internal audit charter.

4.7 Draft Fraud Annual Report

The report set out the range of work undertaken against the anti-fraud workplan.

There have been three fraud prevention notices, and a range of short amination videos to show fraud within the NHS, cyber and working whilst off sick.

The National fraud initiative is concluding and must be completed by the end of the month. Assurance was provided that national fraud initiative work had concluded. £2,208 had been identified as duplicate payments.

International fraud awareness week has now ended with communications being issued and bespoke training for HR and recruitment given. E-learning module has been introduced, 89% compliant as of 4th March.

Whilst there were no new fraud allegations, there have been queries in which advice and support was given.

Counter fraud standards have been benchmarked and the amber was fraud risk assessment, which was in progress.

Overtime proactive review was outstanding which will be completed by the time of the next Audit Committee.

In response to Committee discussion, it was acknowledged that the number of referrals were small. There were local and national benchmarks provided quarterly, and the North-West were not as high in investigations compared to other areas of the country. Comparison was also in line with other specialist trusts.

The Audit Committee noted the report.

DRAFT

5. External Audit

5.1 External Audit Update Report

This was the audit plan for 2021/22 financial statements audit.

The report set out the significant risks identified, which were all common inherent risks for Foundation Trusts. Materiality thresholds had been set.

Fraud and revenue recognition was a presumed risk in the audit standards however this can be rebutted, areas of income at lower risks that is block contracts the risk was rebutted. However, those of higher risks such as patient care income, would involve additional testing.

There was a substantial increase in the fee, the original contract was tendered in 2017 since then the audit scope has changed significantly. There was a focus around fraud, the work on journals has increased.

Grant Thornton were working closely with the Trusts finance team, the Chief Finance Officer was pleased with progress to date.

The Committee approved the external audit plan.

5.2 Informing the Audit Risk Assessment – Enquiries of Management

This was part of the preparation for the audit whereby the auditors make several enquires which require management response. The Trust have thoroughly assessed the enquires and provided the responses.

The Committee noted the responses.

6. Annual Accounts Review

6.1 Review of accounting policies

In preparation for completing the final accounts an annual review is completed of the accounting policies. There were several small changes to do with naming conventions, the main changes were around elective recovery funding asset lives to reflect the valuers report, and the adoption of IFRS16.

The Committee approved the accounting policies.

7. Review of Audit Committee Workplan – 2022/23

The business cycle was reviewed at each meeting, this reflected what was used for each meeting. There was an opportunity for this to be updated at any given time.

The Audit Committee approved the workplan for 2022/23.

8. Minutes of E-Meeting held on Tuesday 11th January 2022

The e-minutes of the meeting held on 11th January 2022 were accepted and recorded as a true record.

9. Action Log

Item 1 – data quality was included twice a year. Raising concerns and Audit Committee reviewing this.

Item 3 – in terms of the bribery awareness session, the full briefing note was provided to the Board of Directors in January 2022 as part of the Chief Executive's report, a briefing session would be the same as a briefing note. This item was closed and removed from the action log.

Item 6 – a deep dive was completed in which this was reviewed at Executive Group Meeting and Risk Management Committee. There were several actions for the Divisions to review. KPIs will come to Audit Committee regularly. A KPI report to come back in July. This item was completed and removed from the action log.

The Audit Committee agreed to remove the closed actions from the action log.

10. AGS Issues

The Audit Committee had nothing further to note.

11. Evaluation of Meeting

The Audit Committee was content with the mechanism in place for the e-meeting, given the on-going social distancing measures.

12. Date and Time of Next Meeting:
Friday 17th June 2022, 8.30am-9.00am, MS Teams

DRAFT