Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Meeting of the Board of Directors (in public)

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

Tuesday 27th April 2021
Microsoft Teams video call at 10.00am

Agenda

1	**Welcome and Opening Matters**		
1.1	**Apologies for Absence:**	**Chair**	**Oral**
1.2	**Declaration of Interests Relating to Agenda Items**	**All**	**Oral**
1.3	**Patient Story**	**Director of Nursing, Quality & Safety**	**Oral**
1.4	**Staff Story**	**Chief People Officer**	**Oral**
1.5	**Chair's Briefing**	**Chair**	**Oral**
1.6	**Clinical Presentation – The Breathe Programme**	**Mark Jackson, Lead Physiotherapist in attendance**	**Presentation**
2	**Patient Safety and Quality**		
2.1	**Infection Prevention and Control:**		
2.1.1	**IPC BAF**	**Medical Director**	**Item 2.1.1(a)**
2.1.2	**Director of Infection Prevention and Control (DIPC) Annual Report**	**Medical Director**	**Item 2.1.2(a)**
2.2	**Learning from Deaths Dashboard Q4 2020/21**	**Medical Director**	**Item 2.2(a)**
2.3*	***LHCH Monthly Staffing Report for Periods: January to March 2021****	***Director of Nursing, Quality & Safety***	***Item 2.3****
2.4*	***Guardian of Safe Working Q4 Report 2020/21****	***Medical Director***	***Item 2.4****
2.5*	***Deprivation of Liberty Safeguards (DoLS) Annual Report 2020/21****	***Director of Nursing, Quality & Safety***	***Item 2.5****
3	**Strategy and Development**		
3.1	**Strategic Objectives KPIs Quarterly Update**	**Director of Strategic Partnerships**	**Item 3.1**
3.2	**People Plan Delivery Report**	**Chief People Officer**	**Item 3.2(a)**
3.3	**Annual Equality, Diversity and Inclusion Update**	**Chief People Officer**	**Item 3.3(a-e)**
4	**Targets and Financial Performance**		

4.1	**Board Dashboard – period ended 31st March 2021**	**Chief Operating Officer**	**Item 4.1(a)**
4.2	**Phase 4 Recovery**	**Chief Operating Officer**	**Presentation**
5	**Governance and Assurance**		
5.1	**Consultant Appointments:** No New Appointments	**Medical Director**	**Oral**
5.2	**Freedom to Speak Up (FTSU) Annual Report**	**FTSU Guardian in attendance**	**Item 5.2**
5.3*	***NHS Constitution Compliance Report****	***Director of Nursing, Quality & Safety and Chief People Officer***	***Item 5.3****
5.4*	***Integrated Complaints, Claims and Incidents Report****	***Director of Nursing, Quality & Safety***	***Item 5.4****
6	**Board Assurance**		
6.1	**Assurance Committee Annual Reports and Review of Terms of Reference – for approval**	**Director of Corporate Affairs**	**Item 6.1**
6.1.1	**Audit Committee:** • **Annual Report** • **Terms of Reference**	**Chair of Audit Committee**	**Item 6.1.1(a)**
6.1.2	**Integrated Performance Committee:** • **Annual Report** • **Terms of Reference**	**Chair of IPC**	**Item 6.1.2(a)**
6.1.3	**Quality Committee:** • **Annual Report** • **Terms of Reference**	**Chair of Quality Committee**	**Item 6.1.3(a)**
6.1.4	**People Committee:** • **Annual Report** • **Terms of Reference**	**Chair of People Committee**	**Item 6.1.4(a)**
6.2	**BAF Key Issues Reports and Approved Minutes of Assurance Committee Meetings:**		
6.2.1	**Audit Committee:** • **BAF Key Issues 23rd March 2021**	**Chair of Audit Committee**	**Item 6.2.1**
6.2.2	**Quality Committee:** • ***Approved Minutes 5th January 2021****	**Chair of Quality Committee**	***Item 6.2.2****
7	**Minutes of the Board of Directors Meeting held (in public) on 30th March 2021 – for approval**	**Chair**	**Item 7**
8	**Action Log from Previous Meeting**	**Chair**	**Item 8**
9	**Legality of Board Documentation and Decisions**	**Chair**	**Oral**
10	**Date and Time of Next Meeting:** Friday 11th June 2021, 9.30am via MS Teams		
11	**Resolution:** To exclude the public from the meeting at this point by reason of the private nature of business to follow.		

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

Board of Directors (in Public)
Item 2.1.1

Subject: **IPC BAF**
Date of Meeting: **Tuesday 27th April 2021**
Prepared by: **Dr Raphael Perry, Medical Director**
Presented by: **Dr Raphael Perry, Medical Director**
Purpose of Report: To Note

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

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 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 Board of Directors meeting and updates included at subsequent meetings. There have been no updates since the last Board of Directors in March 2021.

There was a significant revision of the IPC BAF in February 2021 with an additional 42 fields to be completed. A fully updated BAF with additional assurances is attached with updates highlighted in yellow; there are very few outstanding actions.

The CQC have developed a new emergency support framework for IPC.

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.

The third peak of the coronavirus pandemic has eased considerably with a national lockdown in place and excellent progress of the vaccination program. Covid 19 virus will remains prevalent in the population but the numbers of cases and hospitalisations has fallen significantly. The vaccination program has offered vaccines to cohorts 1-10 and clinically vulnerable patients over 16. The focus of hospitals is the resumption of normal activity.

The meticulous processes in place to keep patients and staff safe and prevent cross infection continue. Nosocomial infections and outbreaks are at a very low level.

In addition there is an HSE checklist of IPC measures. This has been completed and evidenced by the trust and any gaps will be addressed.

3. Update

The updated BAF will be supported by a verbal update on Covid 19.

4. Conclusion

The IPC BAF is being managed proactively. The covid six point plan is complete and further developments added as they occur. The infection prevention team is being strengthened and additional digital systems support is being finalized.

5. Recommendation:

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

Infection Prevention and Control Board Assurance Framework v 1.4 (Updated Feb 2021)			
1. Systems are in place 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 posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • Infection risk is assessed at the front door and this is documented in the patient notes • patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission • compliance with the national guidance around discharge or transfer of COVID-19 positive patients • monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice • monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice • staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	Elective patients assessed prior to admission. Emergency patients, e.g. PPCI patients assessed on presentation to the Cath Lab. All patients tested on arrival or pre-admission.Documented in the patient notes. Patients moved to cohort areas according to COVID 19 status and risk pathway. Positive patients tracked on ICNET Protocols in place Patient discharge information leaflet available. Matrons audits and Infection prevention audits performed Compliance monitored regularly by department heads and reported via Silver Command and safety huddles Staff testing and isolation protocols in place. Daily reports of staff testing sent to Silver Command. Liason with staff testing and IPT when positives identified	Mandatory training	To be reviewed and

• training in IPC standard infection control and transmission-based precautions are provided to all staff • IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training • all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work • all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance • national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Mandatory Training for all staff in place Staff receive training on handwashing, PPE, Fit testing on induction and also receive information pertinent to their area on local induction Posters and signs in public areas. Information within regular corporate communications and also displayed on screensavers Guidance and posters available regarding PPE for different zones/cohorts of patients. Information and educational materials available on the intranet. Training delivered by the education team and Critical Care and Theatre staff. Updates circulated to group emergency planning email and communicated via Trust command structure. And regular corporate briefings All IPC guidance is actioned as received, reviewed by silver command and shared at Gold command – chaired by CEO	workbooks require annual review	updated by IP team and by end of Feb 21

• risks are reflected in risk registers and the board assurance framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens • that Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner**.** • ensure Trust Board has oversight of ongoing outbreaks and action plans	Risks are reflected in risk registers and reviewed regularly. IPC BAF is shared at all BoD. Protocols and policies in place for prevention of other infections. Audit programme in place and data available. IPC committee continues to review all other infections. …… Outbreak summaries and actions presented to Gold Command as they occur.		
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: • designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	Teams assigned on a daily basis for COVID 19 isolation All staff working in areas caring for Covid patients receive appropriate training Terminal decontamination carried out according to PHE guidelines and is		

• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance • increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance • cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses Manufacturers' guidance andrecommended product 'contact time' must be followed for cleaning/disinfectant solutions/products as per national guidance • frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids and electronic equipment e.g. mobile phones, desk phones, tablets,desktops & keyboards should be cleaned a minimum	logged on a database. Additional decontamination using UV-C of single rooms and HPV also used Cleaning Schedules available Robust cleaning schedules in place and enhanced schedules in outbreak areas. 1000ppm chlorine based disinfectant product used for terminal and deep clean and in theatres and Cath labs Disinfectant wipes used for equipment Virusolve solution used for bathrooms Frequently touched surfaces included as part of cleaning schedule- cleaned 3x daily. Monitored as part of Matrons' Weekly audits in place Audit data available Cleaning schedules in place		

of twice daily • rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily) • linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken • single use items are used where possible and according to single use policy • reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance • ensure cleaning standards and frequencies are monitored in nonclinical areas with actions in place to resolve issues in maintaining a clean environment • ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air • there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	Linen policy in place, managed as infectious linen Included in disinfection policy Monitoring performed by Hygiene supervisors regularly. Data available Additional ventilation cannot always be introduced and windows cannot always be left open due to temperature control Disinfectants used for terminal cleans and bathrooms even in low risk pathway. Agreed at Silver Command		Social distancing and mask wearing in communal areas

3.Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship is maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Critical Care ward rounds taking place with microbiologist Antimicrobial group reconvened and strategy updated	Microbiology cover has been reduced across all Liverpool trusts due to pressures of Covid. This has been discussed at Gold and a plan to support microbiology cover has been developed.	To develop the role of Critical Care ANP to assist in ward rounds on Critical Care and a plan for ward cover. Three times weekly MS Teams virtual microbiologist ward rounds. Actions: Contact numbers distributed; Response QA in place; JD and PS to be complete by end Jan 21;Antibiotic pharmacists now attending CCA micro virtual WR; leave cover to be discussed with CD
4. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be	Emergency arrivals are screened for symptoms in the ambulance or on arrival and placed in the appropriate		

undertaken to enable early recognition of COVID-19 cases. • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid19 cases to minimise the risk of cross-infection as per national guidance ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff • staff are aware of agreed template for triage questions to ask and triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible • face coverings are used by all outpatients and visitors • face masks are available for patients with respiratory symptoms • provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	area. Elective admissions screened before admission Screens in place at all reception areas Patients with new symptoms are cohorted promptly and immediately tested. Questions in pre-admission template and admission document and also asked prior to day case admission Masks provided at entrance to all patients. Outpatient arrivals overseen by nurse to check compliance Facemasks provided to all patients, encouraged to use by ward managers, especially if mobilizing. Posters displayed		

• for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly retested and contacts traced promptly • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Testing protocol in place and Contact tracing undertaken by IP team. Contact tracing initiated on positive result or negative result with strong clinical suspicion Retests performed if new symptoms Patients assessed and temperature checked on admission to Outpatients Screening questions asked of patients for scheduled appointments. prior to admission		
5. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	Signage in place. Restricted access to communal areas Training provided by education team		

• all staff (clinical and non- clinical) have appropriate training, in line with latest national guidance to ensure their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to Don and Doff it safely • a record of staff training is maintained • appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managedany incidents relating to the reuse of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited • hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: hand hygiene facilities including instructional posters, good respiratory hygiene measures ,maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care	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 Training records held by Education Team Little equipment that is being reused – if so goes through appropriate decontamination Guidance on intranet PPE audits performed weekly Signage and posters displayed in communal areas and at entrances with information on facemasks and hand hygiene Dispensers of hand sanitizer at all entrances and in all areas Masks provided in all areas Social distancing signage in all public areas		

frequent decontamination of equipment and environment in both clinical and non-clinical areas and clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas • staff regularly undertake hand hygiene and observe standard infection control precautions • • 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 • guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms	Hand hygiene and standard infection control precautions observed and audit results available No Hand dryers in situ Hand hygiene posters displayed No uniform laundering available (other than scrubs). Information on requirements is on the Trust intranet Guidance available on intranet. Communicated frequently through safety huddles. Ongoing surveillance via ICNET and regular reports from laboratory. All cases recorded, monitored and tracked.		

• a rapid and continued response through 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. robust policies and procedures are in place for the identification of and management of outbreaks of infection	Review by IPN for relevant cases. Outbreaks reported – protocol in place COVID outbreak protocol in place and overarching policy for outbreaks of infection in place		
6. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff • areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	Designated cohort areas separated from other areas. Access restricted to certain areas Signage used to indicate different zones at entrances.		

• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Patients with Covid 19 are isolated or cohorted in appropriate areas. Designated as red/yellow zones or individual rooms Defined areas agreed by Gold Command. Limited availability of isolation rooms (negative pressure) Patients with alert organisms managed according to IPC guidance, as usual. Monitored and data available		
7.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: • ensure screens taken on admission given priority and reported within 24hrs • regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available • testing is undertaken by competent and trained individuals	Priority levels designated in lab and in testing protocols Turnaround times monitored regularly. Data available Competency tool for staff Testing protocols in place. Audits performed. Staff screening records		

• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance • 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	held by test and trace team Cases monitored by Infection prevention team. Records available Screening protocols in place for other infections in place. Audits performed		
8. 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: • staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • 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	Training and education undertaken. Records held by education team PHE updates communicated via command structure Waste and linen policy in place. PPE supplies managed by dedicated team who supply individual areas		

• PPE stock is appropriately stored and accessible to staff who require it			
9. 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**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported • that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally • staff who carry out fit test training are trained and competent to do so • all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	Robust staff welfare systems in place including at risk groups Risk assessments have been undertaken Risk assessments have been undertaken by departmental heads Protocol in place for reusable respirators. Register of staff maintained. Fit testing monitored by Silver and Gold meetings for compliance and actions required 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		

• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation • for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods • for 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 • following consideration of reasonable adjustments e.g. respiratory hoods, personal reusable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and	staff All failed fit tests recorded on central database Staff who have failed fit tests have been allocated air powered respirators after consultation with relevant manager. Records available No staff currently require redeployment for this reason as all have been fitted with with either FFP3, reusable respirator or hood. Fit testing results monitored regularly and reports shared with Silver and Gold Command		

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 • all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas • 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 are aware of the need to wear facemask when moving through COVID-19 secure areas. • 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	Unable to completely segregate planned and elective care pathways and urgent and emergency care patients due to limited bed capacity Staff allocation discussed and agreed at Silver Command Monitored and reported regularly by managers Risk assessments undertaken for all workplace areas. Numbers limited in all communal areas. Monitored and audited by Matrons Monitored regularly. Reports available Staff testing guidance / FAQs produced by swabbing team Staff who test positive supported as per normal sickness process by line managers with additional support	Pathways for patients continually under review.	Every effort made to reduce patient and staff moves

	provided by HR/OH as required		

Board of Directors (in Public)
Item 2.1.2

Subject: **Director of Infection Prevention & Control (DIPC) Annual Report**
Date of Meeting: **Tuesday 27th April 2021**
Prepared by: **Nicola Best, Assistant DIPC**
Presented by: **Dr Raphael Perry, Medical Director**
Purpose of Report: To Note

BAF Reference	Impact on BAF
BAF 1	Annual assurance report - IPC measures are in place to mitigate the potential for patient harm

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

1. Executive Summary

This report details the infection prevention and control arrangements, annual report and discusses the achievements that have been made to prevent healthcare associated infections (HCAIs) during the financial year 2020/21.

This has been a challenging year for the infection prevention team because of the demands related to the COVID-19 pandemic. However despite this most of the objectives in last year's forward plan have been met and this paper provides assurances that surveillance systems and audit and education programmes are in place, to monitor and prevent healthcare associated infections.

2. Background

The prevention and control of HCAIs is an important part of both the patient safety and clinical quality agendas. The Trust has a responsibility to ensure that appropriate arrangements are in place to protect patients, staff and visitors against the risk of acquiring a HCAI, as detailed in the *Health and Social Care Act (2008).* There is also a requirement to produce an annual report on Trust activities, in relation to infection

prevention and to make this available to the public. This paper provides such a report and will be made available on the Trust website

3. Annual Report

3.1 Infection Prevention and control Arrangements

Infection Prevention Team (IPT)

The Director of Infection Prevention and Control (DIPC) for the Trust is Dr Raph Perry.

The infection prevention specialist nurse provision for the Trust is 2.4 (wte)

Nicola Best, who is now also assistant DIPC. (0.8wte)

Lynn Trayer –Dowell (0.6wte)

Danielle Brady (1wte)

There is a designated Infection Prevention doctor, Dr Alessandro Gerada (2 sessions per week).

On-site clinical microbiology support has been reduced in 2020/2021 to support Covid diagnostics and due to staff shortages. ITU and POCCU support has been prioritised, with three microbiology-ITU ward rounds scheduled per week.

Administrative support for the team has been increased to 1.3 wte.

Infection Prevention Committee

The Infection Prevention Committee (IPC) meets quarterly and is chaired by the DIPC. Membership is multi-disciplinary and includes the governance manager, senior clinicians and nursing staff and representatives from different clinical areas. There are 3 sub-groups of the committee: Water & ventilation safety, Decontamination and Antimicrobial Stewardship. A report on the committee is included in Appendix 1.

Information Technology

A surveillance software system (ICNET) is used by the infection prevention team as part of a joint project with Royal Liverpool University Hospital and Aintree University Hospital.

3.2 Surveillance

Information on all patients colonised, or infected with, specific “alert” organisms is collected and data is generated monthly and used by the Infection Prevention Committee to monitor performance and trends with regard to HCAIs.

Data is also collected on patients with certain bloodstream infections (bacteraemias) and reported to a healthcare associated infection (HCAI) national system.

3.2.1 MRSA Bacteraemias (Blood stream infections)

There have been 0 cases of MRSA bacteraemia

	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Number of LHCH attributable cases per year	0	0	0	1	0	1	0

3.2.2 Methicillin sensitive Staphylococcus aureus (MSSA) Bacteraemias (Blood stream infections)

There has been no change in the number of MSSA bacteraemias. Reviews of individual cases have been performed and shared with the relevant divisions to improve practice where indicated. A report summarising the outcomes of the patient reviews has been complied and submitted to the Infection Prevention Committee.

One outcome of the reviews has been to identify a need for a Trust wide review of intravenous access devices. The infection prevention team has convened a multi-disciplinary group, in conjunction with the lead clinician to address this and the action plan will be incorporated into the programme for 2021/22.

	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Number of LHCH attributable cases per year	11	8	10	8	8	11	11

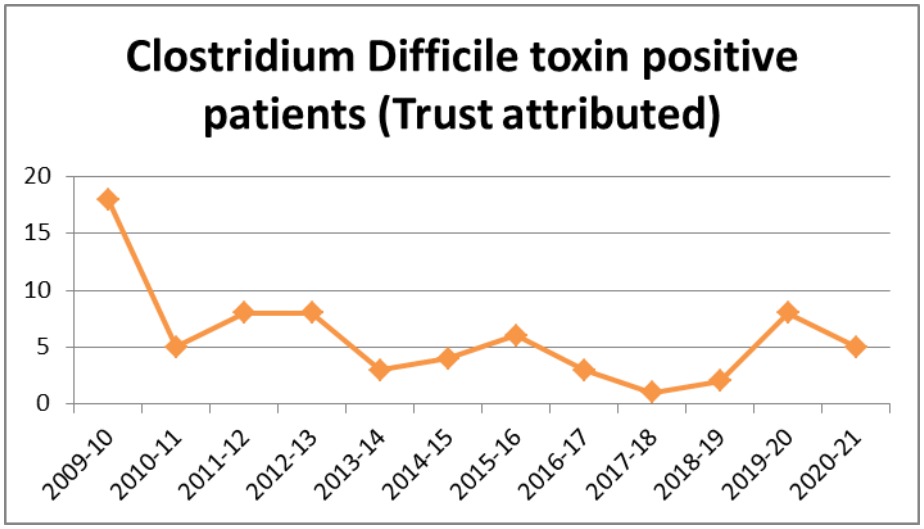
3.2.3 Gram Negative Bacteraemias (Blood stream infections)

Overall there has been a small decrease in the overall numbers of infections caused by this group of bacteria .Patient reviews have been undertaken to identify the probable causes of these infections. In some cases this could not be ascertained but in others was found to be due to a variety of reasons including urinary tract infections and chest infections. The patient reviews have been shared with the relevant divisions to improve practice if indicated.

	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
E. Coli	7	11	9	7	7	3	6
Klebsiella species	Not previously reported			4	2	6	0
Pseudomonas aeruginosa	Not previously reported			5	1	3	3

3.2.4 Clostridium Difficile Toxin positive cases

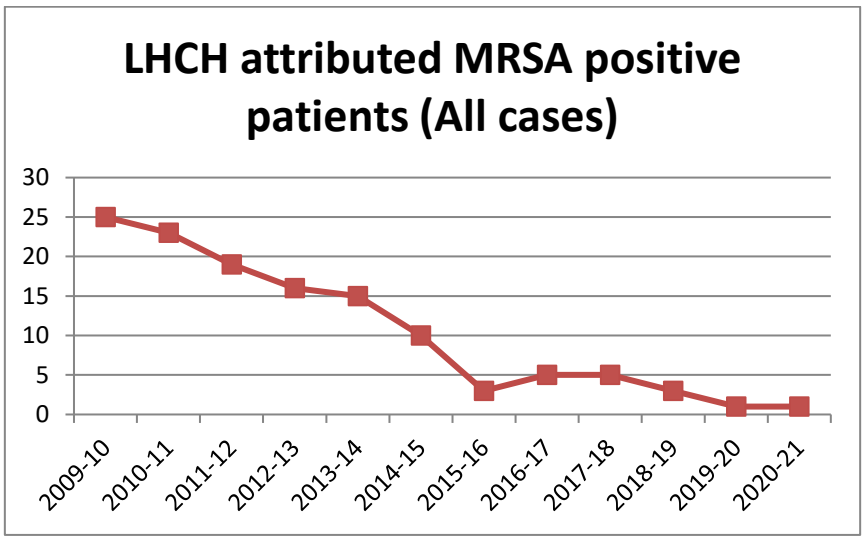
The number of Trust attributed cases of C. difficile infection (toxin positive) has decreased slightly to 5. These cases were not connected to each other. Patient reviews have been undertaken in conjunction with the relevant wards and shared with the divisions to highlight any learning points.



3.2.5 Methicillin Resistant Staphylococcus Aureus (MRSA) -All cases including non-blood stream infections

The total number of patients with MRSA are monitored, this includes patients who are colonised with MRSA or who have an infection at any site. 61 patients were identified with MRSA however the vast majority were identified prior to admission or as part of the admission screening programme.

There was 1 patient with a MRSA attributable to the trust (sputum culture).



3.2.6 Carbapenemase Producing Enterobacteriaceae (CPE)

A number of patients, known to be CPE positive, were admitted from other Trusts and additional patients were found to be CPE positive when they were screened on admission to this Trust. Only 3 patients were identified with CPE after admission i.e. designated as Trust acquired. There were no apparent links between these patients.

3.2.7 Norovirus

There were 0 patients identified with Norovirus

3.2.8 Influenza

There were 0 patients identified with influenza.

3.2.9 COVID 19

299 patients tested positive for SARS CoV2 from April 20 – March 21. The details on whether they were nosocomial cases is given below, using the national definitions.

Onset Categories	Number of Patients
Community-Onset – First positive specimen date <=2 days after admission to trust **(CO)**	177
Hospital-Onset Indeterminate Healthcare-Associated – First positive specimen date 3-7 days after admission to trust; **(HI)**	55
Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission to trust; **(HP)**	42
Hospital-Onset Definite Healthcare-Associated – First positive specimen date 15 or more days after admission to trust. **(HD)**	25

The Trust developed a plan specifically to address the COVID-19 pandemic, which evolved throughout the year. The oversight and decision making was addressed by means of a command and control structure (Gold, Silver, Bronze) which incorporated infection prevention. The command structure ensured that all national and regional guidelines and requirements were enacted and the ongoing Trust plan was monitored and adhered to.

The Infection Prevention team provided specific input and support to many aspects of the plan including ; surveillance, outbreak monitoring and reporting, contact tracing, fit testing, procurement, supply and distribution of PPE (Personal protective clothing), audits, protocol development and patient pathways.

They also provided guidance and advice to both staff, visitors and patients.

3.3. Audit Activity

3.3.1 Hand Hygiene

Clinical areas perform and submit weekly hand hygiene audits to the clinical audit department. Areas should submit 3 audits for their own area each month and one for their peer review ward. Some areas do not always complete the required numbers of audits each month and this has been fedback to the relevant managers and Heads of Nursing. Areas where non-compliance has occurred have also been highlighted to the managers and Heads of Nursing.

Compliance levels for the Trust, by month are given below.

Observational	percent	number
Hand hygiene performed at appropriate time and correct method used	99.4%	6840
Hand hygiene performed at appropriate time but incorrect method used	0.5%	34

Hand hygiene not performed at appropriate time	0.1%	4

3.3.2 Other audits

A number of other audits have been performed throughout the year. Results and actions/recommendations have presented to the IPC and also given to individual areas where relevant. The audits include:

Audit	Performed by:
MRSA and S. aureus screening	IPNs
Screening for CPE	IPNs
Weekly Critical Care screening	IPNs
Decolonisation prior to cardiac surgery	IPNs
Hand gel availability	IPNs
Isolation	IPNs
Compliance with clean trace monitoring	IPNs
Waste management in clinical areas	IPNs with Ward staff
Sharps disposal	IPNs with Ward staff
Decontamination of equipment	IPNs with Ward staff
Linen handling	IPNs with Ward staff
Compliance with decolonisation treatment	IPNs
Bedspace cleanliness	IPNs and Domestic supervisors
Peripheral Intravascular line insertion & care	Ward staff
COVID swabbing audit	IPNs
PPE use	IPNs
UTI audit	IPNs

3.4 Education and Training

Education and training with regard to infection prevention and control was provided by the Infection Prevention Team as part of:

Session	Input from IP Nurses and Frequency
Mandatory Training	Electronic Workbook- Updated annually

	Face to face sessions as requested
Nurse preceptorship programme	1x per year Face to face session
Care Certificate programme	2 x per year Face to face session
Medical Staff Induction programme	1 x per year Face to face session
Anaesthetist induction programme	1 x per year Face to face session
Masters programme	1x per year Face to face session
Ward based updates	As required

3.5. Environmental Hygiene

Hygiene scores

The Hygiene service department experienced a challenging year due to the COVID pandemic with increased cleaning frequencies introduced and a deep cleaning programme across the Trust instituted.

Monitoring of environmental cleanliness by the hygiene supervisors did continue throughout the year on a monthly basis and results are fed back to IPC.

Results are generally very good (usually exceeding the stated target of 95%) with any identified problems rectified immediately.

However staff shortages due to Covid isolation during the month of June impacted on cleaning standards within 1 clinical area and the cleaning standard did not meet the required standard however immediate action was taken to rectify the issues.

Equipment cleaning

Additional monitoring of equipment cleanliness and frequently touched surfaces in the clinical areas by the Matrons has been introduced.

Monitoring of cleanliness of equipment using the Clean Trace system has continued through most of the year although has been discontinued during the last quarter as the system needs to be upgraded.

Enhanced Environmental Decontamination

Decontamination of the patient environment using Ultraviolet-C has been used to a much greater extent across the Trust throughout the year. Additional training has been provided to increase the number of users and a second UV-C machine was purchased to increase the number of areas decontaminated regularly.

Decontamination of the environment using hydrogen peroxide vapour, by external contractors, has been performed in a number of areas including Cedar ward, Elm ward and POCCU 1,2 and 3.

3.6 Antimicrobial stewardship

Quarterly antimicrobial audits have been performed this year that analyse prescribing, compliance with formulary and evidence of stewardship. Quarterly surgical prophylaxis audits (cardiac patients) have been commenced (previous annually)

No CQUINN data has been requested nationally due to COVID pressures.

The Antimicrobial stewardship group has met quarterly to review stewardship issues and is chaired by the Director of Infection Prevention and Control. .

Education has been provided to the junior doctors as part of their induction

Programme only.

A virtual critical care microbiology ward round is in process 3 times a week including the microbiologist, pharmacist and critical care consultant.

An Antimicrobial Stewardship Strategy has been produced

3.7 Surgical Site Infection prevention

A working group to look at all aspects of the prevention of surgical site infection had been re-established but only 1 meeting was held in this year due to additional work pressures on members of the group.

The reviews by members of the SSI group of patients who developed deep sternal wound infections to identify any learning points have continued.

Surveillance data has been collected and reviewed by the IP nurses on 807 patients who had CABG or valve replacement surgery between April and January of this year (infection rate was approximately 3.3%). Data and information on surgical site infections was presented by the lead infection prevention nurse at the audit day for the surgical division. An action plan and audit programme for 2021/22 will be monitored by the Surgical Division and IPC.

A proposal for a more robust surveillance programme has been developed and will be presented to the IPC and Surgical Division.

The infection prevention team have also provided support to the Photo at Discharge project led by the Tissue Viability nurses.

3.8 Water Safety

The Water Safety Group is a sub-group of the Infection Prevention Committee and met 3 times during this year. Ongoing actions to maintain water safety continue; including a water testing programme for Legionella and Pseudomonas aeruginosa, flushing and maintenance programmes. Audits have been performed by independent contractors who are experts in the field of water safety and a number of areas of non-compliance with current guidelines have been identified, an action plan has been developed to address any issues.

A new protocol for testing and maintenance of heater coolers has been developed by the perfusion department with input from the infection prevention team.

3.9 Decontamination.

The multi- disciplinary decontamination group had 1 meeting this year. The Trust commissioned a review of decontamination processes and governance by Merseyside Internal Audit Agency, which was performed in February. The results and report will be submitted to the Trust in April 2021 and will inform the forward plan and strategy for 2021/22.

3.10 Sepsis

The 20/21 annual sepsis report will be presented at the Quality Committee in July2021. This shows the KPI data and a copy is attached as an appendix. There has been an improvement in the management of sepsis with the principal KPIs either achieved or significantly improved. The most clinically important KPI, antibiotic delivered within one hour, is being more consistently achieved. The data on blood cultures has been improved through a system of early validation and only reporting validated data. This KPI has been consistently achieved since Q2. Usage of the screening tool and the sepsis bundle has improved and screening fails are circulated to the individuals concerned. Good practice in treating sepsis is fed back to the staff concerned

The lead for sepsis Dr Al-Rawi continues to lead the sepsis group to ensure continuous improvement of the care of patients with sepsis at LHCH. The group comprises Dr Al-Rawi, Dr Alessandro Gerada, (consultant microbiologist), the infection prevention nurses, the sepsis audit analyst, outreach nurses, EPR reresentation and ITU staff

The drive continues to increase further the use of the screening tool and ensure all KPIs can be measured via EPR. The mortality from sepsis remains low.The weekly and year to date screening data is presented in the executive harm report. High risk screens are identified and the KPIs presented for that subgroup. Data is fedback to the wards and areas and a clear line of responsibility established. Any fails of the KPIs are reviewed by the sepsis lead or the medical director to ensure acuary and appropriateness.

There is a continued education program to deliver teaching sessions for junior doctors outreach and hospital coordinators. Trust wide reminders thorugh screen savers and desktop backgrounds continue. There is a new sepsis eLearning package which is included in mandatory training for clinical staff.

4. Conclusion

This has been a challenging year for the infection prevention team because of the demands related to the COVID-19 pandemic. However despite this most of the objectives in last year's forward plan have been met.

The surveillance programme continues and shows the trust attributable infections remain relatively low. In order to continue to maintain progress and reduce the risks of HCAI a forward plan for 2021/2022 will be developed and progress against this plan will be monitored throughout the year by the Infection Prevention Committee.

5. Recommendations

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

Item 2.1.2a

Appendix 1

Subject: Annual Report of Infection Prevention Committee 2020-2021

1. Executive Summary

The committee has met 4 times in the past year. Details of work overseen by the Committee are provided in the preceding report and annual forward plan.

2. Delivery of Objectives

A summary of progress against each of the agreed objectives is shown below.

ToR Ref	Objective	Evidence to Support Delivery
3.1	To provide strategic direction and planning pertaining to all issues related to infection prevention & control within the Trust.	Annual plan, audit programme, reporting systems.
3.2	To support the infection prevention team, the Heads of Nursing and relevant manages in their activities	Audits as detailed in attached report
3.3	To ensure infection prevention and control policies and protocols are developed, implemented, monitored and updated by the appropriate leads within the Trust.	Policies updated and approved at IPC
3.4	To advise the Trust on the best means for the education and training of hospital staff to ensure successful implementation of policies and protocols and that staff are aware of their roles and responsibilities relation to infection prevention and control	Training provided as detailed in attached report
3.5	To develop and implement an annual programme of work against which progress will be report to the Committee, as per the agreed reporting schedule.	Annual plan submitted during 20/21
3.6	To produce quarterly DIPC reports and annual infection prevention report, and submit these to Trust Board. To receive regular reports on surveillance, key quality indicators and any serious untoward incidents	Quarterly DIPC reports produced Annual Infection Report attached Surveillance reports produced for each IPC meeting.

	related to infection prevention and control and ensure that robust delivery plans are in place to address emerging issues.	
3.7	To co-operate with the other Trust Committees e.g. Health and Safety to ensure that exemplary infection prevention and control practices are applied consistently across the Trust	Joint membership of IPN and Senior Nurses at both IPC, Health and Safety Committee and Emergency Planning
3.8	To monitor and evaluate infection prevention and control practice and performance at directorate level receiving twice yearly directorate reports on related issues.	Reports received from directorates on IP practices. IP audits performed jointly with IP nurses and ward staff and submitted to committee
3.9	To develop the appropriate partnerships with external agencies necessary for improving infection prevention and control practice	Infection prevention representation at meetings with regional groups discussing COVID pandemic guidelines
3.10	To approve the establishment, duration and effectiveness of any time limited working groups of the committee	SSI group was reconvened but only 1 meeting was held therefore regular reports not received.
3.11	To receive regular reports and monitor the effectiveness of the standing sub committees i.e. Water and Ventilation Safety Group , Decontamination Group and Antimicrobial Resistance Group (AMR)	Reports provided to the Committee from Water Safety Group and for Antimicrobial Stewardship. Regular reports not received from Decontamination Group.

3. Membership

The attendance of a number of members has not met the required standard. The chair will contact relevant members to reiterate the importance of attendance at these meetings and review the Terms of Reference with the divisional leads.

Attendance	**Attendance (%)**
Members :	
Chair: Medical Director/DIPC	100%
Infection Prevention Doctor/Consultant Microbiologist (IPT)	100%
Infection Prevention Nurse Specialists (IPT)	100%
Deputy Director of Nursing or Head of Nursing	100%
Support Services Manager	100%
Pharmacist	100%
Matron for Theatre	50%
Estates Manager	75%
Critical Care Unit Manager or deputy	50%

Lead clinicians for: Chest Medicine	50%
Cardiac Surgery	0%
Thoracic Surgery	25%
Cardiology	100%
Anaesthesia & Critical Care	75%
PHE representative	0%
Occupational Health	100%

4. Sub Committees

There are 3 sub-groups that report to the Infection Prevention Committee, the Water Safety Group, Antimicrobial stewardship and Decontamination Steering Group.

5. Conduct of Meetings

A work plan agreed at start of year and meetings / agenda are appropriately scheduled to meet the work plan. Reports and papers are consistently issued ahead of the meeting, although sometimes not within 5 working days. There is an action logging process maintained to ensure actions clearly recorded and followed through.

6. Terms of Reference

The Committee has reviewed its Terms of Reference

7. Recommendations

The Board of Directors is asked to receive assurance that generally the Infection Prevention Committee has operated effectively during 2020/21.

Board of Directors (in Public)
Item 2.2

Subject: **Learning from Deaths Dashboard Q4 2020/21**
Date of Meeting: **Tuesday 27th April 2021**
Prepared by: **Dr Raphael Perry, Medical Director**
Presented by: **Dr Raphael Perry, Medical Director**
Purpose of Report: To Note

BAF Reference	Impact on BAF
BAF 1	Possible avoidable patient harm

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

1. Executive Summary

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

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

This quarterly report presents the mortality dashboard for Q4 20/21 (Appendix 1)

2. Background

The threshold of defining preventable death is now on the basis of more likely than not encompassing the categories of definitely avoidable, strong evidence of avoidability and probably avoidable (greater than 50:50). Deaths are classified using the RCP (Royal College of Physicians) methodology unless they occur in individuals with an identified

learning disability. In those individuals LeDeR (Learning Disability Mortality Review) methodology is used and a full review carried out without prior screening.

The mortality review policy was updated in February 2019 and the robust mortality review process continues.

All deaths have an initial review by the Deputy Director of nursing to assess any issues raised by families and carers. Any concerns raised by the families after a period of reflection are responded to and where appropriate investigated. If the death is considered avoidable or classed as an incident full duty of candour is exercised

3. Dashboard Q4 2020/21

There have been fifty-eight deaths in the trust between January and March 2021. For comparison the total number of deaths in the trust for Q3 2020/21 was forty-nine. In Q4 forty-three of the deaths have been through the mortality review process. There have been no deaths in patients with an identified learning disability.

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

No deaths occurring in Q4 have been classified as greater than 50:50 chance of avoidability. However a death from Q3 was reviewed at the February MRG and classified as probably avoidable – RCP 3.

Of those less than 50:50 in Q4 three deaths (6.8%) were classed probably avoidable but not very likely; two deaths (4.5%) were classed as slight evidence of avoidability; thirty - nine deaths (88.6%) were classed as definitely not avoidable.

Annual Deaths

In 20/21 there were a total of 191 deaths compared to 189 deaths in 19/20. Of the 20/21 deaths fourteen have yet to complete the mortality review process.

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

In 19/20 there were eight potentially avoidable deaths.

4. Conclusion

The Trust complies with national guidance and populates the mortality dashboard. There were no deaths with evidence of avoidability during Q4 20/21. Actions from the MRG process are being taken forward by the appropriate division. This report summarises the annual numbers.

5. Recommendations

The Board of Directors is asked to note the dashboard data.

Item 2.2a

Liverpool Heart and Chest NHS Foundation Trust: Learning from Deaths Dashboard - March 2020-21

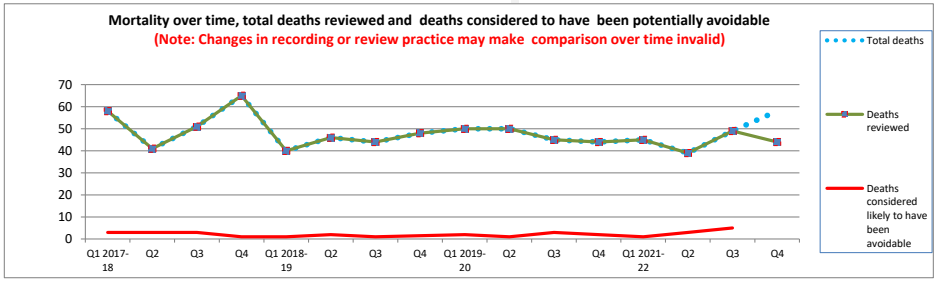
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
16	25	10	18	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
58	49	44	49	0	5
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
191	189	177	189	9	8

Time Series: Start date 2017-18 Q1 End date 2020-21 Q4



Total Deaths Reviewed by RCP Methodology Score

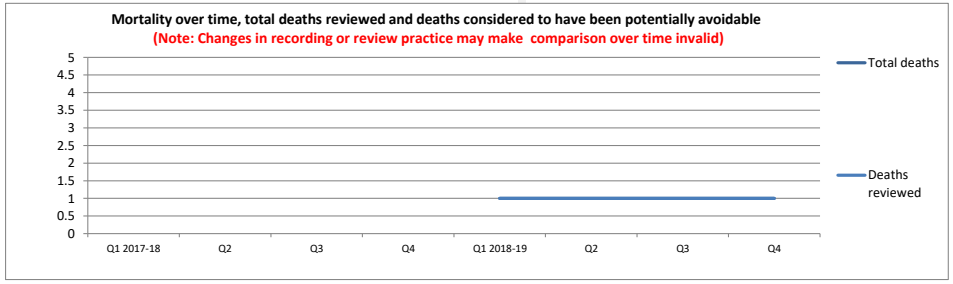
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	10.0%	This Month	1	10.0%	This Month	8	80.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	3	6.8%	This Quarter (QTD)	2	4.5%	This Quarter (QTD)	39	88.6%
This Year (YTD)	1	0.6%	This Year (YTD)	3	1.7%	This Year (YTD)	5	2.8%	This Year (YTD)	11	6.2%	This Year (YTD)	16	9.0%	This Year (YTD)	141	79.7%

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

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

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

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



Board of Directors (Public)
Item 2.3*

Subject: **LHCH Monthly Staffing for Reporting Period for January-March 2021**
Date of meeting **Tuesday 27th April 2021**
Prepared by: **Julie Roy, Divisional Head of Nursing & Quality for Medicine**
Kirsty Dudley, Critical Care Manager,
Presented by: **Sue Pemberton, Executive Director of Nursing & Operations**
Purpose of Report: **To Note**

BAF Ref	Impact on BAF
BAF 4, BAF 5, BAF 6	Assurance that staffing is appropriate and is flexed according to patient need and patient safety risk assessments, following escalation processes.

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

1. Executive Summary

At Liverpool Heart & Chest Hospital, we aim to provide excellent, efficient safe care for our patients and populations every day and our nursing staffing levels are continually assessed to ensure that we achieve this.

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

The National Quality Board (NQB) publication Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing (2016) outlines the expectations and framework within which decisions on safe and sustainable staffing should be made to support the delivery of safe, effective, caring, responsive and well-led care on a sustainable basis. It builds on National Institute for Health and Care Excellence (NICE) guidelines on safe staffing for nursing in adult inpatient wards, and is informed by NICE's comprehensive evidence reviews of research, and subsequent evidence reviews focusing specifically on staffing levels and outcomes, flexible staffing and shift work.

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

The POCCU 3 10 bedded area has remained available for Covid positive patients and is staffed flexibly by the critical care and ward nursing teams. This area has remained open, caring for covid positive ward level patients & critical care level patients during January- March. Due to a reducing number of covid positive patients within the Trust, throughout February and March, Maple Suite has reverted back to a medical ward, utilised flexibly to accommodate surgical transfers when required. Rowan Suite continues as a surgical ward for pre-operative patients including urgent referrals and all CF patients continue to be safely cared for within Cherry ward. In January, Elm ward's name was formally changed to the Acute Cardiac Unit (ACU) and continues to care for acute cardiology patients including those needing higher level coronary care treatment.

During January- March 2021, sickness and other absence including covid absence and absence due to covid contact though track and trace has significantly impacted ward and critical care staffing. Staffing escalation plans for during the covid pandemic have been reviewed, including critical care staffing, although have not needed to be implemented during these months. All RN vacancies across the Trust have been reviewed by the Director of Nursing with the senior nursing team. The Trust's new Recruitment and Talent Lead within HR has also been working closely with the senior nursing team to devise a live dashboard to ensure oversight of all Trust vacancies and recruitment progress against each. This information is validated by the senior nursing team to ensure accurate vacancy reporting data.

All RN vacancies within inpatient areas, are now recruited to but with a significant lag until start dates (particularly for students and overseas nurses). As such, the temporary staffing team are actively recruiting to the LHCH nurse bank in order to support during this time. A pan-Mersey approach to overseas RN recruitment is progressing well with 7 registered nurses planned to arrive in April 2021 and 6 in May 2021, with a further 37 RNs planned to arrive over the next 12 months. The Trust is also supporting 3 members of staff through the Refugee Support programme with a planned start date for April 2021. The Trust now holds a license for the Shelford Safer Nursing Care Tool and this will be utilised during May to review staffing requirements across all inpatient ward areas.

2. Exceptions

All planned staffing for nursing in LHCH is assessed as required for the ward to run at full capacity, if capacity is reduced then the planned staffing changes accordingly. In January-March 2021;

- There were no red flags on Cedar, Oak and Rowan wards. Cross divisional staff movement ensured that all shifts were reported as safe.
- There were no red flags on ACU, Cherry and Maple wards in January- March 2021.
- Maple and Oak wards have been affected by significant RN absence (sickness and vulnerable staff shielding) during these months and have received support from other clinical areas within the divisions.
- Following the ward reconfigurations, the Acute Cardiac Unit (ACU) continues to have a significant number of RN vacancies. The divisional matron works closely with the ward team to ensure appropriate levels of coronary care trained staff are available for each shift. One red flag was reported for Birch ward during March and concerns were raised to the DON. A night shift was short of 1 HCA due to one member of staff being asked to support another ward overnight following short notice sickness in that area. No patient safety incidents were reported but the shift was reported as busy for the remaining 2 HCAs on shift. This was escalated appropriately at the time and reported via datix and a

meeting with the senior nursing team and a meeting has been held with the reporting staff member discuss decision making.

3. Summary

This continues to be a particularly challenging period of time for all staff working with reduced staffing levels at times. The Trust has experienced an increase in staff absence during the third wave of the covid pandemic which has contributed to increased staffing pressures, experienced across the NHS.

Each day a review of staffing takes place Trust wide to ensure that all patients can be cared for safely. This does, however, result in staff moves on occasion to manage risk and to provide additional support for areas where acuity of patients is higher. The ward manager weekend rota continues with a ward manager working each weekend to support the hospital co-ordinator in ensuring safe staffing across all areas and keeping in close contact with the duty on-call manager for the Trust.

4. Recommendations

The Board of Directors are asked to:

- Receive assurance related to nurse staffing for in-patient wards, as per national directives, noting actions being taken to ensure patient safety and quality of care are maintained.
- Receive assurance that staffing is appropriate and is flexed according to patient need and patient safety risk assessments, following escalation processes.
- Receive monthly reports of staffing at all planned board meetings.
- Receive the ‘care hours per patient day’ (CHPPD) data
- Receive assurance that the review of ward establishments and models of care for each inpatient area has been completed and will be reviewed in 2021.
- Receive assurance that a robust recruitment plan continues, including an overseas recruitment plan.
- Receive assurance that revised models of nursing care, utilising Registered Nursing Associates and apprentices continue to be implemented.
- Receive assurance that alternative temporary staffing options are being explored.
- Receive assurance that staffing escalation plans are in place to be enacted when significant staffing pressures are seen during the covid pandemic.

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

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

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

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

CHPPD for January 2021

		Care Hours Per Patient Day (CHPPD)								Day				Night			
		Cumulative count over the month of patients at 23:59 each day	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)
		3614	10.9	3.8	0.0	0.3	0.0	0.0	15.0	91%	89%	45%	108%	91%	85%	-	-
BIRCH	320 - CARDIOLOGY - STANDARD	671	4.1	3.4	0.1	0.1	0.0	0.0	7.8	81%	115%	32%	39%	100%	78%	-	-
ELM	320 - CARDIOLOGY - STANDARD	482	11.9	4.0	0.0	0.4	0.0	0.0	16.3	86%	87%	-	-	82%	83%	-	-
CHERRY	340 - RESPIRATORY MEDICINE - STANDARD	201	6.7	3.3	0.0	0.0	0.0	0.0	9.9	88%	97%	-	-	90%	71%	-	-
CRITICAL CARE	192 - CRITICAL CARE MEDICINE - STANDARD	789	27.2	3.4	0.0	0.0	0.0	0.0	30.6	100%	83%	-	-	99%	85%	-	-
OAK	170 - CARDIOTHORACIC SURGERY - STANDARD	343	5.1	4.6	0.0	0.8	0.0	0.0	10.5	78%	75%	-	87%	76%	90%	-	-
CEDAR	170 - CARDIOTHORACIC SURGERY - STANDARD	770	5.1	4.7	0.0	0.5	0.0	0.0	10.3	78%	96%	-	106%	77%	102%	-	-
MAPLE	320 - CARDIOLOGY - STANDARD	152	7.5	2.7	0.2	0.2	0.0	0.0	10.6	83%	58%	-	-	70%	50%	-	-
ROWAN	170 - CARDIOTHORACIC SURGERY - STANDARD	206	6.2	2.9	0.0	0.4	0.0	0.0	9.6	91%	79%	-	-	74%	81%	-	-

CHPPD for February 2021

		Care Hours Per Patient Day (CHPPD)								Day				Night			
		Cumulative count over the month of patients at 23:59 each day	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)
		3546	**10.2**	**3.9**	**0.1**	**0.3**	**0.0**	**0.0**	**14.4**	**93%**	**97%**	**54%**	**88%**	**92%**	**97%**	-	-
BIRCH	320 - CARDIOLOGY - STANDARD	733	3.8	3.3	0.2	0.2	0.0	0.0	7.5	95%	130%	68%	71%	101%	98%	-	-
ELM	320 - CARDIOLOGY - STANDARD	466	11.2	4.4	0.0	0.6	0.0	0.0	16.2	83%	99%	-	-	87%	104%	-	-
CHERRY	340 - RESPIRATORY MEDICINE - STANDARD	210	6.1	5.8	0.0	0.0	0.0	0.0	11.9	96%	98%	-	-	89%	104%	-	-
CRITICAL CARE	192 - CRITICAL CARE MEDICINE - STANDARD	718	27.9	3.7	0.0	0.0	0.0	0.0	31.6	99%	92%	-	-	99%	90%	-	-
OAK	170 - CARDIOTHORACIC SURGERY - STANDARD	320	4.5	4.0	0.0	0.8	0.0	0.0	9.2	85%	78%	-	62%	75%	96%	-	-
CEDAR	170 - CARDIOTHORACIC SURGERY - STANDARD	772	5.0	4.4	0.0	0.2	0.0	0.0	9.6	89%	99%	-	50%	79%	105%	-	-
MAPLE	320 - CARDIOLOGY - STANDARD	211	3.9	1.8	0.2	0.2	0.0	0.0	6.2	92%	72%	35%	37%	78%	85%	-	-
ROWAN	170 - CARDIOTHORACIC SURGERY - STANDARD	116	7.6	3.8	0.0	0.2	0.0	0.0	11.7	69%	66%	-	-	59%	64%	-	-

CHPPD for March 2021

		Care Hours Per Patient Day (CHPPD)								Day				Night			
		Cumulative count over the month of patients at 23:59 each day	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)
		4207	**9.3**	**3.2**	**0.0**	**0.3**	**0.0**	**0.0**	**12.8**	**93%**	**97%**	**29%**	**97%**	**90%**	**93%**	-	-
BIRCH	320 - CARDIOLOGY - STANDARD	820	3.7	3.2	0.1	0.2	0.0	0.0	7.2	92%	125%	32%	81%	101%	100%	-	-
ELM	320 - CARDIOLOGY - STANDARD	517	10.2	1.4	0.0	0.4	0.0	0.0	12.1	80%	9%	-	-	80%	116%	-	-
CHERRY	340 - RESPIRATORY MEDICINE - STANDARD	209	5.9	3.3	0.0	0.0	0.0	0.0	9.2	78%	106%	-	-	87%	65%	-	-
CRITICAL CARE	192 - CRITICAL CARE MEDICINE - STANDARD	802	26.3	3.4	0.0	0.0	0.0	0.0	29.7	101%	87%	-	-	97%	87%	-	-
OAK	170 - CARDIOTHORACIC SURGERY - STANDARD	499	3.8	3.9	0.0	0.8	0.0	0.0	8.5	88%	97%	-	56%	77%	102%	-	-
CEDAR	170 - CARDIOTHORACIC SURGERY - STANDARD	936	4.6	3.8	0.0	0.5	0.0	0.0	8.9	90%	152%	-	145%	82%	102%	-	-
MAPLE	320 - CARDIOLOGY - STANDARD	303	4.5	2.0	0.2	0.3	0.0	0.0	7.1	94%	93%	26%	45%	87%	58%	-	-
ROWAN	170 - CARDIOTHORACIC SURGERY - STANDARD	121	5.8	3.8	0.0	0.1	0.0	0.0	9.7	76%	136%	-	-	63%	60%	-	-

Board of Directors (in Public)
Item 2.4*

Subject: **Guardian of Safeworking Q4 Report 2020/21**
Date of Meeting: **Tuesday 27th April 2021**
Prepared by: **Fiona Ross, HR Business Partner**
Presented by: **Dr Raphael Perry, Medical Director**
Purpose of Report: To Note

BAF Reference	Impact on BAF
BAF 6	Potential difficulty recruiting and retaining junior doctors/trainees

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 20/21 Q4 report on safe working hours following introduction of the 2016 contract for junior doctors.

At present LHCH has sixty-six 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): 62
Number of doctors / dentists in training on 2016 TCS (total): 62

Amount of time available in job plan for guardian to do the role:	0 PAs (under annual review)
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. Exception Reporting

a) Exception reports (with regard to working hours)

There have been no exception reports in Q4. 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 out of hours cover.
- Problems with February rotation caused by inaccurate information in relation to medic placements from HEE and Lead employer plus last minute withdrawal of WAST doctor creating 3 gaps on cardiology tier one rota (11 slot rota)

c) Actions taken to resolve issues

- Cardiology have engaged an agency medic to support the rota until new recruits commence in post (anticipated May 2021)
- Surgery are also sourcing agency medics to support the rota until new recruits are able to start in post (anticipated August 2021)
- ANP's continue to support day time and evening shifts, with some assistance for weekend daytime shifts
- All gaps are reported to divisions 3 weeks in advance of vacant shifts in order to identify personnel to cover
- DiT Collaborative bank has gone live in order to seek previous medics who are able to provide short term cover for vacant shifts

d) Exception reports (with regard to working hours)

There have been no exception reports in Q4. Only one exception has been received since August 2016.

e) Issues arising

- Current gaps in Tier one rota for both Surgery and Cardiology are causing problems with out of hours cover.
- Problems with February rotation caused by inaccurate information in relation to medic placements from HEE and Lead employer plus last minute withdrawal of WAST doctor creating 3 gaps on cardiology tier one rota (11 slot rota)

f) Actions taken to resolve issues

- Cardiology have engaged an agency medic to support the rota until new recruits commence in post (anticipated May 2021)
- Surgery are also sourcing agency medics to support the rota until new recruits are able to start in post (anticipated August 2021)
- ANP's continue to support day time and evening shifts, with some assistance for weekend daytime shifts

- All gaps are reported to divisions 3 weeks in advance of vacant shifts in order to identify personnel to cover
- DiT Collaborative bank has gone live in order to seek previous medics who are able to provide short term cover for vacant shifts

4. Junior Doctor Forum

The last forum was held on 3rd December 2020 and was chaired by Dr John Holemans in his capacity as Guardian of Safeworking. It was well attended with good representation cross-divisionally. The next meeting will be arranged for May 2021.

5. 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) Annual Report 2020/21**
Date of meeting: **Tuesday 27th April 2021**
Prepared by: **Terri Marshall, Safeguarding, EECS, PFCC Administrator**
Presented by: **Sue Pemberton, Director of Nursing, Quality and Safety**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
BAF 1	Assurance that the Trust has in place safeguards to ensure that patients who lack capacity receive appropriate care and treatment aligned to Human Rights and Mental Health Act legislation

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

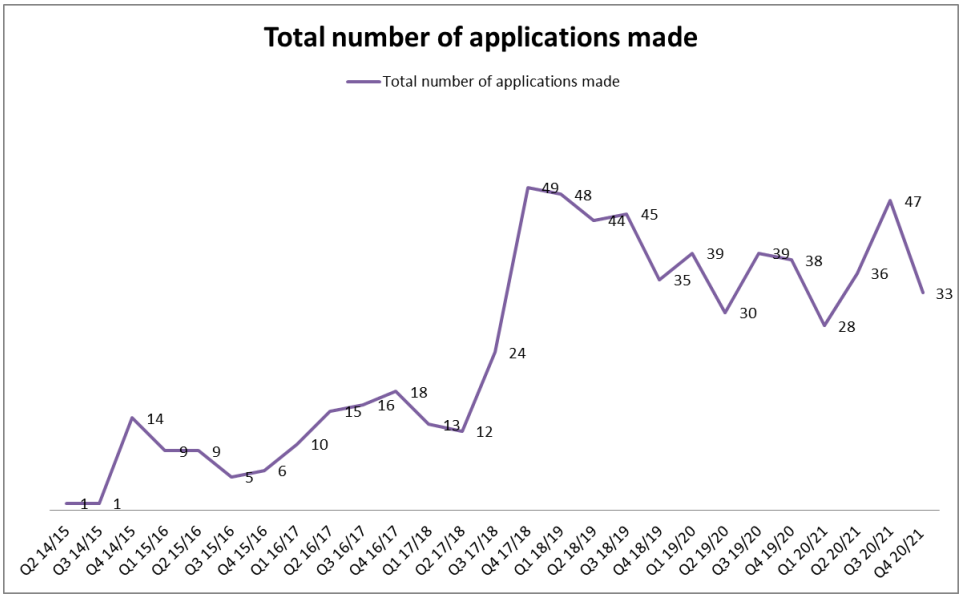
1. Executive Summary

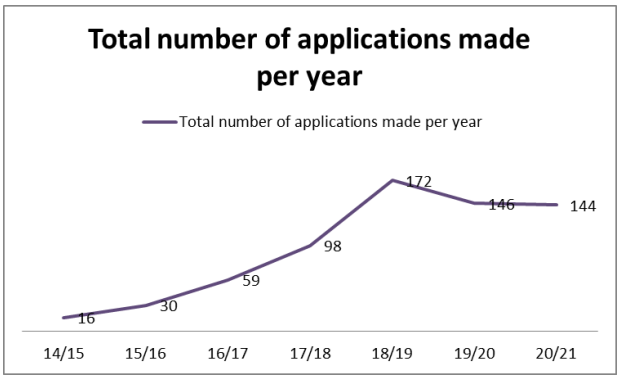
The purpose of this paper is to update the Board of Directors of the number of applications made for the year 2020/21 in relation to the Deprivation of Liberty Safeguards (DoLS).

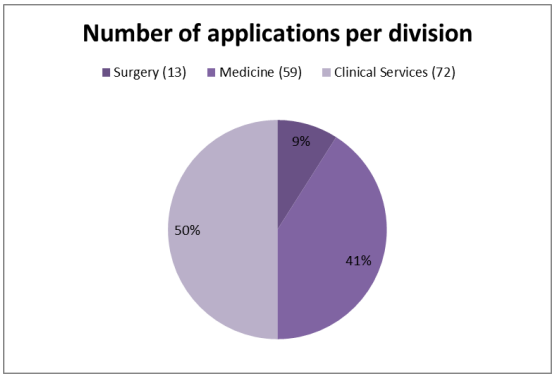
2. Background

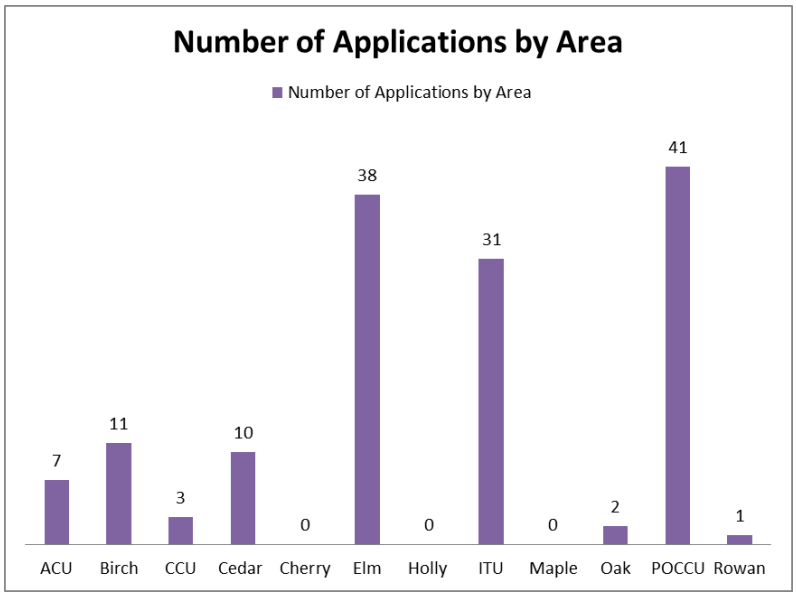
The Deprivation of Liberty Safeguards (DoLS) were introduced in 2009 (as an addendum to the Mental Capacity Act 2005 and a strong link to the Mental Health Act 2007). DoLS aim to prevent the unlawful detention of adults in hospitals and care settings who lack capacity to choose where they live and/or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

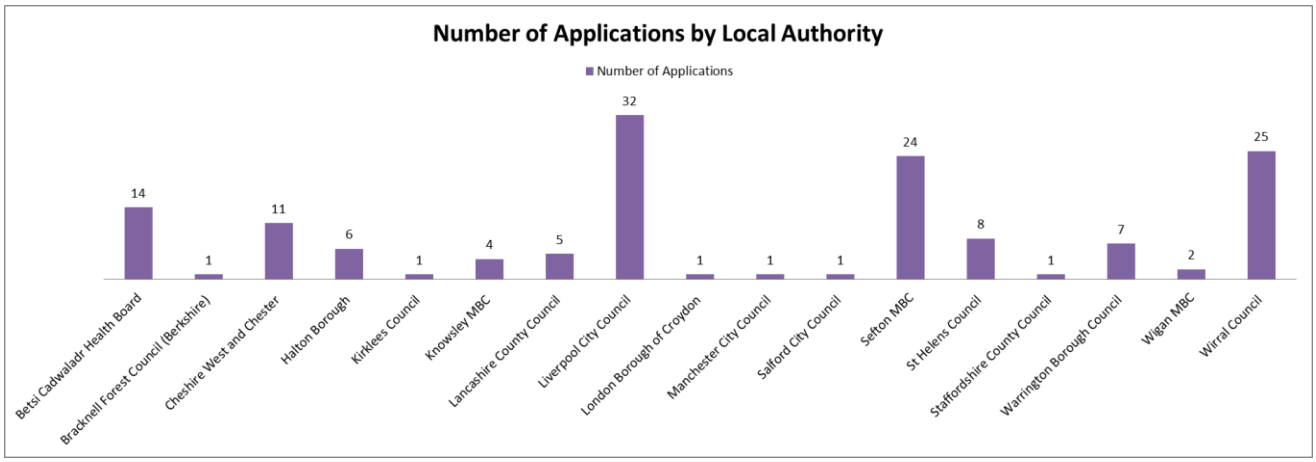
3. Current Position











MCA Assessments and DoLS Applications

For the year a total of 144 Deprivation of Liberty Applications have been received by the Safeguarding Team for 17 different local authorities across the catchment area. This is a 1.4% decrease in applications received compared with the previous year.

Of the total 144, all were standard and urgent applications.

- 22 urgent applications were issued and the standards were not required as the patients were discharged or transferred within the 14 day urgent period, their confusion had settled or the patient passed away.
- In 3 cases no response or decision was received from the Local Authority, despite being chased up.
- 0 applications were rejected by the Authorities.
- In 118 cases, the applications were reviewed and the patients were assessed by the safeguarding team but the applications were not sent. This was due to a number of reasons, either the patients confusion had settled prior to review, the patient met the criteria for a critical care patient and was to be managed under the best interest principles and would be reviewed again once they were ready to be transferred to the ward, the patient was discharged/transferred or passed away prior to review.
- 1 application was received at the end of the review period and remains ongoing.

MCA and DoLS Mandatory training is currently at 95% 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 is asked to note the numbers of applications made and assessments undertaken.

Board of Directors (in Public)
Item 3.1

Subject: **Strategic Objectives KPIs Quarterly Updates Q4**
Date of meeting: **Tuesday 27th April 2021**
Prepared by: **Jonathan Develing, Director of Strategic Partnerships**
Presented by: **Jonathan Develing, Director of Strategic Partnerships**
Purpose of Report: **To Note**

BAF Ref	Impact on BAF
ALL	The quarter four review against the strategic objectives has been undertaken alongside the review of the BAF. Any changes to risks and/or gaps in controls and assurance have been reflected in the BAF and this is considered separately on the agenda.

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

1. Executive Summary

This paper provides an overview, as at Quarter Four 2020/21 of the Trust's strategic objectives as described within the five year strategy, Patients, Partnerships and Populations. Observed risks and/or gaps in controls and assurance have been reflected in the Board Assurance Framework (BAF) and this is considered separately on the agenda.

2. Background

The Board of Directors is responsible for setting the overall strategic direction of the Trust and to monitor performance against its objectives. For 2020/21 the Board of Directors agreed that performance against strategic objectives should be monitored quarterly alongside its quarterly review of the BAF.

3. Performance against Strategic Objectives

Overall performance against the strategic objectives remains on track for delivery over the lifetime of our strategy. It should be note that a small number of objectives have been re-profiled and now

planned in for delivery in future years. These are recorded within the Appendix and recorded as such.

Operational priority and delivery of care during the coronavirus pandemic has also been reflected as appropriate within the delivery of strategic objectives.

The Board of Directors have agreed the following strategic objectives for 2020/21:

i) Delivering World Class Care

- Advance outcomes, safety and reduce harm.
- Achieve international accreditation standards including retaining our Outstanding CQC rating.
- Further develop our patient and family – centred model of care.
- Develop services based on world class research and innovation.
- Develop world class facilities.
- Develop service in line with our 5 year strategy.

ii) Advancing Quality and Innovation

- Embed organisational learning
- Develop the Trusts academic expertise.
- Develop Liverpool Centre for Cardiovascular Science with research partners
- Develop a recognised learning and academic facility
- Deliver our digital strategy
- Deliver the NHS Constitutional standards

iii) Increasing Value

- Deliver financial sustainability
- Develop our business intelligence and benefit realisation
- Maximise alternative income streams, private patient's services and international collaborations.
- Utilise benchmarking and performance data to drive quality, productivity, efficiency and improvement.
- Develop marketing strategy and expand business development
- Develop a plan for environmentally sustainable services and estate. Green Plan

iv) Developing People

- Deliver a new strategy for our current and future workforce.
- Make LHCH the best place to work for everyone
- Promote organisational and cultural leadership
- Promote new ways of working that develop skills in support of continuous improvement
- Support the health, physical and mental wellbeing of our team.
- Widen employment opportunities to support our community

v) Leading Through Collaboration

- Lead the Cardiovascular Disease programme, and deliver the NHS Long Term Plan and CVD Ambitions for Cheshire and Merseyside
- Become a proactive and collaborative partners of choice

- Work collaboratively to develop integrated cardiac, stroke and respiratory services.
- Offer mutual aid to partners to support whole system resilience (critical care/diagnostics/winter pressures).
- Explore new relationships with Public Health, industry and academia

vi) Improving Our Population Health

- Develop predictive and proactive interventions for those at greater risk.
- Support improved primary and secondary prevention and detection of cardiac and respiratory disease. (Lead, Orchestrate Deliver approach)
- Make Every Contact Count
- Develop the targeted healthy lung programme for Knowsley and Halton and a phased roll out as appropriate.
- As a foundation trust, support our membership to promote an awareness of heart and lung disease within their localities

Appendix one sets out the deliverables for each objective agreed by the Board together with the progress made in quarter two.

4. Recommendation

The Board of Directors is asked to note the reported performance against its five year strategic objectives 2020/25 with reference to progress as at quarter four 2020/21 as set out in Appendix One.

Appendix One

Strategic Objectives 2019/20 Quarter 4 Progress

Director of Nursing			Delivery of Personal Objectives				Quarterly Update			
	A	B		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Director Objective	Specific Deliverable Actions	WHO	Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21		Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21	
DON 1	Achieve international accreditation standards including retain CQC rating of outstanding.	Recovery and reset **Ward & Department config and ways of working**	SP	Set terms of reference for key work streams of Ward and Department configuration Infection, prevention and control Emergency Planning 24 hour model of care Education and development for nursing Therapy model of working Review plan fro CQC mock inspections post covid phase	Clarity of outcomes relating to: Ward and department configuration Infection prevention and control Provide plan for new internal assurance relating to CQC mock inspections and standards	Clarity of outcomes pertaining to: The 24 hour model of care Education and development for nursing Therapy model of working Embed new plan for CQC mock inspections and standards	Clarity of outcomes pertaining to the: 24 hour model of care Embed new plan for CQC mock inspections and standards		CQC relationship meetings have taken palce over the past 3 months which have included a review of surgery and elements of well led at trust level. The report from this is awaited. Reset and recovery objectives are progressing well with many complete and the oustanding objectives on plan to complete by the year end. Work is underway to review the Trusts approach to self assessment post covid in line with the CQC standards, with consideration of a new strategy that is expected from the CQC in 2021. In addtion, the Trusts internal EECS is under review to ensure it is fit for purpose to meet this new strategy and the strategic ambitions of the Trust..		CQC relationship meetings have taken place which has included a revew of the medicine division and well led at a trust level. The workplan for EECS nd internal mock inspections is now complete and this will commence in July 2021. The 24 hour model of care for coordinators and outreach teams is in progress and will be concluded in Q1 2021/22.
DON 2	Further develop our patient and family centred model of care	Recovery and reset **Quality**	SP	Set terms of reference for work stream for: The patient and family experience vision The quality agenda	Review the current patient and family experience vision and agree priorities for 2020/21 Review the current quality strategy and agree priorities for 2020/21	Set out the priorities for quality and patient experience in new strategy for the board	Present updated quality strategy and patient experience priorities to the Board and provide a plan to embed		The Trusts patient and family expereince objectives have had to be modified in light of covid and different ways of communicating with families/carers have been introduced. This has been challenging however this has been managed very effectively with the introduction of a patient and family liaison service and a system for telephoning patients within 7-10 post discharge. In the main, postive feedback has been received on the Trusts communciation strategy. Focused work has continued in ensuring that all statges of a patient journey are reviewed and improved as required with a focus on pre care for patients with enhanced needs and on discharge with the introduction of		the patient and family liaison team are currently still in place. As of April 2021 gradual re introduction of visiting is in place and as this increases the patient and family liaison team will be disbanded. The contacting of patient post discharge continues and hs resulted in good feedback from patients and has allowed the trust to recieve positive feedback and areas for improvement. the new priorities for patient and family experience will be included in the new quality and safety strategy.

Chief Operating Officer				Delivery of Personal Objectives				Quarterly Update			
	A	B		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Director Objective	Specific Deliverable Actions	WHO	Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21		Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21	
COO 1	Deliver NHS Constitutional standards	Deliver the operational implications of the reset and recovery plan	DHOs	Assess impact and size of backlog	Mobilise phase two recovery	Assess performance and winter implications	Sustain non-COVID-19 activity		Phase 3 well underway with the restoration of elective services.	Elective restoration paused due to Covid surge and mutual aid support for the system.	Phase 4 elective restoration commenced with amitious trajectories for recovery developed.
		To lead the system wide discussions of the LHCH mutual aid offer	DHOs	Assess the requirement	Plans developed to deliver the offer	Explore other opportunities linked to Winter	Explore long term relationship opportunities		Significant and new mutual aid systems in place with Liverpool hospitals and winter offer for the system in place.	Mutual aid extended further than Liverpool to C&M partners.	Mutual aid continued and further working with partners to focus on system recovery.
COO 2	Utilise benchmarking and performance data to drive quality, productivity, efficiency and improvement	Delivery a Trust wide productivity matrix that identifies the top opportunities and delivers deep dive reviews and plans	MF / JON	Matrix completed and presented	Opportunities agreed, scoped and quantified.	Implementation of at least two of the large scale productivity programmes	Consolidation of the programme and a targeted list of programmes agreed with divisions		Benchmarking updated for all clinical areas and corporate. Slight delay due to other operational pressures but workshops underway to identify priority areas,	Focus and resource within the improvement team moved to support Covid.	Refocus on supporting Trust recovery plans, patient administration transformation and hospital flow.
COO 3	Offer mutual aid to partners to support systems resilience (critical care / diagnostics / winter pressures)	Development of the Trust Winter Plan	HK / DHOs	Link with Emergency Planning	Consider system wide winter offer and develop options	Present plan to Board and confirm with partners	Lessons learnt		Winter plan developed, approved internally and enacted across the system.	Plan implemented to good effect.	Trust is a member of the A&E Delivery Board and will participate in future trust and system levels plans.
		System wide COVID support	Asses s LHCH role	Continue to provide surge capacity	Sustain access to urgent capacity	Sustain access to urgent capacity	Sustain access to urgent capacity		Urgent capacity maintained throughout the surge, cancer capacity provided to local Trust and received well.	Additional mutual aid provided throughout Q3 with capacity focussed on UGI and Liver cancer.	Mutual aid cotinued after the last Covid wave to aid system wide recovery of cancer services.
COO 4	Develop the Targeted Healthy Lung Program in Knowsley and Halton and a phased roll out as appropriate	Lead the development of the service model and agree position with commissioners ready for implementation	JM	Recommence commissioner discussions	Agree service model and financial arrangements	Develop mobilisation plan for service	Implement new service delivery		Significant delay from the commissioner side. LHCH ready to mobilise the model of care and develop the financial model.	Significant delay from the commissioner side. LHCH ready to mobilise the model of care and develop the financial model.	Contractual discussions have been challenging with the relevant CCG and thus delaying the roll out of the programme. The Trust is ready to recruit and operationalise as soon as the contractual discussions are completed.

Medical Director			Delivery of Personal Objectives				Quarterly Update			
	A	B		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Director Objective	Specific Deliverable Actions	WHO	Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21		Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21	
MD 1	Advance outcomes, safety and reduce harm.	Recovery and reset work stream **Clinical**	RAP/AMDs	Post covid	Proposal for seven day consultant cover/ward rounds OPD virtual/face to face job plan structure post covid Medical Model Review Cardiac complications Covid infection Review MDT arrangements Monitor mortality and impact of Covid 19 Finalise six point infection prevention and control plan	Adjust Medical Model of care depending on ward configuration Ensure IPC audit facilities in place and staffing model correct Commence weekend consultant ward rounds in all specialties Plan consultant working from home for SPA/admin/home reporting Finalise OPD clinic arrangements and role out Attend Anywhere heighten awareness of cardiac complications Covid 19 Ensure MDT s fit for purpose	Job planning Round - discuss and adjust for changes in working practices Evaluate impact of Covid 19 on mortality Plan audit of cardiac complications Obtain feedback on OPD changes MDT audits Review impact of IPC plan		Seven day consultant ward round agreed and in place for surgery and medicine No impact of OPD activity on job plans MDT arrangements agreed for all MDTs with a mix of virtual for the majority and face to face for small teams Covid complication literature reviewed by MD - unlikley to have a profound impact on activity at LHCH Six point plan updated		Job planning round alost complete and includes working from home where appropriate Very few direct cardaic complications of Covid19 identifiable Attend anywhere availble on request thogh telephone OPD predominates for ease. Impact of IPC on service provision will be re-evaluated when further guidance on distancing Monthly report to MD on Covid 19 deaths and nosocomial cases. New SJR with approriate incident and SUI reporting
MD2	Embed organisational learning	Continue to monitor and add learning form Covid	RAP/Triumvirates	Post covid	Review C&M critical care network learnings Ensure learning form deaths and other organisational learning processes are continuing normally	Review any regional or national learning from the covid 19 pandemic Implement any recommendations from CCN	Embed relevant recommendations form covid learning		ICNARC feedback receieved and acted on by CC clinical lead Learning presented at BoD from consultant intensivist Organisational learning database to be completed by Q3		SJR and mortality feedback to be embedded as routine Patinet safety lead appointed OL database developed
MD3	Deliver the digital strategy	Recovery and reset work stream **Digital**	RAP/GH/AC	Post covid	Prioritise recommendations from recent external review Support new IPC audit and data gathering including business case for perfect ward or equivalent Ensure data warehouse project and informatics review recommendations on track	Prioritise recommendations from recent external review Support new IPC audit and data gathering including business case for perfect ward or equivalent Ensure data warehouse project and informatics review recommendations on track	Set priorities for 21/22 Align digital strategy with regional plans		Perfect ward business case complete Datawarehouse project making good progress and supporting finalisation of community EPR External review prioritised by CIO		Implementation of Digital Excellence underway. New data centre procured, equipment refresh underway. Trust confirmed as part of national digital excellence programme nationally.

Please Note – Digital reports are reported by Chief Digital and Information Officer and will be separately identified for future reports

Director of Strategy | Delivery of Personal Objectives | Quarterly Update

	A	B		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Director Objective	Specific Deliverable	WHO	Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21		Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21	
DOS P1	Develop world class facilities	Cath Lab Refurbishment	RW/HK	Development of programme and case	Mobilise capital programme through strong governance structure	Commence on site development works	Continue tight management of the programme				Reporting through the Program Management Office
DOS P2	Develop a recognised learning and academic facility (The LHCH Institute)	Development of strategic outline business case for the LHCH Institute	JD/RW/BT	Post Covid recovery period	Identification of scope and options	Engagement and socialisation	Strategic outline business case		Initial discussion have taken place aligned with the Highfield House project. Wider engagement is planned and will be prioritised alongside operational issues (COVID-19)	Highfield House Business Case Approved	The Outline Scope and Specification has not been developed and is to be prioritised in 2021/22
DOS P3	Maximise alternative income streams including Private Patient services and International collaborations.	Fully realise the potential from International collaborations	RW/JD	Post Covid recovery period	Post Covid recovery period	Recommence business activities and mobilisation of SGH contract	Commencement delivery of SGH contract				Now business as usual and aligned to respective divisions
DOS P4	Develop marketing strategy and expand business development	Marketing strategy	JD	Develop the scope for a marketing strategy	Outline resource implications	Develop a bespoke program articulating the value of the LHCH brand	Production of a new marketing strategy		Program that identifies LHCH value will take place at the 18th December Senior Leaders Strategy Day	Clinical Network Development commenced	Market shares have become increasingly less important as the White Paper, Provider Collaborations and Networks emerge
DOS P5	Develop a plan for environmentally sustainable services and estate. Green Plan	Implement the Green Plan	JD/Estates Team	Post Covid recovery period	Delivery of an action plan	Implementation of action plan	Implementation of action plan		Updated Action Plan to be presented to November Board	Updated Plan presented to January BOD	Year end report presented March 2021
DOS P6	Take a leadership role in the Provider and Specialised Provider Alliances	Develop our Leadership offer National and Regionally	JD/RW	Outline of intent	Define the Trust role within Provider and Specialised Provider collaborative	Understand the Value of LHCH Offer	Statement of LHCH value proposition		Director of Partnerships to Chair Joint Working Group of the Alliance.		Guidance on Provider Alliances to be published in Spring. In the interim Specialised Provider Alliance Prospectus and MOPU developed for approval at April 2021 BOD
DOS P7	Lead the Cardiovascular Disease programme, and deliver the NHS Long Term Plan and CVD Ambitions for Cheshire and Merseyside	Develop the CVD Board Work plan	JD/TK/RW/BT/JN	Communications with STP via CVD Board Briefings	Confirm CVD Board work plan post covid pandemic Describe how CVD Board will interface with new STP governance arrangements	Implementation of CVD Board work plan	Evaluation report on CVD Board sponsored projects		CVD Board Work plan confirmed	Combined Prevention/Cardiac/Respiratory and Stroke Submissions made to the Health and Care Partnership	CVD Confirmed as the top priority for the emergent ICS. Transformational funds bid submitted to ICS with positive feedback
		Develop and Deliver the CVD Prevention Group Work plan		Communications with Place and PCNS via the CVD Prevention briefings	Confirm CVD prevention work plan post covid Describe how CVD prevention will interface with new STP governance arrangements	Implementation of CVD prevention work plan	Evaluation report on CVD prevention sponsored projects		CVD Board Prevention Subgroup established and well engaged with all parts of the systems and respective networks	Happy Hearts Website updated content and social media campaigns launched during pandemic	CVD Prevention network well established and bid for transformational monies an integral part of the CVD Board
DOS P8	Work collaboratively to develop and integrate cardiac, stroke and respiratory services	Review Program and Place	RW	Post Covid recovery period	Development of Physician Associate program for PCNs and Place	Sponsor proposal with HCP and wider system	Evaluation of PA program		Physician Associate funding has been confirmed for 2019/20. New proposals and networks now part of wider partnership across the STP	Business as Usual	Place and Program Arrangement will develop in 2021/22 as implications from the White Paper are interpreted locally.
		Review LSCOG with LICP	JD	Post Covid recovery period	Confirm relationship between LSCOG and the Long Term conditions program within LICP	Sponsor proposal for LSCOG within LICP	Evaluation of the LSCOG program		Single services approach to cardiology will continue and form part of the Long Term Conditions approach across Liverpool	LSCOG continues to meet during the pandemic with a focus on the management of Covid / Cardiology and in particular rehabilitation	Maturity Assessment completed with overwhelming support for CVD and LSCOG to remain in place and further develop

Director of People				Delivery of Personal Objectives				Quarterly Update			
	A	B		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Director Objective	Specific Deliverable Actions	WHO	Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21		Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21	
DOPC 1	Deliver a new strategy for our current and future workforce	Recovery and reset work stream **Workforce**		Develop & Agree TOR People Delivery Group re-established to enable delivery Undertake COVID Workforce Assurance review Revised divisional & corporate workforce plans post-COVID Commence engagement development of H&WB support pathways Commence revisions to Educational, Leadership & Development Strategy & supporting materials / development programmes Development of HR & Education Offers, following External Review	Confirm outcomes of Workforce recovery work stream for: Implementation of revised workforce plans & models Implementation of revised H&WB support pathways & interventions, including launch of the Hub NHS Staff Survey 2019 Action plan & communication plan Development & approval of Trust Education, Leadership & Development Strategy & development programmes	Development & approval of Trust People Strategy, alongside alignment with NHS People Strategy Launch of new service offerings / Workforce Intelligence from HR & Education teams Promotion of actions from NHS Staff Survey 2019 & launch of 2020 Survey Review of H&WB Hub pathway & refresh of strategy Improving People Practices	Analysis of results of NHS Staff Survey 2020 and development of action plan Sustain delivery of Trust People Strategy Improving People Practices Succession planning & Talent Management planning		Divisional workforce plans developed for recovery. Corporate workforce plans developed and reviewed by Executive team. Further enhanced H&WB support in place, ongoing psychological support through merseycare and internal packaged being developed for roll out by Trust psychology service, MH first aiders being trained, hub launched. Staff survey 19 action plans developed and taken through divisional governance meetings. Focus groups have taken place with Divisions, HR and OD to collect feedback in relation to LHCH people plan response. A final report and plan for 20/21 will go to Board in January 21.	During pandemic appropriate face to face learning continued whilst ensuring social distancing maintained. Virtual learning has been developed (MS TEAMS) and the Teams are working with the Digital Excellence team to review, develop & maintain appropriate platforms for virtual & interactive learning. Currently 60 active apprenticeships in place at LHCH covering the range of professions nursing, leadership, (pharmacy, and from level 3 to level 7.engineering, administration, radiography, Healthcare scientists, accountancy) and from levels 3 to 7. There are plans to further develop registered nurse apprenticeships, nurse degree top-ups for nursing associates & assistant practitioners, assistant practitioners for Cardiac Diagnostics. Reviewing process to implement apprentice first model for all non-clinical bands 2 - 4 within Trust. Education & recruitment working together to ensure all new posts have been reviewed for apprenticeships prior to being advertised. Further plans to deliver apprenticeship surgeries to encourage managers to support staff development via apprenticeship.	People Plan was launched on 24th March 21 and action plan developed. Education team are designing training for managers to undertake advanced communication skills and conversations for HWB. Additional psychological support now in place with Mersey care as part of EAP provision. Increased support through health and wellbeing group and initiatives such as Stress Awareness month. Review of leadership offerings currently underway, with offerings being linked to relevant CMI / ILM levels, utilising a four staged leadership model. All levels of leadership learning will include relevant aspects of civility, inclusion and compassionate leadership.
DOPC 2	Make LHCH the best place to work for everyone.	Recovery and reset work stream **Workforce**									
DOPC 3	Promote organisational and cultural leadership.	Recovery and reset work stream **Workforce**									
DOPC 4	Promote new ways of working that develop skills in support of continuous improvement	Recovery and reset work stream **Workforce**									
DOPC 5	Support the health, physical and mental wellbeing of our team.	Recovery and reset work stream **Workforce**									
DOPC 6	Widen employment opportunities to support our community	Recovery and reset work stream **Workforce**		Post-COVID Recovery	Assessment of revised widening participation approach	Development, approval & implementation of widening participation strategy	Sustain & assess outcomes		Project Search - working with a 3rd sector voluntary agency to support a range of students, offering a work experience placement for those with learning disabilities. Also working with national leads for nursing, AHP and healthcare scientists to put plans in place to improve diversity and social mobility.	Development of pan-mersey international recruitment	First cohort of RNs to arrive in UK in April and second cohort in May. Cohorts will continue throughout the year to see 50 international nurses join LHCH. 3 HCAs have also so far been recruited through the Refugee programme.

Chief Finance Officer

	A	B		Delivery of Personal Objectives				Quarterly Update			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Director Objective	Specific Deliverable Actions	WHO	Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21		Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21	
CFO 1	Deliver financial sustainability.	Recovery and reset work stream **Finance**	KE/FM	Revise budgets to B/E Mth 1-6 (COVID interim)	Monitor Perf	Assess changes in Finance regime/Ops Plans	Monitor Perf		Budgets revised for B/E regime and Trust received retrospective Top-Up funding + COVID costs	Prospective Top-Up funding + COVID costs added to block contracts = (c£1.3m) deficit CT	Addl sources of national funding received with forecast of B/E minimum position
			KE	Review/ Revise CIP for delivery (COVID)	Monitor & Mitigate gaps	Monitor & Mitigate gaps	Monitor & Mitigate gaps		CIP programme reviewed and reduced to recognise schemes not viable in COVID financial regime or within operational priorities. Non-recurrent schemes identified for slippage on recurrent schemes. Mth 6 perf 92%	CIP revised programme monitoring in place. Mth 9 perf 97% including 24% non-recurrent mitigation	CIP revised programme monitoring in place. Mth 12 perf 96% including 22% non-recurrent mitigation
			KE	Review/ Revise Capriati Plan for delivery (COVID)	Monitor Perf	Monitor Perf	Monitor Perf		Capital programme reprioritised and resource allocated to schemes with contingency in place. Mth 6 perf 66% plan with forecast for full commitment	Addl capital resources available from C&M slippage 0 b/fwd Data Cente & CT Scanner c£2.8m. Spend @ Mth 9 £5.6m vs Plan £7.3m YTD. Slippage expected to recover.	Addl £1.1m capital resources recieved from NHSX Digital Aspirants (Data Centre) allowing b/fwd of clinical equipment replacement from 21/22. Spend Mth 12 £14.4m vs Plan £14.5m YTD.

Director of Corporate Affairs

	A	B		Delivery of Personal Objectives				Quarterly Update			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Director Objective	Specific Deliverable Actions	WHO	Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21		Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21	
DCA 1	As a foundation trust, support our membership to promote an awareness of heart and lung disease within their localities	Recovery and reset work stream **Governance**	LL						Members Matters publication to all members; community events paused due to COVID but will recommence (on line) in Q3		CoG Membership Committee re-started and programme of online engagement events agreed - this is aligned to annual calenar of national/ international awareness days linked to heart and lung disease.
DCA 2	Meet the requirements of regulators	Recovery and reset work stream **Governance**	LL						Command and control structure in operation. Operational Board re-set; digital enabling of meetings complete. Review of risk / legal undertaken and recommendations considered.		Closing report on recovery and re-set to BoD in Jan 2021. Full review of compliance with provider licence conditions completed - Audit Committee March 21

Director of R & I			Delivery of Personal Objectives				Quarterly Update			
A	B		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Director Objective	Specific Deliverable Actions	WHO	Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21		Covid Restart 6 weeks - 6 months		Covid Recovery - 6 months - March 21	
DOR 1	Develop services based on world class research and innovation.	Recovery and reset work stream **Learning**	MPC	establish working group for learning post covid to include research, audit, challenges and opportunities	develop framework of learning	implement framework and changes	embed changes as business as usual		development of EDEN portal in progress; it incorprates education and training tools and links to external recources. Portal is in SharePoint with support from AH team. Established links with Education department under Steven Colfar.		EDEN system developed and being managed through the Knowledge Service team.
			MPC / VW / JW	develop action plan for new R&I strategy	action plan delivery for year 1	action plan delivery for year 1	action plan delivery for year 1		action plan in place. Established new departmental structure for Research; delivery of in-house studies i.e. ARCH trial; all governance processes through SPARK as part of LHP and LHCH plan; new LCCS research studies based in LHCH's research lab under Prof Lip direction; development of new lung cancer studies under Prof Ottensmeier leadership; working with radiology to develop new trials based on the use of AI for radiology reporting libked to the Haelthy Lung project.		As previous period, plus appointment of the Clinical Lecturer in Respiratory aligned to Prpf Ottensmeier; Dr Serene Chee appointed as a clinical academic in partnership between UoL, LUFT and LHCH.
			MPC/ MH	horizon scanning of innovation post COVID	innovation delivery plan with Innovation Agency	implement delivery plan for innovation	assess innovations and horizon scanning		working on new innovation strategy for LHCH in collaboration with IA. Participation in Health Foundation call led by LHP and AH, for adoption of innovation in the LCR system.		Innovation strategy developed and under review for aproval. Part of the LHP innovation working group to define and implement a new innovation model for LHP partners in Liverpool.
			MPC / VW / JW	develop plan for Research restart with clinical leads	phase 1 of project restart	assess and move to phase 2 if possible	assess and move to phase 3 if possible		research restarted at the Trust over the summer; prioritisation criteria developed aligned to NIHR guidelines, priority for UPH studies. New revised criteria approved by R&I committee in light of second COVID surge and LHP system-wide support required.		Research activity impacted by second COVID surge, however, RESTART has been implemented and all trials and studies impacting on patient safety have continued despite COVID. The trust has continued to lead and particpate in the system-wide working as part of the LHP response to COVID.
DOR 2	Develop the Trusts academic expertise.	Recovery and reset work stream Learning	MPC / JW	set up KPIs for honorary apt	produce proposal for new honorary academics		review KPIs of academic posts		developing pipeline of potential candidates working with the clinical lead for R&I.		working with clinical leads and the Clinical Director for Research to identify the most suitable individuals.
DOR 3	Develop Liverpool Centre for Cardiovascular Science with research partners	Recovery and reset work stream Learning	MPC / GL		delivery of LCCS plan for LHCH		yearly assessment of LCCS deliverables at LHCH		LCCS research at LHCH in track; appointment of new clinical trials physician to deliver phase 2 trials under Prof Lip at LHCH.		New clinical trials physician appointed under the leadership of Prof Lip. New AortoVascular Chair recruitment in process.

Board of Directors (in Public)
Item 3.2

Subject: **People Plan Delivery Report**
Date of Meeting: **Tuesday 27th April 2021**
Prepared by: **Vicki Wilson, Head of HR & Ruth Dawson, Head of Learning, Education & OD**
Presented by: **Karen Nightingall, Chief People Officer**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
BAF 4, 5 & 6	Delivery of the People Plan (Action plan for 2021) is critical for the control of the workforce risks.

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

1. Executive Summary

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

2. Background

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

3. Progress Highlights

The delivery plan sets out the key actions and timescales for delivery of the people plan objectives and is included in **Appendix 1**. Key highlights for the first quarter together with key actions for the upcoming quarter are shown below.

	20/21 Q4	21/22 Q1
Looking after our people	• A range of financial wellbeing support offers have been made available within our wellbeing package • Development of plan to implement wellbeing conversations including supporting resources for managers and staff • Flexible working policy updated and due for approval • Resilience study completed and report presented to Executive Team	• Launch of Vivup staff benefit platform with increased availability of a broader range of financial staff benefits. • Launch of wellbeing conversations • Launch revised flexible working policy • Recommendations from Resilience study to be inform revision of learning & support offerings to staff • Appraisal template reviewed to include wellbeing and flexible working conversations
Belonging in the NHS		• Review of leadership offerings underway, to be re: launched June 21
New ways of working and delivering care	• Level 7 Cardiothoracic Skills module developed and delivered.	• Second cohort of Cardiothoracic Skills to commence
Growing for the future	• Pilot of first cohort of Project Search established on placement	• Cadetship placement paused during pandemic returned to placement • Traineeships paused during pandemic returned to placement • Project Search not paused during pandemic with agreement of placements, providers and parents.

4. Conclusion

The HR and Education teams are continuing to progress with the delivery of the LHCH People Plan. Additional resource invested into the teams will further support the delivery of the identified objectives.

5. Recommendations

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

LHCH People Plan - Delivery Plan

Looking after our People	When will this be achieved	Lead	Update
1) Extend our Health and Wellbeing Offer and apply for the wellbeing charter	**July 2021**	VW	Health at work engaged re the Health and Wellbeing Charter to explore initial self assessment and diagnostic.
Increase access to psychological and counselling support to all our people who need it		VW	Additional psychological support available to staff through Mersey care as part of EAP provision. Increased promotion of available support through health and wellbeing group and initiatives such as Stress Awareness month.
Support managers to undertake regular health and wellbeing conversations with their teams, starting at induction		VW / RD	Education team are currently designing training for managers to undertake HWB conversations. These session will be facilitated by the Education Team, to enable all line managers to feel confident to undertake good conversations. HWB conversation training will also be included in current communication & good conversation sessions.
Include a range of financial wellbeing support offers within our wellbeing package		VW/SS	Salad money and wagestream both launched and available to staff (Feb 21). Ongoing promotion of NHS National financial wellbeing resources and implementation of Vivup staff benefit portal (April 21)
2) Strengthen the resilience of our people and the organisation	**December 2021**	RD	
Complete a full resilience study of representative staff across the organisation		SC	A series of 6 focus groups were undertaken by Ben Fuchs & Rachel Lovie, and a further 20 detailed questionnaires were returned to provide information regarding staffs experience of resilience within LHCH during the pandemic. A report has been produced, with a number of key recommendations with the themes of 'Process and Policy', and 'Behaviour and Culture' and this report has been presented to the Executive Team in March 21.
Undertake a consultation to identify what measures help staff improve resilience		RD	Consultation undertaken as part of study above.
Revise our learning and support offers based on staff feedback		RD	Once report feedback from Executive Team has been discussed in Wellbeing group, actions will be instigated into ongoing support and learning.
4) We will commit to flexible working by reviewing our policies and procedures	**April 2021**	VW	Flexible working policy updated and ready to be launched.
Review potential of flexibility for all future jobs at the point of advertising		SS	Potential for flexible working with each post to be highlighted through recruitment process and all Trust adverts to promote the message that we encourage a variety of forms of flexible working at LHCH.
Ensure support for and role modelling of flexible working is evident at a senior level		KN	Retire and return on a part time basis for several senior leaders along with moves to agile working for senior staff
Promote flexible working is standard induction conversation for new starters		SS	Information provided to new starters by HR at induction updated to promote awareness of available flexible working options.
Include flexible working when undertaking manager led wellbeing conversations and as part of appraisal		PC	Review of appraisal template underway to allow for recording of wellbeing & flexible working conversations, and to develop ongoing record of conversations outside of appraisal process.
Belonging in the NHS	**When will this be achieved**	**Lead**	**Update**
1) **Recruitment and promotion of a diverse workforce that reflects the communities we serve**	**December 2021**	SS	
Complete a full review of our recruitment and promotion procedures to ensure we recruit a workforce that reflects the communities we serve		SS	To commence Q1
Improve the candidate journey and ensure we are an inclusive employer		SS	To commence Q1
Support leadership development for colleagues within minority groups to support achievement of model employer goals		RD / JD	National programmes, supported by LHCH, have been paused during the pandemic. Once running again staff will be encourage to apply as appropriate to role. Specific sessions for interviewing skills have been facilited with good feedback. Further sessions are being developed in response to feedback from colleagues
2) We will review our leadership training to focus on inclusivity, Civility, and compassionate leadership	**June 2021**	RD	
Launch our new leadership development offer		RD / JD	Review of leadership offerings currently underway, with offerings being linked to relevant CMI / ILM levels, utilising a four staged leadership model. All levels of leadership learning will include relevant aspects of civility, inclusion and compassional leadership
Ensure managers are supported in the understanding and application of HR policy with a focus on ensuring inclusion and diversity		RMc	Review of all HR policies is in progress with a number of new policies approved and ready for approval. Policy briefing sessions and bitesize training to be delivered to managers to support the implementation of updated policies and encourage inclusive and compassionate approach.
New ways of working and delivering care	**When will this be achieved**	**Lead**	**Update**
1) We will increase opportunities for staff to upskill and move into new roles	**April 2021**	RD	
Develop new cardiothoracic skills module as part of the Edge Hill accredited postgraduate certificate in cardiothoracic care		RD / JB	A new Cardiothoracic Skills module has been developed at pace. This has been designed and delivered as a L7 (Masters) award, in partnership with EdgeHill University, who acredit the module. The first cohort is currently finishing, having undertaken their OSCE exams 13/04/21, and will be submitting their 1000 word critical reflection. The second cohort is to start 1st June and recruitment of candidates is currently underway. Due to social distancing measures, current cohorts are capped at ten people. As measures are relaxed this will increase. It is planned to run three cohorts per year.
Ensure staff acting as support to Critical Care maintain their core knowledge and skill set		RD	Buddy system in place for staff whose normal roles outside of Critical Care, who worked in Critical Care during pandemic. Staff returning to normal duties have been supported & encouraged to work one shift a month in Critical Care to maintain competencies
Develop new roles in line with the trusts operational plans and strategic objectives		RD / VW	To commence Q1
2) We will champion digital enhanced learning and increase our online CPD offer	**June 2021**	RD	
Introduce new CPD opportunities for our people to extend their knowledge and skills that make use of advanced digital technology and virtual learning		RD	Currently reviewing opportunities available for staff to extend their knowledge and skills, making use of advanced digital technology and virtual learning. Looking to work with the new Digital Excellence Strategy & Committee to bring digitally enhanced learning & skills to all staff at LHCH

Roll out Health Education England's e-learning programme which was developed in response to learning from the covid-19 pandemic		RD	Currently reviewing access to HEE programmes and process to attach to LHCH platform, will then be rolled out for access for all staff
Review existing CPD portfolio to deliver blended learning programmes which incorporate both face to face and virtual learning		RD	Education team has always been able to deliver a blended approach to learning. During pandemic appropriate face to face learning continued whilst ensuring social distancing maintained. Virtual learning has been developed and facilitated via Microsoft Teams, and Education Team working with the Digital Excellence team to review, develop & maintain appropriate platforms for virtual & interactive learning. Current leadership modules both internal & in partnership with external agencies are being delivered virtually.
3) We will review improve our work experience and volunteer strategy to promote future NHS careers	**September 2021**	RD	
Develop new and wider roles for volunteers and provide work experience opportunities for people as a gateway to starting new careers in the NHS		RD	Work experience programme on hold until lockdown measures fully released and schools & colleges support students on hospital site. Review of work experience programme currently underway within Education team, enabling work experience to sit with widening access team.
Create stronger partnerships with local schools and colleges by improving involvement at careers events		RD	Careers events have been during current climate. Widening Access team will work with local schools and colleagues to ensure development of partnerships to enable access to work experience, traineeships and apprenticeships
Growing for the future	**When will this be achieved**	**Lead**	**Update**
1. We will increase the number of apprenticeships and training places in shortage professions	**December 2021**	RD	
Increase the number of apprenticeships by at least 20%		PC	There are currently 60 active apprenticeships in place at LHCH. Current apprenticeships cover the range of professions nursing, leadership, (pharmacy, and from level 3 to level 7.engineering, administration, radiography, Healthcare scientists, accountancy) and from levels 3 to 7. There are plans to further develop registered nurse apprenticeships, nurse degree top-ups for nursing associates & assistant practitioners, assistant practitioners for Cardiac Diagnostics. Reviewing process to implement apprentice first model for all non-clinical bands 2 - 4 within Trust. Education & recruitment working together to ensure all new posts have been reviewed for apprenticeships prior to being advertised. Further plans to deliver apprenticeship surgeries to encourage managers to support staff development via apprenticeship.
Grow the number of cadetship places offered across all nursing and AHP departments		PC	Working in partnership with Hugh Baird College to support cadetships. First cohort started placement with LHCH Dec 20. Placements were paused by Hugh Baird, and are due back to placement April 26th. Plans are for for cadets to access LHCH HCA bank for their second year of cadetship, this will enable LHCH to place next cohort of Cadets each year. Once cadets have completed their two years programme they qualify with level 3 qualification and can acess employment as HCA with experience, or access nursing associate programme or access nurse training. Plans to cadetships to run each year with cohort of 10. Following evaluation of this first cohort, will review possibility of extending clinical cadets to other professions (therapies etc). Project Search, a internship programme for people with learning disabilities, is currently being piloted at LHCH and is evaluating successfully for the two candidates within this pilot. Future cohorts are planned each September, and possible cohort of 5.
Auto enroll all cadets onto the LHCH bank following their first year on placement		DB	Following completion of the cadetships in line with the timeframes above, cadets will be enrolled onto the bank.
Increase our level of traineeship positions by over 50%		PC	There was one cohort of 5 trainees in 2019. All traineeships were pulled from placement by colleges in 2020 due to the pandemic. January 21 fresh cohort of clinical traineeships with 4 trainees started in LHCH, placement was paused due to new lockdown, and placement has now started March 23rd. April cohort of traineeship has therefore been cancelled, and next cohort will be September. Moving forward plan is for 3 cohorts a year, with a capacity of 8 per cohort. LHCH is working in partnership with Wirral Met and Liverpool in work for traineeships.
2) We will improve our recruitment and retention strategy by attracting and retaining the best national and international talent.	**October 2021**	SS	
Undertaking a full review of our recruitment processes		SS	To commence Q1
Review if roles can be delivered flexibly to better support education and development pathways		SS	To commence Q1
Develop roles which support return to practice		RD / VW	To commence Q1
Launch a new international recruitment programme for nursing, leading collaboration across all hospitals in Merseyside.		SS	LHCH leading pan-mersey international recruitment. First cohort of RNs to arrive in UK in April and second cohort in May. Cohorts will continue throughout the year to see 50 international nurses join LHCH. 3 HCAs have also so far been recruited thrtough the Refugee programme.

Board of Directors (in Public)
Item 3.3

Subject: **Annual Equality, Diversity and Inclusion Update**
Date of Meeting: **Tuesday 27th April 2021**
Prepared by: **Rachael McDonald, Senior HR Business Partner**
Presented by: **Karen Nightingall, Chief People Officer**
Purpose of Report: To Note

BAF Reference	Impact on BAF
BAF 4, 5 & 6	No change to assigned risk rating in BAF – belonging to the NHS is a key component of the People Plan 2021

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

1. Executive Summary

This paper is intended to provide a summary of key workforce developments in relation to the Trust's Equality, Diversity and Inclusion agenda and to provide assurance on the Trust's demonstration and compliance with national requirements

2. Background

An annual EDI/Strategy update was presented to the People Committee December 2020 outlining the key EDI developments within the last 12 months, the position and plans from a national perspective and it also featured key highlights for the Trust in relation to EDI activity during the pandemic. This paper builds on that update to include more recent progress and to provide assurance to the Board of Directors.

This paper also sets out the future plan and priorities which will be supported by an integrated EDI Action Plan and People Strategy Dashboard

3. Annual EDI Update

It must be noted that the COVID-19 global pandemic has completely changed the way that we have all had to operate since March 20. Alongside adapting to new ways of working, the

Trust has had to respond to changing and complex national guidance and therefore the traditional approach to the inclusion agenda and our strategy outcomes had to be refocused in order to respond to the challenge ahead. With that being said, the Trust has been extremely pro-active in its approach to supporting staff during the pandemic, specifically for staff in vulnerable groups and good strides have been made to promote and harness inclusion for all.

3.1 *Progress and achievements to date*

- We successfully applied to be part of the 2020 cohort of the NHS Employers Diversity and Inclusion Programme which supports participating health and social care organisations to progress and develop their equality performance and build and inclusive culture and is closely aligned to the Equality Delivery System (EDS2). However, due to the resource constraints of the pandemic, NHS Employers have staggered the intake our Partner Programme experience will commence in June 2021.

- We have been re-accredited as a disability confident employer, which demonstrates our commitment to successfully employing and retaining disabled people and those with long term health conditions. In October 2020 we welcomed a cohort of five students from Project Search. The new students, who have a range of learning disabilities, will be supported to work in a range of placements including Estates, Portering, Administration and Hygiene services

- Over 800 of our people supported the launch of the NHS Rainbow Badge Scheme, an initiative designed to enable people to demonstrate that they are aware of the issues that LGBT+ people can face and make a positive difference by promoting a message of inclusion. The Trust is planning to host a virtual PRIDE event in February 2020 to mark LGBT History Month.

- We delivered a series of inclusion events with keynote speakers helping promote awareness and education of the inclusion agenda. These were followed by equality and inclusion focus groups, led by the Chief Executive, to understand the experiences of our people of ethnic minority groups in regard to progression and development opportunities.

- We have established a staff carers forum, which meets monthly and has more than 90 staff registered. We self-assessed as Carer Confident Active level 1 and have been actively working towards level 2.

- We completed our 2020 Workforce Race Equality/Disability Standard (WRES/WDES) submissions and Equality Delivery System 2 (EDS2) review, designed to help improve the working environment and experience of our people from ethnic minorities. (see below for a key findings update)

- We have supported and continue to support staff during COVID, particularly staff in vulnerable groups. The Trust has taken a pro-active approach to undertaking risk assessments for all staff identified in vulnerable groups for Covid-19 with black, asian and minority ethnic (BAME) staff being prioritised.

- We have successfully implemented an international recruitment programme and also led the way in developing an implemented a Refugee Support Programme

- We completed and published our Gender Gap Reporting in line with the *(this was presented to the Board of Directors in March 21)*

3.2 *Key EDI /Future Focus*

The EDI agenda has never been more important and whilst we have made great progress during very challenging time, there needs to be heightened focus on the agenda to ensure that we can deliver on our priorities and that our vision to be a truly inclusive employer is embedded.

To help focus and support the direction of travel, an integrated EDI Action Plan **(Appendix 1)** has been developed which brings together themed actions that are not only aligned to the People Plan and our national requirements, but it reflects the direct feedback from staff following our staff inclusion events and other follow-up engagement events. Timescales for completion will be built into the plan and ongoing implementation will be driven by the E&I Steering Group and updates on progress will be provided to both the People Delivery Group and People Committee.

In addition, an LHCH Dashboard is has been developed in response to the '*Belonging in the NHS'* national priority which will monitor our progress against the specific actions as set out within our People Strategy.

4. National Requirements

4.1 *WRES/WDES*

The NHS Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) is a nationally-mandated system for NHS Trusts to report the relative experiences of Black, Asian and Minority Ethnic (BAME) and Disabled staff compared with the rest of their workforce. NHS England and Improvement had previously advised that they had suspended the WRES and WDES and data collection process for 2020 due to Covid-19. However, the pandemic highlighted the critical importance of workforce equality; therefore WRES and WDES implementation continued as usual this year and the Trust submitted its data in line with the deadline date of 31st August 2020 *(data used for WRES 2020 is the period 1st April 19 – 31st March 2020)*

A summary of the WRES indicator and results has been provided in **(Appendix 2).**

In terms of key highlights for the Board, the table below shows a comparison of results on four of the WRES metrics as taken from the national staff survey:-

- Results from 2018-19 compared to 2019-20
- Results of the average (median) for Acute Specialist Trusts
- Results for the Walton Centre
- Results for Clatterbridge

		Your Trust 18-19	Average (Median) for Acute Specialist Trusts	The Walton Centre NHS Foundation Trust	The Clatterbridge Cancer Centre NHS Foundation Trust	2019-20
Indicator 5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	WHITE	12.2%	21.0%	25.3%	14.1%	13.5%
	BME	20.7%	20.2%	35.1%	21.1%	26.0%
Indicator 6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	WHITE	18.3%	23.2%	16.4%	23.5%	17.5%
	BME	34.9%	29.4%	21.6%	18.4%	34.6%
Indicator 7. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	WHITE	89.8%	88.4%	92.5%	85.1%	91.7%
	BME	75.9%	76.1%	77.8%	90.9%	80.0%
Indicator 8. In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?	WHITE	5.7%	5.5%	4.5%	5.5%	3.6%
	BME	14.1%	13.2%	13.5%	5.6%	11.8%

The comparison tells us that 2 of the 4 metrics follow a local and national trend, but the Trust remains an outlier in relation to the percentage of our minority ethnic staff reporting the experience of harassment, bullying and/or abuse from patients and relatives and the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

The comparison also shows that the Trust has improved in the percentage of staff believing that the organisation provides equal opportunity for career progression or promotion and the percentage of staff that have personally experienced discrimination from a team leader or other colleague. However, with that said, a comparator trust has reported a 6% reduction/difference and supports that further work needs to be done to close the gap in experiences.

To support the above, a divisional breakdown has been provided in **(Appendix 2 – Page 2)** in relation to the specific WRES/Staff Survey indicators and whilst we do not have the ethnicity breakdown at this level, it does indicate to areas of focus such as Surgery and Clinical Services.

A summary of the Workforce Disability Equality Standard (WDES) results has been provided in (**Appendix 3)**. The first submission was made in 2019 so there is only 1 year's comparison data. Key findings show that whilst a number of the indicators follow a national and regional trend and there had been some slight improvements in disabled staff reporting bullying and abuse from both Managers, patients and relatives, the percentage of staff reporting bullying or harassment from other colleagues has increased. In addition, the results show that disabled staff are 26 times more likely to enter a capability process.

The associated actions to improve experiences of both our BAME and disabled workforce are set out within the integrated EDI action plan noted earlier.

4.2 *Equality Delivery Standard (EDS2)*

The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, while meeting the requirements of the Equality Act 2010.

A review of the Trusts EDS2 grading report and action plan is updated and reviewed annually in December. With regards to our EDS2 2020 review, Liverpool Clinical Commissioning Group (CCG) normally recommend holding a panel made up of senior leads, patient experience, nursing and Healthwatch representatives to review and agree our grading. Due to Covid-19, they recommended that the approval of EDS2 is taken through our internal governance structure and then published on our internet page.

In terms of assurance to the Board, our EDS2 2020 was reviewed at the E&I Steering Group held in January and Jo Roberts (Accountability Manager for Equality and Contract Administration from the CCG attended to support our grading process and the feedback regarding our progress was extremely positive. **(Appendix 4)**

5. **Emerging Priorities**

Whilst the Trust has made good progress over the last 12 months, it's important the Board are cited on some emerging national priorities which will require focus over the next 3-6 months which include:-

1. Tackling Racism in the NHS – The ambition is for the NHS in the North West to be Anti-Racist and at the forefront of challenging and tackling racism and the health inequalities faced and experienced by people in our communities. The North West Assembly has been set up to help organisations develop actions plan that need to describe our aspirations in terms of tackling racism and inequalities

2. Addressing and closing the gap in areas of underrepresentation by developing plans to deliver on the 19% BAME representation target and to reduce the disparity ratio of greater than 1.5 between Band 1-5 and Band 8/Band 9 staff with implementation timelines, deliverables and success metrics (31st June 21)
3. Overhaul of Recruitment Processes (to include the 6 actions as set out by NHSi/E in Feb 21.
4. Developing Staff Networks by the end of April 21 (BAME, LGBTQ and Disability) as a minimum.

4. Conclusion

As the Trust enters the COVID recovery phase, it is evidence that the Trust Strategy as it currently stands **(Appendix 5)** will require a refresh to ensure that it reflects and considers any changes in policy at both local and national level. Development of our People Strategy and new integrated action plan will help drive some of this work forward, but as the agenda expands rapidly, capacity is likely to become a challenge with EDI roles currently being a 'bolt on' to other substantive role and with an additional risk of single point of failure.

Monitoring and review of equality related activities will take place for both our patients and workforce is undertaken through the Trust's established Equality and Inclusion Steering Group and the last meeting was held on 14th April 2021.

Assurance on activity and progress against plan is provided to the People Committee which is provided on a quarterly basis

5. Recommendations

The Board of Directors is asked to note the contents of this report and the supporting appendices

Item 3.3a

Intergrated EDI Action Plan

V1 - updated April 21

Objective	Actions	Alignment	RAG
We are committed to ensuring diversity across all levels of the workforce and within our senior leadership team.	Increase the diversity within FTSU framework and Staff Governor composition	**People Plan**	G
	Identified board lead for EDI	**People Plan**	G
	Consider and implement Cultural Ambassadors Programme for reducing the risk of discrimination	**People Plan**	R
	We will achieve model hospital standards for representation at board level and at B8a or above	**WRES**	R
	Evaluate impact of adding 'inclusive' to our values framework	**Staff Survey**	R
	Publish our Gender Gap Report and develop a narrative and action plan to help tackle any indentified gap	**Public Sector Duty**	G
	Monitor impact of disciplinary and grievances on staff with protected charatertics	**WRES/WDES**	A
We will encourage people from diverse backgrounds into accessing and developing their NHS careers	Hold a series of Executive Led Engagement Sessions with BAME workforce	**People Plan**	G
	Develop a Inclusive Recruitment Programme	**People Plan**	R
	Talent management - supporting opportunity and career progression across all protected charatertics	**People Plan**	A
	Engage with local Schools and colleges to improve diverse representation into new NHS careers	**People Plan**	A
	Implement the International Recruitment programme	**People Plan**	G
	LHCH Involvement in the Refugee Support Programme	**People Plan**	G
We will review our leadership training offer focussing on civility, inclusivity and compassionate leadership.	Develop Compassionate & inclusive leadership Training programme including a focus on civility	**People Plan**	A
	Develop a Peope Manager leadership training to support managers in ensuring a fair, equal and transparent approach is applied to all HR policy development and its implementation	**People Plan**	A
	Develop and implement Reasonable Adjustments Policy as part of wider policy review process	**EDS2/WDES**	A
	Develop a calender of inclusion events to support and educate staff and to promote a message of inclusion for all	**People Plan**	A
	Tap into and target external resource to support new managers and leaders e.g promotig the use of Leadership Circles	**People Plan**	A
	Provide Deaf Awareness Training to Managers	**WDES**	G
We will celebrate and support diversity within our people	Apply to the NHS Employers Diversity and Inclusion Programme to help progress and develop our equality performance and build an inclusive culture in the workplace	**EDS2/People Plan**	G
	Develop a timetable of events aligned to national campaigns, which celebrate diversity in the workplace	**People Plan**	G
	Refresh the Carers Network and implement the Employers for Carers Scheme	**People Plan**	A
	Develop a evidence portfolio of best practice and staff experiences	**People Plan**	A
	Review corporate displays , intranet and Trust publications to ensure the promote inclusion and diversity within terminology and images used	**EDS2/Accessible Information Standard**	A
	Completion and monitoring of risk assessments to target vulnerable groups including the BAME workforce	**People Plan**	G
	Improve support around neuro-diversity – Identify workplace assessors and provide associated training	**WDES**	A
	Review of Disabilty Self-assessment and identify any gaps / actions	**Disability Confident/WDES**	A
	Review and implement policy reccomendations as advised by the The Race and Health Observatory	**WRES**	R

Item 3.3b Appendix 2

Relative Likelihood of Appointment from Shortlisting:

2019	2019	2020	2020	Diff 19 to 20	Diff 19 to 20
White	BME	White	BME	White	BME
22.34%	17.95%	17.00%	6.37%	-5.33%	-11.58%

**Relative likelyhood of White staff being appointed from shortlisting compared to BME Staff:*

A figure below "1" would indicate that white candidates are less likely than BME candidates to be appointed from shortlisting.

Therefore a figure of "2.67" indicates White staff are 2.67 times likely to be appointed from shortlisting

1.24		2.67		1.42

** Calc = White % / BME %*

Likelihood of staff entering the formal disciplinary process:

2019	2019	2020	2020	Diff 19 to 20	Diff 19 to 20
White	BME	White	BME	White	BME
0.28%	0.53%	0.54%	0.00%	0.26%	-0.53%

**Relative likelyhood of BME staff entering the formal disciplinary process:*

A figure below "1" would indicate that BME staff members are less likely than white staff to enter the formal disciplinary process.

Therefore a figure of "0.00" indicates BME staff are 0.00 times likely to enter the formal disciplinary process

	1.90		0.00		-1.90

** Calc = BME % / White %*

Number of staff accessing non-mandatory training and CPD:

2019	2019	2020	2020	Diff 19 to 20	Diff 19 to 20
White	BME	White	BME	White	BME
71.98%	84.21%	77.90%	87.63%	5.92%	3.42%

**Relative likelyhood of White Staff accessing non-mandatory training and CPD compared to BME Staff (2019 data only 9 months data (Jul 18 - Mar 19))*

A figure below "1" would indicate that white staff members are less likely to access non-mandatory training and CPD than BME staff.

Therefore a figure of "0.89" indicates White staff are less likely to enter the formal disciplinary process

0.85		0.89		0.03

** Calc = White % / BME %*

% Staff experiencing harassment, bullying or abuse from patients, relatives or public in last 12 months

2019	2019	2020	2020	Diff 19 to 20	Diff 19 to 20
White	BME	White	BME	White	BME
12.20%	20.70%	13.50%	26.00%	1.30%	5.30%

% Staff experiencing harassment, bullying or abuse from staff in last 12 months

2019	2019	2019	2019	Diff 19 to 20	Diff 19 to 20
White	BME	White	BME	White	BME
18.30%	34.90%	17.50%	34.60%	-0.80%	-0.30%

% of staff believing that the Trust provides equal opportunities for career progression or promotion

2019	2019	2020	2020	Diff 19 to 20	Diff 19 to 20
White	BME	White	BME	White	BME
89.80%	75.90%	91.70%	80.00%	1.90%	4.10%

% of staff personally experienced discrimiation at work from Manager/Team leader or colleague

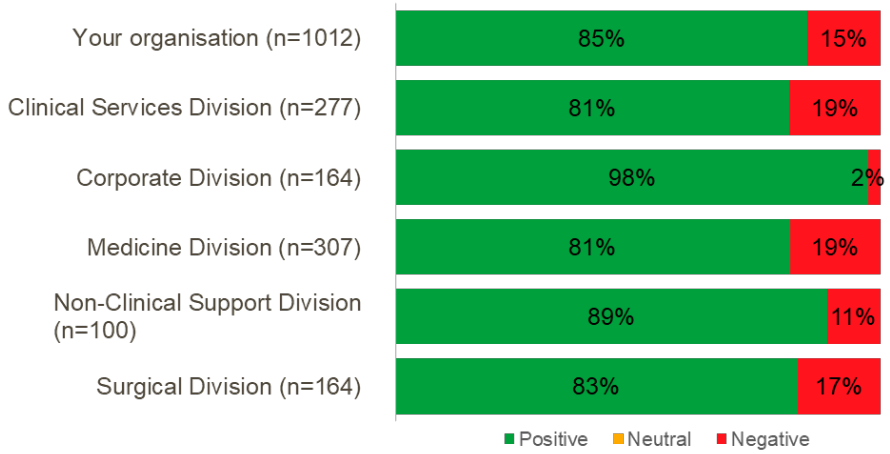
2019	2019	2020	2020	Diff 19 to 20	Diff 19 to 20
White	BME	White	BME	White	BME
5.70%	14.10%	3.60%	11.80%	-2.10%	-2.30%

Board Members by Ethnicity

2019	2019	2020	2020	Diff 19 to 20	Diff 19 to 20
White	BME	White	BME	White	BME
84.60%	7.70%	87.50%	6.30%	2.90%	-1.40%

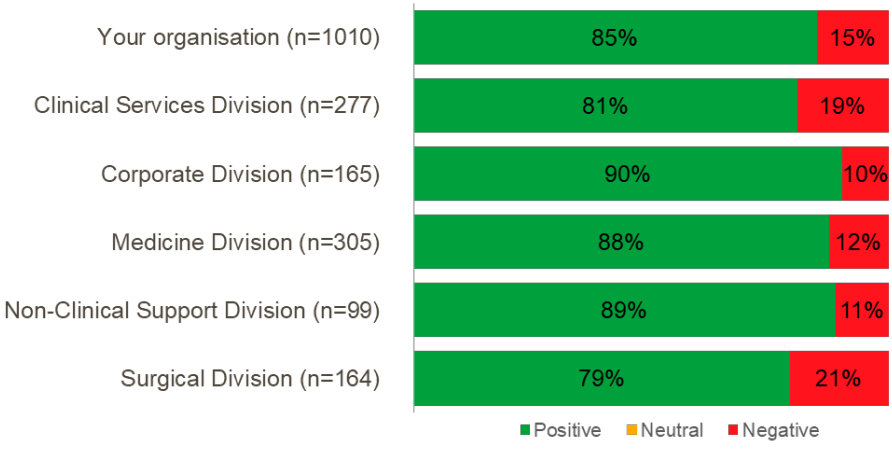
Q13a. In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...Patients / service users, their relatives or other members of the public?

Locality	Positive Score (%)	Number of Respondents					
		Never	1-2	3-5	6-10	More than 10	Total
Your Organisation	85.0%	860	108	34	6	4	1012
Corporate Division	97.6%	160	3	0	1	0	164
Non-Clinical Support Division	89.0%	89	8	3	0	0	100
Surgical Division	82.9%	136	18	8	1	1	164
Medicine Division	81.4%	250	43	12	1	1	307
Clinical Services Division	81.2%	225	36	11	3	2	277



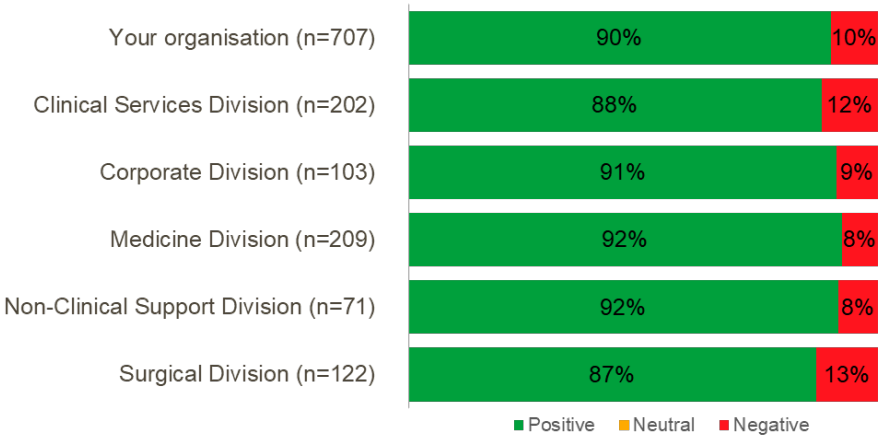
Q13c. In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...Other colleagues?

Locality	Positive Score (%)	Number of Respondents					
		Never	1-2	3-5	6-10	More than 10	Total
Your Organisation	85.0%	858	113	25	7	7	1010
Corporate Division	90.3%	149	10	6	0	0	165
Non-Clinical Support Division	88.9%	88	6	3	0	2	99
Medicine Division	87.5%	267	31	5	2	0	305
Clinical Services Division	80.9%	224	41	6	3	3	277
Surgical Division	79.3%	130	25	5	2	2	164



Q14. Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?

Locality	Positive Score (%)	Number of Respondents			
		Yes	No	Don't know	Total
Your Organisation	90.0%	636	71	305	1012
Medicine Division	92.3%	193	16	96	305
Non-Clinical Support Division	91.5%	65	6	27	98
Corporate Division	91.3%	94	9	60	163
Clinical Services Division	88.1%	178	24	77	279
Surgical Division	86.9%	106	16	45	167



Q15b. In the last 12 months have you personally experienced discrimination at work from…Manager / team leader or other colleagues

Locality	Positive Score (%)	Number of Respondents		
		Yes	No	Total
Your Organisation	95.1%	50	966	1016
Medicine Division	97.1%	9	297	306
Corporate Division	97.0%	5	159	164
Non-Clinical Support Division	97.0%	3	97	100
Clinical Services Division	95.0%	14	266	280
Surgical Division	88.6%	19	147	166

Item 3.3c Appendix 3

Local/Workforce Equality Standards/WDES

http://www.nhsstaffsurveyresults.com/homepage/local-results-2019/workforce-equality-standards-wdes-2019/

		Your Trust 2018	Average (Median) for Acute Specialist Trusts	The Walton Centre NHS Foundation Trust	The Clatterbridge Cancer Centre NHS Foundation Trust	2019
Indicator 4a: q13a-c - Harassment, bullying or abuse: Managers	Disabled	13.6%	15.1%	5.9%	17.4%	11.0%
	Non-Disabled	7.6%	10.0%	7.5%	9.8%	7.5%
Indicator 4a: q13a-c - Harassment, bullying or abuse: Other colleagues	Disabled	18.5%	27.3%	15.1%	27.4%	21.1%
	Non-Disabled	15.5%	16.6%	13.4%	15.7%	13.9%
Indicator 4a: q13a-c - Harassment, bullying or abuse: Patients / service users, their relatives or other members of the public	Disabled	20.0%	27.8%	32.5%	15.2%	15.1%
	Non-Disabled	11.6%	19.0%	24.2%	14.4%	14.7%
Indicator 4b: Reporting Harrassment, bullying or abuse (q13d)	Disabled	55.0%	53.5%	52.2%	45.6%	56.3%
	Non-Disabled	52.4%	47.3%	50.7%	40.6%	50.0%
Indicator 5: Equal opportunities for career progression/promotion (q14)	Disabled	84.1%	80.5%	90.4%	79.3%	89.7%
	Non-Disabled	88.9%	87.5%	91.8%	86.7%	90.2%
Indicator 6: Expriencing pressure from your manager to attend work when unwell (q11e)	Disabled	30.6%	26.7%	24.4%	39.3%	26.7%
	Non-Disabled	26.9%	20.6%	14.9%	22.5%	20.4%
Indicator 7: Staff satisfaction with extent work is valued by organisation (q5f)	Disabled	52.1%	44.3%	51.7%	38.8%	46.3%
	Non-Disabled	59.9%	56.1%	61.8%	47.5%	60.1%
Indicator 8: Adequate adjustments made for disabled staff (q28b)	Disabled	75.0%	76.5%	86.1%	72.1%	77.8%
Indicator 9a: Staff Engagement (score 0 - 10)	Disabled	7.50	7.20	7.50	6.70	7.20
	Non-Disabled	7.70	7.60	7.70	7.30	7.70

Relative Likelihood of Appointment from Shortlisting:

2019	2019	2020	2020	Diff 19 to 20	Diff 19 to 20
Disabled	Non-Disabled	Disabled	Non-Disabled	Disabled	Non-Disabled
12.24%	21.87%	10.19%	14.89%	-2.05%	-6.98%

**Relative likelyhood of Non-Disabled Staff being appointed from Shortlisting compared to Disabled staff:*

A figure below 1 indicates that Disabled staff are more likely than Non-Disabled staff to be appointed from shortlisting.

Therefore a figure of "1.46" indicates Non-Disabled staff are 1.46 times likely to be appointed from shortlisting

	1.79		1.46		-0.33

** Calc = Non-Disabled % / Disabled %*

Likelihood of staff entering the formal capability process:

2019	2019	2020	2020	Diff 19 to 20	Diff 19 to 20
Disabled	Non-Disabled	Disabled	Non-Disabled	Disabled	Non-Disabled
5.43%	0.24%	2.08%	0.08%	-3.35%	-0.17%

**Relative likelihood of Non-Disabled staff entering the formal disciplinary process compared to Disabled Staff:*

A figure above "1" would indicate that Disabled staff members are more likely than Non-Disabled staff to enter the formal capability process.

Therefore a figure of "26.65" indicates Disabled staff are 26.65 times likely to enter the formal capability process

22.25		26.65		4.40	

** Calc = Disabled % / Non-Disabled %*

Equality Delivery System for the NHS

EDS2 Summary Report

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: **http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf**

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS organisation name:

Liverpool Heart and Chest hospital

Organisation's Board lead for EDS2:

Sue Pemberton

Organisation's EDS2 lead (name/email):

Joanne Shaw joanne.shaw@lhch.nhs.uk and Rachel McDonald HR

Level of stakeholder involvement in EDS2 grading and subsequent actions:

This assessment was undertaken by the trust leads for Equality and Inclusion in Jan 2021 .

Organisation's Equality Objectives (including duration period):

Objectives:
1. Improve the patient experience by reviewing of our current translation and interpretation services to ensure they meet the local demand. This is a key area across the region and the trust are part of the local steering group
2.Work with HR and Training team to determine whether Equality data can be collected for evaluation of programmes across LHCH .
3. Embed equality and inclusion in mainstream business processes.
4. Improve information and data collected, in respect of protected characteristics.

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

We successfully applied to be part of the 2020 cohort of the NHS Employers Diversity and Inclusion Programme
Staff carers network group
Sunflower lanyard scheme
Rainbow badge launch
Reasonable adjustments care plan for staff
Development of agile working – helping people work from home and improving flexible working opportunities
Deaf awareness training and see through masks
Working as part of the northwest better together network

Publication Gateway Reference Number: 03247

Date of EDS2 grading January 2021 **Date of next EDS2 grading** January 2022

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; ✓ Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating: The services are designed to meet the needs of patients and families. CIP and New build have equality impact assessments undertaken The trust has a E and I group to look at issues arising and to lead on the strategy development for the trust Monitoring is in place via the Equality objective plan	✓
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Accessible information standards across the trust Letters available in easy read Communication books in all areas Hearing loops available across the trust External review undertaken by Deaf society New matron in post to support complex needs patients across the trust • Post discharge phone calls	✓
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; ✓ Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating: We have an excellent transition service for CF patients The new ACHD service is a key area of focus for transition as well as ICC	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes, continued	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** The clinical lead for EDS is also the safeguarding lead for the trust to a key focus is safety Speak out safely Speak out safely for patients and family Robust complaints process Daily safety huddle 3pmcovid safety meeting	✓
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** The trust is working as part of the healthy Lung programme and is a key provider of CVD services Smoking cessation Cardiac rehab programmes Health initiatives for staff We have been a key centre for the vaccination for COVID across the city	✓
Improved patient access and experience	2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Some key areas of work have been home visits for capacity for patients who live with a diagnosis of dementia or LD Dementia friends campaign across the trust over 1000 staff trained as dementia friends Key links to safeguarding agenda ie FGM Dementia strategy to be refreshed 2021 LD policy for reasonable adjustments	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Improved patient access and experience	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☐ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☐ Race; ☑ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Care partner programme PFCC vision and PFCC degree pathway looks at inequalities Engagement and listening events with targeted events across the system Family liason support during covd	☐
	2.3	**People report positive experiences of the NHS** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Post discharge phone calls Engagement events Family experience survey PFCC approach Beds for family Theatres contacting families to keep them up to date Family allowed in theatres to support reasonable adjustments •	☑
	2.4	**People's complaints about services are handled respectfully and efficiently** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** All complaints are screened and assessed , the numbers are small and a visit with a Head of Nursing is offered Complaints policy in place Staff go to patients homes to meet with complaints	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ☐ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Refresh of Recruitment and Selection policy and practices in line with the People Plan Lead for international recruitment pro gramme LHCH Involvement in the Refugee Support Programme Launch of NHS Jobs 2 Disability Confident Employer	☐
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** National AFC Job Evaluation used and NHS T&Cs Gender Gap Reporting Workforce Monitoring Report	☐
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** We have ensured our people are protected by facilitating risk assessments across all staff groups We have kept our people safe by developing a robust fit testing programme and ensuring we have the PPE we need to deliver careW	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☑ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Refresh of the Trust Values and Behavious to include Making and Difference and Inclusion (IMPACT) Refresh of the B&H in line with improving people practices FTSU Guardian/Champions - Increase the diversity within FTSU framework and Staff Governor composition Safety Seven CEO Pledge	☐
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Development of agile working – helping people work from home and improving flexible working opportunities Development of LHCH People Plan Core HR People Manager Training pilot Flexible Working Policy in place - review of recruitment and selection policy and practices underway Staff Survey results	☐
	3.6	**Staff report positive experiences of their membership of the workforce** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Review of Staff Survey Results Held a series of Executive Led Engagement Sessions with BAME workforce to seek direct feedback which supported the development of the integrated EDI action plan Staff carers network Launch Feedback via E&I Steering Group Staff Stories / Case Studies	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Inclusive leadership	4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** Grade: Undeveloped / Developing / **Achieving** / Excelling Which protected characteristics fare well: ☑ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☑ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation Evidence drawn upon for rating: Board development session undertaken on its roles and responsibilities in relation to E&I Board session on system leadership including compassionate leadership and unconscious bias. Further work can be undertaken to support the board with Cultural competence Support to BAME leadership programmes Support to the traineeship and per-employmnet programme	☐
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** Grade: Undeveloped / Developing / **Achieving** / Excelling Which protected characteristics fare well: ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation Evidence drawn upon for rating: This had been an area for improvement over the last twelve months Policies undertake EIA All CIPs had a scrutiny meeting to see if any needed for EIA merged QIA and EIA process for all CIPs and new services E&I Strategy Bi annual E&I strategy updates to People Committee and QPFEC and quarterly updates to the commissioners	☐
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** Grade: Undeveloped / Developing / **Achieving** / Excelling Which protected characteristics fare well: ☐ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation Evidence drawn upon for rating: DevelopedCompassionate & inclusive leadership Training programme including a focus on civility Developed a People Manager leadership training to support managers in ensuring a fair, equal and transparent approach is applied to all HR policy development and its implementation	☐

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Item 3.3e

Equality & Inclusion Strategy

2019 – 2021

Our aim

To promote inclusion and diversity for both staff and patients, tackling all forms of discrimination and removing inequality in the provision of both health services and employment.

This strategy identifies our priorities and objectives and addresses the national requirements that are embedded in the Equality Act 2010 (Public Sector Equality Duty), Human Rights Act 1998, Workforce Race Equality Scheme (WRES) and from 2019 Workforce Disability Equality Scheme (WDES) and identifies how we will deliver improved outcomes, based on the Equality Delivery System (EDS2).

We aim to demonstrate that that the inclusion agenda is meaningfully embedded into our core business.

Why an equality & inclusion strategy?

As an NHS organisation, we have both a legal and a moral duty to demonstrate fairness and equality to our patients, service users, their carers and families, and to our employees and volunteers.

This strategy explains and responds to the Trust's statutory duties to promote equality against all groups of people. It replaces and builds on our previous Equality and Inclusion Strategy 2015-2018.

The delivery of our Equality and Inclusion Strategy is underpinned by our Trust Values and Behaviours - PACT

- **Patient and Family Centred**
- **Accountability**
- **Continuous Improvement**
- **Team Work**

Our key priorities

- **Improving our understanding**

We recognise that equality monitoring is central in understanding whether people from all backgrounds are being treated fairly.

- **Have a greater input into service design and transformation**

Undertaking equality impact assessments helps us to understand how our policies, practices and service provision affect different groups of people.

- **Improving patient and staff experience and accessibility**

We recognise that the key to measuring the success of our actions is to ensure that patients and staff have the opportunity to share their experience and feedback with us.

- **Developing more inclusive leadership**

We recognise that by training and educating our staff, we can develop more inclusive leaders to drive forward inclusion and diversity and support a fully inclusive culture and service provision.

- **Promoting partnership working**

We will continue to work effectively in partnership with other organisations to promote health and wellbeing and to tackle health inequalities within our catchment area.

Our equality objectives

The Equality Act 2010 requires public sector organisations to publish equality objectives at least every four years and share its progress in achieving those objectives.

In determining our equality objectives for 2019, we reviewed local and national data, patient feedback, complaints analysis, staff survey results and aspects for service delivery that present a local challenge.

The following objectives were agreed by the E&I steering group:

EDS2 Goal	LHCH Equality Objective
Goal 1: Better Health Outcomes **Goal 2:** Improved patient access and experience **Goal 3:** A representative and support-ive workforce **Goal 4:** Inclusive leadership	• Improve the patient experience by reviewing of our current translation and interpretation services to ensure they meet the local demand. This is a key area across the region and the trust are part of the local steering group • Work with HR and Training team to determine whether Equality data can be collected for evaluation of programmes across LHCH. • Embed equality and inclusion in mainstream business processes. • Improve information and data collected, in respect of protected characteristics. • The Trust will also be working with the region wide group across the STP footprint on a number of key projects

These objectives have been agreed by the Equality and Inclusion Steering Group and Trust Board. Although these objectives only need to be revised at four yearly intervals in line with the legislation, the Trust's Equality Objectives will be reviewed annually.

The Equality and Inclusion Strategy is one of a suite of enabling strategies designed to work together to support and enable the Trust to achieve its overarching vision "to be the best - leading and delivering outstanding heart and chest care and research"

Our mission for LHCH is to provide excellent, compassionate and safe care for every patient, every day. This is underpinned by always putting our patients first, to value each person as an individual, and respect their diverse aspirations, beliefs and priorities.

At LHCH, we recognise that good inclusive practice is central to the provision of high quality health services that meet people's individual needs. The Trust is committed to fulfilling its General Duty under the Equality Act 2010 to promote equality and demonstrate that we have given due regard to the need to: Eliminate unlawful discrimination, harassment and victimisation.

What is equality, diversity, inclusion and human rights?

- **Equality**
  Equality is about fair treatment – making sure everyone is treated fairly and given the same life opportunities. It is not about treating everyone in the same way, to achieve the same outcomes. Different people have different needs. For example making reasonable adjustments for disabled people (providing correspondence in audio for visually impaired patients removes barriers to equality of opportunity and helps prevent discrimination). Equality recognises that people's needs may need to be met in different ways.

- **Diversity**
  Diversity is about recognising difference. It recognises that everyone is an individual with their own background, experiences, styles, perceptions, values and beliefs and that we need to understand, value and respect these differences.

- **Inclusion**
  Inclusion is a sense of belonging, of feeling respected and valued for who you are.

- **Human Rights**
  Human rights are the basic rights all individuals have, regardless of who they are, where they live or what they do. Human rights represent all the things that are important to human beings, such as the ability to choose how to live their lives and being treated with dignity and respect.

Our legal duties

There are a number of equality based national laws and guidelines which mandate and guide how NHS organisations should demonstrate equality. The principle equality drivers include:

Legislation	Requirement
The Human Rights Act 1998	The Human Rights Act is underpinned by the core values of Fairness, Respect, Equality, Dignity and Autonomy for all. All public bodies must comply with the convention rights.
The Equality Act 2010	Protection from discrimination on the basis of 9 protected characteristics (See Appendix 1) • Age • Sex • Ethnicity • Religion or Belief • Disability • Sexual Orientation • Gender Re-assignment • Pregnancy & Maternity • Marriage & Civil Partnership
Genera Equality Duty	To eliminate unlawful discrimination, harassment and victimisation. Advance equality of opportunity. Foster good relations.
Public Sector Equality Duty From 5 April 2010	To Publish relevant, proportionate information demonstrating compliance with the Equality Duty. To analyse effect of policies and practices on equality. Set specific, measurable Equality Objectives.
Accessible Information Standards	DCB1605 Accessible Information (formerly SCCI1605 Accessible Information) – the 'Accessible Information Standard' – directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.
Gender Recognition Act 2004	The GRA legislation provides a mechanism to allow trans people to obtain recognition for all legal purposes to their preferred gender role.
Workforce Race Equality Standard (WRES) From 1 April 2015	Must demonstrate through the nine point Workforce Race Equality Standard (WRES) metric how we are addressing race equality issues in a range of staffing areas. Must demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board Representation. This will be included in the Standard NHS Contract.
Workforce Disability Equality Scheme (WDES) From April 2019	The Workforce Disability Equality Standards (WDES) is a set of specific measures that will enable NHS Organisations to compare the experiences of disabled staff to non-disabled staff, this will then be sued to develop any required actions
Over and above the nine equality groups, we do have a duty of care to all our service users and staff who may be vulnerable to potential discrimination for a range of reasons	• Carer responsibility • Military service • Homelessness • Poverty • Geographical isolation • Long term unemployment • Stigmatised occupations e.g. prostitution • Drug use • Limited family and social networks • Offenders

Equality Delivery System (EDS2) Framework

This Equality and Inclusion Strategy links to a number of local and national drivers but is based on the requirements of the NHS Equality Delivery System, which aims to be embed equality into all policies and practices whilst driving up performance and going beyond legislation.

The Equality and Delivery System (EDS2) is a toolkit which has been designed to help NHS Organisations to meet the requirements of the Public Sector Equality Duty. The EDS2 toolkit supports NHS organisations to identify areas for improvement. From April 2015, EDS2 implementation by NHS provider organisations was made mandatory in the NHS standard contract. EDS2 implementation is openly referred to within the Clinical Commissioning Group (CCG) Assurance Framework and embedded within the Care Quality Committee (CQC) new inspection regime for hospitals.

EDS2 provides a robust framework against which we can assess and grade our performance against a range of nationally determined indicators grouped under the following four goals:

- Better health outcomes
- Improved patient access and experience
- A representative and supported workforce
- Inclusive leadership

Our progress in meeting these aims has been assessed and scored in discussion with local population and staff, including seeking views through peer review and Health Watch. EDS2 is a public commitment of how we plan to meet the needs and wishes of local people and our staff, and meet the duties placed on us by the Equality Act 2010. It also sets out how, Liverpool Heart and Chest Hospital recognises the differences between people, and how we aim to make sure that any form of discrimination is identified and addressed.

Our equality delivery system scores and action plan

Our Action Plan (Appendix 2) identifies a series of high level actions which are planned to assist in furthering our equality and inclusion achievements across the Trust.

These actions relate to the workforce, service provision and the four EDS2 Goals: they are managed by the Trust's Equality and Inclusion Leads for patients and staff and monitored by the Trust's Equality and Inclusion Steering Group.

Improving our understanding – equality monitoring

The idea of collecting and analysing data for us is not about the law; it's about measuring our employment practices and service delivery to ensure we are the best we can be.

LHCH recognises that equality monitoring is central in understanding whether people from all backgrounds are being treated fairly in terms of service delivery and employment practice. We need information about the characteristics of our service users and staff, if we are to understand people's needs and monitor whether or not we are meeting them and to ensure that everyone has equal access to services and opportunities.

Equality monitoring has been identified as a key priority area for improvement and we will be working closely with staff and service users over the next four years to improve the way that we ask for, collect and use information about our staff and service users. This will include explaining the reasons why we need to collect this data.

Greater input into service design and transformation – equality analysis

Undertaking Equality Impact Assessments (EIAs) helps us to understand how our policies, procedures and functions may affect different groups of people.

We use EIAs to help us identify what we need to do better to meet people's needs. EIAs help us to think about how what we do may impact on all members of the community and provide us with an opportunity to consider how we can further promote inclusion and diversity in everything we do. We consider all 9 of the protected characteristics as well as carers and vulnerable groups who are socially and economically disadvantaged, such as asylum seekers and refugees.

LHCH approach to EIAs has been embedded within our policy development framework with all key policies requiring an assessment to be completed in order to be approved. Although EIAs have been integrated into much of the organisations decision making process, we will be focussing our efforts on ensuring that good quality assessments are undertaken on all service changes and business cases moving forward.

Engagement and consultation

LHCH recognises that the key to measuring the success of our actions is to ensure that stakeholders, including service users, patients, carers, staff, Foundation Trust members and the public have opportunities to share their experience with us, and that we use these shared experiences to inform and improve the design of future services.

The Trust has a number of ways in which it regularly involves local people and staff in the development of services and the working environment for patients and local people. The Trust has a very active and engaged Council of Governors and this forum is used to consult on strategies and any significant service changes.

Whilst we recognise the importance of engaging with service users and staff when developing, delivering and designing services, we do recognise that this is an important area for continual improvement. We want our patient and public engagement activities to fully represent the diverse communities we serve and we are committed to ensuring that the way in which we communicate with people is fully inclusive and equitable. In line with Equality Delivery System, we will engage with all our stakeholders, involving them in assessing our progress towards achieving our equality objectives.

The Trust will provide staff members with access to both internal and regional Equality Network Groups such as LGBT, BAME, Women's Network etc

The Trust is launching its own Staff Carers Network in April 2019 to support staff with caring responsibilities and the group will be supporting the Trusts H&WB Open Day moving forward.

Access to services

LHCH is committed to improving access to our premises and services by removing physical and other barriers experienced by our staff and service users.

We will ensure that equality impact assessments are undertaken on all modifications to premises and service redesigns. All the Trust's estates schemes are designed and constructed in accordance with Disability Legislation and the Building Regulations Part M standards. In addition wherever practicable designers consult with Equality and Inclusion leads within the trust which often encompasses patient groups and forums. The Trust is fully committed to ensuring that it promotes and influences inclusion and diversity issues through its procurement process.

Our Interpreter and Translation Services Policy ensures that all patients whose first language is not English and patients with disabilities, such as hearing and visual impairments, have access to quality health services regardless of the language they speak or any disability they may have. It also ensures that staff follow the correct procedures for obtaining interpreter and translation services.

Developing more inclusive leadership

High-level leadership on equality and inclusion issues is in place within the Trust as demonstrated within our EDS2 assessment.

A regular update session takes place with Trust Board Members and, within this, agreements are reached regarding priorities around equality and inclusion and their roles in promoting these.

The Trust has a leadership strategy with equality and inclusion at its core. It also promotes a wide range of leadership courses and actively encourages staff from our BAME Network onto bespoke NHS Leadership Academy programmes.

Sustained activity is needed against the key action within the EDS action plan so as to enable managers to deal confidently with equality and inclusion issues and give their staff the confidence to get involved in Equality and Inclusion initiatives within the Trust. Master Classes are run within the Trust to raise the awareness of protected characteristic groups.

Promoting partnership working

The Trust is actively involved and hosts a number of Patient Forums. We are active members of the Regional Equality Network and support a number of the associated work streams.

Implementation of the strategy

The Trust Board has overall responsibility for the Equality and Inclusion and achievement of our EDS2 Objectives. The Director of Workforce and Service Improvement and Director of Nursing have responsibility for promoting equality and inclusion on behalf of the Trust.

Monitoring and review of this Strategy and action plan will be through the delivery and implementation of our E&I Action Plan with quarterly updates to the Trust's established Equality and Inclusion Steering Group.

Assurance will be provided against key milestones of the strategy and action plan to the People Committee bi- annually and an annual update to the Trust Board.

We are committed to ensuring that this Strategy is not seen as being separate, but is clearly linked with existing policies and business plans, so that it can successfully act as a lever for change and service improvement. The expectation is that all leaders and managers will be familiar with this strategy and ensure equality considerations are an integral part of the Trust's business including: Policy development; Service redesign and development; Service delivery; Staff recruitment and retention; Professional development and staff training; and Procurement and commissioning of any goods and services.

All staff will have a responsibility to eliminate discrimination in their day to day work and recognise and respect the diverse backgrounds and circumstances of patients and colleagues.

Existing groups and networks will be used as a source of advice and expertise in order to achieve annual priorities.

We will publish evidence and progress of how we have implemented the E&I Action Plan and delivered on our equality objectives.

Measures and assurance

- Successful implementation of this strategy and delivery of our equality objectives will be measured as follows:

- Progressive development towards ‘achieving’ and ‘excelling’ in the Equality Delivery System (EDS2) annual assessment.

- Improved patient and staff experience as measured by annual patient and staff surveys.

- Evidence of equal access, experience and outcomes for all protected groups through better monitoring and use of data.

- Improved community engagement held in conjunction with wider public engagement events the Trust undertakes.

- Avoidance of costly litigation; employment tribunals and / or patients seeking legal redress for discrimination.

- Measures will be reflected in the Trust’s key performance indicators and will be measured through Trust Board. This approach demonstrates LHCH commitment to equality and inclusion and enables issues to be escalated from the services to the Board. All measures will be included in the E&I Action Plan which underpins this strategy.

Risks

The key risk in failing to deliver our equality objectives is the potential for legal challenge if LHCH failed to meet its duties under equality legislation or if knowingly or unknowingly allowed discrimination to occur. Non-compliance / failure to address national requirements could impact on our Care Quality Commission Scores.

Available in easy read

Appendix A
PROTECTED CHARACTERISTICS – EQUALITY ACT 2010

The protected characteristics covered by the Equality Act 2010 are as follows:

Age:
Where this is referred to, it refers to a person belonging to a particular age (e.g. 32 year olds) or range of ages (e.g. 18-30 year olds).

Disability:
A person has a disability if he/she has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.

Race/Ethnicity:
This refers to a group of people defined by their race, colour and nationality (including citizenship), ethnic or national origins.

Gender:
A man or a woman.

Sexual Orientation:
Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

Gender Reassignment:
The process of transitioning from one gender to another.

Marriage and Civil Partnership:
Marriage is defined as a 'union between a man and a woman'. Same-sex couples can have their relationship legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters.

Pregnancy and Maternity:
Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.

Religion and Belief:
Religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.

Appendix B

Outcome/Objective	Source	Grading	Current Position	Actions	Update/Progress	Lead	Timescale	Update	RAG	Closed
Services are commissioned, designed and procured to meet the health needs of local communities.	EDS	EDS: Achieving	The Trust does not commission services, however in the design Equality Analysis's are carried out to ensure the service meets the health needs of the local community. Equality and Diversity performance and metrics are subject to commissioner scrutiny on a quarterly basis including EDS2 performance, WRES compliance. Information on Equality Impact assessment has been established on Trust Intranet site as point of reference for consideration during Equality Analysis process. Equality analysis guidance and form reviewed to ensure still fit for purpose and user friendly and profile of conducting Equality Analysis raised.	Data analysis and work with services to understand who/ which communities they are serving and identify any gaps/actions. NICE guidance regarding Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups to be scrutinised Review and evaluate the EIA process across the trust		JS JS JS	Apr-19 Apr-19 Apr-19			
Individual people's health needs are assessed and met in appropriate and effective ways	EDS	EDS: Achieving	Accessible Information Standard has been implemented We have translation services with Beacon and language line – no complaints this year about service provision	Review of accessible information to be undertaken Review of our Current translation and interpretation services to be undertaken to ensure they meet the local demand. This is a key area across the region and the trust are part of the local steering group			Apr-19 Apr-19			
People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.	EDS	EDS: Achieving	Equality Lead has been involved in PLACE assessments to ensure access from protected characteristic groups perspective is considered. 24/7 interpretation and translation services (telephone, face to face and document translation) available in all areas.(for review 2018/19) NHS England's Accessible Information Standard implemented. Review of PLACE Assessment results to take place to identify any equality related concerns and support to address.	Review of PLACE Assessment results to take place to identify any equality related concerns and support to address. (Q4)			Mar-19			
Recruitment and selection processes lead to a more representative workforce at all levels	EDS/WRES	EDS: Achieving	Inclusive Recruitment and Selection Policy NHS Job and TRAC Systems embedded in standard processes Standard recruitment process includes anonymised demographic information Disability confident employer	Values based recruitment to be implemented throughout all recruitment activity Consideration of BAME representative to attend interviews/recruitment open days Expand advertising to reach BAME groups		SJ SJ/FR SJ	Oct-20 Apr-19 Oct-20			
The organisation is committed to equal pay for equal values	EDS	EDS: Achieving	National AfC Job Evaluation implemented NHS T&C as a standard	Analysis of Pay Determination protocol Review of Gender Pay Gap reporting		SJ SJ	Apr-19 Apr-19			
Training and development opportunities are fair, taken up and positively evaluated by staff from all demographic groups	EDS/WRES Staff Survey	EDS: Developing	The L&D department registers attendance of staff at statutory and mandatory training and using information from the trust staff database (ESR) Non-mandatory training logged on OLM is analysed via protected characteristics collected on ESR. Target development for BAME staff e-learning programme available to all staff	Review of current training feedback processes, scope process for gathering demographic information for analysis Panel to be established to ensure fair and equitable training opportunities to all staff Statutory and mandatory training policy to be reviewed Identify training opportunities relevant to BAME groups Promote NHS Leadership Academy opportunities		RD	Feb 19? Apr 19 (subject to change) Apr 19 (subject to change) Jan 19 (subject to change) Jan 19 (subject to change)			
Staff are free from abuse,	EDS/WRES	EDS:	Bullying and Harassment Policy updated and communicated widely FTSU Guardian/Champions developed in consultation with BAME network	Scope opportunity for engagement/network events for other Protected Characteristic groups Review of Corporate Induction E&I package			Feb-19 Dec-18			

harassment, bullying and violence from any source	Staff Survey	Developing	Safety Seven developed and communicated throughout the Trust	Further promote Safety Seven	FR	Quarterly	
			CEO Pledge communicated throughout Trust BAME Network Groups arranged quarterly Disability Champions identified	Progress B&H training, liaising with OD team regarding raising the B&H profile		Mar-19	
Staff report positive experiences of their membership of the workforce	EDS2	EDS: Developing	Poisitve staff survey results	Review of Flexible working options for staff to ensure opportunities for flexible working are fair and equitable for all staff	FR/KT/ EH/ME	Aug-19	
			FFT	Co-ordination of themes from exit interviews to be undertaken	FR/KT EH/ME	Aug-19	
			Culture Survey	Co-ordination of themes from FTSU summit	VW	Aug-19	
			LIA Pulse Check	Review of current data collection and build upon any opportunities to action the results	FR/VL	Apr-19	
			BAME Group	Network groups to be established and seek further experiences to develop actions	FR	Apr-19	
			Big Conversations	Establish a staff Carers Netwok	JS	Apr-19	
			Disability Network Launch	Undertake veterans covenenat self assessment and assessment	JTw	Apr 19 ongoing	
Inclusive Leadership at all levels	EDS2	EDS: Developing	Equality Analysis has been developed, presented at board and committee level. Tracking process has been developed for all Equality Impact Analysis to initially be reviewed by Equality Leads. EIA review process to be incorporated into QIA training	Revise Equality and Inclusion Strategy	JT/VW/FR	Mar-19	
			Trigger process in place on business case, CIP template that has to be completed for any changes to take place.	Quality Impact Assessment training to be revised to include EIA processes	AN/FR	Jan-19	
			The template for Board papers includes a section for Equality Analysis which acts as a trigger if this has not been completed before then.	Equality and Inclusion Policy to be reviewed	FR/EISG	Jan-19	
			Data hub has been set up on Intranet site for people to be able to access when completing Equality Analysis.	Review use and quality of EIA/QIA submissions	AN/FR	Apr-19	
			All CIPs had a scrutiny meeting to see if any needed for EIA merged QIA and EIA process for all CIPs and new services E&I Strategy	EIA to be undertaken for all policies	FR/KT	Feb-19	
			BI annual E&I strategy updates to People Committee and QPFEC and quarterly updates to the commissioners				

Glossary

E&I	Equality and Inclusion
BAME	black, Asian and minority ethnic
EIA	Equality Impact Assessment
ESR	Employee Staff Record
EDS2	Equality Delivery System
WRES	Workforce Race Equality
AFC	Agenda for Change
OLM	Organisational learning platform
NHS T&cs	NHS terms and conditions
TRAC	Recruitment platform
FTSU	Freedom to Speak Up
PLACE	Patient led assessments of care
FFT	Family and Friends Test
CEO	Chief Executive Officer
LiA	Listening into Action
QIA	Quality Impact assessmnet
CIP	cost improvement programme
QPFEC	Quality Patient Family Experinence Committee

Appendix B

Board of Directors (In Public)
Item 4.1

Subject: **Board Dashboard-period ended 31st March 2021-Month 12**
Date of Meeting: **Tuesday 27th April 2021**
Prepared by: **Hayley Kendall, Chief Operating Officer**
Presented by: **Hayley Kendall, Chief Operating Officer**
Purpose: **To Note**

BAF Reference	Impact on BAF
BAF 2	No adverse impact on the BAF

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

- Six week diagnostic performance has narrowly underperformed in month with a position of 98.64% against a target of 99%. This demonstrates the tremendous work undertaken by the imaging teams to reduce the backlog of patients waiting.
- Referral to treatment waiting times remain below target as expected due to the significant

backlog accumulated during the surge. Performance in month stands at 76.53% for English commissioned activity and 76.04% for welsh commissioners, a slightly improved position compared to the previous month.

- There were 125 patients waiting longer than 52 weeks at the end of March, a static position compared to the previous month. All 52 week waiting patients undergo a harm review by the consultant responsible for the patients care. This figure will unfortunately continue to rise through quarter one as the Trust focusses elective capacity on the backlog of P2 patients, in line with the recovery trajectories previously shared with the Board and submitted to the regional recovery programme.
- Sickness increased to 4.44% in month with a couple of challenging areas across the Trust.

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

Other performance exceptions to note are summarised as follows:

- Infections (Dr Perry) – in month there was 1 C Diff, 1 MSSA and 1 gram negative bacteraemia. There were 12 MSSA's in the year and work is ongoing to improve this. A task and finish group is established to improve cannula and line care which is associated with bloodstream infections. The surgical site infection group has been re-established and has a clear robust work plan to monitor and reduce surgical site infections. Local targets are being considered in line with national benchmarking.
- VTE risk assessment (Dr Perry) – The weekly performance figures are revised by the Executive and two of the three VTE KPIs are able target. The 24 hour assessment is below target and the Divisions continue to work on improving performance against this indicator.

2. Financial Position

The Trust achieved a surplus of £421k for year ending 31st March 2021.

This is an improved position against the forecast submitted to NHSI as a result of additional national distribution of funds and lower than anticipated clinical supplies costs resulting from lower activity (winter Covid surge).

The Trust has achieved 96% of its revised Cost Improvement Plan including 22% of non-recurrent efficiencies.

Capital expenditure for the year totalled £14.4m enabling significant investment in estates infrastructure improvements including the ongoing Catheter Lab and Electrical works as well a digital and clinical equipment replacement.

The Trust retains a strong cash position improved by the surplus position achieved. The full financial position is detailed under a separate agenda item on the agenda.

3. Conclusion

The Trust is well underway with a focus on recovering elective activity to address backlogs and improve performance against the statutory indicators. The clinical and operational teams have robust plans and trajectories in relation to activity and waiting times that are reviewed on a weekly basis.

4. Recommendation

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

Item 4.1a

LIVERPOOL HEART AND CHEST HOSPITAL PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Operational Performance

measure	target	in month	variation
RTT 18 weeks in aggregate - Incomplete Pathways	92.0%	76.53%	
All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	85.0%	100.0%	
Maximum 6-week wait for diagnostic procedures	99.0%	98.64%	
Dementia - Find	90.0%	100.0%	
Dementia - Assess	90.0%	100.0%	
Dementia - Refer	90.0%	100.0%	
Cancelled Operations for non-clinical reasons	2.0%	4.0%	
Patients not booked in within 28 days (non clinical cancellations)	0	0	
Delayed Transfers of care	5.0%	4.31%	
Bed Occupancy	80.0%	75.62%	
Referral to treatment - Incomplete Pathways 52+ weeks	0	125	

Operational Performance

measure	target	in month	variation
Cancer: 14 day GP referral to 1st Outpatient Appointment	93.0%	100.0%	
Cancer: 31 day diagnosis to 1st treatment for all cancers	96.0%	100.0%	
Cancer: 31 day Second or subsequent treatment (surgery & drug)	94.0%	100.0%	
Cancer: 62 day Consultant Upgrade	85.0%	100.0%	
Welsh Patients: 26 weeks Referral To Treatment waiting times - Incomplete	95.0%	76.04%	
In-Hospital mortality	11	25	

Quality of Care

measure	target	in month	variation
Quantity of complaints	6	2	
Occurrence of any Never Events	0	0	
Mixed sex accommodation breaches	0	0	
Inpatient scores from Friends & Family Test - % positive	95.0%	98.25%	
Venous thromboembolism (VTE) risk assessment	95.0%	93.97%	
Clostridium Difficile	0	1	
MRSA Bacteraemias	0	0	
MSSA Bacteraemias	0	1	
Gram Negative Bacteraemias	0	1	
Hospital Standardised Mortality Ratio (HSMR) - basket diagnoses	100	62	
Hospital Standardised Mortality Ratio (HSMR) - all diagnoses	100	58	
Outpatient scores from Friends & Family Test - % positive	95.0%	95.0%	
Incidents - Serious incidents, Never Events, Adverse Events (Red)	1	0	

Organisational Health

measure	target	in month	variation
Staff Sickness (All Staff)	3.4%	4.44%	
Staff Turnover	10.0%	8.97%	
Executive Team Turnover	25.0%	30.3%	
Mandatory Training Compliance	95.0%	93.0%	
Appraisals Compliance	90.0%	90.0%	

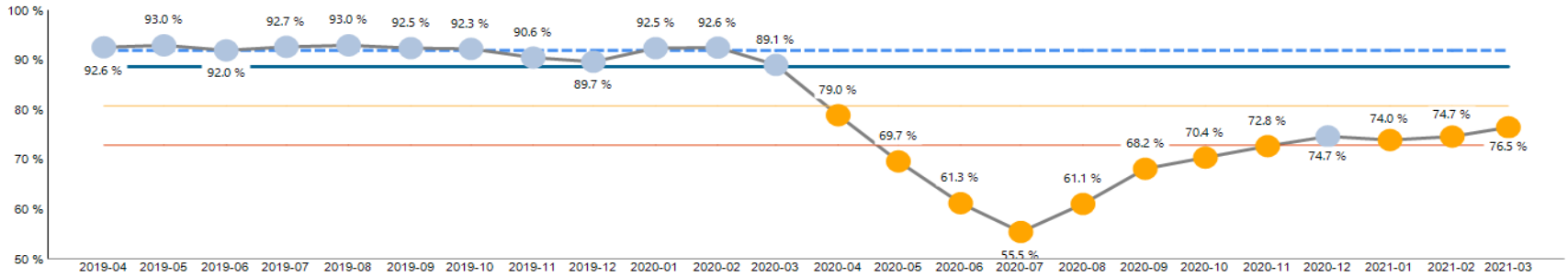
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

RTT 18 weeks in aggregate - Incomplete Pathways

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
>=92%	92.6%	93.0%	92.0%	92.7%	93.0%	92.5%	92.3%	90.6%	89.7%	92.5%	92.6%	89.1%	79.0%	69.7%	61.3%	55.5%	61.1%	68.2%	70.4%	72.8%	74.7%	74.0%	74.7%	76.5%



Concern

ucl	88.74%
mean	80.85%
target	92.0%
lcl	72.96%

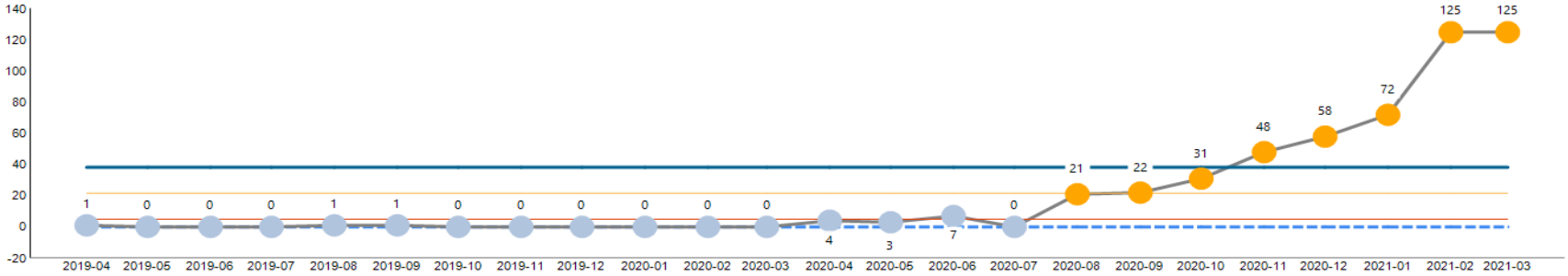
Commentary:

Slightly improved position in month, but as expected performance remains challenged with the backlog of elective waiting lists. Clear trajectories in placefor improvement to the end of the financial year.

Referral to treatment - Incomplete Pathways 52+ weeks

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
<0	1	0	0	0	1	1	0	0	0	0	0	0	4	3	7	0	21	22	31	48	58	72	125	125



Concern

ucl	38
mean	22
target	0
lcl	5

Commentary:

Performance remained static compared to the previous month. As predicted the recovery of zero patients waiting longer than 52 weeks will be in Q4 of this financial year and thus this target is expected to be unachieved for the foreseeable future.

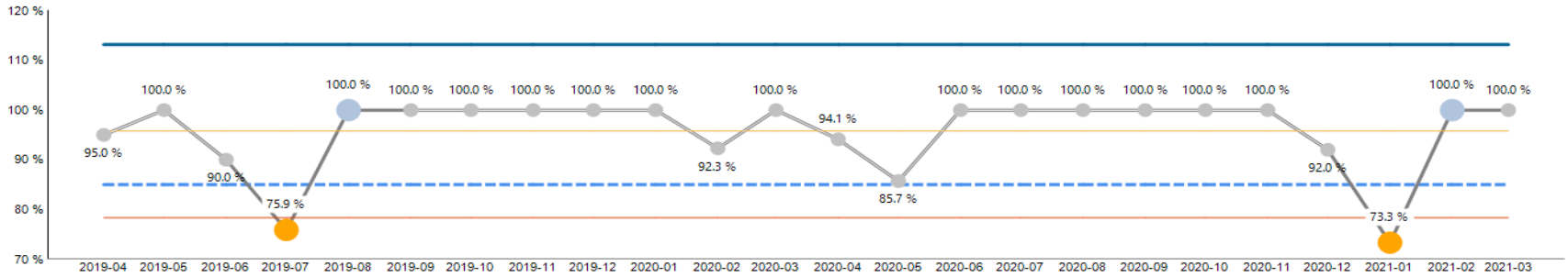
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

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

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
>=85%	95.0%	100.0%	90.0%	75.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	94.1%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.0%	73.3%	100.0%	100.0%



Common Cause

ucl	113.18%
mean	95.76%
target	85.0%
lcl	78.34%

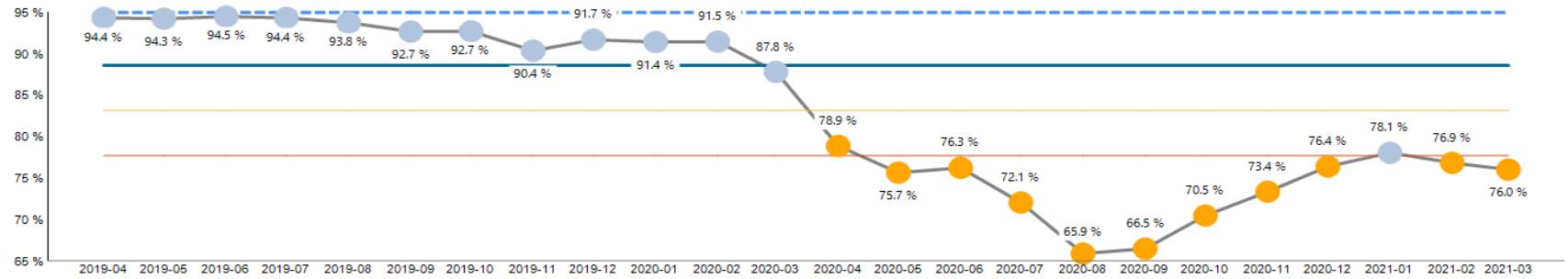
Commentary:

No exceptions to note.

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

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
>=95%	94.4%	94.3%	94.5%	94.4%	93.8%	92.7%	92.7%	90.4%	91.7%	91.4%	91.5%	87.8%	78.9%	75.7%	76.3%	72.1%	65.9%	66.5%	70.5%	73.4%	76.4%	78.1%	76.9%	76.0%



Concern

ucl	88.62%
mean	83.17%
target	95.0%
lcl	77.73%

Commentary:

Performance slightly declined in month but overall performance is in line with the english RTT target.

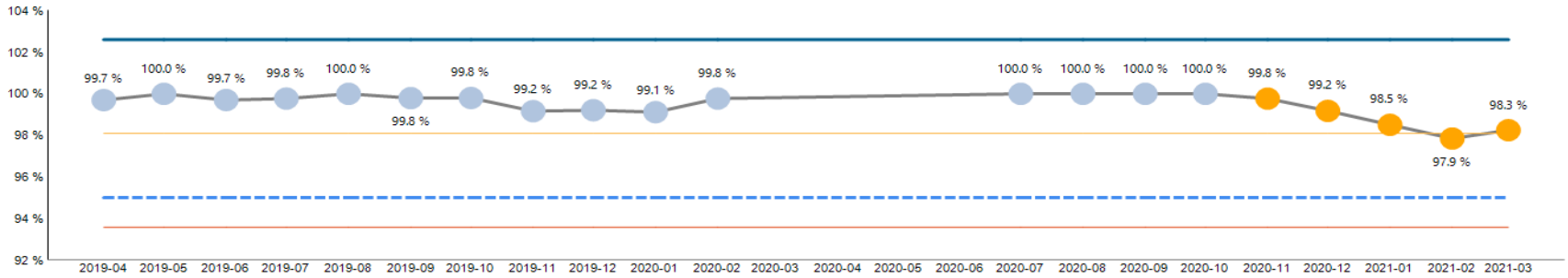
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Inpatient scores from Friends & Family Test - % positive

Percentage of inpatients rating the service good or very good

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
>=95%	99.7%	100.0%	99.7%	99.8%	100.0%	99.8%	99.8%	99.2%	99.2%	99.1%	99.8%	100.0%	100.0%	100.0%	100.0%	99.8%	99.2%	98.5%	97.9%	98.3%



Concern

ucl	102.61%
mean	98.09%
target	95.0%
lcl	93.58%

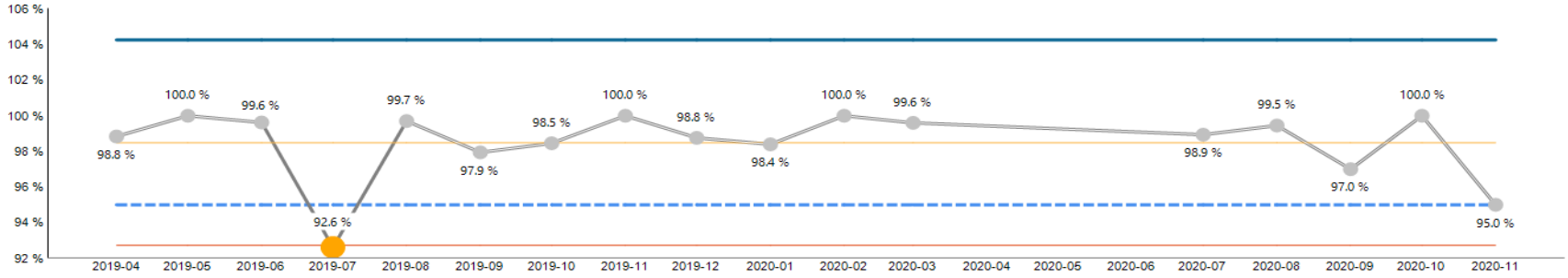
Commentary:

No exceptions to note.

Outpatient scores from Friends & Family Test - % positive

Count of outpatient friends and family test responses that are rated as positive / Count of friends and family tests taken within outpatients

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-07	2020-08	2020-09	2020-10	2020-11
>=95%	98.8%	100.0%	99.6%	92.6%	99.7%	97.9%	98.5%	100.0%	98.8%	98.4%	100.0%	99.6%	98.9%	99.5%	97.0%	100.0%	95.0%



Common Cause

ucl	104.26%
mean	98.49%
target	95.0%
lcl	92.72%

Commentary:

No exceptions to note.

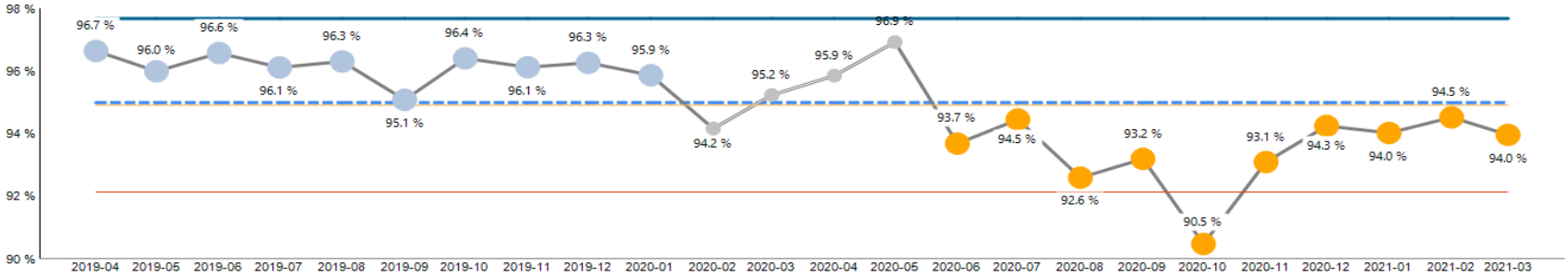
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Venous thromboembolism (VTE) risk assessment

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
>=95%	96.7%	96.0%	96.6%	96.1%	96.3%	95.1%	96.4%	96.1%	96.3%	95.9%	94.2%	95.2%	95.9%	96.9%	93.7%	94.5%	92.6%	93.2%	90.5%	93.1%	94.3%	94.0%	94.5%	94.0%



Concern

ucl	97.69%
mean	94.92%
target	95.0%
lcl	92.14%

Commentary:

The weekly figures are reviewed at Execs. Two of the three KPIs are above target. The 24 hour assessment is below and has led to the average being below 95%. The division continue to work on improving the 24 hour assessment

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

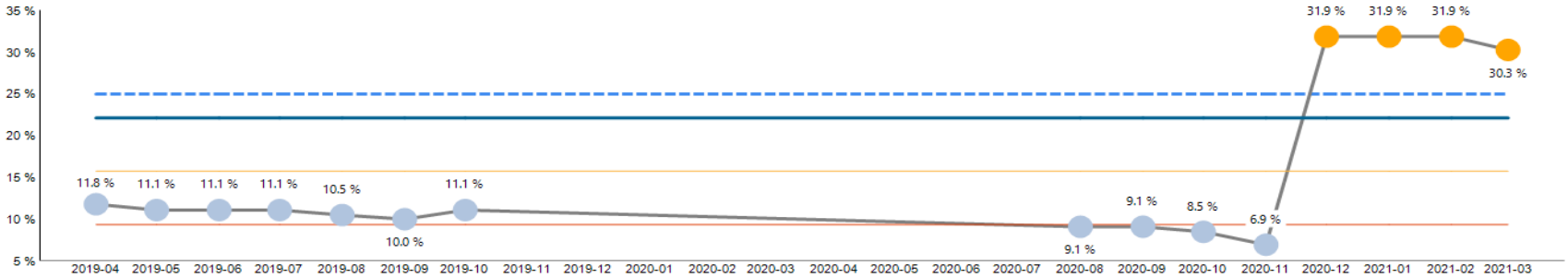
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Executive Team Turnover

Rate of turnover among the executive team

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
<=25%	11.8%	11.1%	11.1%	11.1%	10.5%	10.0%	11.1%	9.1%	9.1%	8.5%	6.9%	31.9%	31.9%	31.9%	30.3%

Concern



ucl	22.15%
mean	15.75%
target	25.0%
lcl	9.36%

commentary:

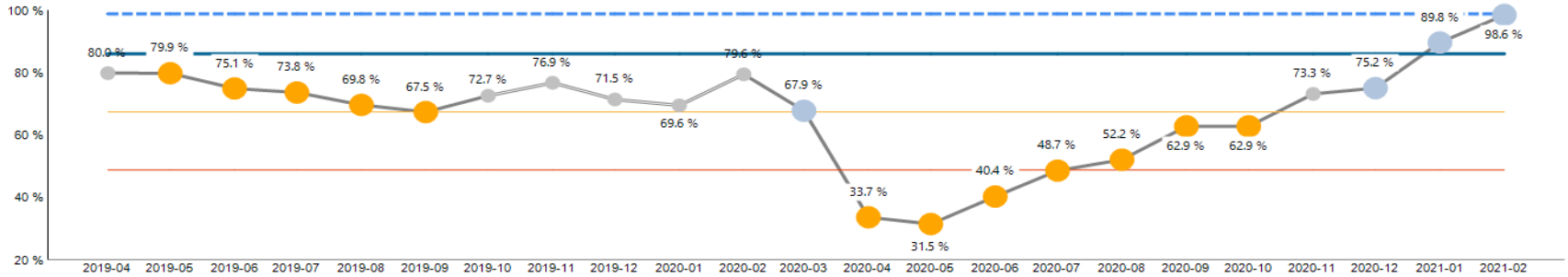
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Maximum 6-week wait for diagnostic procedures

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02
>=99%	80.0%	79.9%	75.1%	73.8%	69.8%	67.5%	72.7%	76.9%	71.5%	69.6%	79.6%	67.9%	33.7%	31.5%	40.4%	48.7%	52.2%	62.9%	62.9%	73.3%	75.2%	89.8%	98.6%



Improvement

ucl	86.19%
mean	67.54%
target	99.0%
lcl	48.88%

Commentary:

Strong performance over the last four months and recovery plan successful.

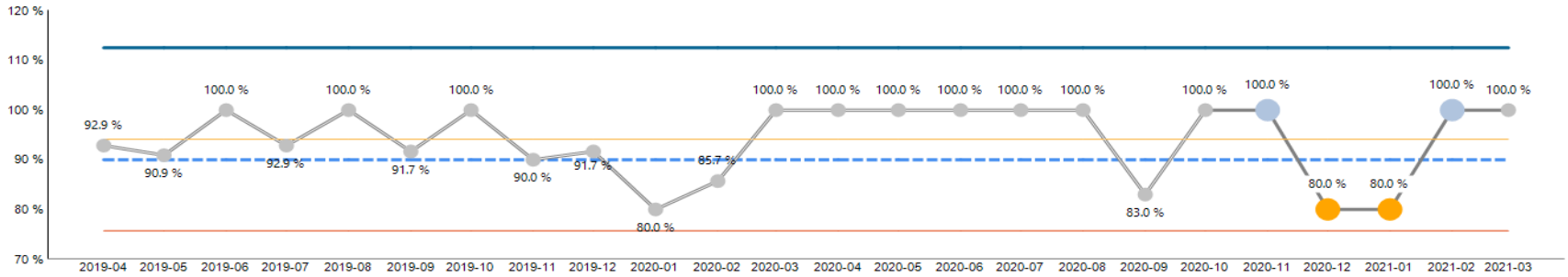
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Dementia - Find

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
>=90%	92.9%	90.9%	100.0%	92.9%	100.0%	91.7%	100.0%	90.0%	91.7%	80.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.0%	100.0%	100.0%	80.0%	80.0%	100.0%	100.0%



Common Cause

ucl	112.54%
mean	94.11%
target	90.0%
lcl	75.69%

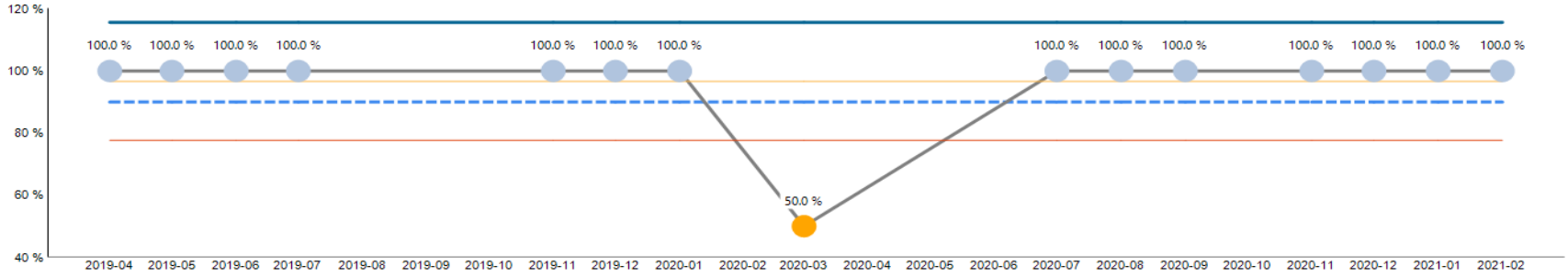
Commentary:

No exceptions to note.

Dementia - Assess

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

Target	2019-04	2019-05	2019-06	2019-07	2019-11	2019-12	2020-01	2020-03	2020-07	2020-08	2020-09	2020-11	2020-12	2021-01	2021-02
>=90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Improvement

ucl	115.67%
mean	96.67%
target	90.0%
lcl	77.67%

Commentary:

No exceptions to note.

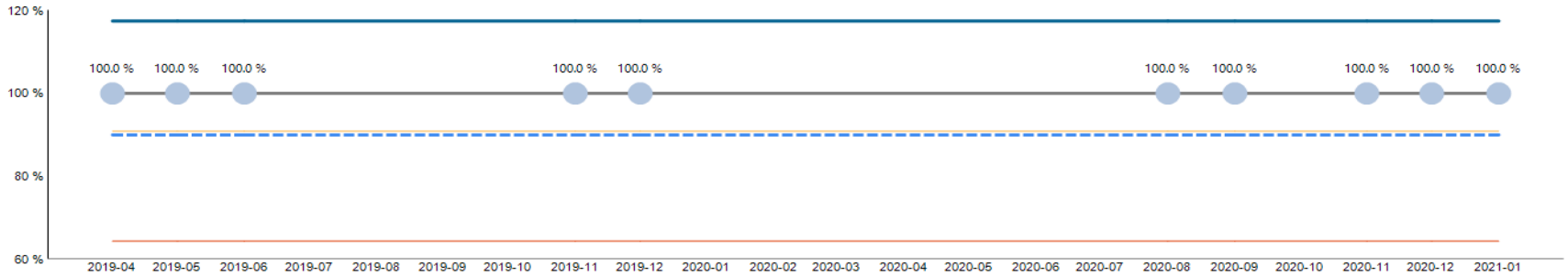
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Dementia - Refer

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

Target	2019-04	2019-05	2019-06	2019-11	2019-12	2020-08	2020-09	2020-11	2020-12	2021-01
>=90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Improvement

ucl	117.51%
mean	90.91%
target	90.0%
lcl	64.31%

Commentary:

No exceptions to note.

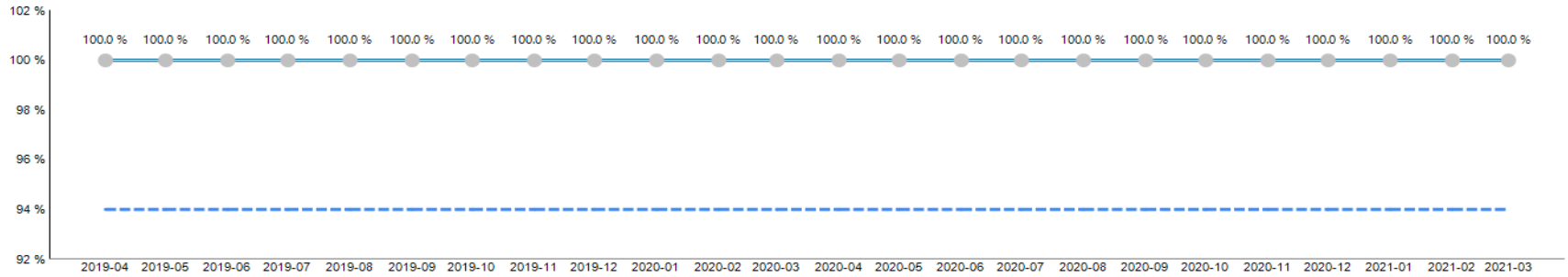
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

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

Patients waiting a maximum of 31 days for all subsequent treatments

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
>=94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Common Cause

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

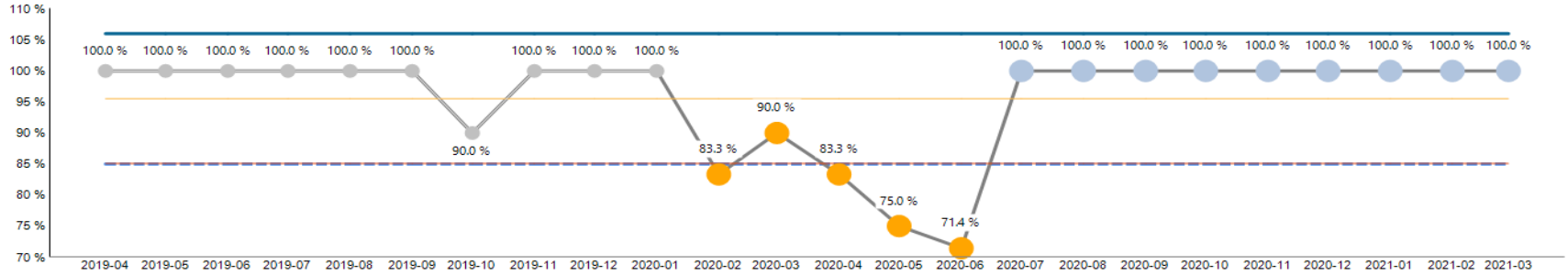
Commentary:

No exceptions to note.

Cancer: 62 day Consultant Upgrade

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
>=85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%	83.3%	90.0%	83.3%	75.0%	71.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Improvement

ucl	106.01%
mean	95.55%
target	85.0%
lcl	85.08%

Commentary:

No exceptions to note.

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

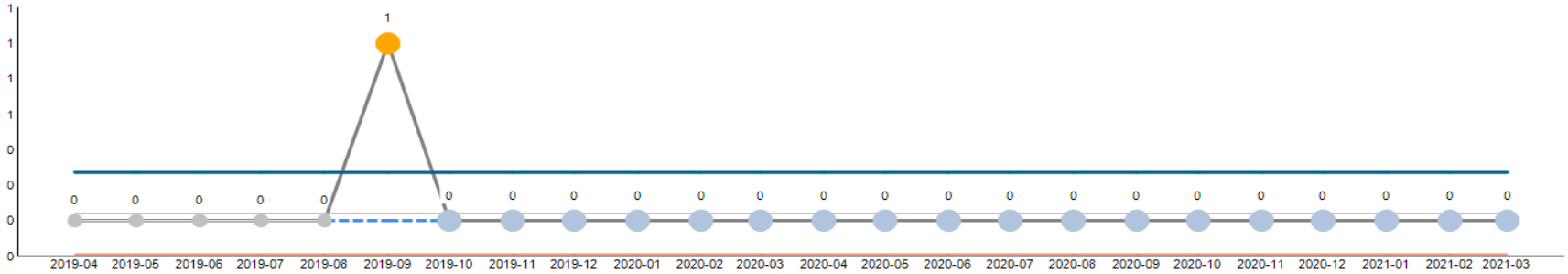
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Occurrence of any Never Events

Count of Never Events

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Improvement



ucl	0
mean	0
target	0
lcl	-0

Commentary:

No exceptions to note.

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

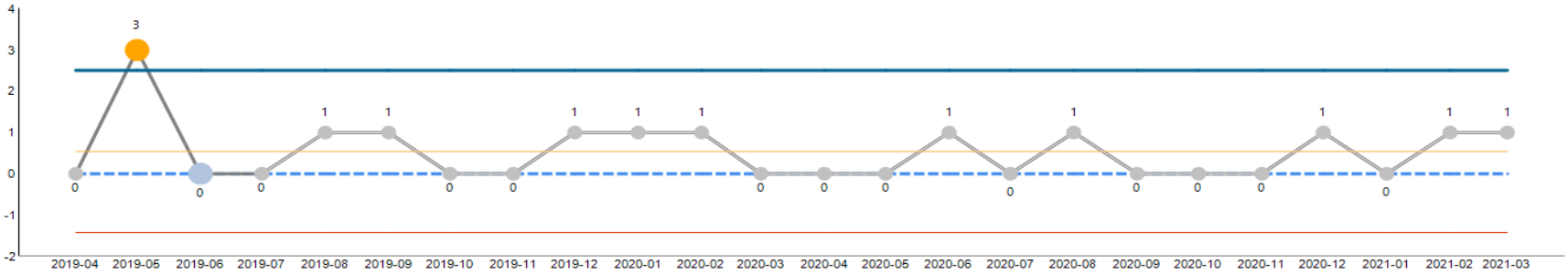
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Clostridium Difficile

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
	0	3	0	0	1	1	0	0	1	1	1	0	0	0	1	0	1	0	0	0	1	0	1	1

Common Cause



ucl	3
mean	1
target	0
lcl	-1

Commentary:

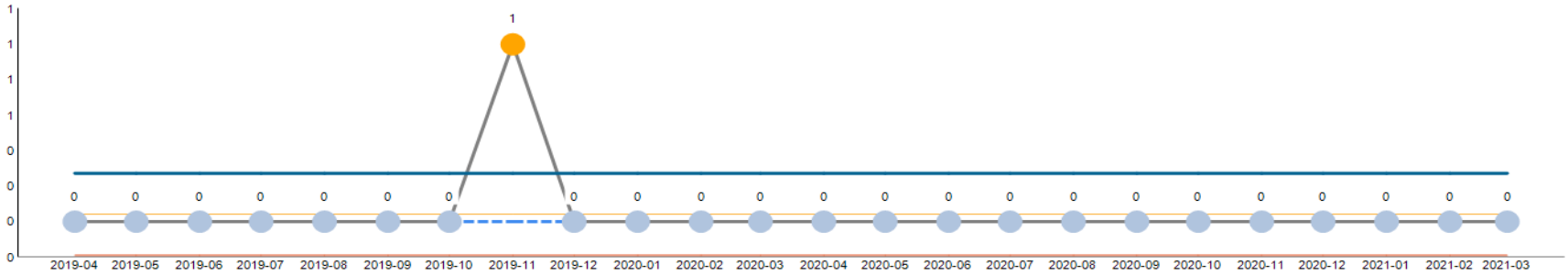
The dashboard targets are all zero and not in line with national targets. This is being reviewed with other dashboard targets.

MRSA Bacteraemias

Count of trust assigned MRSA infections

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Improvement



ucl	0
mean	0
target	0
lcl	-0

Commentary:

No exceptions to note.

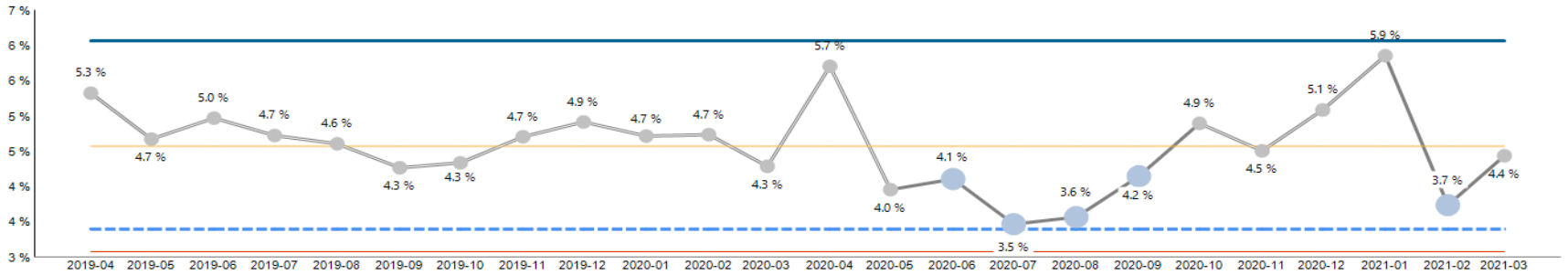
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Staff Sickness (All Staff)

Rate of sickness across all staff

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
<=3.4%	5.3%	4.7%	5.0%	4.7%	4.6%	4.3%	4.3%	4.7%	4.9%	4.7%	4.7%	4.3%	5.7%	4.0%	4.1%	3.5%	3.6%	4.2%	4.9%	4.5%	5.1%	5.9%	3.7%	4.4%



Common Cause

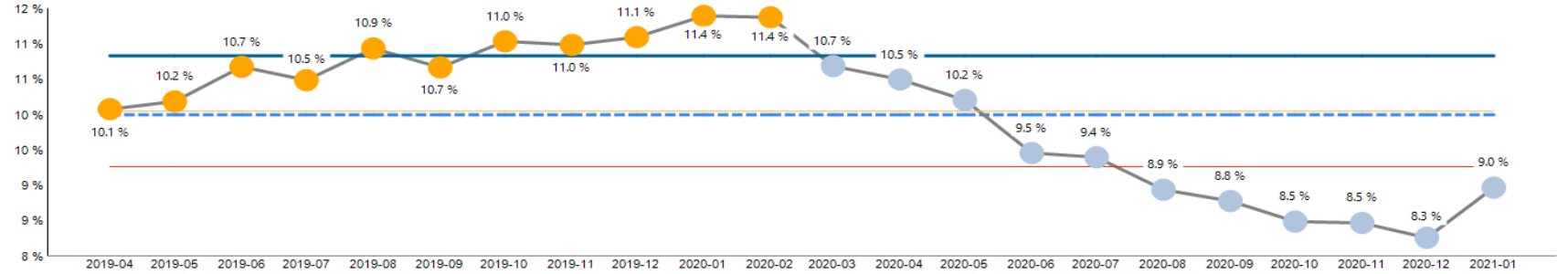
ucl	6.07%
mean	4.58%
target	3.4%
lcl	3.08%

Commentary:

Staff Turnover

Rate of turnover among voluntary leavers

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01
<=10%	10.1%	10.2%	10.7%	10.5%	10.9%	10.7%	11.0%	11.0%	11.1%	11.4%	11.4%	10.7%	10.5%	10.2%	9.5%	9.4%	8.9%	8.8%	8.5%	8.5%	8.3%	9.0%



Improvement

ucl	10.84%
mean	10.05%
target	10.0%
lcl	9.27%

Commentary:

No exceptions to note.

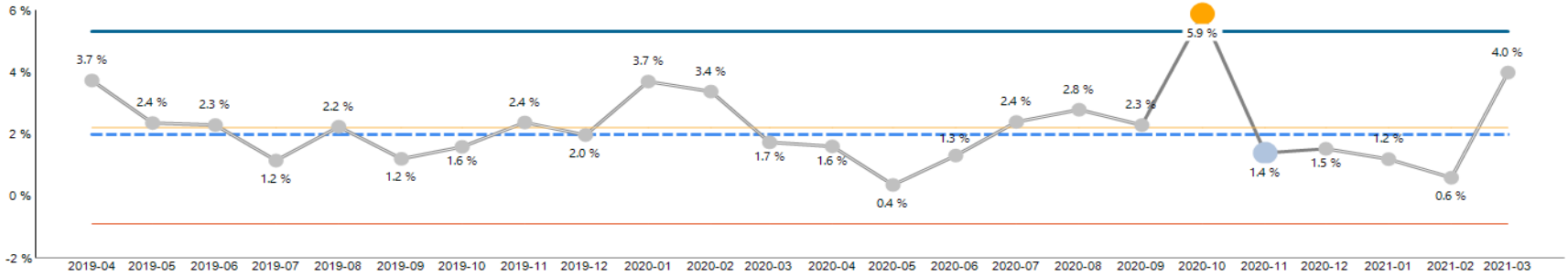
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Cancelled Operations for non-clinical reasons

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
<=2%	3.7%	2.4%	2.3%	1.2%	2.2%	1.2%	1.6%	2.4%	2.0%	3.7%	3.4%	1.7%	1.6%	0.4%	1.3%	2.4%	2.8%	2.3%	5.9%	1.4%	1.5%	1.2%	0.6%	4.0%



Common Cause

ucl	5.33%
mean	2.22%
target	2.0%
lcl	-0.89%

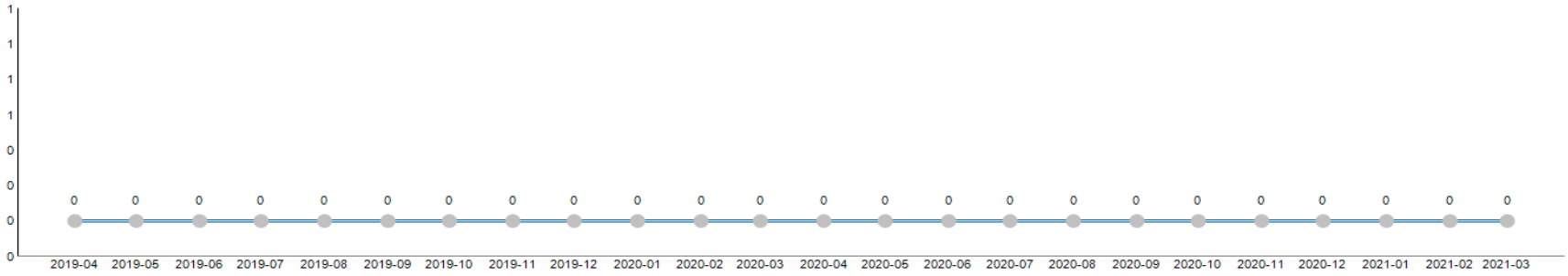
Commentary:

No exceptions to note.

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

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



Common Cause

ucl	0
mean	0
target	0
lcl	0

Commentary:

No exceptions to note.

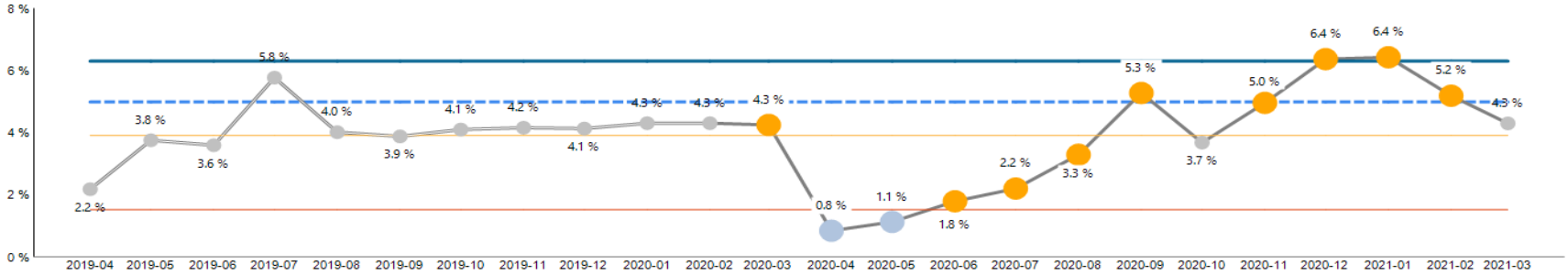
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Delayed Transfers of care

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
<=5%	2.2%	3.8%	3.6%	5.8%	4.0%	3.9%	4.1%	4.2%	4.1%	4.3%	4.3%	4.3%	0.8%	1.1%	1.8%	2.2%	3.3%	5.3%	3.7%	5.0%	6.4%	6.4%	5.2%	4.3%



Common Cause

ucl	6.31%
mean	3.92%
target	5.0%
lcl	1.53%

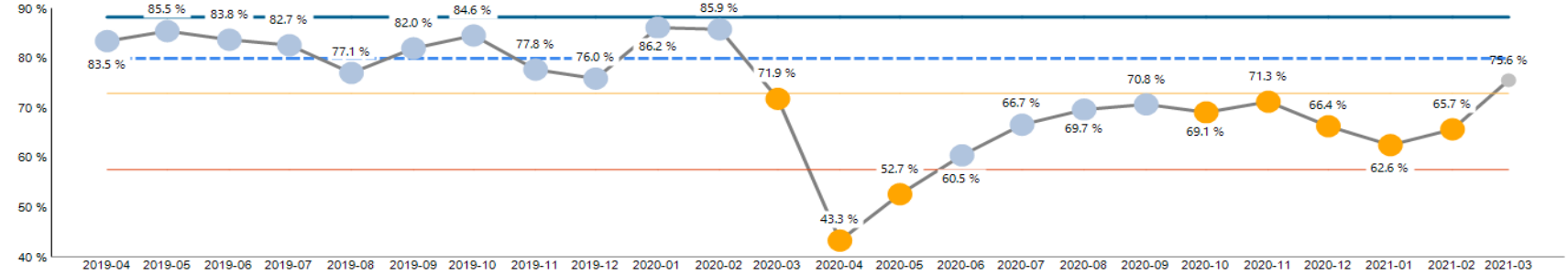
Commentary:

Performance improved over the last two months and no future concerns to note.

Bed Occupancy

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
>=80%	83.5%	85.5%	83.8%	82.7%	77.1%	82.0%	84.6%	77.8%	76.0%	86.2%	85.9%	71.9%	43.3%	52.7%	60.5%	66.7%	69.7%	70.8%	69.1%	71.3%	66.4%	62.6%	65.7%	75.6%



Common Cause

ucl	88.34%
mean	72.97%
target	80.0%
lcl	57.61%

Commentary:

Bed occupany increasing as more elective work is scheduled and will increase from April 2021 onwards.

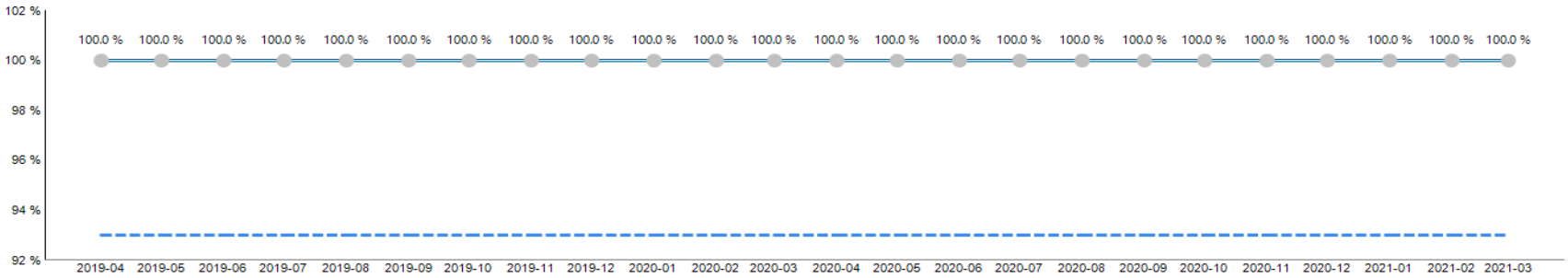
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Cancer: 14 day GP referral to 1st Outpatient Appointment

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
>=93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Common Cause

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

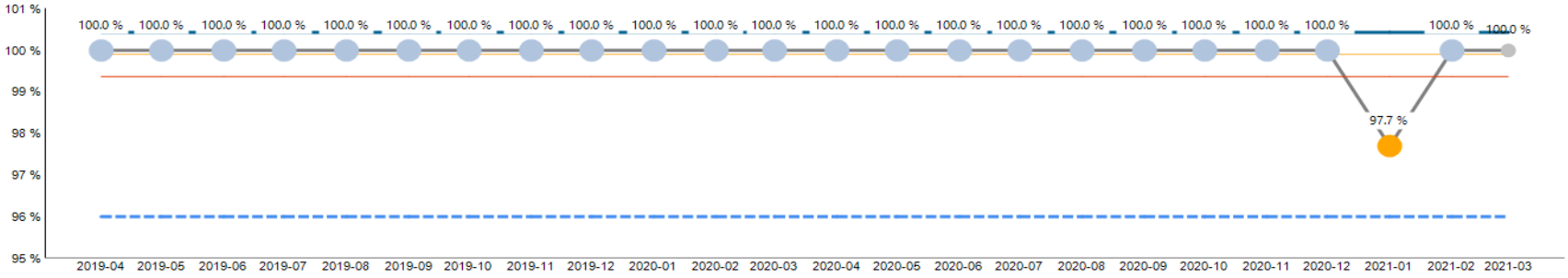
Commentary:

No exceptions to note.

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

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
>=96%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	100.0%	100.0%



Common Cause

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

Commentary:

No exceptions to note.

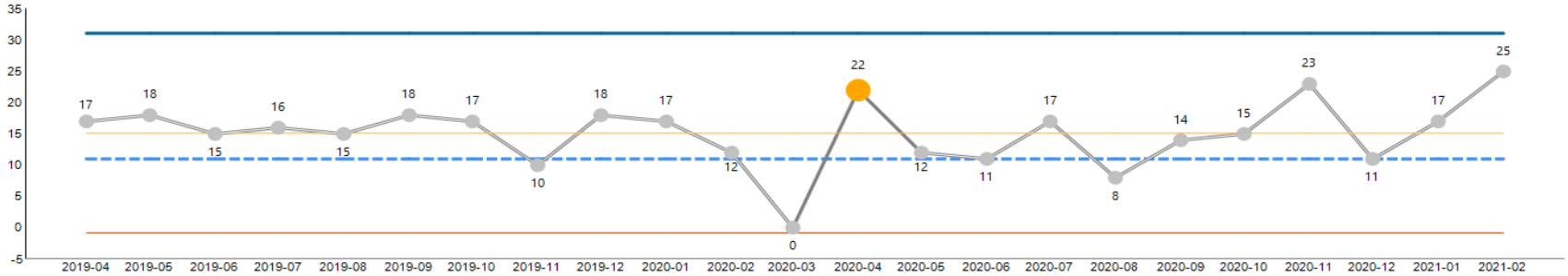
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

In-Hospital mortality

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02
<=11	17	18	15	16	15	18	17	10	18	17	12	0	22	12	11	17	8	14	15	23	11	17	25



Common Cause

ucl	31
mean	15
target	11
lcl	-1

Commentary:

This raw data is not risk adjusted and is subject to normal biological variation month to month. The annula number of deaths in 20/21 is almost identical to 19/20

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

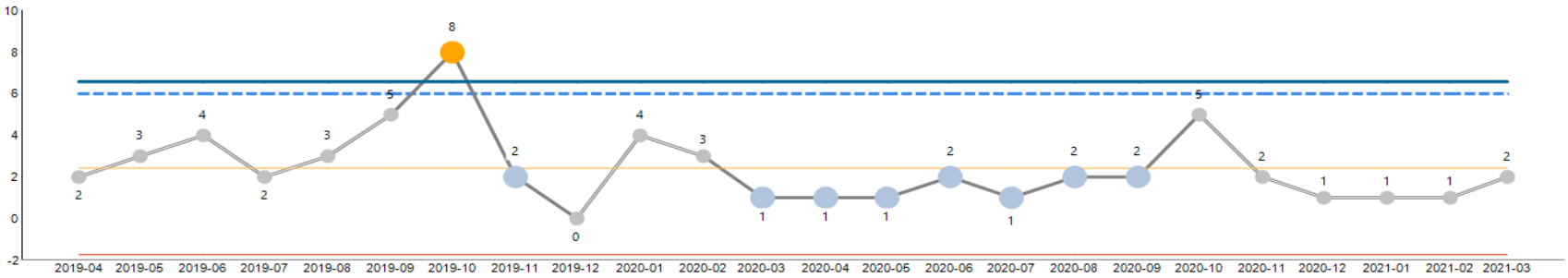
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Quantity of complaints

Quantity of complaints

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
<=6	2	3	4	2	3	5	8	2	0	4	3	1	1	1	2	1	2	2	5	2	1	1	1	2

Common Cause



ucl	7
mean	2
target	6
lcl	-2

Commentary:

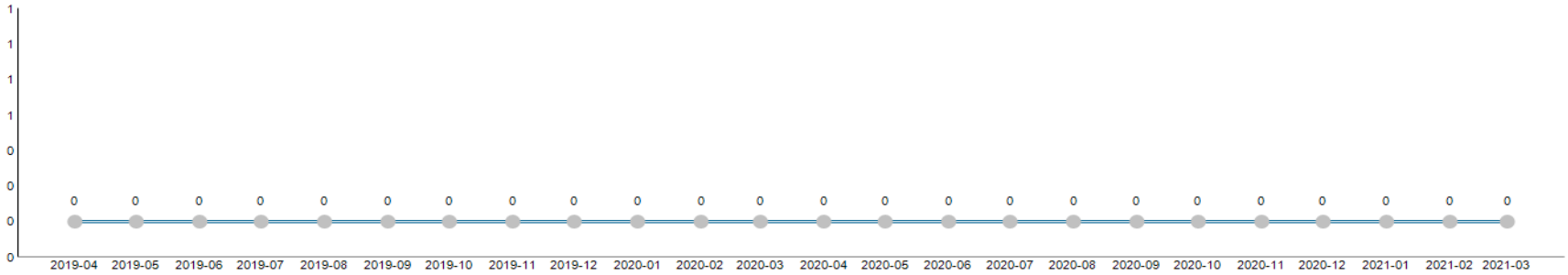
No exceptions to note.

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Mixed sex accommodation breaches

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



Common Cause

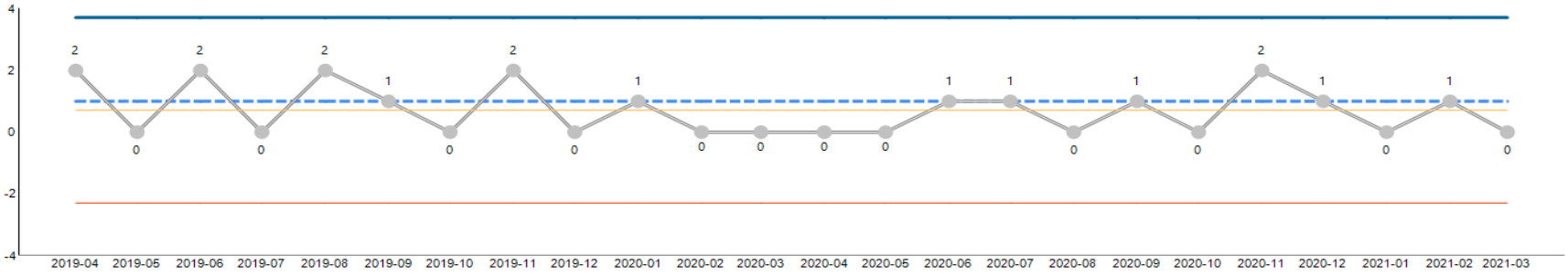
ucl	0
mean	0
target	0
lcl	0

Commentary:

No exceptions to note.

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

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
1	2	0	2	0	2	1	0	2	0	1	0	0	0	0	1	1	0	1	0	2	1	0	1	0



Common Cause

ucl	4
mean	1
target	1
lcl	-2

Commentary:

No exceptions to note.

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

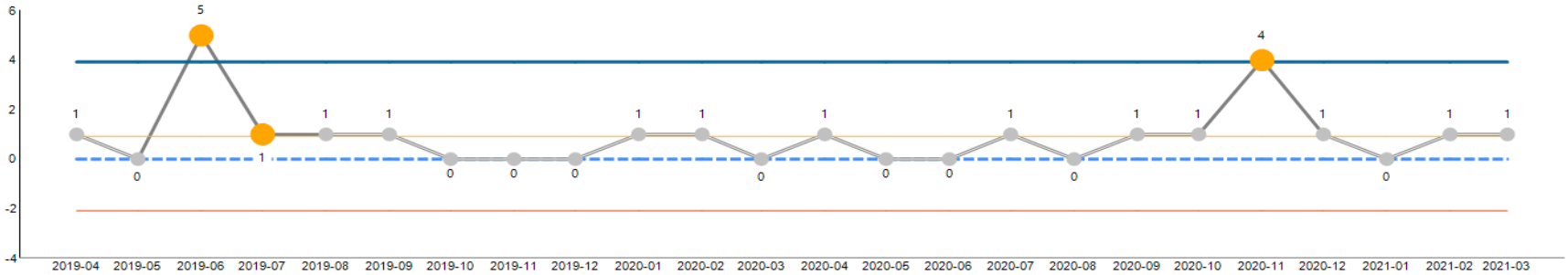
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

MSSA Bacteraemias

Count of trust assigned MSSA infections

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
	1	0	5	1	1	1	0	0	0	1	1	0	1	0	0	1	0	1	1	4	1	0	1	1

Common Cause



ucl	4
mean	1
target	0
lcl	-2

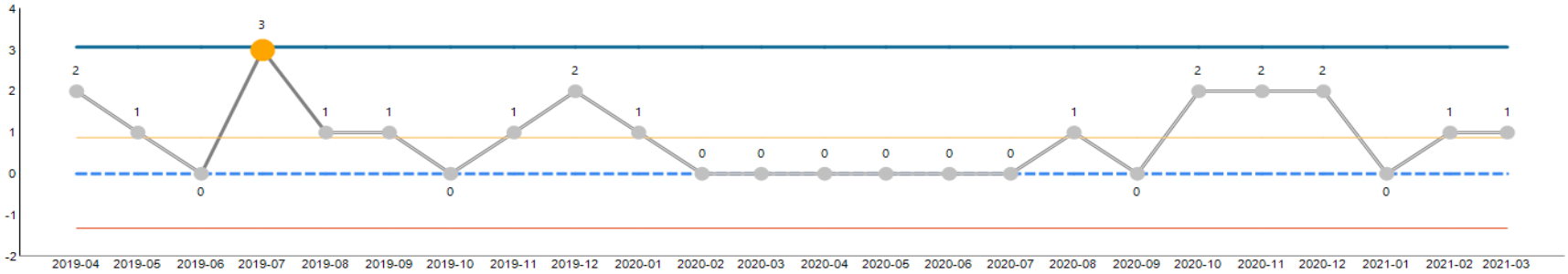
Commentary:
There have been 12 MSSA infections though the year, work is ongoing to improve this. A task and finish group is established to improve cannula and line care which is a frequent cause of MSSA bloodstream infection. The surgical site infection group is re-established and has a robust workplan to monitor and reduce SSI.

Gram Negative Bacteraemias

Count of trust assigned Gram Negative Bacteraemias infections

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
	2	1	0	3	1	1	0	1	2	1	0	0	0	0	0	0	1	0	2	2	2	0	1	1

Common Cause



ucl	3
mean	1
target	0
lcl	-1

Commentary:

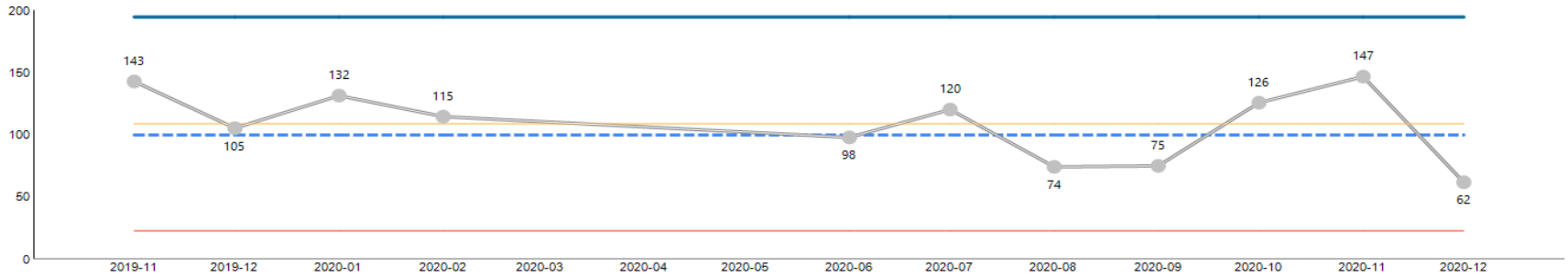
One infection in month.

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Hospital Standardised Mortality Ratio (HSMR) - basket diagnoses

patient characteristics for those treated there.

Target	2019-11	2019-12	2020-01	2020-02	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12
<=100	143	105	132	115	98	120	74	75	126	147	62



Common Cause

ucl	195
mean	109
target	100
lcl	23

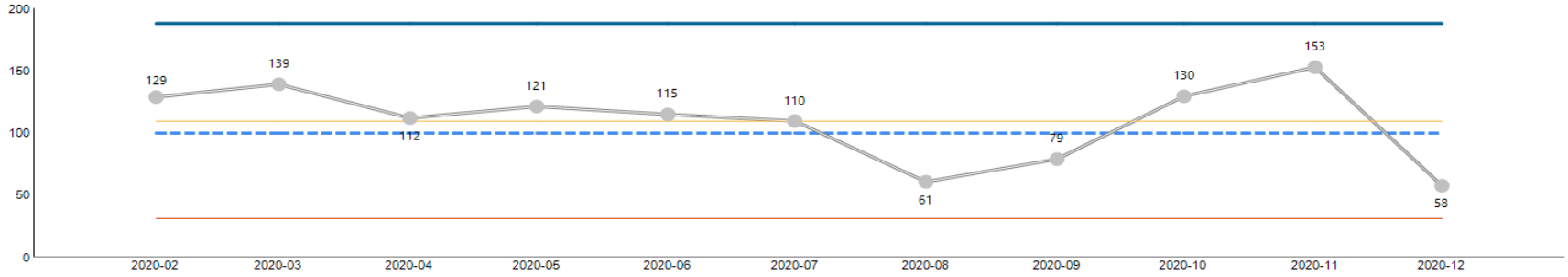
Commentary:

HSMR has reduced with no specific actions

Hospital Standardised Mortality Ratio (HSMR) - all diagnoses

of patient characteristics for those treated there.

Target	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12
<=100	129	139	112	121	115	110	61	79	130	153	58



Common Cause

ucl	188
mean	110
target	100
lcl	31

Commentary:

No exceptions.

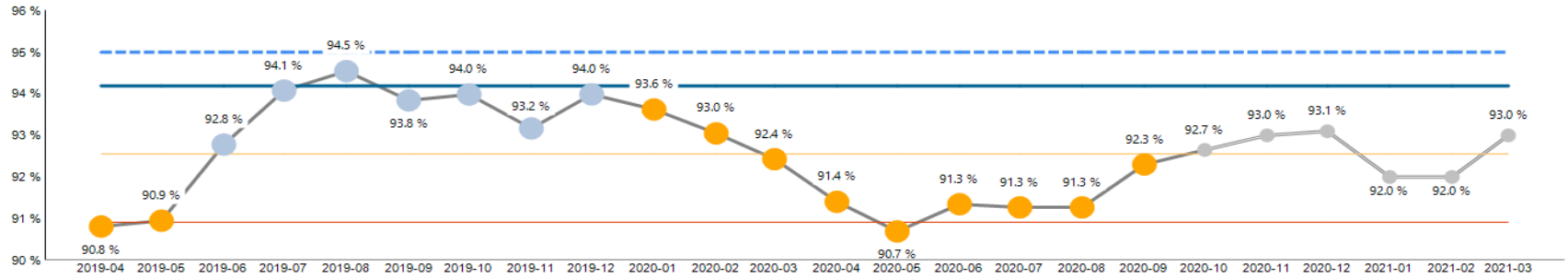
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Mandatory Training Compliance

Percentage of completed mandatory training

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
>=95%	90.8%	90.9%	92.8%	94.1%	94.5%	93.8%	94.0%	93.2%	94.0%	93.6%	93.0%	92.4%	91.4%	90.7%	91.3%	91.3%	91.3%	92.3%	92.7%	93.0%	93.1%	92.0%	92.0%	93.0%



Common Cause

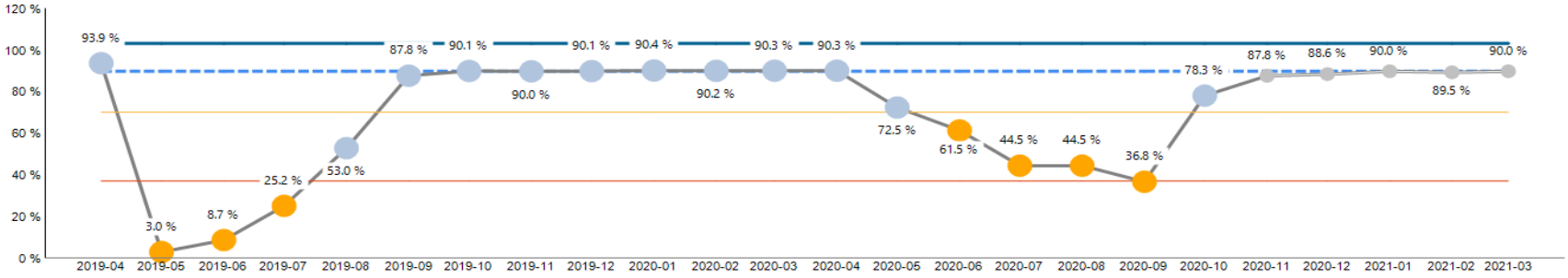
ucl	94.19%
mean	92.55%
target	95.0%
lcl	90.91%

Commentary:

Appraisals Compliance

Percentage of annual appraisals completed

Target	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
>=90%	93.9%	3.0%	8.7%	25.2%	53.0%	87.8%	90.1%	90.0%	90.1%	90.4%	90.2%	90.3%	90.3%	72.5%	61.5%	44.5%	44.5%	36.8%	78.3%	87.8%	88.6%	90.0%	89.5%	90.0%



Common Cause

ucl	103.41%
mean	70.29%
target	90.0%
lcl	37.16%

Commentary:

No exceptions to note.

Board of Directors (in Public)
Item 5.2

Subject: **Freedom to Speak Up Annual Report**
Date of meeting: **Tuesday, 27th April 2021**
Prepared by: **Peris Widdows, FTSU Guardian**
Presented by: **Peris Widdows, FTSU Guardian**
Purpose of Report: **To Note**

BAF Ref	Impact on BAF
BAF1-4	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

This paper provides a reflection on the work undertaken during the fifth year of implementation and its effectiveness in supporting positive cultural change through enabling staff to freely speak up.

There has been an increase in FTSU concerns in 2020/21, undoubtedly linked to the coronavirus pandemic and requirement for many staff to work differently.

A summary of FTSU activity over the last 12 months is provided 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 annual report and progress made to date.

2. Background

The 2020/2021 financial year has marked the fifth year of the Freedom to Speak up Guardian (FTSUG) role and that of the Freedom to Speak Up (FTSU) Champions Network.

During the year a new FTSU Guardian was appointed, following the departure from the Trust of the previous post-holder and the network of FTSU Champions has been refreshed.

The Trust has in place a Freedom to Speak up Policy the role of the FTSUG supports the Trust's well -embedded culture of safety. An escalation procedure has been adopted this year to formalise the timely notification of concern themes as they arise to the Chief Executive and relevant Executives. This provides the opportunity to triangulate with any other related issues and supports early intervention from management and/ or HR if required.

The Chief Executive regularly re-emphasises her personal pledge to all staff that they have a duty to speak up and when they do so, there concerns will be investigated and they will be protected from any detriment as a result of speaking up.

At a National Level, the Office of the National Guardian (NGO) continues its work to make speaking up business as usual across the health sector through development, promotion, support and expansion of a network of Freedom to Speak Up Guardians, to support workers within their organisations to speak up - aims: to effect speak-up culture change. The NGO also supports and challenges the health system in England on all speaking up matters and new national initiatives for 2020/21 focus on training support, including:

- Review and update in October 2020 of Speak-Up Core training for all workers: https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/
- Newly launched Listen-Up training – "for all line and middle managers, focussed more on listening up and the barriers that can get in the way of speaking up." https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/
- Coming soon: Follow Up Training – "for all senior leaders including executive board members (and equivalents), Non-Executive Directors, and Governors to help them understand their role in setting the tone for a good speaking up culture and how speaking up can promote organisational learning and improvement"

3. LHCH Key Achievements - organisational

Responding to both our local and national context, key achievements during 2020/21 include.

- Appointment of new FTSUG following the exit of the previous FTSUG to take up a post in another trust,
- Refreshing of the FTSU Champion's Network and ensuring this is a diverse and representative of the workforce.
- Staff survey 2020: LHCH ranked top or above average for key questions compared to other Acute Specialist Trusts with 73.3% of LHCH respondents agreeing or strongly agreeing that they feel safe to speak up about concerns. The results of LHCH staff survey questions that relate to the FTSU index are available on table 6.1.
- Shared learning and improvements from FTSU speak-ups (refer paragraph 5)
- Strengthened governance arrangements (refer paragraph 8)
- Benchmarking and reporting of LHCH against NGO case reviews in quarterly FTSUG reports to identify any learning from other organisations.
- FTSU maintains a high profile within the organisation, examples outlined below:
    - FTSU monthly presentation at team brief
    - FTSU Awareness Month – October 2020
    - Participation at Safety Surveillance Group
    - FTSUG active member of the Equality and Inclusion Steering Group
    - FTSUG involvement in Trainee Doctors forum.
    - Dedicated intranet page available to all staff

4. Concerns Raised 2020/21

- 34 Concerns were raised to the FTSU Guardian and/or champions in 2020/21 (compared to 19 in 2019/20, which reflects a 78% increase of speak-ups through the FTSU policy, compared to 2019/20 figures). This increase is undoubtedly linked to the coronavirus pandemic which has seen many staff working differently and anxieties linked to resilience and wellbeing.
- Categories of concerns raised in the year are available on the table 4.1 below. These include concerns that relate primarily to patient safety and staff values and behaviours but also some issues associated with working practices and system processes.
- Of the concerns raised, 2 have been raised anonymously.
- All concerns were escalated within 24 hours of receipt, investigated, and actioned appropriately.
- At the point of writing, 23 concerns are closed; other cases at different stages of investigations, under review or awaiting outcomes.
- The detail of concerns raised have been reported quarterly throughout the year – Appendix 1 provides the detail of concerns raised during Quarter 4

Note: These concerns relate only to those raised directly through the FTSU Guardian / Champions route. Concerns raised through other channels e.g. through the safety huddle, Datix reports, with line managers or through Human Resources are not logged here, unless referred to the FTSU Guardian.

4.1 The table below shows the concerns raised in 2020/21 as categorised by the NGO

Concerns raised	Bullying and Harassment	Patient Safety	Other	Total
Q1	2	0	3	**5**
Q2	2	1	4	**7**
Q3	4	2	3	**9**
Q4	2	4	7	**13**
Total	**10**	**7**	**17**	**34**

Of the 17 concerns raised in the 'Other' category, 13 were related to system processes, working environment and working practices, 3 were to COVID–19 anxiety or guidance related: (PPE, social distancing) and 1 was to related racist comment which has been investigated and ruled out as a misinterpretation.

All concerns were acknowledged with 24 hours of the speak-ups. Of the 34 concerns raised, 23 are closed. The rest of the concerns have been progressed and awaiting outcomes or are under investigations. Further details of concerns raised in Q4, 2020/21, including actions and outcomes can be seen in Appendix 1.

4.2 The table below shows a year on year comparator of concerns raised.

Year	Bullying and Harassment	Patient Safety	Other	Total cases raised
2017/18	9	6	2	**17**
2018/19	10	6	9	**25**
2019/20	7	1	11	**19**
2020/21	10	7	17	**34**

The increase in concerns raised this year can be expected given the ongoing coronavirus crisis, which has impacted upon roles and brought many changes as well as impacting on stress and anxiety. Whilst the Trust continues to put patient and staff safety at the centre of its work, there is still work to do to improve culture and values and behaviours within some pockets of the organisation.

4.3 The table below reflects the professional level of individuals who spoke up for each quarter of 2020/21, as per the latest reporting guidance issued by the National Guardian Office:

Concerns raised by staff bands	**Worker**	**Senior Manager**	**Senior Leader**	**Unknown / Not disclosed**
Q1	5	0	0	0
Q2	3	2	1	1
Q3	8	0	0	1
Q4	12	0	0	1
Total	**28**	**2**	**1**	**3**

4.4. The table below reflects the professional groups of the 'speak ups' for each quarter 2020/21 as per the current National Guardian Office guidelines.

Concerns raised by professional group	Medics	Registered nurse & Midwives/ ANP	Nursing Assistants & HCA	Allied Health Practitioners	Admin, Clerical	Maintenance / Ancillary/ Cleaning/ Catering	Corporate Service Staff	Unknown
Q1	0	2	0	0	0	0	2	0
Q2	0	3	0	1	0	1	2	1
Q3	2	2	2	1	2	0	0	0
Q4	1	4	1	4	2	0	0	1
Total	**3**	**11**	**3**	**6**	**4**	**1**	**4**	**2**

In keeping with the national trend nurses raised the most concerns with concerns ranging across all the themes and categories. Allied Health Practitioner staff was the second biggest group.

5. Learning from speak ups

Learning from speak ups is a key priority from both the Trust and NGO perspective.

One example of shared learning from the speak-ups arose from concerns raised by group of Trier 1 doctors in Q3; an action plan was created, which was reviewed by the executive team and will be circulated in the next issue of Sharing and Organisational Learning (SOLE) bulletin.

Some of the areas of the improvements identified included:

- Enhancement of teaching by engaging in more discussion and encouraging T1s to present case studies (looking at journal club concept).
- The need for dedicated teaching space and resources: looking at a current refurbishment project which will allow for dedicated teaching space and resources.
- Looking at 'The Modern Ward Round' to see what can be adapted.
- Looking to see if there is a more streamlined and efficient system to fill locum gaps and offer pay rates more comparable to other trusts in the region.
- Regular 'checking in' process to seek feedback from Tier 1s.
- Regularly reminding consultants of responsibilities around teaching and using ward rounds to teach.

Dr James Greenwood is leading the delivery of the action plan.

Similarly in Radiology, a number of speak ups informed a comprehensive OD review led by the Division of Clinical Services and a detailed action plan was shared at Operational Board and will be monitored via Divisional Governance. The Radiology Department has also nominated a new FTSU Champion who is engaged in the delivery of the action plan.

6. Comparative Review of Organisational Performance in relation to FTSU

The National Guardian's Office, working with NHS England, has brought together four questions into the NHS Staff Survey, relating to whether staff feel knowledgeable, secure and encouraged to speak up and whether they would be treated fairly after an incident, which are:

- If you were concerned about unsafe clinical practice, would you know how to report it?
- I would feel secure raising concerns about unsafe clinical practice
- I am confident that my organisation would address my concern
- I feel safe to speak up about anything that concerns me in this organisation

6.1 The table below provides the LHCH score to the Freedom to Speak Up questions, benchmarked against the National Average and Best Scores:
https://www.nhsstaffsurveyresults.com/wp-content/uploads/2021/03/!sta$$21!/NHS_staff_survey_2020_RBQ_full.pdf

LHCH ranked top on three of the FTSU questions and above the national average score in one.

7. Internal Evaluation

Where possible and once the case is closed we ask the following questions in line with national guidance to those who have spoken up:

"Given your experience would you speak up again?" Yes/No/Maybe/Don't Know
"Please explain your response"

In 2020/21:

5 speak ups' have responded Yes
0 Maybe
6 haven't responded
11 cases are in progress or awaiting follow up
8 cases have not been asked which includes 2 anonymous cases.
4 speak ups' staff have left the Trust (some were on rotation or temporary workers).

Feedback comments include:

- "Speaking to yourself and others did make me feel better within myself as I felt for the first time I was actually being understood and listened to so I want to thank you for listening and supporting me. …."
- "Listened, polite, kind and caring."
- "……I did feel that on the occasion I raised a concern, I was happy to be able to have a contact FTSUG to talk to and note the concern prior to escalation. ….following my chat with FTSUG and obtaining psychology support, I was more confident to speak out to my line manager. …..I was given the chance to off load at my follow up meeting and I explained that since my initial chat with FTSUG …… I did feel FTSU were happy that I had addressed some concerns."
- "I believe a problem shared is sometimes a problem halved, I never want myself or any other member of staff to feel like they wasn't being listened too. This can affect

mental and physical health. Sometimes all it takes is for someone impartial to listen and maybe they have an insight to how the problem can be resolved quicker, they bring a new perspective on the problem.

- "Speaking up allowed the situation explained to the FTS Lead to be highlighted and kept on the radar. Speaking to the FTS Lead provided me with the assurance that the Department Head would take the matter seriously and action as appropriate."
- "Whilst some staff don't feel confident in addressing issues directly with managers or senior staff or feel they couldn't do so without risk of putting their foot in their mouth its reassuring to know that they have a voice through FTSU and someone is listening."

8. Governance

In 2020/21 the governance processes linked to FTSU were reviewed and strengthened as follows:

- An escalation process was documented and approved to ensure timely communication of themes to the CEO and other Directors, as required.
- Quarterly meetings established between the FTSUG, Director of Corporate Affairs, NED Lead for FTSU and the Chair to brief on the issues raised, actions taken and learning.
- Quarterly 'Improving People Practices' meeting between the FTSUG, Director of Corporate Affairs, Chief People Officer and HR Business Partner. This enables FTSU concerns to be triangulated with ongoing employee relations cases and facilitates a review of welfare support being given to any staff member undergoing an HR process.
- Cessation of the FTSU summit in favour of participation by the FTSUG and Director of Corporate affairs in the quarterly Safety Surveillance meetings to triangulate FTSU with other patient safety metrics.

These developments supplement the routine 1:1 meetings between the FTSUG and Director of Corporate Affairs; and cascade of any learning via the monthly team brief and SOLE bulletin.

9. Next Steps

During 2021/22, the FTSU agenda will be progressed as follows:

- Revisit and launch FTSU Strategy (this was paused in 2020/21 due to the coronavirus pandemic) and ensure it is aligned with the new Quality and Safety Strategy.
- FTSU to develop a mechanism for regular engagement with the new FTSU champions and to facilitate their learning and development in relation to FTSU.
- Facilitate a Board review of the national self-assessment toolkit for FTSU which is due for review by November 2021
- Review the Freedom to Speak Up (Raising Concerns) policy which is due in July 2021.
- Plan for FTSU awareness month – October 2021
- Continue to engage with the National Office and regional network to ensure LHCH continues to lead the way in relation to best practice.
- Review NGO Annual Report 2020 – learning and updates will be reported to BoD in the next quarter.
- The FTSU Guardian will continue to provide reports as follows:
  - Updates to the BoD quarterly on the number of concerns raised through the FTSU Network and any common themes an annual report to the Board of Directors;
- Regional and national meetings/conferences have been on hold for due to CoVid-19 pandemic – FTSUG to regain attendance as soon as they commence again.

10. Recommendations

The Board of Directors is asked to:

i) note the annual report;
ii) note the Q4 concerns raised (Appendix 1)

iii) accept assurance that local FTSU arrangements are in place and meet best practice guidance

References:

NATIONAL GUARDIAN FREEDOM TO SPEAK UP: Annual Report 2020: [Online] Available at: https://www.nationalguardian.org.uk/wp-content/uploads/2021/03/ngo_ar_2020_digital.pdf Accessed on: 14th April 2021.

NATIONAL GUARDIAN FREEDOM TO SPEAK UP: News: Leeds Community Healthcare Trust wins 2020 Freedom to Speak Up Organisation of the Year HSJ Award [Online] Available at: https://www.nationalguardian.org.uk/news/leeds-community-healthcare-trust-wins-2020-freedom-to-speak-up-organisation-of-the-year-hsj-award/ Accessed on: 14th April 2021.

NATIONAL GUARDIAN FREEDOM TO SPEAK UP: Next Steps: Priorities 2020- 2021: [Online] Available at: https://www.nationalguardian.org.uk/wp-content/uploads/2020/04/ngo_priorities_2020-2021.pdf Accessed on: 7th April 2021

NHS ENGLAND: Survey Coordination Centre. Liverpool Heart and Chest Hospital NHS Foundation Trust 2020 NHS Staff Survey Benchmark Report: [online] Available at: https://www.nhsstaffsurveyresults.com/wp-content/uploads/2021/03/!sta$$21!/NHS_staff_survey_2020_RBQ_full.pdf Accessed on: 22nd March 2021.

Appendix 1:

The table below provides further details of the concerns raised in Q4 2020/21, with actions taken and outcomes at the time of writing.

Category	Detail	Action	Outcome
1: Patient Safety	• Patient fall: Incident was reported on Datix. • Concerns relating to departmental falls /emergency policies and staffing levels.	This is one of 4 concerns raised in the same department. All 4 were reported to Divisional Director and Senior Management team and actioned jointly.	Comprehensive action plan which was presented to OB in March; to be reviewed and updated at bi-monthly departmental operational meeting; implementation of action plans in progress. • Patient Fall – Full RCA completed and ready for presentation to Department Audit Day. • All staff have been debriefed and reminded (also in writing) of process for responding to an emergency / deterioration in patient condition.
2: Patient Safety and Other: Working practices	Lack of blood sugar monitoring equipment in the department.	Escalated to Divisional Director and Senior Management team as above.	• Staff aware of need to access equipment as needed from OPD but decision made to acquire a blood glucose machine for the dept. and ordered. • The action plan references need for skills in use of this to be refreshed. • Blood sugar monitoring: all staff have been re-educated on process
3: Patient Safety and other: Working practices	Poor layout of patient waiting areas & lack of sub-receptionist impacting on staff work load and patient safety (temporary issues arising from building works)	Escalated to Divisional Director and Senior Management team as above.	• Action plan in place with Estates Department. • Communication between managers and local team in place to update on progress.
4: Other: Working Practices	Concern relating to working processes, and perception of unbalanced shift rostering and unfair application of flexible working policy.	Escalated to Divisional Director and Senior Management team as above.	• Managers met with the team member and options discussed. • A piece of work has been commissioned to reviewed cultural issues in the department.

5: Patient Safety and System Processes	Concern about staffing levels which could impact on ability to provide safe patient care; work related stress and anxiety. Feelings of a lack of satisfaction to resolution of previous speak-up.	Highlighted to Highlighted to Director of Nursing	DoN and Divisional Matron review of staffing and satisfied that this matched the acuity of patients. HoN will continue working with staff to gain regular feedback and team member receiving support. A review of ward leadership is underway.
6: Bullying and Harassment (Staff values and behaviours)	Team member concerned for colleagues have experienced bullying behaviour from a supervisor.	Concern highlighted to departmental manager.	Escalated to senior manager for review. Senior Manager will maintain regular presence in the department to make observations and support staff as necessary.
7: Patient Safety	Team member concerned whether there was sufficient doctor coverage at COVID Vaccination to deal with anaphylaxis.	Directed to the Deputy Medical Director happened to be in the department at the time.	Team member reassured about the high level of training provided to the Vaccination Team and emergency escalation processes already in place in the trust and accessible to the Vaccination Centre.
8: Working Practices/ Bullying and Harassment	Anonymous letter sent to Director of Nursing and Chief People Officer.	DoN met with Head of Nursing.	• A full review of the issues raised was undertaken by HoN & matron. • Concerns had previously been dealt with and this was an historic issue. • Agreement: - Nursing Leadership and FTSUG and to maintain visibility in the department. - Continued review.

9, 10,11: (Three related concerns) Other: System Processes (working practices)	Disruption in working environment impacted by the national COVID Vaccination in the trust; anxiety around social distancing and noise levels in working environment.	Escalated to the senior managers for two teams concerned.	• Liaisons commenced between the two teams to improve communication and team support while accommodating COVID Vaccination at a national level. • Alternative working processes for the team
12: Other: System Processes and: (Staff behaviours)	Department undergoing organisational change. Team member unhappy with proposed changes to working patterns and terms of referral for an Occupational Health Assessment.	Referred to Head of Nursing to facilitate a review.	HoN met with team member and also with line manager to review the OH referral; facilitated meetings with the team are in progress.
13: Other: System Processes and (Staff behaviours)	Department undergoing organisational change. Team member voicing unfair rostering of shift patterns between two teams causing strained team dynamics.	Referred to Head of Human Resources & Divisional Head of Operations	Facilitated meeting with the collective in progress.

Board of Directors (in Public)
Item 5.3*

Subject: **NHS Constitution: Compliance Report**
Date of Meeting: **Tuesday 27th April 2021**
Prepared by: **Sue Pemberton, Director of Nursing, Quality & Safety**
Karen Nightingall, Chief People Officer
Presented by: **Sue Pemberton, Director of Nursing, Quality & Safety**
Karen Nightingall, Chief People Officer
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
BAF 1, BAF 4	Annual report on compliance with NHS Constitution with some areas for improvement.

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 Board of Directors is required to ensure that the Trust is compliant with the legal requirement to "take account of the NHS Constitution in provision of health care services for the purpose of the NHS". All NHS organisations are legally required to take account of the NHS Constitution in performing their NHS functions. This is also a legal requirement of our Provider Licence under Condition G6 Systems for Compliance with Licence Conditions and Related Obligations Section 1 (c) 'requirement to have regard to the NHS Constitution in providing health care services for the purpose of the NHS'. The NHS Constitution establishes the principles and values of the NHS in England. It sets out the rights that patients, public and staff are entitled to and the pledges which the NHS is committed to achieve together with responsibilities that the public patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

Compliance with the patient and staff pledges of the NHS Constitution has been assessed for LHCH for the year 2020/21. This paper outlines the rights, pledges, legal duties and

expectations that the NHS is committed to achieve for patients and staff and gives evidence of compliance with meeting these and the actions to ensure all areas achieve full compliance. (Appendix 1)

On 23rd March 2020 a lockdown was ordered throughout the UK due to Covid 19 pandemic. The pandemic changed the way NHS services could function. Restrictions were placed on how patients could access services. Emergency services continued whilst all other elective work ceased, in order to protect the services needed to treat patients as a consequence of the pandemic. Changes to performance have occurred as a consequence to the pandemic. This is reflected in this report for the period 2020-2021.

2. Findings

Overall, the Trust has assessed itself as compliant in all areas for the NHS Constitution with the exception of the element in relation to access to services. This has been driven by the national response to the covid 19 pandemic which is still currently in progress. The Government published emergency laws in March 2020 which to support them in their decision making to respond to the pandemic to maximise the safety of patients during this time. The impact of the covid pandemic has resulted in many patients being delayed in accessing the treatment they have required during this time and patients are now waiting longer to be treated.

With regard to the workforce in LHCH the 2020 NHS Staff Survey Results were extremely positive across all themes and there were a number of areas, as reported in the Staff Constitution section, with slight or significant improvement. Overall, LHCH ranked number 1 for overall positive scores compared to other Acute Specialist Trusts. LHCH also reported the top specialist trust score for 5 out of the 10 overall key themes, including;

- Equality, diversity & inclusion
- Immediate managers
- Safety culture
- Staff engagement
- Team working

Staff at LHCH report some of the highest level of positive experience amongst all organisations that worked with Picker for 2020, relating to:

- Staff being able to show initiative and make improvements happen in their area of work
- Relationships with immediate managers
- Relationships with senior managers

where the Trust was the best against its peer group of specialist trusts.

However, there remains scope for further improvement in the area highlighted in red within the Staff Constitution section in relation to the following two themes within the NHS Staff Survey 2020, ‘Quality of Care’ and ‘Safe Environment - violence’ themes

3. Recommendation

The Board of Directors is asked to receive the assessment of compliance in the majority of areas within n the NHS Constitution with the exception of the rights for access to services as a result of the covid 19 pandemic.

The Board of Directors to note the areas for improvement.

Appendix 1

Patients' Rights

1. Access to Health Services			
Pledges: • To provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution; • To make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered • To make the transition as smooth as possible when you are referred between • Services, and to put you, your family and carers at the centre of decisions that • Affect you or them.			
Rights	**Evidence**	**RAG**	**Compliant/Non-Compliant**
You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.	• CCG and specialised commissioned services are provided free of charge.		Compliant
You have the right to access NHS services. You will not be refused access on unreasonable grounds.	• Access to services through Choose & Book was restricted during covid 19. The Trusts PPCI/Emergency pathways have all been offered throughout the pandemic • There is a 24 hour open access policy for patients who have cystic fibrosis and a 24 hour advice line.		Non-compliant during covid 19 pandemic. .
You have the right to Receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.	• EPR Flow sheets for specific care needs. Opportunity to record when a patient has enhanced needs and to specify the care that is required. • Visiting has been suspended during the covid pandemic apart from cases where patients are at the end of life or have enhanced care needs. • We have a clinical lead for dementia.		Compliant
You have the right to expect your NHS to assess the health requirements of your community and to commission and put in	• Commissioning plans in place to commission services. • LHCH Specialised commissioning contract meetings in place however these were suspended during		Compliant

place the services to meet those needs as considered necessary and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community	the pandemic. • Waiting targets performance reported to Trust Board.		
You have the right, in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment which would be available to you through your NHS commissioner.	• Commissioner responsibility		Compliant
You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.	• LHCH Single Equality Scheme in place. • Equality & Inclusion Steering Group in place to monitor Trust's performance inclusive of BAME. • Equality impact assessment on policies/plans on-going • Interpreter service is available at all times for patients and families.		Compliant
You have the right to access certain services commissioned by NHS Bodies within maximum waiting times or for the NHS to take all reasonable steps to offer you a range of alternative suitable providers if this is not possible.	• Waiting times monitoring has been monitored by the Trust however elective activity was suspended during covid. • As a tertiary centre we have a number of late referrals and complex patients to manage who cannot be treated within these defined targets. We also carry out a number of procedures which other local units could not perform. We treat patients in order of clinical need and any patients who express any concerns with their waiting times who be reviewed by the clinical team and if appropriate discussions held with patient regarding options and choices.		Non-Compliant

2. Quality of Care and Environment			
Pledges: • To identify and share best practice in quality of care and treatments			
Rights	**Evidence**	**RAG**	**Compliant/Non-Compliant**
You have the right to Be treated with a professional standard of care, by appropriately qualified and experienced staff in a properly approved or registered organisation that meets required levels of safety and quality.	• CQC registration maintained without conditions • NHSI quarterly reporting in accordance with Licensing • NPSA alerts regarding patient safety issues. • Adherence to NICE guidance • Quality Strategy • Trust Safety Huddle • Monthly review of nurse staffing – reported to Board of Directors – this was suspended for periods during the pandemic. • Compliance with Employment Check Standards • Mandatory Training Compliance & levels of attainment • Revalidation & Appraisal adherence		Compliant
You have the right to Be cared for in a clean, safe, secure and suitable environment. You have the right to receive suitable and nutritious food and hydration to sustain good health and wellbeing.	• Place Results good • EECS award status all wards are assessed for Excellent safe and Compassionate care • Infection and Control standards across all clinical areas		Compliant
You have the right to Expect NHS organisations to monitor and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.	• Quality Accounts were produced in 2020/21 although in a limited format. • Internal clinical and non-clinical audits are undertaken against standards however were paused during the pandemic. • PLACE audits demonstrate clean and safe environments • Patient and family feedback • National in patient survey Programme • Quality Strategy • Family Experience and monthly		Compliant

	and annual patient and family shadowing programme across the Trust – patient and family centred care approach • Performance dashboards used • Follow up calls in place for patients discharged during the pandemic.		
3. Nationally approved treatments, drugs and programmes			
Pledges: The NHS commits to provide screening programmes as recommended by the UK National Screening Committee			
Rights	**Evidence**	**RAG**	**Compliant/Non-Compliant**
You have the right to drugs and treatment that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you	• Medicines Policy • NICE guidance adherence monitored via formulary audit • Area Prescribing Committee recommendations included in local formulary and audited • Antibiotic prescribing policy • Drug and Therapeutics Committee monitors annual audit plan • Medication Safe Practice Committee Annual report and monitoring by exception at patient and family experience committee • Anticoagulation policy – monitored and audited at Drug and Therapeutics committee (includes NICE recommendations re NOACS) • QPFEC monitors all aspects of quality and safety		Compliant
You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or	• Medicines Policy • Senior pharmacists attend Area Prescribing Committee to discuss local decisions and attend New Medicines sub-committee • Antibiotic prescribing policy • Medicines Safety Committee		Compliant

treatment you and your doctor feel would be right for you, they will explain that decision to you.	• NICE guidance adherence monitored and influence by senior pharmacy attendance at the area prescribing committee • Drugs and therapeutic committee • AMD decision making on individual patient basis		
You have the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS provided immunisation programme	• N/A National Programme		Compliant
4. Respect, Consent and Confidentiality			
Pledges: • To ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively • If you are admitted to hospital you will not have to share sleeping accommodation with patients of the opposite sex except where appropriate in line with details set out in the handbook to the NHS Constitution • To anonymise the information collected during the course of your treatment and use it to support research and improve care for others • Where identifiable information has to be used, to give you the chance to object wherever possible • To inform you of research studies in which you may be eligible to participate • To share with you any correspondence sent between clinicians about your care			
You have the right To be treated with dignity and respect, in accordance with your human rights.	• Dignity and Respect Policy in place • Clinical care policies, procedures and guidance are in place. These are subject to impact assessments. • Compliance with mixed sex accommodation – monthly returns completed • Chaperone Policy • Patient Experience Survey • Learning from complaints monitoring • Family experience survey • Action plans from inpatient survey		Compliant
You have the right to be	• Safeguarding ambassadors		Compliant

protected from abuse and neglect and care and treatment that is degrading	trained to level 3 • Safeguarding policies and procedures in place for both Adults and Children. • Mental capacity act policy. • Domestic violence policy • Privacy and dignity policy • Deprivation of liberty policy		
You have the right To accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must in your best interests	• A range of clinical care policies, procedures and guidance are in place - these are subject to impact assessments. • Chaperone Policy adhered to. • Treatments are explained to patients as far as possible and repeated if necessary. • Consent policy and consent audits undertaken • Learning from complaints monitoring • Vulnerable children/adults safeguarding policies in place • Learning disability hospital passports in place • MCA/DoLs policies are in place • LD training now in place for all staff • LD ambassadors across the trust		Compliant
You have the right to privacy and Confidentiality and to expect the NHS to keep your confidential information safe and secure.	• Data Security and Protection Toolkit compliance • 8 years significant assurance audit opinion on IG Toolkit submissions • Information Governance Framework including Caldicott guardian, SIRO, IG Team, Data Protection Officer ○ Information Governance Policies ○ Information Governance Policy ○ Data Protection		Compliant

	Policy ○ Code of Conduct for Handling Personal Data ○ Information Security Management System and Standards ○ Information Risk Policy • Mandatory induction and annual training and awareness for Trust staff • Individual outpatient consulting rooms • GDPR implementation and action plan 2018/19 ensuring legal basis for data processing documented • Nil reportable data security breaches within last 5 years • Organisational culture for learning and sharing, learning from complaints • Contractual and data sharing agreements with NHS organisations • Data Protection Impact Assessment processes for new technology or changes in data processing activities • EECS assessments at ward and department level • Detailed and informative guidance and information available for patients via the Trust website: • http://www.lhch.nhs.uk/about-lhch/information-governance/data-protection-and-confidentiality/ • LHCH patient experience surveys • Information / Data Security external audit and assurance		
You have the right to be informed about how your information is used.	• GDPR Privacy Notice (legal requirement): • http://www.lhch.nhs.uk/about-lhch/information-		Compliant

	governance/data-protection-and-confidentiality/privacy-notice/ • Consent processes for audit and research i.e. non direct care uses of data • Patient awareness materials – 'In Confidence' patient leaflet and various other patient information leaflets: • http://www.lhch.nhs.uk/our-patients/patient-information-leaflets/ • Mandatory induction and annual training and awareness for Trust staff regarding obligations to inform patients • LHCH patient experience surveys		
You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered and where your wishes cannot be followed, to be told the reasons including the legal basis.	• GDPR Privacy Notice (legal requirement): • http://www.lhch.nhs.uk/about-lhch/information-governance/data-protection-and-confidentiality/privacy-notice/ • Data Processing Request Process including objections, opt outs, restriction of data processing etc.: • http://www.lhch.nhs.uk/about-lhch/information-governance/data-protection-and-confidentiality/data-processing-requests/ • Consenting for Research Policy • Data Protection Policy • LHCH patient experience surveys • Patient and Family Support Team • Being Open Policy		Compliant
5. Informed Choice			
Pledges : • To inform you of healthcare services available to you, locally and nationally			

• To offer you easily accessible, reliable and relevant information in a form that you can understand, and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available			
You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons	• N/A Primary Care		
You have the right to express a preference for using a particular doctor within your GP practice and for the practice to try to comply.	• N/A Primary Care		
You have the right to transparent, accessible and comparable data on the quality of local health care providers and on outcomes as compared to others nationally	• FFT national data set • Patient opinion website		Compliant
You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs. Details are set out in the Handbook to the NHS Constitution	• Patient Information • Leaflets • Leaflets are also available in alternative formats such as large print Braille alternative languages and audio. • Leaflets are available for download on the internet/intranet • Information on National ratings on NHS Choices Website • CQC ratings • Consultant Profiles on internet • Friends and Family test • CQC websites		Compliant
6. Involvement in your healthcare and in the NHS			
Pledges: • To provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services • To work in partnership with you, your family, carers and representatives.			

• To involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one • To encourage and welcome feedback on your health and care experiences and use this to improve services			
Rights	**Evidence**	**RAG**	**Compliant/Non-Compliant**
You have the right to be involved in planning and making decisions about your health and care, with your care provider or providers including your end of life care and to be given information and support to enable you to do this. Where appropriate this right includes your family and carers. This includes being given the chance to manage your own care and treatment if appropriate	• Decision in clinical care monitored by national survey programme • Information on how to become involved in the design and delivery of services is distributed via the comms team via members matters and corporate communications • Patients and Volunteers are used to comment on patient information • Monitoring through national and internal surveys • Friends and Family test • Bereavement Service • Specialist Nursing services • NHS Choices website • Patient Letters assessment in national survey • Advance care planning		Compliant
You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional has caused, or could still cause, significant harm or death, You must be given the facts, an apology, and any reasonable support you need.	• HALT for patients and families • Speak out safely campaign • Duty of Candour • SI framework • QPFEC – monitoring experience of patients		Compliant
You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and	• Involvement in planning of services has been difficult throughout 2020/21 as governor meetings have been virtual. • When the current pandemic		Compliant

consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the Operation of those services.	restrictions are relaxed Members will be invited directly from the Trust to become involved in setting the Trust quality priorities • Governors are supported in their roles to enable them to represent members effectively. For example, through implementation of the strategy including facilitation of members events in the community. • The Council of Governors represent members of the public and partner organisations and are actively engaged in the Trusts strategic planning. • Patient and family feedback forms • FFT • Engagement with Health watch • Governor and patients involved in service redesign • COG involvement in service planning • Membership events in the Community have been suspended during the pandemic.		

7. Complaint and redress

Pledges:

- To ensure you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and the fact that you have complained will not adversely affect your future treatment
- Ensure that when mistakes happen of if you are harmed when receiving health care you receive an appropriate explanation and apology, delivered with a sensitivity and recognition of the trauma you have experienced and know that lessons will be learned to help avoid a similar incident occurring again.

• To ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services			
Rights	**Evidence**	**RAG**	**Compliant/Non-Compliant**
You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated	• Patient and family support team complaints monitoring reported at Trust Board • Complaints reported within the Annual Report • Internal target for response to complaints set • Update on complaints handling received at Quality and PFEC Committee/Quality committee • Divisional governance committees receive monthly updates on concerns and complaints within their respective areas • Complaints Annual Report presented at Trust Board • All complaints acknowledged within three working days in writing and it they are available discussions take place with complainants regarding expectations • Visible complaints teams in clinical areas		Compliant
You have the right to discuss the manner in which the complaint is to be handled and to know the time period within which the investigation is likely to be completed and the response sent	• Complaints Policy • Patient and family support team reports to the Quality committee and Board of Directors		Compliant
You have the right to be kept informed of progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.	• All complaints are reviewed by and signed off by the CEO • Meetings facilitated by Patient and family support team to discuss individual complaints • Survey of complaint satisfaction • Non-Executive complaints review panel in place • Complainants are asked how they would like to receive their responses in writing/meeting		Compliant

	• Learning from complaints shared with divisions • Governance meetings		
You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS	• Complaints policy in place in accordance with legislation requirements • Reporting of PHSO complaints in annual report • Patients are invited to contact the trust in the first instance following their response if they require further clarity then they are provided with the details of the PHSO if they remain dissatisfied		Compliant
You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority	• Complaints policy in place in accordance with legislation requirements • Claims policy in place		Compliant
You have the right to compensation where you have been harmed by negligent treatment.	• Legal Services Department in place for compensation claims • IICC report received by the Board includes claims		Complaint

Staff Rights

2020 NHS Staff Survey Results

The NHS Staff Survey focuses on 10 key themes. Therefore, comparison against the NHS Constitution Staff Pledges is against the overall theme or individual questions in the themes.

Sections have also been analysed related to:

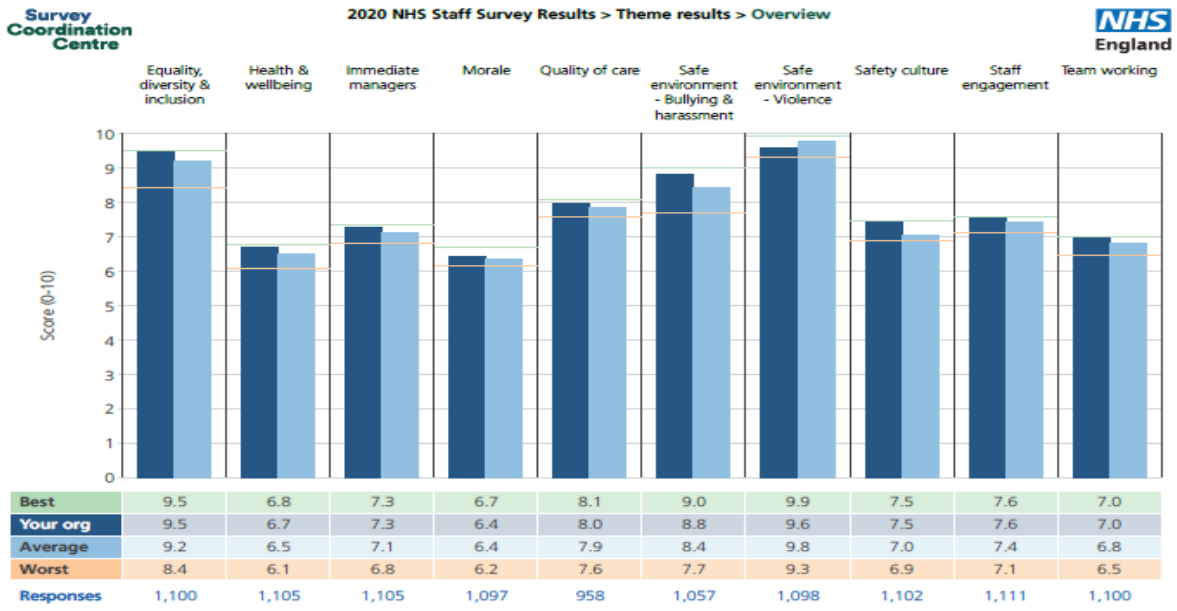
- Equality, Diversity & Inclusion
- Safety Culture
- And Patient Experience.

Graph One (below) provides an overview of the 10 themes within the NHS Staff Survey and our results against our peer (specialist trust) average. LHCH also reported the top specialist trust score for 5 out of the 10 overall key themes, including; Equality, diversity & inclusion, Immediate managers, Safety culture, Staff engagement and Team working

Staff at LHCH reported some of the highest level of positive experience amongst all organisations relating to: Staff being able to show initiative and make improvements happen in their area of work, Relationships with immediate managers and Relationships with senior managers

In addition, Table Two indicates the statistically significant changes year on year for the 11 themes, with Team Working indicating a statistically significant reduction year on year.

Overview of the 11 Key themes – Graph One



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.8	7.3	6.7	8.1	9.0	9.9	7.5	7.6	7.0
Your org	9.5	6.7	7.3	6.4	8.0	8.8	9.6	7.5	7.6	7.0
Average	9.2	6.5	7.1	6.4	7.9	8.4	9.8	7.0	7.4	6.8
Worst	8.4	6.1	6.8	6.2	7.6	7.7	9.3	6.9	7.1	6.5
Responses	1,100	1,105	1,105	1,097	958	1,057	1,098	1,102	1,111	1,100

Significance testing comparing NHS Staff Survey 2019 to 2020 results – Table Two

Survey Coordination Centre

2020 NHS Staff Survey Results > Appendices > Significance testing – 2019 v 2020 theme results

NHS England

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2020 score is significantly higher than last year's, whereas ↓ indicates that the 2020 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.4**	1015	**9.5**	1100	Not significant
Health & wellbeing	**6.5**	1021	**6.7**	1105	Not significant
Immediate managers †	**7.3**	1021	**7.3**	1105	Not significant
Morale	**6.5**	1008	**6.4**	1097	Not significant
Quality of care	**8.1**	890	**8.0**	958	↓
Safe environment - Bullying & harassment	**8.7**	1006	**8.8**	1057	Not significant
Safe environment - Violence	**9.7**	1012	**9.6**	1098	↓
Safety culture	**7.5**	1017	**7.5**	1102	Not significant
Staff engagement	**7.6**	1037	**7.6**	1111	Not significant
Team working	**7.1**	1028	**7.0**	1100	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

† The calculation for the immediate managers theme has changed this year due to the omission of one of the questions which previously contributed to the theme. This change has been applied retrospectively so data for 2016-2020 shown in this table are comparable. However, these figures are not directly comparable to the results reported in previous years. For more details please see the technical document.

STAFF PLEDGE 1 : To provide all staff with clear roles, responsibilities and rewarding jobs

	Change since 2019 survey	Ranking compared with all acute specialist Trusts in 2020
Q18c & Q18d staff recommendation of the organisation as a place to work or receive treatment	Marginal reduction on 2019	*Better than average*
Immediate Managers theme results	Same results as 2019	*Better than average*
Morale theme results	Marginal reduction on 2019	*Better than average*
Team Working theme results	Marginal reduction on 2019	*Better than average*
Staff Engagement theme results	Same result as 2019	*Better than average*

STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential

	Change since 2019 survey	Ranking compared with all acute specialist Trusts in 2019
Immediate Managers theme results	Same result as 2019	*Better than average*

STAFF PLEDGE 3 : To provide support and opportunities for staff to maintain their health, well-being and safety

	Change since 2019 survey	Ranking compared with all acute specialist Trusts in 2020
Health & Wellbeing theme results	Improvement on 2019	*Better than average*
Safe Environment – Bullying & Harassment theme results	Improvement on 2019	*Better than average*
Safe Environment – Violence	Marginal reduction on 2019	*Slightly lower than average*

STAFF PLEDGE 4 : To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services

	Change since 2019 survey	Ranking compared with all acute specialist Trusts in 2019
Staff Engagement theme results	Same result as 2019	*Better than average*

Q9b % reporting good communication between senior management and staff	Reduction on 2019	*Better than average*
Q9c % Senior Managers here try to involve staff in important decisions	Marginal reduction on 2019	*Significantly better than average*
Q9d % Senior Managers act on feedback	Marginal reduction on 2019	*Significantly better than average*

ADDITIONAL THEME: Equality, Diversity & Inclusion		
	Change since 2019 survey	**Ranking compared with all acute specialist Trusts in 2019**
Equality, Diversity & Inclusion theme results	Improvement on 2019	*Better than average*
Q15a % experiencing discrimination at work in last 12 months from patients, relatives or the public	Same result as 2019	*Better than average*
Q15b % experiencing discrimination at work in last 12 months from manager / team leader or other colleagues	Marginal increase on 2019	*Much better than average*
Q14 % Organisation acts fairly with regard to career progression	Improvement on 2019	*Significantly better than average*
Workforce Race Equality Standard - % of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months	Improvement on 2019	*Better than average*
Workforce Race Equality Standard - % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	Improvement on 2019	*Better than average*
Workforce Race Equality Standard - % of staff believing that the organisation provides equal opportunities for career progression or promotion	Significant Improvement on 2019	*Better than average*
Workforce Race Equality Standard - % of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	Significant Improvement on 2019	*Better than average*

ADDITIONAL THEME: Safety Culture

	Change since 2019 survey	Ranking compared with all acute specialist Trusts in 2019
Safety Culture theme results	Same result as 2019	*Better than average*
Q16a % My organisation treats staff who are involved in an error, near miss or incident fairly	Marginal reduction on 2019	*Better than average*
Q16b % My organisation encourages us to report errors, near misses or incidents	Marginal improvement on 2019	*Better than average*
Q16c % When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	Marginal improvement on 2019	*Better than average*
Q16d % We are given feedback about changes made in response to reported errors, near misses and incidents	Marginal reduction on 2019	*Better than average*
Q17a % If you were concerned about unsafe clinical practice, would you know how to report it?	Marginal improvement on 2019	*Better than average*
Q17b % I would feel secure raising concerns about unsafe clinical practice	Marginal improvement on 2019	*Better than average*
Q17c % I am confident that my organisation would address my concern	Marginal reduction on 2019	*Better than average*

ADDITIONAL THEME: Patient experience measures		
Q18a % Care of patients / services users is my organisation's top priority	Same result as 2019	*Better than average*
Q18b % My organisation acts on concerns raised by patients / service users	Same result as 2019	*Better than average*
Q7a % I am satisfied with quality of care I give to patients/service users	Reduction on 2019	*Better than average*
Q7b % I feel my role makes a difference to patients/service users	Reduction on 2019	*Better than average*

Q7c % I am able to provide the care I aspire to	Reduction on 2019	*Better than average*

Staff Rights

Number one: Have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives			
Rights	**Update**	**RAG**	**Compliant/Non-Compliant**
To fair treatment regarding leave, rights and flexible working and other statutory leave requests relating to work and family, including caring for adults that you live with.	Equality and Inclusion Strategy Special Leave and Toolkit Flexible Working Bullying and Harassment Policy Health and Wellbeing Group Flexible Retirement Policy Buying of Annual Leave Carers Group 2021 People Plan		Y
To request "other" reasonable time off for emergencies (paid and unpaid) and other statutory leave subject to expectations.	Special Leave Policy Flexible Working Policy		Y
To expect reasonable steps are taken by the employer to ensure protection from less favourable treatment by fellow employees, patients and others (e.g. bullying and harassment).	Equality and Inclusion Policy Equality and Inclusion Strategy Equality and Inclusion Steering Group Staff Survey Results and Action Plans Bullying and Harassment Policy Health and Safety Group Report Leadership Training Whistleblowing / Freedom to Speak Up/Speak Out Safely Inclusion Events		Y
Number two: Have a fair pay and contract framework			
Rights	**Update**	**RAG**	**Compliant/Non-Compliant**
To pay: consistent with the national minimum wage or alternative contractual agreement.	Agenda for Change Pay Scale Consultant Contract Job Evaluation Process		Y
To provide fair treatment regarding pay.	Apprenticeships Disciplinary Policy Freedom to Speak Up		Y
To be accompanied by either a trade union official or a work colleague at disciplinary or grievance	Maintaining High Professional Standards (MHPS) Grievance Policy Bullying and Harassment Policy		Y

hearings in line with legislation, your employer's policies or your contractual rights.	Annual Audit to People Committee on Employment Relations Work Monthly update to Executive Team on Employee Relations work Partnership Forum Informal Staff Side Meetings Organisational Change Policy Improving People Practices		
To consultation and representation either through the trade union or other staff representatives (e.g. where there is no trade union in place) in line with legislation and any collective agreements that may be in force.	Human Resources policies as above Partnership Forum Local Negotiating Committee Staff Governors People Delivery Group Staff "Big Conversations" Inclusion Events & network development Junior Doctors' Forum Guardian of Safe Working Access to regional staff equality networks		Y
Number three: Have healthy and safe working conditions and an environment free from harassment, bullying or violence			
Rights	**Update**	**RAG**	**Compliant/Non-Compliant**
To work within a healthy and safe workplace and an environment in which the employer has taken all practical steps to ensure the workplace is free from verbal or physical violence from patients, the public or staff, to work your contractual hours, take annual leave and to take regular breaks from work.	Bullying and Harassment Policy Disciplinary Policy Grievance Policy IMPACT – Values and Behaviours Framework 2019 Staff Survey Action Managing Violent and Anti-Social Behaviour Freedom to Speak Up Policy Freedom to Speak Up Guardian and Champions Freedom to Speak Up Summits & Quarterly reports to the Board Junior Doctors' Safe Working Report Supporting staff following a traumatic or stressful incident policy		Y
Number four: Be treated fairly, equally and free from discrimination			
Rights	**Update**	**RAG**	**Compliant/Non-Compliant**
To a working environment (including practices on recruitment and promotion) free from unlawful discrimination on the basis	Equality and Inclusion Strategy and KPIs monitored through People Committee Equality & Inclusion Steering Group		Y

of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.	Workforce Race Equality Standard (WRES) Workforce Disability Equality Standard (WDES) Equality Delivery Scheme (EDS2) Equality Impact Assessments (EIAA) IMPACT – Values and Behaviours Framework Annual Report to People Committee on Employee Relations Recruitment Policy and Procedures and Training Bullying and Harassment Policy Equality and Inclusion Training Raising Concerns Policy Inclusion events Improving People Practices		
Number five: Can in certain circumstances take a complaint about their employer to an employment tribunal			
Rights	**Update**	**RAG**	**Compliant/Non-Compliant**
To appeal against wrongful dismissal. If internal processes fail to overturn a dismissal you have the right to pursue a claim in the employment tribunal if you meet required criteria.	Policies with clear processes within them Disciplinary Grievance Capability Sickness Absence MHPS Improving People Practices		Y
Number six: Can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest			
Rights	**Update**	**RAG**	**Compliant/Non-Compliant**
To protection from detriment in employment and the right not to be unfairly dismissed for whistleblowing or reporting wrong doing in the workplace.	Speak Out Safety Campaign Freedom to Speak Up Policy Lessons Learnt approach to sharing Sharing & Learning Freedom to Speak Up Guardian & Champions Freedom to Speak Up Summit Freedom to Speak Up briefing to Team Brief and quarterly report to the Board Daily Safety Huddle		Y
Number seven: Have employment protection (NHS employees only)			
Rights	**Update**	**RAG**	**Compliant/Non-Compliant**
You have a right to employment protection in terms of continuity of	Contract of Employment National NHS Pension Scheme		Y

service for redundancy purposes if moving between NHS employers.			

Staff Pledges

Update	**RAG**	**Compliant/Non-Compliant**
Staff engagement and wellbeing • Wellbeing Guardian/ / Team Brief / LHCH Staff App/Wellpoint Kiosk • Partnership Forum / Local Negotiating Committee and Junior Doctors Forum • Staff Support Team • Health and Wellbeing Steering Group • Staff Wellbeing Hub		Y
Regular appraisal and training opportunities • Mandatory Training Programme (E-Learning) • Appraisal Process • IMPACT – Values and Behaviours Framework • IMPACT education programme to be developed • Personal Development Plans (PDPs) • Leadership and Management Development Programme to be redesigned following the learnings from COVID-19		Y
Pledge two: The NHS commits to provide all staff with clear roles and responsibilities		
Update	**RAG**	**Compliant/Non-Compliant**
Role design and responsibilities to enable high quality care • Agenda for Change Handbook • Job Evaluation Process • Job Description Template • Standard Contract of Employment		Y
Contract of employment for staff supports this pledge • Paragraph included in Contract of Employment and reference to constitution		Y
Regular appraisals and training opportunities • Appraisal Process and E-Learning System • Mandatory and Essential Training > 95% target • Analysis of Training Needs analysis linked to appraisals & PDPs • CPD monies and utilisation		Y

Pledge three: The NHS commits to provide all staff with personal development, access to appropriate education and training for their jobs and line management support to enable them to fulfil their potential		
Update	**RAG**	**Compliant/Non-Compliant**
Spotting and developing confident leaders • IMPACT – Values and Behaviours Framework • IMPACT education programme to be developed • Leadership, Education & Development Strategy to be reframed following COVID • Leadership Development Programme to be redesigned following COVID-learnings • Talent management process to be developed • Inclusion mentoring & shadowing programme in development		Y
Pledge four: The NHS commits to provide support and opportunities for staff to maintain their health, wellbeing and safety		
Update	**RAG**	**Compliant/Non-Compliant**
Trusts are required to prevent violence against staff whenever possible and to take all appropriate action, including prosecutions of offenders, when violence occurs • Disciplinary Policy • Bullying and Harassment Policy • Unreasonable Behaviour Policy • Wider Communication to be developed		Y
Staff, patients and others are protected against the risks of acquiring a healthcare associated infection • Induction • Mandatory Training • Occupational Health Self-Referral • Health and Wellbeing Steering Group • Infection prevention policies in place • Infection prevention reports received by the Board • Infection prevention training mandatory • Risk Assessments (COVID)		Y
Staff are supported in their health and wellbeing • Health and Wellbeing Steering Group • Staff Wellbeing Hub • Staff Gym • Staff Support Team • Occupational health available for self-referrals • Employee assistance programme in place • Flu Campaign • LHCH Staff App • Health & Wellbeing Strategy, delivery plan and pathways in development		Y

Pledge five: The NHS commits to engage staff in decisions that affect them and the services they provide, individually through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families		
Update	**RAG**	**Compliant/Non-Compliant**
Social partnership forum • Staff Partnership Forum • Informal Staff Side Meetings • Equality and Inclusion Steering Group • Staff Governors' Role • LNC		Y
Staff, patients and others are protected against the risks of acquiring a healthcare associated infection • Training in Infection Prevention Control (as above) • Risk Assessments (COVID)		Y
Staff are supported in their health and wellbeing (as above)		Y
Pledge six: The NHS commits to have a process for staff to raise an internal grievance		
Update	**RAG**	**Compliant/Non-Compliant**
Grievance procedure Annual Report to People Committee on Employee Relations activity (as above)		Y
Pledge seven: The NHS commits to encourage and support all staff in raising concerns at the earliest opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the public interest Disclosure Act 1998		
Update	**RAG**	**Compliant/Non-Compliant**
Raising concerns • Freedom to Speak Up Policy • FTSU Guardian Role & Champions • Daily safety huddle • Updates to Team Brief • Staff Support Team		Y

Staff Legal Duties

Duty one: To accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your professional role		
Update	**RAG**	**Compliant/Non-Compliant**
• Annual PDR • Appraisal and Mandatory Training Programme • Training and Development as appropriate		Y

• CPD opportunities • Professional Membership – PINs • Revalidation Policies		
Duty two: To take reasonable care of health and safety at work for you, your team and others and to co-operate with employers to ensure compliance with health and safety requirements		
Update	**RAG**	**Compliant/Non-Compliant**
• Occupational Health Process • Managers' Development Process • Leadership Development Programme • IMPACT – Values and Behaviours Framework • Health and Safety Group/Risk Committee • Risk Assessments		Y
Duty three: To act in accordance with the express and implied terms of your contract of employment		
Update	**RAG**	**Compliant/Non-Compliant**
• IMPACT – Values and Behaviours • Clear Job Descriptions • Job Evaluation Scheme • Employment Policies • Values Based Recruitment in development linked to IMPACT		Y
Duty four: Not to discriminate against patients or staff and to adhere to equal opportunities and Equality and Human Rights legislation		
Update	**RAG**	**Compliant/Non-Compliant**
As above: • Equality Delivery Scheme 2 in place • Equality and Inclusion Policy in place with plan and Equality Action Plan • Staff Survey Results/WRES / WDES data		Y
Duty five: To protect the confidentiality of personal information that you hold		
Update	**RAG**	**Compliant/Non-Compliant**
• Data Protection Act • Information Governance Process & Mandatory Training • Contract of Employment • Trust Policies • GDPR •		Y
Duty six: To be honest and truthful in applying for a job and in carrying out that job		
Update	**RAG**	**Compliant/Non-Compliant**
• Recruitment and selection procedures • ESR NHS Jobs • Safe Employment Standards • Fit and proper person processes		Y

• Values Based Recruitment in development linked to IMPACT		

Expectations for Staff

Expectation one: You should aim to maintain the highest standards of care and service, treating every individual with compassion, dignity and respect, taking responsibility not only for the care you personally provide but also for your wider contribution to the aims of your team and the NHS as a whole		
Update	**RAG**	**Compliant/Non-Compliant**
• LHCH IMPACT Values and Behaviours refreshed • Attitude and Behaviours as part of appraisal system • Induction Mandatory Training • Full Preceptorship • IMPACT Education programme to be developed • Civility education to be developed and incorporated with a focus on being inclusive for all		Y
Expectation two: You should take up training and development opportunities provided over and above those legally required of your post		
Update	**RAG**	**Compliant/Non-Compliant**
• Mandatory and Essential Training Programme • Full range of CPD opportunities managed by electronic application • Management and Leadership Programme/Clinical Leadership Programme/Leadership Strategy • LHCH Cardiothoracic Degree Programme • In-house job description training available including clinical skills development • Developing People Strategy in development		Y
Expectation three: You should aim to play your part in sustainably improving services by working in partnership with patients, the public and communities framework		
Update	**RAG**	**Compliant/Non-Compliant**
• Patient and family engagement events • Shadowing Programme		Y
Expectation four: You should aim to raise any genuine concern you have about a risk, malpractice or wrongdoing at work (such as a risk to patient safety, fraud or breaches of confidentiality) which may affect patients, the public, other staff or the organisation at the earliest possible opportunity		
Update	**RAG**	**Compliant/Non-Compliant**
• Freedom to Speak Up Policy • Guardian & Champions Role • Speak Out Safety Campaign • Daily Safety Huddle • FTSU Summit • Inclusion events		Y

Expectation five: You should aim to involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis and their individual care and treatment		
Update	**RAG**	**Compliant/Non-Compliant**
• Care partner programme • Patient and Family Experience vision • Open visiting • Sharing & Learning		Y
Expectation six: You should aim to be open with patients, their families, carers or representatives including if anything goes wrong, welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation		
Update	**RAG**	**Compliant/Non-Compliant**
• Being Open Policy • Duty of Candour • Staff Training		Y
Expectation seven: You should aim to contribute to a climate where the truth can be heard, the reporting of and learning from errors is encouraged, and colleagues are supported where errors are made		
Update	**RAG**	**Compliant/Non-Compliant**
• Freedom to Speak Up Policy • Sharing/Learning • Speak Out Safely Campaign • Executive led Safety Huddle • Incident Reporting Process		Y
Expectation eight: You should aim to view the services you provide from the standpoint of a patient and involve patients, their families and carers in the service you provide, working with them, their communities and other organisations, making it clear who is responsible for their care		
Update	**RAG**	**Compliant/Non-Compliant**
• Shadowing • Patient and family listening events • Patient and family stories • Named boards above all inpatient beds		Y
Expectation nine: You should aim to take every opportunity to encourage and support patients and colleagues to improve their health and wellbeing		
Update	**RAG**	**Compliant/Non-Compliant**
• Health and wellbeing group and events • Cardiac rehab programme		Y
Expectation ten: You should aim to contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access or outcomes between differing groups or sections of society requiring healthcare		
Update	**RAG**	**Compliant/Non-**

		Compliant
• Equality and Diversity Training • Equality Delivery Scheme 2 and Action Plan		Y
Expectation eleven: You should aim to inform patients about the use of their confidential information and record their objections, consent or dissent		
Update	**RAG**	**Compliant/Non-Compliant**
• Data Protection Procedures/GDPR • Information Governance Policy • Induction Process • Mandatory Training		Y
Expectation twelve: You should aim to provide access to patient information to other relevant professionals, always doing so securely, and only where there is a legal and appropriate basis to do so		
Update	**RAG**	**Compliant/Non-Compliant**
• Data Protection Procedures/GDPR • Information Governance Policy • Induction Process • Mandatory Training		Y

Board of Directors (in Public)
Item 5.4*

Subject: **Integrated Incidents Complaints and Claims (IICC) Report – Q3 and Q4 2020/21**

Date of Meeting: **Tuesday 27th April 2021**

Prepared by: **Helen Martin, Risk and Safety Lead with contributions from Matthew Shaw, Senior Clinical Information Analyst**
Laura Allwood, Complaints Manager
Sarah Disbury, Claims Administrator
Peris Widdows, FTSU Guardian

Presented by: **Sue Pemberton, Director of Nursing and Quality**

Purpose of Report: **To Note**

BAF Ref	Impact on BAF
BAF 1, BAF 4	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

The purpose of this paper is to provide the Board of Directors with quantitative and qualitative analysis of reported incidents, complaints and claims (IICC). This analysis relates to Quarters 3 and 4 of 2020/21 and is compared with Q1 and 2 2020/2021. Incident reporting, and the learning from them, together with complaints and claims feedback is important to the Trust in our ambition to continually improve the safety culture and ultimately improve the safety of care for

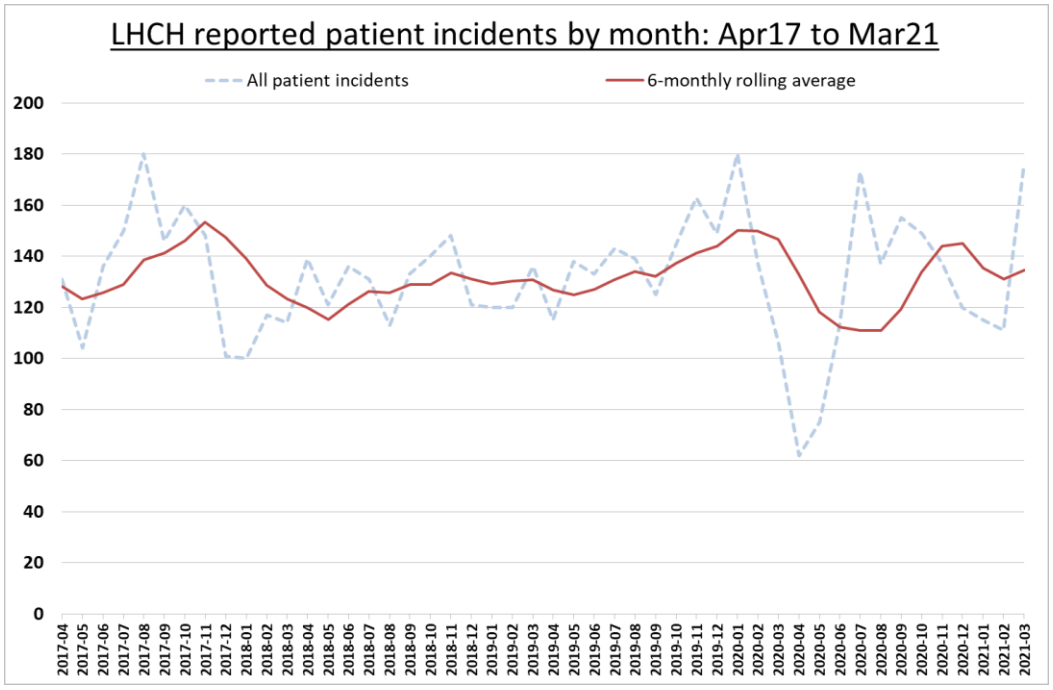
patients. Understanding what went wrong within complaints, incidents and claims is important to enable the organisation to learn and improve.

The Trust has recently appointed a Patient Safety Lead/Deputy Medical Director who will work closely with the Director of Nursing, Quality and Safety in taking forward the NHS patient safety strategy and what this could mean for LHCH patients in the prevention of harm. The focus will be on the next steps and areas for improvement will include how we strengthen and build upon the achievements made so far. In order to ensure this strategy is informed by our staff across the Trust a series of quality and safety summits are being held in April 2021 to hear the ideas and thoughts from our workforce. The outcome of this will the development of a new LHCH quality and safety strategy that will outline the priorities for improvement for 2021 and beyond and will include the key objectives from the National Patient safety strategy (2019)

2. Background

This report is presented to the Board of Directors six monthly and reports concurrent information pertaining to incidents, complaints and claims reporting within the organisation. This report will highlight any key issues that have arisen and the improvements required to prevent reoccurrence.

3. Reporting Culture



Reported patient incidents continue to be the main focus for staff; the graph above demonstrates a varying trend in reports via the Datix system. The strategy to improve incident reporting will be a focus within the LHCH quality and safety strategy.

Divisional Reporting Culture

The tables below show the numbers of reported incidents in each of the Divisions. Incident reporting saw a slight decrease in Q1 as the national directive to reduce elective activity was

implemented. Incident reporting has recovered across all the Divisions from Q2 onwards. Incidents and incident reporting are discussed in the Divisional Governance meetings on a monthly basis.

Surgery

Q1 19-20	**Q2 19-20**	**Q3 19-20**	**Q4 19-20**	**12 month total**
155	135	150	161	601
Q1 20-21	**Q2 20-21**	**Q3 20-21**	**Q4 20-21**	**12 month total**
91	155	131	132	509

Medicine

Q1 19-20	**Q2 19-20**	**Q3 19-20**	**Q4 19-20**	**12 month total**
176	188	219	228	811
Q1 20-21	**Q2 20-21**	**Q3 20-21**	**Q4 20-21**	**12 month total**
133	204	165	207	709

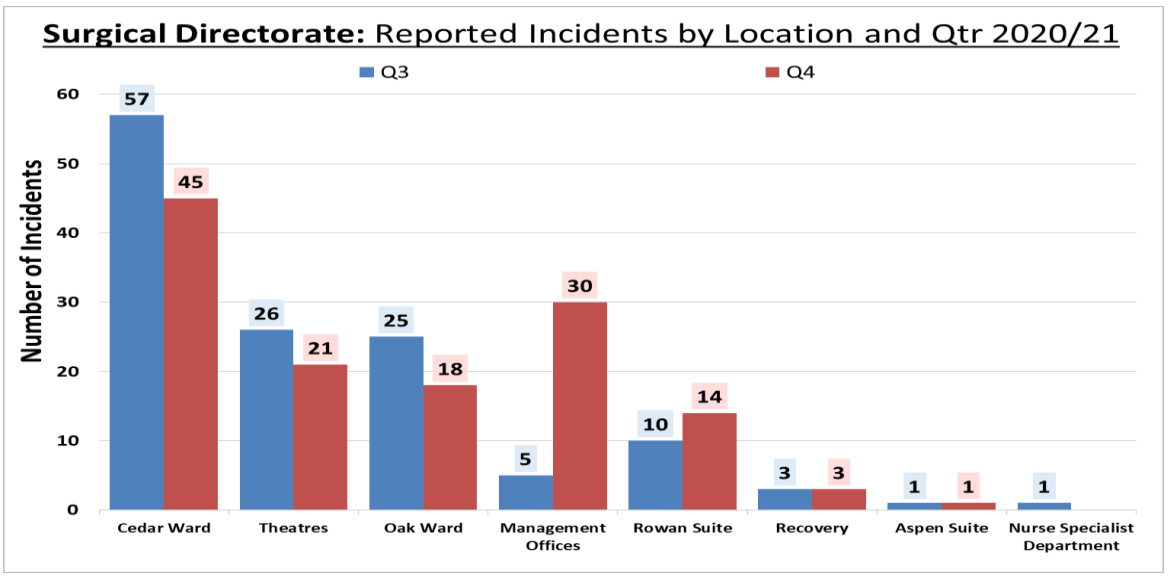
Clinical Services

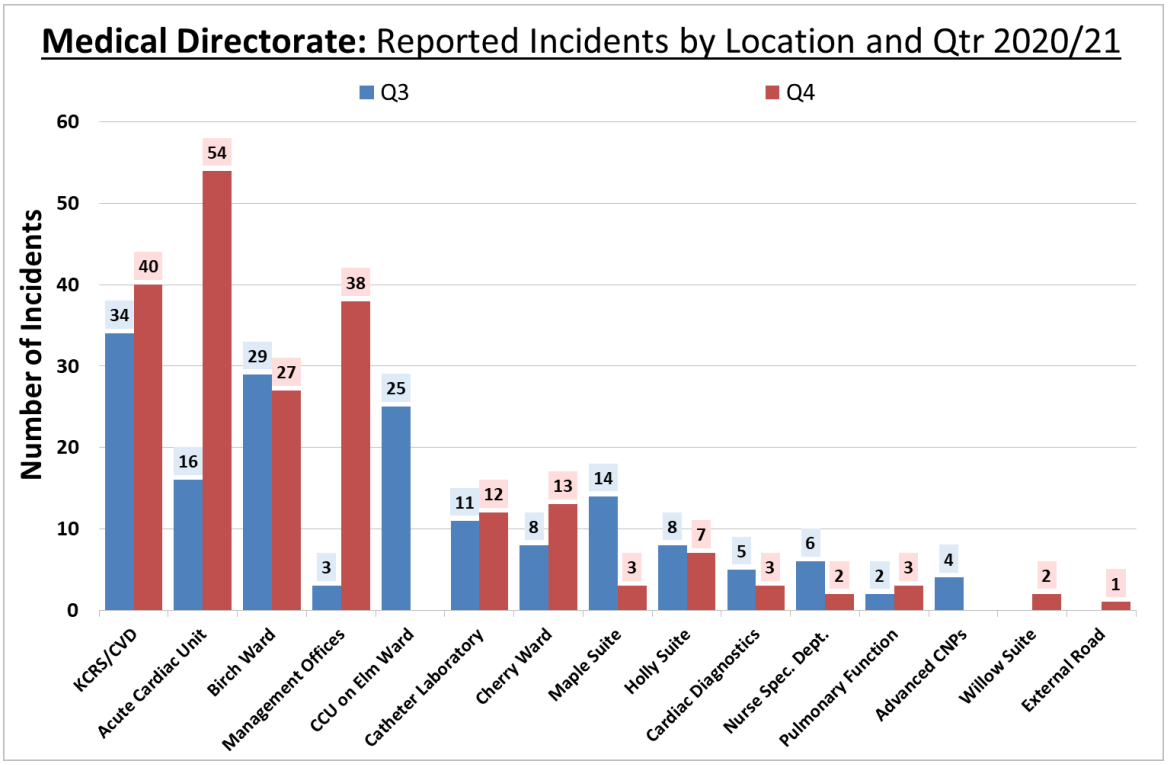
Q1 19-20	**Q2 19-20**	**Q3 19-20**	**Q4 19-20**	**12 month total**
136	162	168	129	595
Q1 20-21	**Q2 20-21**	**Q3 20-21**	**Q4 20-21**	**6 month total**
84	176	194	124	578

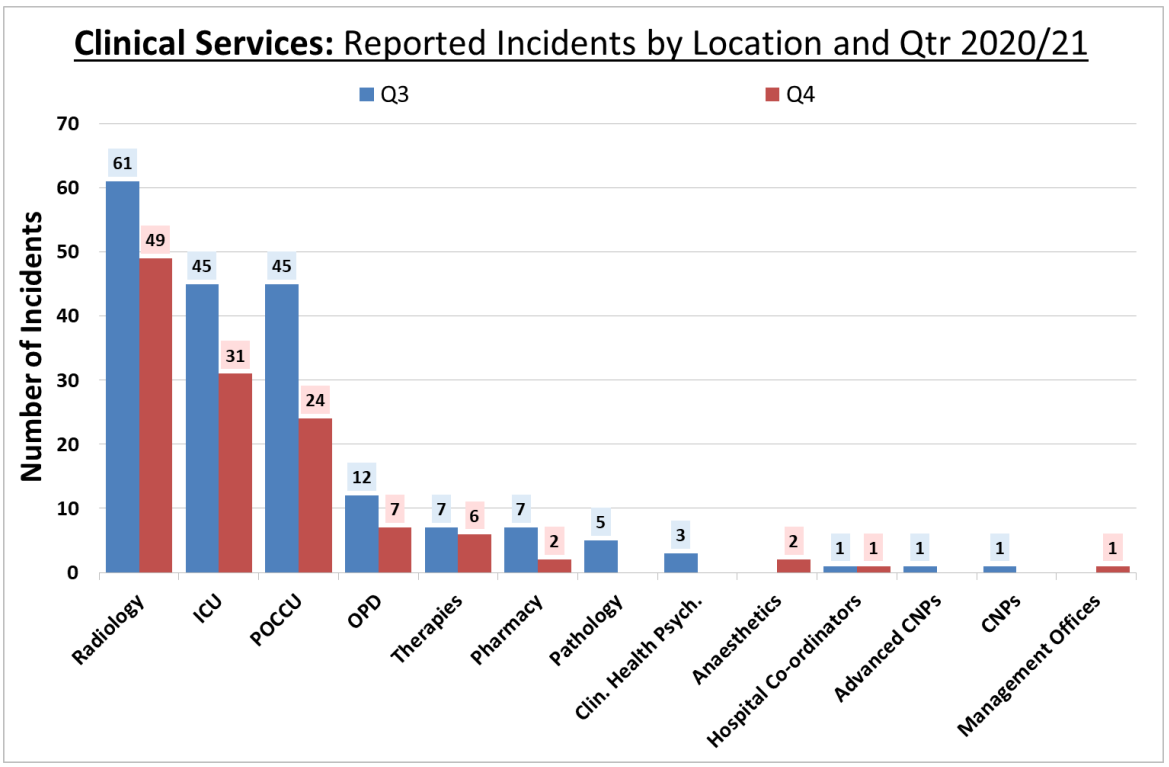
Corporate

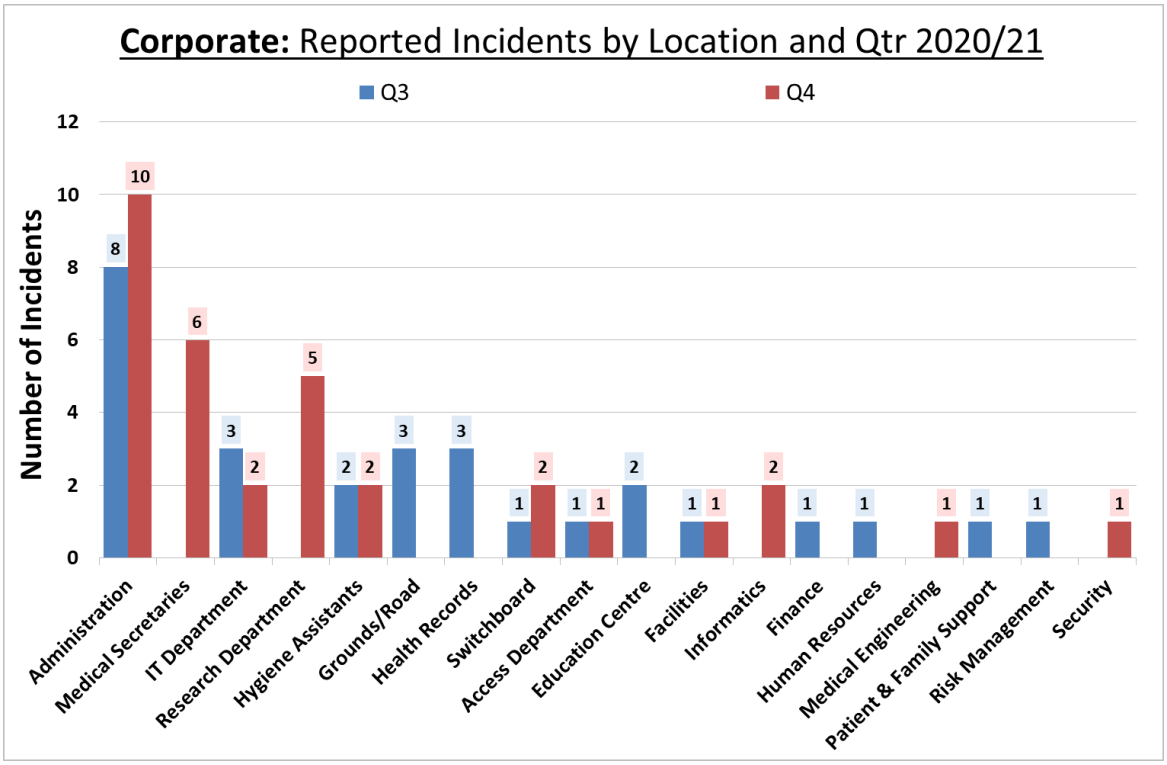
Q1 19-20	**Q2 19-20**	**Q3 19-20**	**Q4 19-20**	**12 month total**
17	27	47	19	110
Q1 20-21	**Q2 20-21**	**Q3 20-21**	**Q4 20-21**	**6 month total**
19	33	28	33	113

A breakdown of the number of reported incidents within the areas can be seen by location as detailed below. (*Blue Q3 Red Q4.*)


Surgical Directorate: Reported Incidents by Location and Qtr 2020/21
Q3
Q4
Number of Incidents
0
10
20
30
40
50
60
57
45
26
21
25
18
5
30
10
14
3
3
1
1
1
Cedar Ward
Theatres
Oak Ward
Management Offices
Rowan Suite
Recovery
Aspen Suite
Nurse Specialist Department


Medical Directorate: Reported Incidents by Location and Qtr 2020/21
Q3
Q4
Number of Incidents
0
10
20
30
40
50
60
34
40
16
54
29
27
3
38
25
11
12
8
13
14
3
8
7
5
3
6
2
2
3
4
2
1
KCRS/CVD
Acute Cardiac Unit
Birch Ward
Management Offices
CCU on Elm Ward
Catheter Laboratory
Cherry Ward
Maple Suite
Holly Suite
Cardiac Diagnostics
Nurse Spec. Dept.
Pulmonary Function
Advanced CNPs
Willow Suite
External Road


Clinical Services: Reported Incidents by Location and Qtr 2020/21
Q3
Q4
Number of Incidents
70
60
50
40
30
20
10
0
61
49
45
31
45
24
12
7
7
6
7
2
5
3
2
1
1
1
1
1
Radiology
ICU
POCCU
OPD
Therapies
Pharmacy
Pathology
Clin. Health Psych.
Anaesthetics
Hospital Co-ordinators
Advanced CNPs
CNPs
Management Offices



The importance of incident reporting continues to be highlighted through team brief, the daily safety huddle, senior leads and manager meetings and within the Divisional Governance meetings. The graphs above show the main areas for reporting continue to be ward and community areas. Historically non patient facing areas have had low reporting numbers, this will be a focus of attention In 2021/22 by engaging with those Heads of department in the development of the new quality and safety strategy.

Top five reported incidents

In total, there were 895 reported incidents in Q3 – Q4 (902 reported incidents in Q1 – Q2); of these there were:

Administration processes Q3: 91 incidents, Q4: 90 incidents; Total = 181 (Q1: 40 Q2: 115)

Datix categorises these incidents as: administrative, clinical record keeping, documentation and communication.. Radiology incidents form the majority reported, however there has been significant improvements within the radiology department including risk culture, revision of standard operating procedures, staff training and audits. Key themes identified in Q3 and Q4 administration incidents include appointment and admissions processes, incomplete documentation, and discharge processes. The following actions are being undertaken to support process improvement and incident reduction:

- Digital Excellence Strategy – supporting process automation Robotic Process Automation (RPA) innovation and technology for administrative processes to reduce human error
- Review and monitoring of radiology incidents and improvement via the Radiology Operational Group

- Implementation and go live of EMIS for community services from 1st April 2021
- Administrative review and transformational plan supported by the quality improvement team
- Review and monitoring of data quality, via weekly performance committee

Medications Q3: 59 incidents, Q4: 42 incidents; Total = 101 (Q1: 61 Q2: 80)

These include

- Dose omitted
- Drug given by wrong route
- Wrong dose administered
- Wrong dose dispensed
- Wrong dose prescribed
- Wrong drug administered
- Wrongly prescribed and administered
- Prescribed duplicate
- Pharmacy dispensing errors

On induction prescribers receive a presentation on medications management from pharmacy which includes highlighting key prescribing areas to ensure patient safety. Prescribers are also given direction to key prescribing policies that also include high risk drugs e.g. insulin, intravenous antibiotics and anticoagulation. Prescribers also work through an electronic prescribing and medicines administration (EPMA) workbook and are assessed at the end to assess their learning. A medications management training suite has been developed in conjunction with learning and development that is available on ESR for nurses. This now forms part of mandatory training for all nurses. This includes a range of training such as policy reading, 1:1 assessments on administration, videos and a drug calculation test. A mini MDT meets weekly, that includes the incident managers to review incidents. The meeting quality assesses each incident to ensure correct classification and scoring of harm/potential harm. The incidents are usually finally approved at the meeting and these then auto populate the medication incidents dashboard. These incidents are included in the Executive weekly harm report, and are presented at each divisional governance meeting.

The Safe Medication Practice Committee meet monthly to review and discuss any significant medication incidents raised at the mini MDT. The medication incidents dashboard enables the committee to focus on trends, harm/potential harm, learning and cascade.

Key medication safety themes are communicated to the Trust via the monthly safe medication bulletin and also ad hoc corporate communications as required

Communication Q3: 48 incidents, Q4: 40 incidents; Total = 88 (Q1: 31 Q2: 36)

This category includes

- communication between teams;
- handover between teams;

- communication with patients;
- communication with other healthcare providers such as ambulance for outpatients bookings;
- referral information not being completed correctly

The nursing documentation review has progressed significantly. The nursing admission and risk assessment documents have been amalgamated with the frequency of completion reduced. Work has been completed on handover particularly between nursing staff when transferring patients from one area to another with a standard operating procedure agreed for how this should be conducted.

Medical Devices Q3: 46 incidents, Q4: 32 incidents; Total = 78 (Q1: 19 Q2: 33)
Theatres, Catheter Labs, and ITU are the main users of complex medical equipment these areas report the highest number of medical equipment issues. User error/user damage is a consistent theme. All medical device incidents are reviewed by the Education Practice Facilitator, to identify if training is required or should be considered.

Documentation Q3: 17 incidents, Q4: 57 incidents; Total = 74 (Q1: 12 Q2: 22)
Incidents in this category often cross over with communication and include incorrect ID name bands; healthcare professionals documenting in the wrong notes and incorrect next of kin details being recorded.
On investigation the majority of these incidents are identified as "human error" with staff counselled appropriately regarding preventing reoccurrence.
The documentation audit has been reviewed and will now be completed on Perfect ward auditing system.

Severity of Incidents

	No/low harm	Moderate (short term harm)	Severe (permanent or long term harm)	Death
Q1 2020/21	**320**	**6**	**1**	**0**
Q2 2020/21	**558**	**6**	**1**	**2**
Q3 2020/21	**501**	**6**	**1**	**1**
Q4 2020/21	**476**	**15**	**0**	**1**

No harm/low harm continues to be the main category reported within the incident reporting systems.

Severe harm in Q1

- Incident reported regarding a missed KALERT which had highlighted the requirement for an abnormal finding on the kidneys to be investigated in 2017. The investigation did not

take place and the patient presented in 2020 with renal cell carcinoma. This was reported as an SI (See SI section)

Severe harm in Q2

- Patient became unresponsive on transfer from POCCU to ward. Suspected stroke. Delay in transfer to Walton Hospital – NWAS contacted and advised that there was high demand for the service on that day

Death in Q2

- Patient took their own life. This was reported as an SI (See SI section)
- Insertion of right chest drain performed as per policy. Iatrogenic lung injury occurred which led to cardiac arrest. Incident reviewed by senior clinical team for Surgery and Mortality review Group. No gaps in care identified

Severe harm in Q3

- A request was received from South Manchester Coroner requesting a report on a patient's care that had recently died. On review of the records, it was discovered that a ruptured aorta had not been reported on for 2 years when the patient had attended for scans. This was reported as an SI (See SI section)

Death in Q3

- There was an unexpected death of an ACHD patient following lung injury during catheter intervention to balloon the pulmonary valve. This was reported as an SI (See SI section)

Death in Q4

- the deterioration and death of a respiratory patient is under investigation

Serious Incidents (SI's)

During quarter 1 of 2020/21, one serious incident was reported

- It was reported that in November 2017 a patient had a CT to assess the position of a chest drain. Cysts in the kidneys were noted with a KALERT recommending further imaging. The further investigation was not arranged. The patient presented in June 2020 with a renal cell carcinoma.
  The investigation found that human error played a major part in the incident.
  Lessons learnt - The complete report should be read as pertinent incidental information is often at the end of the report. Reporting structure reviewed.

During quarter 2 of 2020/21, one serious incident was reported

- A report was made of a patient who had taken his own life while an inpatient on Cedar ward. The gentleman had been transferred from the CCA where he had exhibited intermittent delirium for which he was risk assessed with no concerns raised.
  Lessons learnt – No immediate lessons were identified from this tragic incident however consideration has been give n for a review of ligature points in bathrooms, and continue the SLKA with Mersey care

In quarter 3 of 2020/21, three serious incidents were reported

- A request was received from South Manchester Coroner requesting a report on a patient's care that had recently died. On review of the records, the investigation found

the previous surveillance scans did not report the presence of a leak which was evident on further review..
Lessons learnt - Involvement of specialist teams with high volumes of experience in the follow up of such complex patients may reduce the chance of these subtle abnormalities being missed on serial scans.

The aortic CT scans the images should always be viewed in multiple planes – so called multiplanar reconstruction.

Scan should be reviewed by the two Consultants

- November 2020 – there was an unexpected death of an ACHD patient following lung injury during catheter intervention to balloon the pulmonary valve.
  Lessons learnt - ACHD interventional colleagues require an enhanced induction at LHCH. Changes in operator skill-mix for ACHD interventions are required to ensure optimal case performance and recognition/management of complications as well as to ensure an optimal training environment for the junior colleague.

- November 2020 – injury to subclavian artery leading to complications with the patient's condition
  Lessons learnt - There is a need for clear description of the most up to date method of insertion and care of the cannula in question

  Presence of an experienced operator could have helped to recognise guide wire migration and prevention of the injury
  The use of serial dilation for the Biomedicus Cannula is not required and may increase the risk of injury to adjacent structures

- Quarter 4 – no SI's reported

RIDDOR Reportable Incidents
(Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995)

Q1 – No RIDDORS reported
Q2 **-** 1 RIDDOR reported – staff fall which resulted in the staff member having to take time off due to the injuries sustained.
Q3 – 1 RIDDOR reported regarding a manual handling incident
Q4 – 1 RIDDOR reported regarding a staff fall resulting in a broken shoulder.

Speak out safely / Freedom to Speak Up

Freedom to speak up (FTSU) has been successfully integrated at Liverpool Heart and Chest Hospital alongside the Trusts other forms for speaking out called the safety seven.

The FTSU team comprises of:

- Executive Lead – FTSU Guardian
- FTSU Guardian

- Deputy FTSU Guardian
- 11 multi-disciplinary champions

Q3 and Q4

In Quarters 3 and 4 there were 22 speak-ups as below:

Themes	Q3	Q4
Element of Patient Safety	2	4
Element of Bullying and Harassment / (Staff Values and Behaviours)	4	2
System processes /working practices	2	7
Other (Anxiety due to COVID)	1	0
No. of Speak-ups per Quarter	9	13

There were 6 patient safety issues raised through the FTSU policy in Q3 and Q4, all of which have been escalated within 24 hours of receipt and actioned appropriately.

Other themes

- Staff values
- Working practices
- Breakdown in communication/relationship

.

FTSU continues to be communicated to all staff within the Trust with the aim of encouraging staff to raise any issues of patient care quality or safety in a safe and supported way.

4. Complaints Analysis

Complaints and concerns are managed in line with DOH guidance who advises that that all complaints are dealt with using the same process. The Patient & Family Support Manager produces a monthly complaints report that is presented to each Divisional Governance Meeting which details the numbers of concerns and complaints received the key issues and action taken. Any action plans and learning from complaints are presented by the relevant lead at the relevant Governance Committees.

Formal Complaint Themes

	Q3	Q3 20/21 Total= 7	Q4	Q4 20/21 Total = 4
Surgery	**5**	**Clinical care and treatment: 4**	**1**	**Care and treatment: 3**
Medicine	**2**	**Communication/Information:2**	**3**	**Communication with family:1**
Clinical Services	**0**	**Discharge process: 1**	**0**	
Corporate	**0**		**0**	

The Trust has seen a decrease in the numbers of complaints received, compared to the previous year 2019-2020 of 35 with this year 2020 – 2021 a total of 20.In Q1 and Q2 elective

procedures ceased this potentially had an impact on the reduction of formal complaints received, There was a slight rise in Q3 in complaints and a further reduction in Q4. Complainants are contacted at the earliest opportunity in an attempt to resolve their concerns as soon as possible- during the covid 19 pandemic we have utilized other methods of resolving concerns raised- MS teams and telephone conference calls. These have been of benefit to the patients as they are being dealt with in a quicker way and resolving issues before they turn into formal complaints.

Learning from complaints

All complaints are discussed in the respective governance committees and all closed complaints were responded to within the negotiated timeframe. Two formal complaints had to be renegotiated with the division and the complainant, however close communication continued to ensure the complainant was kept up to date with progress.
During Q3 and Q4 there are 3 not upheld complaints, 3 partly upheld and 1 upheld an action plan was provided swiftly by the team and implemented. This action plan was shared at the Divisional Governance meeting.

Summary of learning

- Review of practices across the team and make sure staff are following correct protocols
- Reinstate team meetings and 1:1 meetings
- Administration processes being reviewed
- Discharge processes to be reviewed including transport specifications

All complaint responses either verbal or written were honest and open in line with the statutory Duty of Candour.

Patient and Family support contacts

There were 134 contacts in Q3 and Q4 of 20/21, 89 of which were informal concerns, 45 contacts for advice/information. Informal concerns in Q3 - 44 and Q4 - 45.
This is an increase compared to Q1 and 2 were we received 61 informal complaint/concerns.

Top themes include:

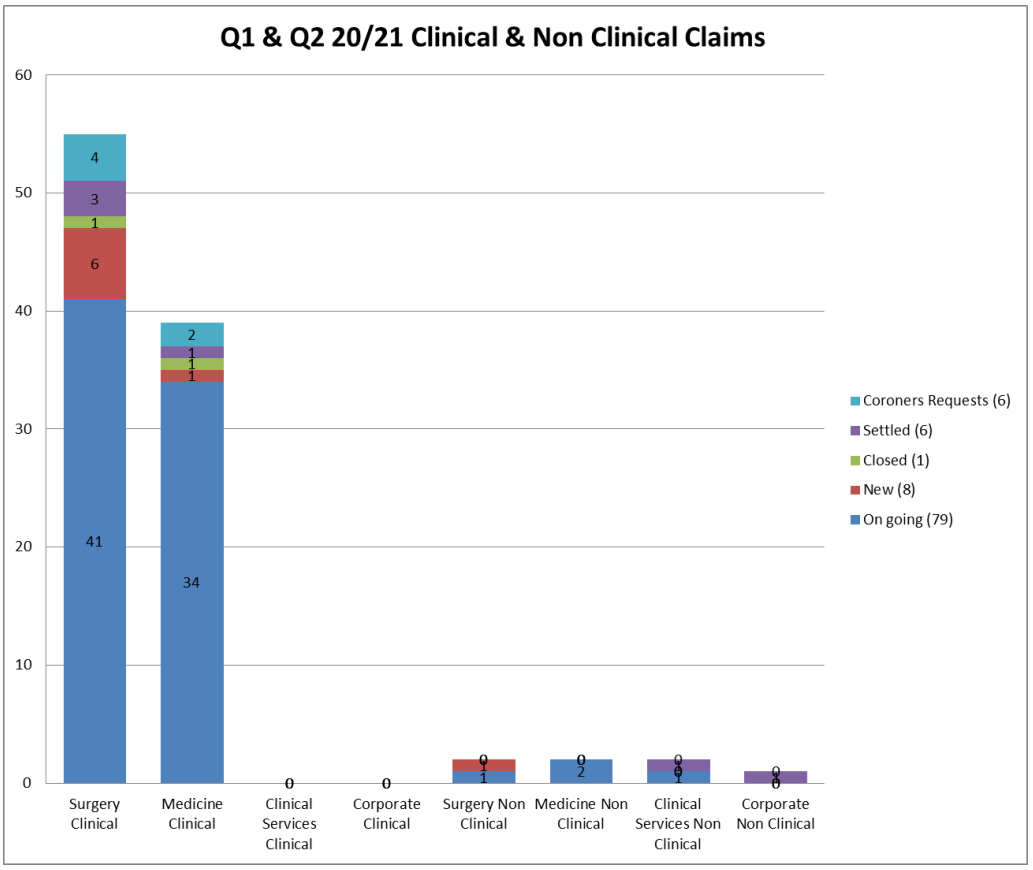
- Covid 19 related- Lost property- deceased and inpatient enquires.
- Vaccine centre- hard to find location of the centre, social distancing in the waiting area and patient wasn't provided with enough information.
- Administration- lack of follow ups booked within timeframe.
- Administration- unanswered calls and return calls not made

Learning included:

- Improved communication between patient and departments- especially with the increase in telephone consultations and enquires- managing patients anxieties around Covid 19.
- Improvement of following correct property processes, increase the use of reporting incident relating to property to allow the team to look at themes and share learning.
- New deceased property storage located in the hospital which will be ready end of Q4 which will improve the property process.

5. Claims Analysis

Claims data relating to Quarters 1 & 2 20/21 (April-September 2020) for comparison with Quarters 3 & 4 (October 2020-March 2021) this reporting period.



When reviewing the individual claims for this reporting period no recurring themes were identified as the circumstances within each case are different, with different operators and incident dates ranging from 2017-2020

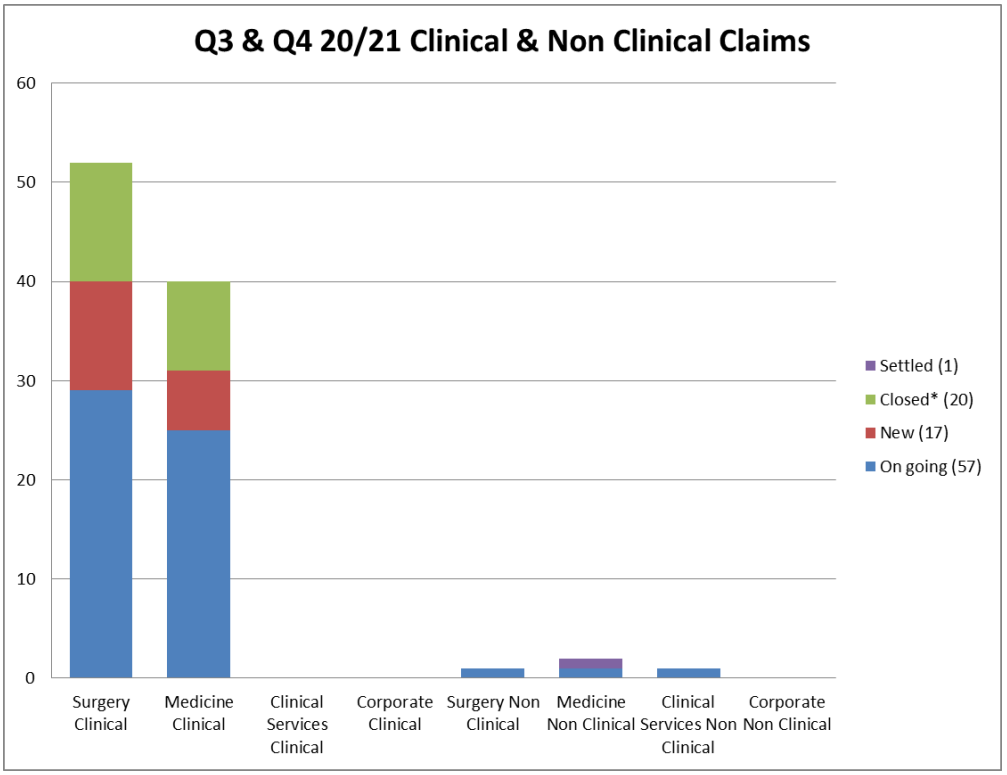
No themes have been highlighted within the letters before action or the claims received.

In 1 ongoing clinical case we have received insufficient details of the claim; the patient has received both medical and surgical treatment therefore the cases have been marked for both divisions until further details have been received.

In 1 clinical case the claim has been correctly marked as both surgery and medicine

No of Claims	Management Status	Letter Before Action – Pre Action stage claim currently being managed in house by the Trusts Legal Services	Letter of Claim/Proceedings – Formal claim being managed by the NHSR	Letter of Claim/Proceedings – Formal claim being managed by Panel Solicitors, Hill Dickinson/Clyde & Co
Clinical Existing (73)		56	6	11
Clinical New (7)		4	2	1
Non Clinical Existing (4)		0	1	3

Non Clinical New (1)	0	1	0



No of Claims	Management Status	Letter Before Action – Pre Action stage claim currently being managed in house by the Trusts Legal Services	Letter of Claim/Proceedings – Formal claim being managed by the NHSR	Letter of Claim/Proceedings – Formal claim being managed by Panel Solicitors, Hill Dickinson/Clyde & Co
Clinical Existing (54)		35	5	14
Clinical New (17)		13	3	1
Non Clinical Existing (3)		0	1	2
Non Clinical New (0)		0	0	0

Data relating to claims Quarters 3 & 4 (October 2020 – March 2021)

Over the 6 month period of quarters 3 and 4 (2020/21) in comparison with the previous 6 month period of quarters 1 and 2 (2020/21):

- The number of new clinical negligence claims received has increased by 59% from 7 to 17.
- The number of new non clinical negligence claims received has reduced from 1 to 0.
- The number of on-going clinical claims has decreased by 34% from 74 to 54.
- The number of on-going non clinical claims decreased by 25% from 4 to 3.
- The number of settled clinical claims has decreased from 4 to 0 and the number of closed/discontinued clinical claims has increased by 90% from 2 to 20. The large increase is due to a review of ongoing clinical claims which was undertaken by the

claims administrator. The review identified some early stage claims (Letters before Action) that has passed the limitation period and were therefore unable to progress to a formal claim. These files have now been closed.

- The number of settled non clinical claims decreased by 50% from 2 to 1 and the number of closed/discontinued non clinical claims remained the same at 0.

Integration of incidents, complaints and claims

The diagram below depicts the integration of incidents, complaints and claims for quarters 3 & 4 (this reporting period)

6. Organisational Learning

The Trust has an approved Organisational Learning Policy, which sets out how LHCH applies the learning from incidents complaints and claims received..

In order to ensure staff are aware of the learnings from received incidents complaints and claims the monthly team brief meeting is used to ensure all staff are updated on the learning identified from the previous month.

7. Patient Experience

In the National Inpatient survey, Liverpool Heart and Chest Hospital was rated joint second in the country for overall patient experience and rated the top hospital in Cheshire and Merseyside.

Due to Covid the Trust has had to suspend its Care Partner programme and visiting for all patients with the exception of those at end of life and for complex patients with learning disabilities. However, to ensure that patients and families remain in touch through this time of restricted visiting, our Patient and Family Liaison team have rung every next of kin, every day to give an update on their condition and pass on messages and information.

In addition to this, each patient who has had an overnight stay received a Follow Up call between 7-10 day post discharge home to check on their well-being, levels of support at home and to answer any concerns or worries. To date over four thousand calls (83%) have been made since this initiative was gradually rolled out over 2020. Some of the feedback from our patients has noted the excellent care and professionalism of the staff.

The Trust has also collected patient stories and shadows to understand what is important to our patients and to learn and develop.

Our Patient and Family experience over previous years has been monitored through quarterly engagement events. This year due to COVID restrictions it was necessary to find an alternative way of understanding family experience. A questionnaire was sent out in July 2020 to families of patients who received care in the trust prior to the visiting restrictions which were put in place due to Covid. The response was that 100% of families when asked, stated they were happy with the care their loved one received during their stay. This is in addition to the trust Friends and Family Test which has had a 100% positive response (February 2021).

8. Summary and Conclusion

Incident reporting, learning from incidents, complaints and claims remain a focus for all Divisions.

Quarters 3 and 4 have seen a marginal increase of 2 in complaint reporting compared to Q1 and 2.

The numbers of clinical claims has seen an increase from 7 to 17 compared to the previous reporting period.

Incident reporting remains relatively consistent and continues to be emphasised in team brief, at safety huddle and in the Divisional Governance Committees. Training for incident reporting is continuing across all areas.

Monthly learning and sharing meetings take place and the organisational learning session has

been incorporated into the monthly team brief. All staff are invited to present learning from incidents complaints, claims and patient experience events.

Due to Covid the Trust has had to suspend its Care Partner programme and visiting for all patients with the exception of those at end of life and for complex patients with learning disabilities. However, to ensure that patients and families remain in touch through this time of restricted visiting, our Patient and Family Liaison team have rung every next of kin, every day to give an update on their condition and pass on messages and information.

9. Recommendations

The Board of Directors are asked to:

- Receive assurance that mitigation to prevent harm to patients and staff by the reporting of and learning from reported incidents, complaints, claims and patient experience events continue to be monitored by the Divisional Governance Committees.

Board of Directors (in Public)
Item 6.1

Subject: **Assurance Committee Annual Reports 2020/21**
Date of Meeting: **Tuesday 27th April 2021**
Prepared by: **Lucy Lavan, Director of Corporate Affairs**
Presented by: **Julian Farmer, Audit Committee Chair**
Purpose of Report: **For Approval**

BAF Ref	Impact on BAF
N/A	The report provides assurance that Assurance committees have operated effectively during 2020/21, albeit in the context of the pandemic crisis, and supports the Annual Governance Statement.

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

Each Assurance Committee has reviewed its Terms of Reference and produced an Annual Report as part of the annual evaluation process required by the Trust's Board Assurance Framework (BAF) Policy. The Audit Committee has reviewed each report to assess the extent to which each Committee has operated effectively and in accordance with its Terms of Reference during 2020/21 and to provide assurance and any recommendations for change to the Board of Directors. The opportunity to review all reports together has allowed the Audit Committee to consider any areas of duplication or gaps and to triangulate any themes from the assurances received. In undertaking its review, the Audit Committee noted that 2020/21 was a unique year with the pandemic crisis impacting for the full 12 months. As a result the Trust's governance arrangements were adapted to support the command and control structures and in light of government guidance around reducing the burden and releasing capacity to save lives. The impact of these adaptations is reflected in each Committee's annual report.

Within this context, the Audit Committee concluded that each of the Assurance Committees had

operated effectively in 2020/21 and supported recommendations made in respect of amendments to Terms of Reference for the Board's consideration and approval.

Attachments are as follows:

- Audit Committee – annual report and terms of reference (no amendments required)
- Quality Committee – annual report and terms of reference (refer proposed tracked changes)
- Integrated Performance Committee (IPC)– annual report and terms of reference (no amendments required)
- People Committee – annual report and terms of reference (recently reviewed and no further amendments required)

2. Recommendations

The Board of Directors is asked to:

i) Support the recommendation of the Audit Committee that each Assurance Committee has operated effectively in 2020/21 and in accordance with the Terms of Reference delegated by the Board; and

ii) Review and approve the amendments to the Quality Committee Terms of Reference (indicated as tracked changes).

iii) Review and confirm that the Terms of Reference for Audit, IPC and People Committees will remain extant.

Audit Committee
Item 6.1.1

Subject: **Annual Report of the Audit Committee 2020/21**
Date of meeting: **Tuesday 27th April 2021**
Prepared by: **Lucy Lavan, Director of Corporate Affairs**
Presented by: **Julian Farmer, Chair of Audit Committee**
Purpose of Report: **To Note**

1. Introduction

As recommended in the Audit Committee Handbook, this report sets out how the Committee has functioned and supported the Board of Directors at LHCH during 2020/21, by critically reviewing governance and assurance processes on which the Board of Directors place reliance.

The Audit Committee is established under delegation of the Board of Directors with approved terms of reference that are aligned with the *Audit Committee Handbook 2018*. The Terms of Reference were reviewed and updated by the Audit Committee and approved for adoption by the Board of Directors in July 2020.

The Committee's membership consists of five non-executive directors and this reflects the importance that the Board of Directors places upon the ability of the Committee to enable effective non executive challenge as well as the wider remit of the Committee. The Committee has met on five occasions during 2020/21 and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation's business.

It should be noted that 2020/21 has been an exceptional year characterised by the emergency response to the coronavirus pandemic and therefore governance processes and arrangements have been adapted in line with government guidance and new ways of working as a result of social distancing and new infection prevention requirements. The Trust has operated in 'command and control' mode throughout the year to enable agile response to the national emergency and the Board has reviewed and approved revised governance arrangements which have been stepped up and down throughout the year.

2. Principal Review Areas

This annual report reflects the key objectives of the Committee as set out in the terms of reference.

2.1 Internal Control and Risk Management

The Committee having reviewed relevant disclosure statements for 2020/21 and other appropriate independent assurances together with the anticipated receipt of the Head of Internal Audit Opinion and external audit opinion at its June 2021 meeting, considers that the draft 2020/21 Annual Governance Statement is consistent with the Committee's view on the Trust's system of internal control. Accordingly the Committee supports the recommendation that the Board of Directors approve of the 2020/21 Annual Governance Statement.

The Trust has continued to maintain the risk management systems in place throughout 2020/21 and a strategic risk review has commenced (March 2021) which will include a refresh of the Board's appetite for risk and Risk Management Policy – the changes will be implemented and embedded during 2021/22. Operational risks are recorded and monitored via the Athena system and the Datix system supports incident reporting and integration of incidents, claims, complaints and risk management. The Committee reviewed the risk management KPIs in July 2020 and January 2021. The majority of indicators were rated 'green' and focus was put on ensuring timely review of risk registers with compliance at 93% against a target of 95% at the end of September 2020. Incidents open beyond 28 days remained 'amber 'rated with 68% closed within this timeframe at the end of September 2020. Both of these indicators will be a focus for improvement in 2021/22 as part of a wider review of risk management and change in executive responsibilities. The Risk Management Policy was reviewed in July 2020 and rolled forward in lieu of the planned review of risk appetite (March 2021), which will inform a refresh of the Risk Management Policy for rollout in 2021/22.

The latest edition of the Audit Committee handbook (2018), identified the need for Audit Committees to focus on new areas, namely partnership working at scale, cyber security and working with the regulators. Cyber security arrangements were reviewed in October 2020 and January 2021. Regulatory action plans were introduced onto the agenda as a standing item but regulatory visits and formal reviews have been limited (risk-based) in 2020/21 and therefore there have been no significant regulatory issues this year for the Audit Committee to consider. The Trust has retained its CQC rating of outstanding and CQC engagement meetings have taken place but without formal reports. At the end of 2019/20, the Audit Committee also tasked itself with ensuring appropriate governance arrangements and risk management processes are in place to support wider systems / partnership working; it considered third party assurances in 2020/21 and has prioritised an internal review of hosted services for 2021/22. It is anticipated that this area of assurance will evolve over the next 12 months as ICSs develop and the regulatory framework turns its focus towards systems/ partnership working.

The Audit Committee has received and reviewed annual reports for 2020/21 from each assurance committee of the Board of Directors (March 2021); these enabled the Audit Committee to test the effectiveness of the Assurance Committees and be satisfied that the assurance mechanisms are fit for purpose in terms of discharging the responsibilities delegated by the Board of Directors. All internal audit recommendations in relation to the effectiveness of the assurance committees have been considered and followed up. It should be noted that some assurance committee work was reprioritised in 2020/21 due to the COVID pandemic and where applicable, this is referenced in the Assurance Committee annual reports

The Committee has continued to reinforce the importance of management follow up in respect of audit work and the Chief Finance Officer has introduced a new tracking system in 2020/21 to support this process.

The Committee has undertaken an annual comprehensive review of compliance with the provider licence and reviews a quarterly checklist of key provisions to identify any new or emerging licencing risks. Licence conditions relating to access – waiting times and diagnostics – were breached throughout the year due to the pandemic and the Trust's focus for 2021/22 will be on recovery.

The Committee has maintained a close focus on data quality assurance and received management updates in July 20202, October 2020 and January 2021. National indicators demonstrated that the Trust's maturity score was in the top 10% of all data providers monitored, with two areas below the expected standard to be followed up by the data management team. A data quality App was demonstrated to the Committee with rollout plans via the Divisional Chief Clinical information Officers. Amongst other attributes, the App will provide aggregate monitoring of the Trust's data quality position.

2.2 Internal Audit
Throughout the year, the Committee has worked effectively with internal audit to ensure that the design and operation of the trust's internal control processes are sufficiently robust.

A comprehensive risk-based programme of internal audits was planned but the impact on the organisation of COVID-19 required MIAA to review the internal audit risk assessment and plan for 2020/21. MIAA supported the design and operation of effective control processes by publishing assurance checklists for a variety of areas which have had to adapt in response to the COVID pandemic. The Trust has utilised these throughout the year to identify and mitigate any risks and gaps in control.

In respect of planned audits carried out, there was one limited assurance opinion issued in 2020/21 relating to 'Research Finances'; a review for which internal audit resources had been directed by management to identify the opportunity to strengthen internal controls. A management response and action plan has been compiled and the Audit Committee will seek assurances on the delivery of actions in 2021/22. Any limited assurance report is reviewed in full at Audit Committee with the relevant officer in attendance to present the management response. The Research Finances audit was by management request and had not been audited before; the internal auditors were directed to the area which showed the risk management process was working well.

The Committee has considered all major findings of internal audit reviews and has given increased focus in 2020/21 to the controls in place to mitigate cyber security threat and ensuring data quality.

A review of evidence to support provider licence self-certification was undertaken.

MIAA has supported the non executive directors over the year through the provision of networking events, policy advice, and Insight updates.

MIAA routinely reviews the papers received by the Board of Directors and minutes of Board meetings to pick up on areas of potential risk for inclusion in the audit programme.

2.3 Anti-Fraud
The Committee reviewed and approved the anti-fraud work plan for 2020/21 at its March 2020 meeting, noting coverage across all mandated areas of strategic governance, inform and involve, prevent and deter and hold to account. The Committee also during the course of the year regularly reviewed updates on proactive anti-fraud work – no specific fraud investigations were undertaken in 2020/21 and the anti-fraud officer has worked with the Trust to promote fraud awareness and assess to re-assess fraud risk in light of the pandemic.

2.4 External Audit
The external audit service was last market tested during 2017/18 with a new contract awarded by the Council of Governors to Grant Thornton with effect from October 2017. In consultation with the Council of Governors and taking account of the external market position, the external audit contract with Grant Thornton has been extended for 2020/21 with scope to extend again for a further year (2021/22 audit).

The Committee routinely receives a progress report from the external auditor, including an update annual accounts audit timetable and programme of work, updates on key emerging national issues and developments which may be of interest to Committee members alongside a number of challenge questions in respect of these emerging issues which the Committee may wish to consider.

2.5 Management Assurance
The Committee has frequently assessed the adequacy of wider corporate assurance processes as appropriate and has requested and received assurance reports from executives, managers and

wider Committee representation throughout the year. These have included a progress updates on data quality, reviews of the clinical audit programme and compliance with NICE guidelines and a review into the processes for scheduling private patient activity.

2.6 Financial Assurance
The Committee has reviewed the accounting policies and annual financial statements prior to submission to the Board and considered these to be accurate. It has ensured that all external audit recommendations had been addressed. The Audit Committee noted the changes to the value for money arrangements for the external audit 2020/21 and risk associated with financial viability given the uncertainty surrounding the future financial regime. It was noted that the limitation of scope opinion in respect of the year end 2019/20 stocktake would apply for 2020/21 also, given that the opening stock balances could not be verified. This was due to the social restrictions imposed at the outbreak of the coronavirus pandemic.

2.7 Other Assurance
The Committee has routinely received reports on Losses and Special Payments and Single Supplier Tender Waivers.

The Committee has reviewed and updated the Governance Manual including Standing Financial Instructions and Schemes of Delegation and has formally adopted the revised manual. It has considered any variations requested by hosted organisations. The Committee has also periodically reviewed the Trust's register of external visits.

Members of the Committee have met privately with the internal and external auditors, without the presence of any Trust officer.

3. Review of the Effectiveness and Impact of the Audit Committee

The Audit Committee has undertaken its annual self-assessment by self-assessing compliance with selected areas of the Audit Committee checklist, as set out in the Audit Committee handbook. All Audit Committee members completed the checklist and a follow up report was provided by MIAA – there were no significant actions arising from this or areas for further development.

Attendance at Audit Committee during 2020/21 is set out in the table below:

Member	**19th June 2020**	**14th July 2020**	**19th Oct 2020**	**12th Jan 2021**	**22nd March 2021***
Julian Farmer (Chair)	✓	✓	✓	✓	✓
Nick Brooks	✓	✓	✓	✓	✓
Mark Jones	✓	✓	✓	✓	✓
Bob Burgoyne	✓	✓	✓	✓	✓
Karen O'Hagan	✓	✓	✓	✓	✓
Attendees					
Karen Edge (Chief Finance Officer)	✓	✓	✓	✓	✓
Lucy Lavan (Director of Corporate Affairs)	✓	✓	✓	✓	✓
Paul Dossett (Grant Thornton)	✓	✓	✓	✓	
Georgia Jones (Grant Thornton)	✓	✓	✓	✓	✓
Christopher Whittingham (Grant Thornton)					✓

Nigel Woodcock (MIAA)	✓	✓	✓	✓	✓
Michelle Moss (MIAA)	✓	✓	✓	✓	X *

**Karen McArdle , MIAA attended the March meeting in the absence of Michelle Moss.*

The Chair of the Audit Committee reports on the Audit Committee's work to the Council of Governors at each quarterly meeting* (*except CoG in March 2021 when the agenda was reprioritised to free up capacity to manage COVID 19 – this item has been rolled forward to CoG, June 2021).

In order to meet social distancing and other Covid-safe requirements, all 2020/21 meetings were held via videoconferencing.

4. Looking Ahead

In the coming year the Audit Committee will continue to focus its attention on the following:

- Assurance processes to support data quality;
- Assurance processes to support cyber security;
- Maintaining oversight of action plans required by regulators;
- Ensuring appropriate governance arrangements and risk management processes are in place to support wider systems / partnership working;

It will also review the new risk management arrangements made in response to the strategic review of risk.

The internal audit programme will be carefully risk-assessed and prioritised in accordance with the prevailing circumstances and operational environment.

There will be a continued role for the Committee in testing the effectiveness of formal Board Assurance Committees, given that these are key controls in ensuring the delivery of the Trust's annual plan and discharge of effective governance and risk management.

The Committee will adapt its work programmes in order to respond to any new emerging policy on health and risks associated with the economic and external environment.

5. Terms of Reference

The Committee's Terms of Reference are compliant with the latest edition of the Audit Committee Handbook (March 2018) and were updated in January 2019 to reflect the Audit Committee's responsibility for the oversight and assurance of data quality processes and were approved by the Board of Directors on 30th April 2019. They were further reviewed as part of the annual review of the corporate governance manual, which was signed off by the Board of Directors on 28th July 2020. No further changes to the terms of reference are recommended at this time and these shall remain extant. An annual business cycle is maintained to support the Committee in effectively discharging its responsibilities as delegated by the Board of Directors.

6. Conclusion

This annual report summarises the work of the Committee in 2020/21 and concludes that that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

7. Recommendation

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

Audit Committee

Item 6.1.1a

Terms of Reference

For completion by Author			
Author(s) Name and Title:	Lucy Lavan, Director of Corporate Affairs Karen Edge, Chief Finance Officer		
Scope:	Trust Wide	Classification:	Terms of Reference
Version Number:	8.2	Review Date:	1st July 2021
Replaces:	Audit Committee Terms of Reference v8.1		
To be read in conjunction with the following documents:	Audit Committee Handbook		
Document for public display:	No		
Executive Lead	Lucy Lavan, Director of Corporate Affairs		

For completion by Approving Committee			
Equality Impact Analysis Completed:		N/A	
Endorsement Completed:	N/A	Record of Changes	N/A
Authorised by:	Board of Directors	Authorisation date:	28th July 2020

For completion by Document Control					
Unique ID No:	TOR/TB/02(09)	Issue Status:	Approved	Issue Date:	04/08/2020
After this document is withdrawn from use it must be kept in archive for the lifetime of the Trust, plus 6 years.					
Archive:	Document Control		Date Added to Archive:		
Officer responsible for Archive:		Document Control Administrator			

Contents

1. Constitution and Remit

The Board of Directors hereby resolves to establish a committee of the Board to be known as the Audit committee ("the Committee").The Committee is a non- executive committee of the Board of Directors and has no executive powers, other than those specifically delegated in these terms of reference.

2. Purpose of the Audit Committee

2.1 The Board of Directors is responsible for ensuring effective internal control including: management of the trust's activities in accordance with statute and regulations; the establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

2.2 The Committee will report to the Board of Directors annually on its work in support of the Annual Governance Statement, specifically commenting on its review of financial and corporate governance arrangements, assurance processes and embeddedness of risk management within LHCH.

3. Authority

3.1 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Audit Committee.

3.2 The Committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice. The committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

4. Main Priorities

4.1 The Board of Directors has determined that some of its responsibilities will be exercised on its behalf by the Committee. The priority for the Committee is to monitor the integrity of the Trust's financial statements and to review the Trust's financial and non-financial controls and management systems. The Committee shall take a risk based approach to the overarching scrutiny of the Trust's assurance, risk and governance structures and processes so that the Board may be provided with assurance in conjunction with assurances received via the Integrated Performance and Quality committees that corporate objectives shall be met. In particular the Committee shall commission and scrutinize assurances that the Trust has and shall continue to operate in accordance with its license conditions and that compliance requirements of NHS Improvement and the Care Quality Commission shall be met, thereby ensuring that the Trust's license to operate is maintained.

4.2 The Audit Committee will ensure full consideration of the implications for the Trust in respect of the evolution of Sustainability and Transformation Partnerships (STPs) and accountable Care Systems (ACS) - including accounting arrangements, risk management procedures, potential conflicts of interest and information flows. It will also seek assurance on any significant risks associated with mergers and acquisitions.

5. Main Duties & Responsibilities

5.1 Integrated Governance, Risk Management and Internal Control

The committee shall review the establishment and maintenance of an effective system of Integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of LHCH's objectives.

5.1.1 In particular, the Committee shall review the adequacy and effectiveness of;

- All risk and control related disclosure statements(in particular the governance statement)together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances ,prior to submission to the Board
- The underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications;
- The policies and procedures for all work related to counter fraud and security as required by NHS Protect.
- Controls and risk management arrangements associated with cyber security
- The policies and procedures in place to support high quality Data Quality for robust decision making and external reporting.

5.1.2 In carrying out this work the Committee will primarily utilize the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

5.1.3 As part of its integrated approach, the Committee will have effective relationships with other key committees notably the Quality Committee and Integrated Performance Committee, such that it understands processes and linkages.

5.2 Internal Audit

5.2.1 The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards 2013* and provides appropriate independent assurance to the Committee, Accountable Officer and Board of Directors. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the

audit needs of the organization as identified in the Board Assurance Framework
- Considering the major findings of internal audit work (and management's response) and ensuring coordination between the internal and external auditors to optimize the use of audit resources
- Ensuring the internal audit function is adequately resourced and has appropriate standing within the organization
- Monitoring the effectiveness of internal audit and carrying out an annual review

5.3 External Audit

5.3.1 The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management responses of their work. This will be achieved by:

- Considering the appointment and performance of the external auditors and making recommendations to the Council of Governors
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit, as set out in the annual plan
- Discussing with the external auditors their evaluation of audit risks and assessment of the organization and the impact of the audit fee
- Reviewing all external audit reports and any work undertaken outside of the audit plan, together with the appropriateness of management responses
- Ensuring there is in place a clear policy for the engagement of external auditors to supply non audit services

5.4 Counter Fraud

5.4.1 To satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Protect standards and shall review the outcomes of work in these areas.

5.5 Financial Reporting

5.5.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements made by the Trust in relation to its financial performance.

The Committee shall ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submission to the Board of Directors, focusing particularly on:

- The wording of the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted miss-statements in the financial statements
- Significant judgments in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letters of representation

- Explanations for significant variances

5.6 Governance

5.6.1 To review on behalf of the Board of Directors the operation of, and proposed changes to the Governance manual including standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

5.6.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing at 5.6.1, whether those departures relate to a failing, an overruling or a suspension.

5.6.3 To review the scheme of delegation.

5.6.4 To ensure that action plans relating to regulatory requirements are monitored and delivered

5.7 Raising Concerns

5.7.1 The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence)concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionally and independently.

5.8 Other

5.8.1 To review performance indicators relevant to the remit of the Audit Committee.

5.8.2 To examine any other matter referred to the Audit Committee by the Board of Directors and to initiate investigation as determined by the audit committee.

5.8.3 To ensure the effective use of the Board Assurance Framework to guide the Audit Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as the CQC's Intelligent Monitoring report and reports and assurances sought from directors and managers and other investigatory outcomes so as fulfill its functions in connection with these terms of reference.

5.8.4 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

6. Equality and Diversity

Ensure that equality and diversity and due consideration to the Human Rights Act are regarded in all aspects of the Audit Committee's work. In addition, the Committee will have regard for the NHS Constitution in delivering its objectives.

7. Membership

The Audit Committee, shall be appointed by the Board and shall comprise all independent non-executive directors (excluding the Chairman), at least one of whom must have recent and relevant financial experience.

8. Attendance

8.1 The Chief Finance Officer, Director of Corporate Affairs and appropriate internal and external audit representatives shall normally attend meetings of the Audit Committee. The counter-fraud specialist will attend a minimum of two meetings per year.

8.2 The Accountable Officer should be invited to attend at least annually to discuss the process for assurance that supports the Annual Governance Statement (AGS). He / she should attend when the Committee considers the draft AGS and the annual report and accounts.

8.3 Other directors and/or managers shall be invited to attend those meetings in which the audit committee will consider areas of risk or operation that are their responsibility.

8.4 Representatives from other organisations (e.g. NHS Protect) and other individuals may be invited to attend on occasion.

8.5 The secretary to the audit committee will provide administrative support and attend to record the minutes. In addition, the secretary will provide appropriate support to the Chair and Committee members.

9. Quorum and Frequency

9.1 A quorum shall be two members.

9.2 The Committee shall meet at least 4 times each year with an additional meeting/s scheduled for approval of the annual accounts. At least once per year the Committee shall meet privately with the external and internal auditors

10. Reporting

10.1 The minutes of all meetings of the audit committee shall be formally recorded and the approved minutes submitted, together with recommendations where appropriate, to the next meeting of the Board of Directors. The submission to the Board of Directors may take the form of a 'BAF Key Issues' report and should include details of any matters in respect of which actions or improvements are needed. This will include details of any evidence of potentially ultra vires, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the chair of the Audit Committee shall present details to a meeting of the board of directors in addition to submission of the minutes.

10.2 The Committee will report annually to the Board of Directors in respect of the fulfillment of its functions in connection with these terms of reference. Such report shall include but not be limited to functions undertaken in connection with the Annual Governance Statement and any significant issues that the Committee has considered in relation to the financial statements; the fitness for purpose of the Board Assurance Framework; the effectiveness (completeness and embeddedness) of risk management within the trust; the integration of and adherence to governance arrangements; the appropriateness of evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business; the robustness of the processes behind the quality accounts

10.3 The Chair of the Committee shall provide a regular report to the Council of Governors.

10.4 The foundation trust's annual report shall include a section describing the work of the Audit Committee in discharging its responsibilities.

11. Conduct of Committee Meetings

The Chair of the Committee will ensure that the appropriate processes are followed:

- Minutes are kept by the secretary to the committee
- The agenda is drafted and agreed by Chair prior to circulation
- An action log is maintained and actions followed up between meetings
- The agenda and supporting papers will be sent out to committee members 5 working days prior to the the committee, unless authorised by Chair for exceptional circumstances
- Authors of papers presented must use the required template and indicate whether the paper is for decision by the committee, for discussion, for information or for approval.
- Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of their paper/report and key issues. Committee members may question the presenter.
- The Chair shall ensure that the Committee members receive the development and training they need.

Board of Directors (in Public)
Item 6.1.2

Subject: **Annual Report of the Integrated Performance Committee 2020/21**
Date of Meeting: **Tuesday 27th April 2021**
Prepared by: **Karen Edge, Chief Finance Officer**
Presented by: **Karen Edge, Chief Finance Officer**
Purpose of Report: To Note

1. Executive Summary

The Integrated Performance Committee (IPC) has met 3 times during the financial year 2020/21 with the normal frequency being 4 times in line with the ToR. The planned January meeting was cancelled due to the impact on the Trust of the COVID-19 surge, however, updates on operational and financial matters have been provided to the Non-Executive Directors through the weekly meetings introduced as part of the pandemic command and control arrangements.

The committee's main priority is to review and scrutinise assurances that the Trust is operating and will continue to operate within the terms of its licence, regulatory requirements and statutory obligations.

The work of the committee has been focused on management of risk arising from the COVID-19 pandemic and the interim financial regime. The committee identified risks associated with the delivery against the CIP programme given the changes and also the deployment of capital resources resulting from new system constraints on spending and the emergence of increased risk for planned priorities (Electrical infrastructure) and emerging risks to support the COVID-19 response.

In addition, the impact of COVID-19 on activity has been a key consideration and recovery trajectories and performance has been scrutinized throughout the year.

The Terms of Reference have been reviewed by the Chief Finance Officer and no changes are recommended.

This paper provides an overview of progress against each of the objectives set out within the committee Terms of Reference and concludes that the Committee has met all of its objectives. However, it should be noted that the operational and financial performance of the Trust has been impacted significantly in 2020/21 by the COVID-19 pandemic and the emergency response arrangements that have been put in place.

Recovery will continue into 2021/22 and addressing the backlog of activity and achieving financial sustainability will be a priority, taking into account the planned changes in the NHS landscape. The impact of the external environment and trajectory of recovery will be a key focus for the committee balancing the internal recovery with providing system wide mutual aid for the benefit of patients.

2. Delivery of Objectives set by the Board of Directors

A summary of progress against each of the agreed objectives is shown below.

ToR Reference	Terms of Reference	Evidence to support delivery	Outstanding Issues/Actions
(i)	Annual Plan and in-year NHSI Returns	The Annual Plan submission for 2020/21 was abandoned as a result of the COVID-19 pandemic and an interim financial regime was put into place. The Committee have focused on Capital and CIP performance and the risks associated with delivery. It also reviewed the Q4 19/20 Patient Level Costing and gave authority for submission of the 2020/21 Reference Cost return as this was not available for the October meeting as the submission date had been deferred to November. This will be reviewed post submission at the January 21 meeting.	CIP delivery remains a significant risk for financial sustainability going into 2021/22 with the uncertainty of the financial regime. Performance risks continue as a result of the backlog of patients arising from the reduction in activity during the COVID pandemic. These pressures continue into 2021.

ii)	Integrated Governance	The Committee has reviewed relevant financial and performance reports for 2020/21 and noted the challenges arising from the COVID-19 pandemic impact upon performance in relation to RTT and Diagnostic targets and the underlying, recurrent financial position. A new performance report format was introduced in October focusing on special causes for concern and was seen as a positive change by the Committee. Capital monitoring and delivery has received an enhanced focus in 2020/21 as a result of new STP system constraints on spending plans, the need to prioritise schemes based on risk and progress key strategic projects such as the Cath Labs replacement. The 5 Year planning process for Capital has received scrutiny with the impact of the 6-facet survey and digital priorities being considered. This work will conclude in January 2021.	The committee has asked for assurance on the prioritisation process for Capital within the STP when is becomes available. In addition, it has considered the impact of COVID-19 and the change in the financial regime on the delivery of recurrent CIP and more assurance on progress is required.
(iii)	Regulatory and statutory guidance	Received updates on new and emerging guidance from regulators and external agencies where relevant to its remit. For example, in relation to the interim financial regime and capital allocations for 2020/21.	Final planning guidance for 2021/22 was not published in time for the October IPC and will be shared when published.

(iv)	Risk	The committee identified and received assurances in relation to a number of risks identified during the course of its work. For example, the committee has also identified risk associated with the delivery against the CIP programme and the impact on the Trusts longer term financial sustainability as well as the risk associated with non-delivery of RTT targets.	Continued focus and scrutiny on CIP programme will be required as it is a key risk to financial sustainability. Increased focus on recovery of performance targets will be required in 2021/22.

3. Membership

Attendance	**Attendance (%)**
Members:	
Karen O'Hagan-Chair	100%
Bob Burgoyne	100%
Mark Jones	100%
Attendees:	
Karen Edge (CFO)	100%
Hayley Kendall (COO)	100%
Frankie Morris (Deputy CFO)	100%

It is noted that the attendance above represents the 3 meetings that have occurred in 2020-21 with the January meeting being cancelled as a result of the COVID-19 surge. However, updates on operational and financial matters have been provided to the Non-Executive Directors through the weekly meetings introduced as part of the pandemic command and control arrangements

4. Sub Committees

The committee has received minutes of the Finance and Improvement Steering, to support assurance on progress of the Cost Improvement Programme and Financial performance.

5. Conduct of Meetings

A committee work plan was agreed at the start of the year and has been delivered as planned, with additional information requested regarding Surgical underperformance, Medical

underperformance and CIP underperformance. Minutes and action logs have been maintained and all outstanding actions followed up at each meeting. All meetings have been quorate.

6. Terms of Reference

The Terms of Reference are included in Appendix One and no changes are proposed.

7. Recommendations

The Board of Directors is asked to:

- Note the contents of the report and confirm that the committee has operated effectively during 2020/21, with key risks associated the impact of the COVID-19 pandemic on CIP and activity levels. In addition, deployment of capital resources have been scrutinised and this will continue as well as performance recovery in 2021/22.

Integrated Performance Committee

Item 6.1.2a

Terms of Reference

For completion by Author			
Author(s) Name and Title:	Karen Edge, Chief Finance Officer		
Scope:	Trust Wide	Classification:	Terms of Reference
Version Number:	3.0	Review Date:	1st July 2021
Replaces:	Integrated Performance Committee Terms of Reference v2.0		
To be read in conjunction with the following documents:	Governance Manual, Provider Licence, Single Oversight Framework, Board Assurance Framework		
Document for public display:	No		
Executive Lead	Karen Edge, Chief Finance Officer		

For completion by Approving Committee			
Equality Impact Analysis Completed:		N/A	
Endorsement Completed:	N/A	Record of Changes	N/A
Authorised by:	Board of Directors	Authorisation date:	28th July 2020

For completion by Document Control					
Unique ID No:	TOR/TB/10(09)	Issue Status:	Approved	Issue Date:	
After this document is withdrawn from use it must be kept in archive for the lifetime of the Trust, plus 6 years.					
Archive:	Document Control		Date Added to Archive:		
Officer responsible for Archive:	Document Control Administrator				

Contents

1. Constitution and Remit

This Committee is established as an Assurance Committee of the Board of Directors of Liverpool Heart and Chest Hospital NHS Foundation Trust in order to provide the Board with assurances in respect of the Trust's current and forecast performance and its operations in relation to compliance with the licence, regulatory requirements and statutory obligations. This is a Non-Executive Committee.

2. Authority

The Integrated Performance Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires of any employee (or contractor acting on behalf of the Trust) and all employees (or contractors acting on behalf on the Trust) are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain legal advice or other independent professional advice.

The Committee is authorised to request the attendance of individuals and authorities from inside or outside of the Trust with relevant experience and expertise, where it considers this is necessary or expedient to the carrying out of its functions.

Trust Standing Orders and Standing Financial Instructions apply to the operation of the Committee.

3. Main Priority and Objective

The Integrated Performance Committee shall provide the Board of Directors with a means of independent and objective review and assurance to the Board of the Trust's current and forecast performance. The Committee's main priority is to review and scrutinise assurances that the Trust is operating and will continue to operate within the terms of its licence, regulatory requirements and statutory obligations. In particular, it shall:

4. Duties and Responsibilities

The Committee will focus on the current and forecast performance against all regulatory and statutory targets. Specifically, the Committee will:

i) **Annual Plan and in-year returns:** review the integrity of data prior to submission

ii) **Integrated Governance:** Receive assurance in relation to:

- Current and forecast financial and operational performance against annual plan submitted to NHS Improvement
- CIP progress
- Contract performance
- Financial and operational performance at directorate and service line level
- Capital planning
- Productivity
- Relevant Workforce metrics

iii) **Regulatory and statutory guidance:**

- Receive reports which summarise new and emerging guidance from regulators and external agencies
- Receive external assurance reports from regulatory bodies and external agencies on matters falling within the remit of the Committee
- Receive assurance on relevant workforce metrics

iv) **Risk**
The Committee will consider and seek assurances in relation to any risks relating to its remit and will identify and escalate any new or emerging risks arising from its work, through the BAF key issues reporting process.

v) Consider urgent or material matters referred to the Committee by the Operational Board, Audit Committee or Board of Directors

5. Equality and Diversity

Ensure that equality and diversity and due consideration to the Human Rights Act are regarded in all aspects of the committee's work. This will include review of any equity analyses that are commissioned against the Trusts clinical services portfolio.
In addition the Committee will have regard for NHS Constitution in delivering its objectives.

6. Integration

The Committee will support the integration of clinical, organisational and financial governance across the Trust.

7. Membership

Three nominated Non-Executive Directors, one of whom will be the Chair and one the Vice Chair.
In attendance at all meetings:

Chief Finance Officer
Chief Operating Officer

All of the above to appoint a nominated Deputy who will attend in his / her absence.

The Committee may invite other officers to attend meetings as required.

All Board members have a right to attend any meeting of the Committee.

8. Quorum and Frequency

In order for decisions taken by the Committee to be valid, the meeting must be quorate. The Chair or Vice Chair plus one other member of the Committee must be present at the point when any business is transacted.

The Committee will meet quarterly (4 times per year).

The Chair may at any time call an extraordinary meeting to deal with urgent matters.

9. Reporting

The Committee Chair will provide a BAF Key Issues Report to the Board of Directors following each meeting, along with approved minutes and an annual report, which will include a review of the Committee's Terms of Reference.

The Chair of the Committee will escalate urgent matters and exceptions to the Board and / or Audit Committee in-between meetings as deemed appropriate.

10. Conduct of Committee Meetings

The Chair of the committee will be supported by a lead Executive Director who will ensure that the appropriate processes are followed:

- Minutes and action log are accurate, comprehensive and timely
- The agenda and supporting papers are sent out to committee members 5 working days prior to the meeting, unless authorised by the Chair for exceptional circumstances
- Authors of papers presented must use the required template and adhere to BAF Policy.
- Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of their paper/report and key issues.
- Committee members and those in regular attendance should actively participate in discussions pertaining to the agenda, ensuring that solutions and action plans have multidisciplinary perspectives and consideration of Trust-wide impact

Board of Directors (in Public)
Item 6.1.3

Subject: **Annual Report of the Quality Committee 2020/21**
Date of meeting: **Tuesday 27th April 2021**
Prepared by: **Sue Pemberton, Director of Nursing and Quality**
Dr Nicholas Brooks, Non-Executive Director & Quality Committee Chair
Presented by: **Dr Nicholas Brooks, Non-Executive Director**
Purpose of Report: **To Note**

1. Executive Summary

This report provides assurance to the Board of Directors on the performance of the Quality Committee. It summarises the Committee's activity for the financial year (April 2020–March 2021) and outlines how it met its Terms of Reference (TOR) and achieved its key priorities.

At the onset of the Covid-19 epidemic it was decided to avoid physical attendance and all the Committee's meetings were carried out remotely on Microsoft Teams.

The purpose of the Quality Committee is laid down in its TOR; in summary, it is responsible for providing the Trust Board with assurance on all aspects of quality including delivery, governance, and clinical risk management. The report identifies the core issues discussed and debated and the assurances received. It also highlights where improvements are required for 2021/22 to strengthen the assurance on quality for the Board of Directors.

2. Background

The Trust has four assurance committees of which the Quality Committee is one. The Committee operates through a work plan derived from its terms of reference.

The Trust is rated outstanding by the CQC. No onsite inspections have taken place throughout 2020/21, but the Trust has had virtual reviews with the Trust's CQC lead of surgery and of the leadership.

3. Main Priority and Objective

The role of the Quality Committee is to provide the Board of Directors with an independent and objective review of quality governance. The main priority is to review and scrutinize assurances that the Trust's strategic priorities for quality improvement are identified, implemented, and monitored.

4. Duties and Responsibilities

The Committee exists to promote safety and quality in patient care and experience, and to help to identify priorities and risks arising from clinical care and treatment on a continuous basis.

4.1 Quality Strategy

The Committee received the Trust's updated Quality and Safety Improvement Strategy (2017-2020) in October 2018. Assurance on delivery of the strategy during the last financial year was received as outlined below. In addition, the national safety strategy is currently under review and a new Quality and Safety strategy is planned to ensure the Trust's proposals align with the national mandate. The new strategy will be presented to the Board of Directors in May 2021.

4.2 Quality Impact Assessments (QIAS) relating to cost improvements

Assurance on progress with completion of QIAs for cost improvement programmes (CIPs) was received at every meeting during the year. CIPs are also assessed for any potential impact on equality. In addition, as part of a special agenda item at its meeting in April 2021, the Committee received assurance from a presentation on the process of sign off for QIAS.

4.3 Clinical Effectiveness

The committee received quality reports via the Quality and Patient and Family Experience Committee (QPFEC) and a Quality dashboard which provided assurance on all domains of quality at every meeting. The key areas of note are:

4.3.1 Mortality

Two outlier alert reports from Dr Foster Mortality Intelligence were subjected to deep dive investigations during the year:

A report of excess mortality among Welsh patients was discussed at the Committee in July 2020. The investigation by the Director of Research and Innovation concluded that there was in fact no difference, or even a trend towards a difference, in mortality compared with English referrals.

A report, covering the period from February 2019 to January 2020, was of significantly higher mortality rates compared with peer group hospitals among patients coded as myocardial infarction and cardiac imaging, and of higher mortality from myocardial infarction at weekends compared with week days. The deep dive carried out by the Director of Research and Innovation was discussed in depth by the Committee.

Assurance was received that the high mortality was among patients who had been fast-tracked by the paramedic ambulance service directly to LHCH following an out of hospital cardiac arrest (OOHCA). It was explained that although the acceptance of OOHCA patients for consideration for primary angioplasty is now a national policy, the other specialist cardiac centres do so only after triage and discussion with the doctors at the initially admitting DGH, whereas LHCH admissions are brought directly to the hospital by the paramedic teams. Accordingly, LHCH the patients were unselected and inevitably included many for whom primary angioplasty would have been futile, as exemplified by those who underwent an imaging procedure but no subsequent intervention. An additional factor likely to affect the mortality disparity between LHCH and centres in the Southeast of England – The Royal Brompton and Papworth Hospitals – is the very much higher deprivation score in the Northwest. These conclusions were further supported by the higher proportion of LHCH patients with no recorded Charlson comorbidity score than in other centres; this would most probably have reflected the severity of illness among these patients, many of whom were in extremis and consequently unable to provide information to complete the score. Moreover, absence of the comorbidity score would probably have resulted in attribution of an erroneously low predicted relative risk.

In response to the excess mortality at weekends, the Medical Director pointed out that staffing for AMI admissions was essentially the same on weekdays as at weekends, and that the observation was

most likely to be a reflection largely of random variation. However, a contributory factor might relate to transfer requests from A&E units at weekends being more often made by junior staff, resulting in a higher number of inappropriate – and futile - referrals. The Director of Nursing and Quality added that a consultant ward round, seven-days a week, had recently been instituted.

Although not reported as an outlier alert in the Dr Foster report, the Committee requested further information on seven deaths that had occurred in August 2020. Two cases, which were assessed by the MRG as being "possibly avoidable but not very likely", were discussed in detail. Both had been carried out by the same locum surgeon, during one of which he was being supervised by a senior colleague. At the January 2021 meeting of the Committee, the MD explained that the surgeon performed generally well and, since completing the locum appointment, has been appointed as a fellow in the Trust. Surgeons are appointed to locum positions only if they hold a certificate of specialist training (CST) or have completed their training and are awaiting formal award of their CST; or, if qualified overseas, have undergone training and accreditation that is recognised by the Royal College of Surgeons and have supportive references. Moreover, surveillance of individual surgeon performance is a regular part of audit and quality control (see below – CUSUM curves). The Committee accepted assurance that all appropriate actions, including the duty of candour, had been taken in relation to the deaths.

The CUSUM curves for cardiac surgery and coronary angioplasty were reviewed by the Committee in October 2020. The Medical Direct (MD) confirmed that he and the divisional AMDs reviewed the data and, as part of the Trust's performance management policy, would meet with any consultant outlier to discuss actions that might be required to restore their performance. It was noted that, by nature of the statistical process, negative curves took a long time to reflect improved practice. The MD reminded colleagues that the Trust has adopted tighter confidence intervals than are utilised nationally such that LHCH is alerted to possible issues earlier than the National Society.

4.3.2 Quality Dashboard

The Trusts quality dashboard was reviewed at all Quality Committee meetings. Indicators contained within the quality strategy include: the incidence of pressure ulcers, falls, infections, mortality data, patient and family experience, medication errors, mortality reviews and sepsis. The Committee received assurance from the QPFEC key issues report that all quality indicators are discussed, monitored, investigated where necessary, and the learning shared.

Good progress in ensuring a low incidence of pressure ulcers, falls and infection rates was noted. Sepsis screens, and escalation and treatment within the target time frames have also improved but further effort is required. At its July 2020 meeting the Quality Committee was updated by the Medical Director over the on-going problem of the documentation of blood cultures in patients with sepsis. The Trust continues to focus on this area with intensive training and changes to the EPR. It was emphasized, however, that essentially all patients are having an appropriately timed blood culture. Patient and family experience has remained excellent. Significant work has been undertaken to reduce medication errors, and this continues.

4.3.3 Delirium

At its October 2020 meeting the Committee was made aware of a presentation by the Deputy Director of Nursing to the QPFEC, which highlighted an ever-increasing rate of aggressive behaviour towards staff, and of patients with paranoia, hallucinations, and suicidal ideation, resulting in considerable pressure on the clinical workforce and involvement of the safeguarding team. Numerous factors had been identified as contributing to the problem, including complex needs such as alcohol and drug dependency, frequent and potentially disorientating moves within the hospital, and the Covid-19 pandemic which precluded patients from receiving support from visiting relatives.

In the preceding 12 months 375 patients had had some form of delirium and, between April and August 2020, 91% of the referrals to safeguarding related to delirium, low mood, and other mental health issues. It was recognised that a new approach was required, and a delirium lead was appointed. The Director of Strategic Partnerships subsequently led a delirium group of selected

colleagues together with Merseycare and the Trust's Mental Health Lead, to identify new ways of managing the condition more effectively. The Committee was updated at its January 2021 meeting on a service level agreement with Merseycare to develop a plan as soon as possible for patients presenting with mental health issues.

The Committee was also informed that discussions were taking place over additional support from the LHCH in-house psychology team for both patients and staff.

4.3.4 Stroke Service Quality & Annual Assurance Report 2019/20

The Quality Committee received assurance at its meeting in October 2020 regarding the LHCH stroke service. Members were informed that the Trust had experienced a year-on-year increase in the number of inpatient strokes, which is attributable to the increasing number or patients with multiple co-morbidities and stroke risk factors undergoing complex surgical procedures.

The results of the patient satisfaction survey were included for the first time in the report and the question was raised as to how the team planned to address the small number of less positive results; in particular, a concern that the diagnosis was often not explained to the patient and relatives by a doctor. The In- Hospital Therapy Lead explained that although there was 24/7 access to the Royal Liverpool team, discussion with the patient relied on local colleagues. Usually this took place after the stroke MDT and was often deferred to the therapy team. The team, however, considers that this conversation should ideally be led by a doctor, and that conversations about long-term aftercare should not be conducted at a time when it is too early to anticipate how far patients were likely to progress in their rehabilitation.

It was noted that the survey questionnaire would be reviewed to decide if any changes in format or question content could be made better to align it with the patient care pathway.

Committee members had previously suggested that it would be valuable if information on the late outcome of stroke patients could be recorded, and this had, in principle, been taken up by clinical colleagues. In practice, however, it was not feasible to collect the information with the existing staff and clinic facilities. It was suggested that there might be better commitment if this were to form the basis of a research project of which the Director of Research & Innovation would be fully supportive. The MD undertook to liaise with the AMD for the surgery division to encourage involvement from its members.

4.3.5 GIRFT Report Actions & Progress Update

The on-going GIRFT action plan had been progressing well within the surgical division, although certain sizeable elements had taken time to implement. The cardiology GIRFT was being dealt with on a regional basis, with data from the Wirral still outstanding. The Medical Director was expecting to receive a partial overall view of any gaps in the service by the end of the year.

In relation to the Liverpool Lung Cancer service, no specific issues were raised at the recent meeting, but a full report was imminently anticipated.

GIRFTs for radiology, intensive care and pathology were anticipated, although delays had been experienced due to Covid-19. Once these reports are published, the Medical Director will present them to the Committee.

4.3.6 Consent

The Committee received an update on consent at the July 2020 meeting. Members shared the Medical Director's concern over the most recent audit that had shown little improvement during the last two years. The issue is of high priority, and the medical and surgical divisions have been asked to develop action plans for improvement. It was requested that the timeframe for implementation of the plans should be fed back to the Committee**.**

4.3.7 Quality risks.

The Committee received an update at all meetings on the current risks relating to quality and the mitigating actions in place to address them.

4.3.8 Clinical audit

At its July 2020 meeting the Committee received the annual report of the Clinical Audit and Effectiveness group. Members noted the support the group had provided for completion of all mandated national audits, and for compliance with directives from NICE and NCEPOD, the evaluation of new technologies, mortality reviews and learning from deaths.

4.3.9 Infection Prevention and Coronavirus

The 2019/20 infection prevention annual report was presented at the July 2020 meeting. A small cluster of surgical site infections was discussed. Assurance was provided by reestablishment of the Surgical Site Group. The number of blood stream infections with 'alert organisms' had remained low and all cases were thoroughly investigated. There had been one case of Trust attributable MRSA in the year.

In October 2020 the Medical Director informed the committee of a Coronavirus outbreak on POCCU and Cedar ward. Several patients and staff had been affected. Additional infection prevention and control processes were put in place immediately, with deep cleaning of the affected areas, re-segregation of wards and asymptomatic testing of staff. On 5th October, all elective surgery (apart from cancer) was stopped, and further measures were implemented to minimise the risk of nosocomial outbreaks.

The Committee was informed that two staff members had come to work while having symptoms and had subsequently tested positive. The Senior Leadership Team had reinforced the message that coming to work with Covid symptoms was a disciplinary matter. From 6th October, temperature checking on arrival at work was introduced in all departments. The importance of wearing masks was re-emphasized, and the social distancing rules were reinforced; signs on the doors of rest areas were reviewed to ensure they indicated an appropriate maximum capacity. Staff breaks were more structured and daily hand hygiene audits by matrons and ward managers were being carried out. Silver command was meeting daily to assess compliance with the measures and to review the daily audits.

The Medical Director (MD) explained that the number of Coronavirus cases in Liverpool continued to rise and it was considered unavoidable that some asymptomatic staff would bring the virus from the community into the Trust. LHCH had proposed to carry out five day testing for all inpatients, but the laboratories were concerned that they would become overwhelmed if all hospitals adopted the policy. Since it was thought to be unlikely that the relatively small number of LHCH patients would make much of an impact, discussion were on-going.

The Committee was informed that fixed transparent screens had been installed between beds across the Trust, and ward staff had been trying to dissuade patients from entering another's space. It was mandatory for patients to wear a mask unless their medical condition precluded them from doing so.

Additional assurances received

The committee received assurance of compliance with key performance indicators and improvement work in relation to:

- Secure health messaging
- Mortality reviews
- Incident reporting
- Infection rates
- Dementia screening
- VTE screening and prophylaxis
- PPCI call to balloon times

- Patient and family experience
- Quality priorities
- CQUINS
- Complaints management
- Resuscitation outcomes and do not resuscitate (DNR) compliance
- Radiology discrepancy reporting
- CQC updates
- Acute kidney policies and improvement work

4.4 Annual Reports

The Committee received annual reports directly or via the Quality and Patient and Family Experience Committee for:

- Diabetes
- Medications assurance
- Drugs and Therapeutics
- Safe medications
- Mortality
- Infection prevention
- The NHS National patient survey
- Cancer
- Incidents complaints and claims
- Complaints management
- Patient and family experience
- The clinical quality forward plan 2018/19
- NICE guidelines and new technology appraisals
- Tissue viability
- End of life care
- Clinical audit and effectiveness
- Sepsis

4.5 Annual Quality Report

The quality report has been completed in accordance with statutory requirements, and forms part of the annual report.

5. External Regulations

In January 2019, the Trust underwent an unannounced CQC inspection of the surgical specialty, and this was followed, between 5th and 7th February, by a planned well led inspection. The outcome of these inspections was that surgery was rated outstanding, which was an improvement from 2016 when it was rated good, and the Trust leadership was rated outstanding.

6. Patient and Family Experience

The Committee has been provided with assurance against the Patient and Family Experience measures via the quality report and an annual report.

7. Research and Development

The Committee has received assurance relating to objectives included in the updated research and development strategy document. It was noted that two of the principal research initiatives had been taken forward. The department has implemented an action plan to prepare for an anticipated Medicines and Healthcare Products Regulatory Authority (MHRA) inspection.

8. Membership and Attendance

The TOR specify that membership of the Committee comprises three nominated non-executive directors, one of whom will be chair and one vice-chair, and that at all meetings the Director of Nursing and Quality, the Medical Director, and the Director of Research and Informatics should be in attendance.

Position - month meeting occurred	Non-Executive Director (Chair)	Non-Executive Director	Non-Executive Director	Director of Nursing and Quality	Medical Director	Director of Research and Informatics
April 2020	√	√	√	√	√	√
July 2020	√	√	√	√	√	√
October 2020	√	√	√	√	√	√
Jan 2021	√	√	√	√	√	√

9. Equality and Inclusion

The committee is due to receive its Equality and inclusion update in April 2021.

10. Priorities for 2021/22

Priorities for 2021/22 include:

- Continued focus on improving sepsis documentation and management
- Continued reduction in infection rates and all harms
- Mortality reduction
- Consent improvement

11. Conclusion

Throughout the past twelve months the Quality Committee has received assurance on all aspects of quality, including delivery, governance, and clinical risk management. The Committee met quarterly, on four occasions. Review of the minutes confirmed good attendance.

This annual assurance report, derived from the minutes of the meetings, confirms that the Committee has received assurance against the criteria of the TOR. Amendments, subject to Board approval, have been made to the TOR to highlight areas identified as in need of attention in 2021/22.

12. Recommendations

The Board of Directors to receive assurance that the Quality Committee has met its terms of reference, and to note the areas requiring improvement in Trust performance.

Quality Committee

Item 6.1.3a

Terms of Reference

For completion by Author			
Author(s) Name and Title:	Sue Pemberton, Director of Nursing and Quality Lucy Lavan, Director of Corporate Affairs		
Scope:	Trust Wide	Classification:	Terms of Reference
Version Number:	6.0	Review Date:	1st July 2021
Replaces:	Quality Committee Terms of Reference v5.0		
To be read in conjunction with the following documents:	Governance Manual, Provider Licence, Board Assurance Framework		
Document for public display:	Yes		
Executive Lead	Sue Pemberton, Director of Nursing & Quality		

For completion by Approving Committee			
Equality Impact Analysis Completed:		N/A	
Endorsement Completed:	N/A	Record of Changes	N/A
Authorised by:	Board of Directors	Authorisation date:	28th July 2020

For completion by Document Control					
Unique ID No:	TOR/TB/14(14)	Issue Status:	Approved	Issue Date:	
After this document is withdrawn from use it must be kept in archive for the lifetime of the Trust, plus 6 years.					
Archive:	Document Control		Date Added to Archive:		
Officer responsible for Archive:	Document Control Administrator				

Contents

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The Committee is authorised by the Board to obtain legal advice or other independent professional advice. The Committee is authorised to request the attendance of individuals and authorities from inside or outside of the Trust with relevant experience and expertise, where it considers this is necessary or expedient to the carrying out of its functions.

Trust Standing Orders and Standing Financial Instructions apply to the operation of the Committee.

3. Main Priority and Objective

The Quality Committee shall provide the Board of Directors with a means of independent and Objective review of quality governance. The Committee's main priority is to review and scrutinise assurances that the Trust's strategic priorities for quality and safety improvement are identified,

i) Ensure that appropriate quality standards in relation to clinical outcomes, safety and patient and family experience are set and compliance with them is monitored;

4. Duties and Responsibilities

The Committee will promote safety and quality in patient care and experience and help to identify priorities and risks arising from clinical care and treatment on a continuing basis.

Specifically the Committee will:

i) Receive assurances on the content of the Quality Strategy in relation to the targets set and on the quality of data reported to measure these targets

ii) Assess the clinical and quality impact of financial decisions e.g. Cost Improvement programmes

iii) Review and scrutinise in-year quality monitoring reports, ensuring the integrity of data

iv) Seek assurance that the Trust is compliant with external regulations and standards of quality governance, including but not limited to:

-National targets in relation to quality
-Contractual requirements – CQuINs
-Receive the outcome of the EECS assessments from the clinical areas annually

v) **Patient Safety**: Receive assurance that the patient safety agenda is implemented throughout the Trust including:

- Infection prevention and control via the quality report at each meeting and via the Quality Safety Experience Committee (QSEC) key
- issues report.
  Safeguarding – via the via the key issues report from e QSEC
-
- Incident reporting process and implementation of learning from incidents from the IICC report
- Annual report from the medications safety group
- Receive assurances on the management of diabetes across the Trust via the key issues report from QSEC
- Receive monthly updates via the quality dashboard in relation to compliance with the sepsis bundles and improvement works in place and receive updates from the annual report via the QSEC key issues report and report on performance against the trusts sepsis bundle at each meeting

vi) **Clinical Effectiveness**: Receive assurance that the clinical effectiveness agenda is implemented throughout the Trust including via quarterly key issues reports from the QSEC committee meeting and via:

- Updates from any clinical effectiveness initiatives
- Effectiveness of governance processes relating to mortality via an annual mortality assurance paper and via the mortality data presented at each meeting via the quality report and via the key issues report from QSEC
  Receive the clinical audit annual assurance report
- Receipt and review of benchmarking data relating to outcomes
- Assurance around adherence to best practice e.g. NICE guidance, Royal
- College standards etc
  Receive assurance regarding readmissions and the Trusts improvement
- plan to reduce incidence
  Receive assurance that the trust is meeting the outcomes for cancer
- services via the key issues report from QSEC
  Receive assurance in relation to compliance with Natsips and Loccsips
- annually
  Receive assurance in relation to resuscitation standards via the key issues
- report from QSEC
  Receive assurance on the incidence and improvements in preventing falls,
- and pressure ulcers via the quality report and via the key issues report from QSEC
  Receive assurance on nutritional standards trust wide via the key issues
- report from the QSEC
  Receive assurance reports regarding progress with the GIRFT Improvement
- plan
  Receive the root cause analysis for all incidents deemed serious as per the
- incident reporting policy and assurance that there is a comprehensive action plan in place to address any identified improvements.

vii) **Patient and Family Experience**: Receive assurance via the quality report that the patient and family experience agenda is implemented throughout the Trust including:

- Receipt of assurance report on action planning in relation to the annual patient survey and the key issues report from QSEC
  Assurance on quality of data relating to complaints, claims and PALS
- processes – identification of trends and assurance on implementation of learning via the customer care reports
  Annual assurance report patient and family experience progress via the QSEC
- key issues report

viii) **Research & Development**: Receive assurance that the R&D agenda is implemented throughout the Trust including:

- Assurance on data demonstrating implementation of research a nd d innovation strategy via assurance reports

ix) Receive external assurance reports from the CQC and from regulatory / statutory bodies in relation to the quality and patient safety agenda and ensure that management responses / action plans are robust.

x) Consider urgent or material matters referred to the Committee by the Operational Board, Audit Committee or Board of Directors.

5. Risk

The Committee will consider and seek assurances in relation to any risks relating to its remit and will identify and escalate any new or emerging risks arising from its work, through the BAF key issues reporting process. The committee will receive key issues from the risk management committee via the key issues report from QSEC.

6. Equality and Diversity

Ensure that equality and diversity and due consideration to the Human Rights Act are regarded in all aspects of the committee's work. This will include review of any equity analyses that are commissioned against the Trusts clinical services portfolio. In addition the Committee will have regard for NHS constitution in delivering its objectives.

7. Integration

The committee will support the integration of clinical, organisational and financial governance across the Trust.

8. Membership

Three nominated Non-Executive Directors, one of whom will be the Chair and one the Vice Chair. In attendance at all meetings:

Director of Nursing & Quality
Medical Director
Director of Research & Innovation

All of the above attendees to appoint a nominated Deputy who will attend in his / her absence

The Committee may invite other officers to attend meetings as required. All Board Members have a right to attend any meeting of the Committee.

9. Quorum and Frequency

In order for decisions taken by the Committee to be valid, the meeting must be quorate. The Chair or Vice Chair plus three other members of the Committee must be present at the point when any business is transacted.

The Committee will meet quarterly (4 times per year).

10. Reporting

The Committee Chair will provide a BAF Key Issues Report to the Board of Directors following each meeting, along with approved minutes and an annual report, which will include a review of the Committee's Terms of Reference.

The Chair of the Committee will escalate urgent matters and exceptions to the Board and / or Audit Committee in between meetings as deemed appropriate.

11. Conduct of Committee Meetings

The Chair of the committee will be supported by a lead Executive Director who will ensure that the appropriate processes are followed:

- Minutes and action log are accurate, comprehensive and timely
- The agenda and supporting papers are sent out to committee members 5 working days prior to the meeting, unless authorised by the Chair for exceptional circumstances
- Authors of papers presented must use the required template and adhere to BAF Policy.
- Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of their paper/report and key issues.
- Committee members and those in regular attendance should actively participate in discussions pertaining to the agenda, ensuring that solutions and action plans have multidisciplinary perspectives and consideration of Trust-wide impact

Board of Directors (in Public)
Item 6.1.4

Subject:	**Annual Report of the People Committee 2020/21**
Date of Meeting:	**Tuesday 27th April 2021**
Prepared by:	**Vicki Wilson, Head of Human Resources**
	Ruth Dawson, Head of Learning, Education & OD
Presented by:	**Mark Jones, Chair of People Committee**
	Karen Nightingall, Chief People Officer
Purpose of Report:	**To Note**

1. Executive Summary

Despite the challenges wrought by the Covid pandemic and a hiatus mid-year whilst we sought a new Chief People Officer the People Committee continued to meet, albeit virtually, through the year with the exception of the March'21 meeting which we cancelled in response to Government guidance during the surge in hospital C19 cases. The Non Exec Chair and Chief People Officer will meet through March and this together with the weekly calls with the Non-Executive Directors will provide updates on staff wellbeing.

The focus of the Committee during the year has been to seek further assurance that potential safety and workforce issues our BAME colleagues may face are addressed and the Committee, with Board Approval, has amended its Terms of Reference to reflect our increased focus on these matters. In addition, we have tracked the people component of the Trust's recovery plan and worked closely with the executives on the roll out of the NHS People Plan.

The Committee has been informed at our meetings on the outstanding work by the HR and OD Teams during the pandemic not least on Fit Testing; on-going mandatory training; the recruitment review; reductions in Bank and Agency spend; International recruitment programme and others listed in the tables below.

The review of papers discussed at People Committee has been taken over the course of 2020/21, resulting in several papers being condensed into HR, Education and OD Assurance Paper, detailing current activity, new activity, work plans and assurances for next quarter with emerging risks identified.

The pandemic has necessitated new ways of working as a Committee not least in conducting matters virtually. Of particular value has been the Trust-wide initiative of submitting questions in advance of meetings to the Executives (in the PC case, HR/OD team members) which provided a prospective insight on the areas where the Non-Exec would like to focus and worked particularly well at the People Committee.

2. Delivery of Objectives set by the Board of Directors

A summary of progress against each of the agreed objectives is shown below

	Terms of Reference	Evidence to Support Delivery	Outstanding Issues/Actions
	Excellence in Compassionate and Collective Leadership	Development of new LHCH People Strategy in response to the NHS People Plan and People Promise, launched March 2021. The Committee has continued to place significant focus on Equality, Diversity and Inclusion and receives regular progress reports on the implementation of the Trust's E&I Strategy aligned to the EDS2 goals and outcomes and WRES and WDES metrics. Leadership programme offered externally via Leadership Academy paused during pandemic and then re-established virtually.	Embedding LHCH People strategy into all streams, reviewing actions against each pillar at each People Committee 2021/22 Continue to monitor actions from equality analysis findings from the staff survey, BAME staff sessions and WRES data and WDES. Internal leadership offers under review against LHCH People Strategy
	Attract	The Committee received a workforce dashboard tracking the deliverables of Team LHCH Framework at each meeting held. Refresh of workforce intelligence identified and discussed at March 2020 meeting but paused due to Covid and in Dec 2020 paper outlining plans to develop dashboard linked to new LHCH People Plan was discussed. The Committee has continued to monitor agency and bank usage data against planned spend along with turnover and recruitment data and Trust workforce plans. The Committee has continued to monitor the work being undertaken to reduce the reliance on using agency staffing by increasing the internal temporary staffing bank, partnership with NHSP and also improved utilisation of e-roster. Recruitment and retention review was initially paused during pandemic, it is now incorporated into the LHCH People Plan priorities. Implementation of new NHS Jobs system was delayed as a result of covid, however successful switch over to the new system began in Sept 20 as part of the pilot programme.	Progress with development of new People Plan dashboard. Continue to monitor impact in relation to reduction in bank and agency spend, harmonising bank rates of pay, on call and WLI payments. The Committee will continue to monitor progression of recruitment plans, including international recruitment. Comprehensive review of recruitment process as part of LHCH People Plan to ensure we develop a compelling employee value proposition and recruit a diverse and inclusive workforce. Full roll out of enhanced NHS Jobs system following completion of national pilot.

	Develop	Normal activity reduced during pandemic, with little access to HEIs and agency learning. Work experience and other agency schemes including cadets, traineeships and pre-employment pulled by the relevant provider. Support given to all areas to redeploy staff to areas required, with access to relevant training and learning as required. Two cohorts of deployed students supported the organisation during surges in the pandemic. Both cohorts supported by Education Centre, with almost all students being retained for current and future employment. Evidence of Education and HR teams working as one. Education team took on the task of successfully ensuring 100% staff requiring Fit Testing to appropriate FFP3 mask, and training to appropriate PPE. Mandatory training (93%) and appraisal (90%) maintained to appropriate levels during timeframe other NHS Organisations reduced capacity During pandemic access to appropriate learning venues have been reviewed. Project undertaken to update and regenerate Highfield House for use as Education & Knowledge Hub by Q2 2021. During pandemic range of new services developed including new clinical skills module (Level 7), increase uptake of apprenticeships, development of cadet programme to add to traineeships and pre-employments, virtual learning platforms, engagement events with bands 2-4. Apprenticeship schemes have continued to grow despite the pandemic and pausing of some programme by providers. LHCH has enabled other schemes to continue by supporting staff in different ways.	Apprenticeship Strategy, delayed due to pandemic and providers pausing programme Talent Management strategy and tool kit delayed due to pandemic, to be reviewed against the needs of staff & the organisation in lines with the NHS People Plan, and LHCH People Strategy Completion of Highfield House regeneration and development of learning venues. Embedding of updated CPD policy following HEE CPD review Implementation of International Recruitment strategy, including refugee programme.
	Retain	The Committee received assurance on the work being undertaken to support Learning Lessons to Improve People Practices.	The Committee needs to receive assurance on the staff engagement to support IPP and the embedding of the IPP principles into culture and

		The Committee received update on the progress for the 2019 Staff Survey at the June meeting and plans were adjusted to align communication and engagement with ongoing covid related staff engagement. Full review of HR policies has been undertaken by senior HR BP linked to Improving People Practices, learning from results of COVID19 and priorities of workforce support in recovery work stream. The Committee received regular updates on the Health & Wellbeing offer to LHCH staff. The Trust's offer was adapted during the pandemic including the establishment of a Health & Welfare team and significant investment in additional psychological support (via Mersey Care). The Trusts internal Psychology Team have worked with HR & Education colleagues to develop a sustainable model for supporting our staff.	behaviors at LHCH. Review and analysis of 2020 staff survey results and robust monitoring action plan progress. Further revision of key policies aligned to new People Strategy including Recruitment and Flexible Working. Training programme for frontline staff to enable team base psychological support at the point of need. This is being developed currently with roll out plans early quarter 1.
	Governance/Risks	The Committee received updates on the national NHS People Plan. The Committee received updates on the development of the LHCH People Strategy, developed in response to the NHS People Plan and People Promise. The Committee identified and received assurance in relation to a number of key workforce risks during the course of its work. The Committee received assurance on the People risks within the Board Assurance framework. COVID19 Assurance Reports providing an important addition to Governance Records in relations to actions that have been and will be taken during pandemic.	Continue to monitor progress against the delivery of the LHCH People Strategy.

3. Membership and Attendance

Annual Attendance for 2020/21	Attendance (%)	June 20	Sept 20	Dec 20
Members:				
Mark Jones (Chair)	100%	Yes	Yes	Yes
Bob Burgoyne	100%	Yes	Yes	Yes
Nick Brooks	100%	Yes	Yes	Yes
Attendees:				
Sue Hodkinson	100% of meetings applicable	Yes	N/A	N/A
Karen Nightingall	100% of meetings applicable	N/A	N/A	Yes
Sue Pemberton	100%	Yes	Yes	Yes
Raph Perry	100%	Yes	Yes	Yes
Vicki Wilson	100%	Yes	Yes	Yes
Ruth Dawson	100%	Yes	Yes	Yes

4. Conduct of Meetings

A committee work plan was agreed at the start of the year. Priorities changed due to COVID19 and actions have been provided against reviewed schedules and recovery plans. Minutes and action logs have been maintained and all outstanding actions followed up at each meeting. All meetings have been quorate and one meeting was cancelled (March 2021).

5. Term of Reference

The current terms of reference are included as an Appendix and no changes are proposed.

6. Recommendations

The Board of Directors is asked to note the contents of the report and confirm that the Committee has operated effectively during 2020/21.

Item 6.1.4a

People Committee

Terms of Reference

For completion by Author			
Author(s) Name and Title:	Karen Nightingall, Chief People Officer		
Scope:	Trust Wide	Classification:	Terms of Reference
Version Number:	4.3	Review Date:	1st July 2021
Replaces:	People Committee Terms of Reference v 4.2		
To be read in conjunction with the following documents:	Governance Manual, Provider Licence, NHSI Single Oversight Framework, Board Assurance Framework, Risk Management Policy		
Document for public display:	No		
Executive Lead	Karen Nightingall, Chief People Officer		

For completion by Approving Committee			
Equality Impact Analysis Completed:		N/A	
Endorsement Completed:	N/A	Record of Changes	N/A
Authorised by:	Board of Directors	Authorisation date:	26th January 2021

For completion by Document Control					
Unique ID No:	TOR/TB/07(15)	Issue Status:	Approved	Issue Date:	
After this document is withdrawn from use it must be kept in archive for the lifetime of the Trust, plus 6 years.					
Archive:	Document Control		Date Added to Archive:		
Officer responsible for Archive:	Document Control Administrator				

Contents

1. Constitution and Remit

This Committee is established as an Assurance Committee of the Board of Directors of Liverpool Heart and Chest Hospital NHS Foundation Trust in order to provide the Board with assurance in respect of workforce governance. It is a Non-Executive Committee.

2. Authority

The People Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires of any employee (or contractor acting on behalf of the Trust) and all employees (or contractors acting on behalf of the Trust) are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain legal advice or other independent professional advice.

The Committee is authorised to request the attendance of individuals and authorities from inside or outside of the Trust with relevant experience and expertise, where it considers this is necessary or expedient to the carrying out of its functions.

Trust Standing Orders and Standing Financial Instructions apply to the operation of the Committee.

3. Main Priority and Objective

The People Committee shall provide the Board of Directors with a means of independent and objective review of Team LHCH at its Best Framework in line with the annual planning process. The Committee's main priority is to review and scrutinise assurance that the Trust's strategic priorities for attracting, developing and retaining the best staff are identified, implemented and monitored. Key priorities for 2020/21 will include receiving assurance regarding the development and the delivery of the Trust's emerging Developing People Strategy, monitoring of equality & diversity/BAME issues and the actions to resolve these, to continue to monitor the organisation's sickness absence levels, the use of bank and agency against the planned reduction, implementation of the recruitment and retention strategy and to ensure overall improvement in the quality of appraisals.

4. Duties and Responsibilities

The Committee will promote best practice in HR, Organisational Learning, Development and Leadership and help to identify priorities and risks on a continuing basis.

Specifically, the Committee will:

4.1 Excellence in Compassionate and Collective Leadership

4.1.1 Receive assurance that Team LHCH at its Best and the emerging Developing People Strategy is being developed, delivered and will monitor effectiveness in supporting the Trust's Strategic Objectives and is aligned with the NHS Interim People Plan and NHS People plan (when published).

4.1.2 Receive assurance that staff engagement and satisfaction levels are improving through developed Service Improvement and engagement methodologies, recognition and reward initiatives.

4.1.3 Receive assurance that the Equality and Inclusion Strategy 2019-2021 is being delivered and measures that address the issues that staff of an ethnic background face have been put in place, with clarity regarding what has changed as a result.

4.1.4 Receive assurance reports on compliance with the Workforce NHS Constitution pledges

4.1.5 Receive external assurance reports from CQC and other regulatory / statutory bodies in relation to the workforce agenda and ensure that management responses / action plans are robust

4.1.6 Consider urgent or material matters referred to and from other Committees or Board of Directors.

4.2 Attract

4.2.1 Review Key Workforce Performance Indicators including sickness absence, bank/agency usage and expenditure, education and development, appraisal and staff turnover and ensure agreed targets are being met

4.2.2 Receive assurance that the Trust is recruiting the right staff first time with the roll out of value based recruitment

4.2.3 Provide assurance to the Board on compliance with relevant HR legislation and best practice including doctors and nursing revalidation.

4.2.4 Review and monitor implementation of the Trust's annual workforce plans to ensure the Trust develops new roles and innovative ways of working to deliver appropriate, efficient and safe care 7 days a week

4.2.5 Monitor performance against relevant HR policies and procedures.

4.2.6 Receive an annual report on all Employee Relations activity, including the Staff Partnership Forum, Local Negotiating Committee , Workforce Development Group and People Delivery Group

4.2.7 Receive reports and action plans on the requirements of new and emerging guidance from regulators and external agencies that relate to workforce

4.2.8 Receive assurance the Trust has a robust Job Planning process in place and that maximum value is being achieved.

4.3 Develop

4.3.1 Receive summaries of high level contractual agreements and associated risks from external agencies/ bodies including HENW, HEIs and other partnerships.

4.3.2 Receive the 'Doctors in Training' annual survey and the Deanery annual visit results and monitor delivery of any action plans arising.

4.3.3 Receive assurance that all staff are receiving an effective annual appraisal and that robust succession plans and talent management processes are in place.

4.3.4 Receive assurance that the trust is providing the right education and development opportunities for all our staff to achieve their maximum potential and adhere to their professional standards

4.3.5 Receive assurance that the trust is developing a well led workforce with the right leadership behaviours and management skills to deliver Team LHCH

4.3.6 Receive assurance that the Trust is supporting effective organisational change to deliver our priorities and ensuring our service are sustainable

4.4 Retain

4.4.1 Receive the results and receive assurance against action plans in relation to the National NHS Staff Survey, Staff Friends and Family Test and other workforce satisfaction measures as agreed.

4.4.2 Receive assurance that the workforce can be its best through offering Health and Wellbeing support, flexible working options and creating a healthy workplace enabling good attendance.

4.4.3 Receive assurance that staff are rewarded and recognised for their contribution and performance.

4.4.4 Receive assurance against the delivery of key deliverables of the Trust Retention Plan

5. Risk

The Committee will consider and seek assurance in relation to any risks relating to its remit and will identify and escalate any new or emerging risks arising from its work, through the BAF reporting process.

6. Equality and Diversity

Ensure that equality and inclusion and due consideration to the Human Rights Act are regarded in all aspects of the committee's work.

7. Membership

Three nominated Non-Executive Directors, one of whom will be the Chair and one the Vice

Chair In attendance at all meetings:

Chief People Officer
Director of Nursing & Quality
Medical Director
Head of Human Resources
Head of Learning, Education & Organisational Development

All of the above attendees to appoint a nominated Deputy who will attend in his / her absence

The Committee may invite other officers to attend meetings as required. All Board Members have a right to attend any meeting of the Committee.

8. Quorum and Frequency

In order for decisions taken by the Committee to be valid, the meeting must be quorate. The Chair or Vice Chair plus one other member of the Committee must be present at the point when any business is transacted.

The Committee will meet four times per financial year (quarterly).

9. Reporting

The Committee Chair will provide a BAF Key Issues Report to the Board of Directors following each meeting, along with approved minutes and an annual report, which will include a review of the Committee's Terms of Reference.

The Chair of the Committee will escalate urgent matters and exceptions to the Board and / or Audit Committee in-between meetings as deemed appropriate. Audit reports will be reviewed by the Committee as a standing item.

The Committee will oversee the work of and reports from the Operational Board in respect of matters set out within these terms of reference.

10. Conduct of Committee Meetings

The Chair of the committee will be supported by the Interim Director of People & Culture who will ensure that the appropriate processes are followed:

- Minutes and action log are accurate, comprehensive and timely

- The agenda and supporting papers are sent out to committee members 7 days prior to the meeting, unless authorised by the Chair for exceptional circumstances
- Authors of papers presented must use the required template and adhere to BAF Policy.
- Presenters of papers can expect all committee members to have read the papers and should keep to a summary that outlines the purpose of their paper/report and key issues.
- Committee members and those in regular attendance should actively participate in discussions pertaining to the agenda, ensuring that solutions and action plans
- have multidisciplinary perspectives and consideration of Trust-wide impact

Board of Directors (in Public)

Item: **6.2.1**
Subject: **Audit Committee BAF Key Issues Report**
Date of Meeting: **Tuesday 27th April 2021**
Prepared by: **Jennifer O'Brien, Senior Executive Assistant**
Presented by: **Julian Farmer, Chair Audit Committee**
Meeting Held: **Tuesday 23rd March 2021**

Agenda Item	Lead Exec	Assurance Received	New/Emerging Risks	Actions/Comments
3.1	LL	Draft Annual Governance Statement		The statement would be updated to reflect that the Research Finances audit was completed following a management request and had not been audited before; the internal auditors being directed to the area showed the risk management process was working well Committee members confirmed they had each reviewed the draft Annual Governance Statement (AGS) 2020/21 and accepted the draft for finalisation.
3.2	LL	Annual Report of Audit Committee	None	The report was reviewed and accepted subject to two typographical updates and also Section 2.2 would be updated to reflect that the Research Finances audit was by management request and had not been audited before; the internal auditors were directed to the area which showed the risk management process was working well

3.3.1	KE	Integrated Performance Committee Annual Report	None	The Audit Committee noted the report and confirmed its satisfaction that the IPC had operated effectively during 2020/21. The IPC terms of reference were also reviewed and no changes were recommended.
3.3.2	KN	People Committee Annual Report	None	The Audit Committee noted the report and confirmed its satisfaction that the People Committee had operated effectively during 2020/21. The People Committee terms of reference were also reviewed and no changes were recommended.
3.3.3	SP	Quality Committee Annual Report	None	The Audit Committee noted the report and confirmed its satisfaction that the Quality Committee had operated effectively during 2020/21. The changes to the Quality Committee terms of reference which highlighted the additional safety responsibility of the Director of Nursing, Quality & Safety and the updated Quality Safety Experience Committee (QSEC) were noted and recommended for acceptance by the BoD in April 2021
3.4	KE	Losses & Special Payments	None	Reviewed and Noted
3.5	KE	Single Supplier Tender Waivers	None	Reviewed and Noted
3.6	LL	Review Register of Interests	None	The Audit Committee noted the report and confirmed its satisfaction with the internal governance arrangements in place for identifying and managing conflicts of interest.
3.7	LL	2020/21 Audit Committee Effectiveness Review	On-going impact of pandemic on NED colleagues attendance at the Trust	Responses received for the 2020/21 review were overwhelmingly positive across the full range of questions which was a pleasing outcome in a year where the Committee had to conduct all meetings via MS Teams due to the COVID-19 pandemic. The main points raised within the report were discussed and a formal action plan was not required. It was acknowledged that NED visibility within the

				Trust was an important part of the assurance process and colleagues would work to determine how this could be safely facilitated going forward.
3.8	LL	Annual Review of NHSI Licence	Post pandemic pressures	The Audit Committee noted the review of compliance with licence conditions and confirmed that the checklist for quarterly update continued to be of value in providing assurance to the Audit Committee on an on-going basis.
3.9	LL/KE	Regulatory Action Plans	None	The BoD had been updated on the most recent engagement visit carried out virtually by the CQC**,** the contents of which had also been outlined to NED colleagues during the weekly update discussion. There were no specific actions outstanding with either the CQC or NHSE/I.
3.10	KE	Private Patient Activity Review	Post pandemic pressures	The private patient service had improved significantly since the 2017/18 internal audit review. There were clear and defined roles of staff involved in the inpatient and outpatient pathways of the private patient service which was now documented in both workflows which were accessible Trust wide. A change in the management structure in October 2020 had allowed greater operational management overview in accordance with NHS policies and procedures. It was confirmed that there was regular contact with finance colleagues regarding the service and the team were now looking at how to transition the service post COVID.
3.11	KW	Cyber Security Plan 2021/22		The Audit Committee noted the progress made in 2020/21 relating to cyber security and received the outline cyber plan for 2021/22
4.1	KE	Internal Audit Plan: 3 Year and Annual	None	The plan was accepted by the Audit Committee

4.2	KE	Progress Report on Delivery of Plan	None	The report was noted and work was scheduled to be completed on time
4.3	KE	Follow Up Report	None	The full report was noted by the Audit Committee
4.4	LL	Head of Internal Audit Opinion		The Committee noted the draft opinion, the final Head of Internal Audit Opinion (following completion of reports currently in draft) would be included in the Annual Report and Accounts 2020/21.
4.5	LL	Draft Anti-Fraud Plan	None	The anti-fraud plan was approved by the Audit Committee
4.6	LL	Draft Anti-Fraud Annual Report	None	The full report was noted by the Audit Committee
4.7	LL	Government Functional Standard GovS 013: Counter Fraud		The new standards would come into force from the 1st April 2021 and would bring the NHS in line with the government functional standards across all other public sector organisations. Anti-fraud colleagues were proposing that two of the components would be amber and 10 green. The proposed amber components related to the matrix and any losses, although it was noted that colleagues were still awaiting guidance from NHS Counter Fraud Authority regarding their expectations. The other proposed amber could be the risk matrix, as NHS Counter Fraud Authority were changing the process this year, therefore the anti-fraud specialist would have to assess whether any of the 125 risks identified were applicable to LHCH.
4.8	LL	BAF Opinion		The report which confirmed that the structure of the Board Assurance Framework met NHS requirements with evidence that it was visibly used and reflected the risks discussed by the Board.
4.9	LL	Internal Audit Charter	None	The Internal Audit Charter was reviewed and approved by the Audit Committee. There were no changes to note.
5.1	KE	External Audit Plan 2020/21		The plan provided an overview of the detail which included the significant risks, materiality levels, value

				for money arrangements and the audit logistics and fees. The external auditors had been unable to attend the stock take at the end of 2019/20, resulting in a limitation of scope opinion, of which NHSI were aware and understood that would be the position. It was confirmed that arrangements had been made for the external auditors to attend the stock take this year; but likely that the limited assurance opinion would remain in respect of the opening balances.
5.3	KE	Informing the Audit Risk Assessment- Enquiries of Management		The document supported the external auditors in understanding their risk assessment, particularly the environment under which the Trust was operating and whether there were any key points that needed taking into consideration. The document also set out the Trust's legal position in relation to fraud arrangements, any related party transactions and the key accounting estimate around valuation of land and buildings.
6.1	KE	Review of Accounting Policies		The Committee noted five changes to Accounting Policies in 2020/21 for reflection in the annual accounts: • Note 1.3 Interests in other entities The Innovation Agency and Liverpool Network Alliance had been added. • Note 1.9 Property, Plant and Equipment DHSC Donated Assets in relation to COVID treatment had been added. • Note 1.11 Inventories DHSC PPE inventories treatment had been

				added. • Note 1.17 Public Dividend Capital Wording in relation to PDC updated to reflect new DHSC guidance. • Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted. This note reflected the adoption of IFRS 16. The relevant information would be completed for final accounts. Update to other standards was not adopted.

minutes

Item 6.2.2*

Quality Committee

Minutes of the Quality Committee Meeting held on Tuesday 5th January 2021

Present:	
Nick Brooks (Chair)	Non-Executive Director
Sue Pemberton	Director of Nursing & Operations
Raph Perry	Medical Director
Marga Perez-Casal	Director of Research & Innovation
Mark Jones	Non-Executive Director
Karen O'Hagan	Non-Executive Director
In Attendance:	
Megan Underwood	Personal Assistant (Minutes)
Michael Filek	Head of Improvement and Transformation (item 6.3 only)
Jonathan Develing	Director of Strategic Partnerships (item 6.7 only)

1. Apologies for Absence
No apologies had been received.

2. Declarations of Interest
There were no declarations of interest.

3. Minutes of e-meeting held on: 6th October 2020.
The Minutes from the previous e-meeting were recorded as a true and accurate record.

4. Patient Story
The Director of Nursing and Quality read the patient story.

5. Action Log
Item 1 – Quality and Patient Family Experience Assurances / Risk Report 12th July 2020

- Committee members had received the presentation from the QPFEC. The completed action was removed from the log.

- Proposals for management of aggressive patient behaviour were discussed with item 6.7 (Delirium report).
- The Director of Research and Innovation explained that the search for a clinical lead for follow-up of stroke patients had been set aside to be explored later in the year. The item would remain on the action log with an unidentified timescale.

Item 2 – Clinical Quality Performance Report Month 5

- The high HSMR in August 2020 was discussed with item 7.2 (Dr Foster Mortality deep dive).

Item 3 – GIRFT Report Actions and Progress Update

- This process has been paused due to the pandemic and will be addressed in a future meeting.

6. Quality

6.1 Update Serious Incidents

The Medical Director shared an overview of the serious incidents that had occurred during Q1-Q3.

- Failure to follow-up incidental finding on CT scan; patient presented three years later with advanced renal carcinoma. Discussion centred on how to prevent human errors of this type. The secure health messaging system had been refined since the original error, which was made in 2017, and adherence is now audited as a KPI at all QPFEC meetings. The Clinical Services Division is assessing the learning from the incident and will feedback to the next divisional governance meeting and to the Quality Committee and Board in due course. **RAP**

- A patient took his own life while a patient on Cedar Ward. Fully investigated by RCA from which learning has taken place, and actions have been implemented to reduce future risk, though it was concluded that in this case the suicide was not preventable (even by introduction of the proposals in item 6.7). The final responses from STEIS and the CCG are awaited.

- Leak from the aortic suture line missed on two consecutive surveillance CT scans; patient subsequently presented with aortic dissection. The MD pointed out the infeasibility of over-reading every CT scan; currently about 3% are assessed by two observers. A standardised approach to reporting has been introduced together with discussion of the role of 3D scanning, which would have facilitated identification of the leak in this case.

- Fatal complication of balloon pulmonary valvotomy. The initial complication, a recognised risk associated with the procedure, had resulted from perforation of the pulmonary artery with a stiff guide wire. Death was caused by subsequent pneumonia and sepsis. Investigation is incomplete but the MD explained that learning has been implemented and immediate action taken to ensure more appropriate mentoring and partnering of operators by experienced interventional colleagues.

- Injury to subclavian artery during insertion of a subclavian venous catheter resulted in abandonment of the patient's operation. The

preliminary conclusion is that the complication was associated with difficulty in manipulating an unnecessarily long guide wire. Learning has taken place and standardisation of the equipment pack with a shorter wire has been carried out.

6.2 Clinical Quality Performance Report
The Quality Committee reviewed and discussed the Clinical Quality Performance Report.

Mortality
A single, isolated, red indicator related to incomplete mortality reviews by doctors in November.

Infection Prevention and Emergency readmissions
Four gram-negative bacteraemias had occurred in October/November, two of which were associated with urinary tract infections (UTI). The MD explained that UTIs are not treated with antibiotics unless associated with symptoms or bladder catheterisation and a positive culture. All bloodstream infections continue to be investigated by mini-RCA and the results fed back to the ward manager and consultant and followed up to ensure recommended actions are implemented.

Falls and Pressure Ulcers
One pressure ulcer occurred in November from a lapse in care. The Director of Nursing and Quality explained that investigation had determined that the lapse was associated with a gap in the documentation on repositioning the patient. An action plan was in place and the Director of Nursing and Quality has met with the Information Team to redesign the document to include additional narrative. The Committee acknowledged the excellent work of the tissue viability nurse consultant and the rarity of avoidable pressure ulcers.

Reported Patient Safety Incidents and Medication Errors
Medication errors, driven mainly by insulin prescribing, continue to be numerically the largest category of safety incidents. The common theme was failure to prescribe the infusion when patients were being transferred to the other wards. None had resulted in severe harm. The Medical Director assured the Committee of the on-going efforts to eliminate the errors which were being monitored through the QPEFC, with a closed loop system under development.

Complaints, Clinical Claims and SE/NE/AE
A member of the Committee asked if the report could be expanded to include the number of complaints that were closed and, of those that were open, how long they had been under investigation. The Director of Nursing agreed to explore the possibility of including greater detail in the summary reports. **SP**

VTE and PPCI

There has been a small drop below the 95% target for VTE assessment. A new VTE lead has been recruited and the policy is being rewritten. The divisions are aware of the issue and the data are presented each month to the Operational Board.

The Committee expressed on-going concern over the failure of timely PPCI and the inevitable effect this is likely to be having on the mortality from myocardial infarction. A minority of patients admitted to the Trust facing the likelihood of a delay in transfer to the cath. lab do receive thrombolytic therapy at the discretion of the interventional cardiologist.

The Committee requested additional information on the number of patients receiving reperfusion outside the 120- and 150-minute targets, with a breakdown of their times from calling for help to hospital admission and from admission (either direct to LHCH or to another acute trust) to balloon inflation, and whether they received thrombolytic therapy. **MPC**

Sepsis
The gradual improvement in sepsis KPI's was noted (see also item 6.5 Sepsis Annual Report).

6.3 Quality (QIA) and Equality (EIA) Impact Assessments
The Head of Improvement and Transformation joined the meeting to present the quarterly update on the CIP programme, together with an explanation of the protocol for development and implementation of CIPs.

The Committee received assurance from part 1 of the report which confirmed that all CIPs for 2020/21 are compliant with the Trust's QIA and EIA requirements

The review of the protocol for assessment of CIPS had been requested in response to the Audit Committee's conclusion (19th October 2020) that the Quality Committee is responsible for receiving assurance "that the QIA process was robust, through an in-depth review of each scheme, sampling or via assurance from MIAA".

The Head of Improvement and Transformation explained how, for all CIP proposals exceeding £25K, the project lead is mandated to consider whether it could have any impact on individuals with protected characteristics and, if so, to complete the more detailed process set out in the Trust Equality and Inclusion Policy. This is followed by a quality impact assessment, which requires scoring of the risk of an adverse impact on patient safety, clinical effectiveness, patient experience, operational/non-clinical considerations, estate, facilities and environment, finance, or reputation. The documents form part of the Trust Improvement Project Document (IPD) which is then reviewed by the Improvement Team for quality and completeness and, provided it meets the required criteria, is forwarded for review and sign-off by the Medical and Nursing directors. The process was illustrated with a completed IPD.

The Committee discussed the document without raising any concerns and accepted assurance of the thorough, comprehensive, and rigorous process. The Head of Transformation was thanked for his presentation and left the meeting.

6.4 QPFEC Key Assurances / Risks Report

Quality Performance

The Committee noted the expanded participation of pharmacists on ward rounds which, it is anticipated, should address the problem encountered with the new policy of warfarin prescribing at 2.00 rather than 6.00pm. Re-audit will be carried out once problems with point-of-care INR measurement have been resolved.

Resuscitation Report

The progressive implementation of the recommendations of the external review of the resuscitation service was noted; in particular, the training to ALS competence of resuscitation leads and team members.

With reference to the national audit of resuscitation, it was pointed out by the Committee that the comparison of the percentage of resuscitated patients surviving to discharge with other acute trusts is misleading, as the case-mix strongly favours specialist cardiothoracic units; the more informative comparison would be with peer group hospitals.

Covid Update

The MD summarised the actions taken to meet the challenges of the Covid pandemic. In response to questions, he advised the Committee that:

- No problems exist or are anticipated with oxygen supplies.
- It is inappropriate to make comparisons of the outcomes with other trusts since LHCH is largely acting as a secondary referral centre.
- Compared with the first surge, management guidance has been developed and a higher proportion of patients are receiving medical therapies and a smaller proportion are on invasive ventilation.

Radiology Quarterly Report

Quarterly meetings have been established to discuss and learn from discrepancies between imaging reports and subsequent clinical findings. At the request of the DON, an annual report is to be submitted to QPEFC to provide clarity on how incidents are escalated, and their seriousness is calibrated. The report is to be submitted to the Quality Committee at its April meeting. **SP**

Patient and Family Experience Annual Report

The Committee noted the outstanding commitment to the patient and family experience (see also item 8.1). The relatively disappointing results of the post-hospital survey are to be addressed, though this work has temporarily been paused because of priorities related to Covid.

6.5 Sepsis Annual Report

The Medical Director updated the Committee on the Sepsis 2019-2020 Annual Report, which was delayed due to the Covid pandemic. It showed some improvement in the sepsis management KPIs and a substantial uptake in use of the sepsis screening tool.

The Committee also discussed the innovative quality improvement project in which adherence to the key recommendations for sepsis management ('the sepsis six') were assessed in consecutive patients over a five-week period and the results – "pass" or "could do better" - fed-back to the responsible clinician. Whilst the number of episodes was too small to draw a definite conclusion, a distinct trend to improved performance was observed by the final week of the study.

The Committee was assured of the continuing efforts to improve adherence to the KPIs and use of the screening tool.

The 2020/21 report will to be presented at the April 2021 Quality Committee. **RP**

6.6 Statement of Purpose
The Committee noted and approved the document without comment.

6.7 Delirium Report
The Director of Strategic Partnerships joined the meeting to present his report on proposals for further development of mental health services within the Trust. Whilst a major focus is on delirium, an increase in clinical and psychological support, together with development of policies aims to improve:

- Staff support and safety.
- Patient support and safety
- Multi-disciplinary clinical leadership
- Education and training

Two major investments are proposed: a psychiatric liaison contract with Merseycare and additional psychology support for critical care which would transform the psychology service from being dependent on referral, into a multi-disciplinary team able to meet essentially all the Trust's requirements. Whilst Board approval for the scheme is pending; service improvements are already in place with the training of existing staff as mental health first aiders and psychiatric link nurses, and new policies and e-learning modules on care communication, self-harm and suicide, in development.

Discussion centred on the adequacy of the scheme to meet all its objectives, the status of the first aiders and their training (any member of clinical or support staff with training predominately on-line); patient monitoring and the recently introduced measures to prevent suicide. The Director of Strategic Partnerships emphasised that many of the ideas had been put forward by members of staff on the 'front-line', in part from learning after the suicide of a patient and its consequent impact on both the family and staff.

Committee members were supportive of this important quality improvement plan which will build on the actions already introduced to support patients and staff during the Covid pandemic.

The Director of Strategic Partnerships was thanked for his presentation and left the meeting.

7. Clinical Effectiveness

7.1 Annual Report Clinical Audit and Effectiveness Strategy

The Director of Research and Innovation presented the Annual Report of the Clinical Audit and Effectiveness Strategy. The Committee noted that the major objectives of the 2017-2020 strategy had been delivered, despite members of the research team having been working from home during the Covid pandemic.

The Clinical Quality Forward Plan for 2021-22, which builds on the 2017-20 strategy, is to be developed during Q1 for ratification by QPFEC in July 2021

In response to a question from the Committee, the MD explained that the main role for the Medical Examiner was as an independent reviewer to provide an extra layer of scrutiny, prior to issuance of the death certificate, in addition to the existing mortality review process.

7.2 Dr Foster Mortality Deep Dive

The Director of Research and Innovation presented an investigation into two outlier reports identified in Dr Foster Mortality Intelligence. Of the seven deaths, 4 were coded “coronary artery bypass grafting other”, which occurred in August 2020 (to which action point 2 refers) and three were “other respiratory” conditions.

Of the four CABG cases, three were non-elective; all went through the mortality screening process and two had a full review. None were considered to have been avoidable, though two, judged to have been “possibly avoidable but not very likely”, identified technical issues with the surgery. In both cases the operating surgeon was a locum.

Of the three deaths in the “other respiratory conditions” group, two had been inappropriate activations for PPCI, had no procedure and died after transfer to another hospital, and the third had terminal cancer and died from a myocardial infarction. None were considered to have been avoidable.

Members of the Committee expressed some concern over the role of the locum surgeon. The MD explained that the surgeon is held in high regard and, since completing the locum appointment, has been appointed as a fellow in the Trust. During one of the cases, he was being supervised by a senior colleague. Surgeons are appointed to locum positions only if they hold a CST, have completed their training and are awaiting formal award of their CST; or, if qualified overseas, have undergone training and accreditation that is recognised by the Royal College of Surgeons and have appropriate references. The Committee was reminded of the rigorous policy of monitoring of individual surgeon’s performance and accepted assurance that all appropriate actions had been taken in relation to the deaths.

8. Patient and Family Experience

8.1 Patient and Family Experience Annual Report

The Quality Committee noted the outstanding progress documented in the report and the intention to focus on the post-hospital experience (see also item 6.4).

9. Compliance and Regulation

9.1 Quality Risks

The Director of Research and Innovation presented the Quality Risks.

No new risks had been added to the Register. Four static risks are being monitored. In response to concern which was raised over the risk to the service continuity of digital systems it was explained that although a business case had been presented to the Extraordinary Board of Directors the risk remained re-rated as the work had not been completed. Reduction in the risk to quality and safety of care of patients requiring a CT scan are expected to reduce this year with replacement of the CT scanner and the risk to patient safety in Theatres and Cath Labs is being addressed with the appointment of an electrical consultant to design a new electrical supply system.

The Committee accepted assurance that the risks are being managed appropriately.

10. Date and Time of Next Meeting

Tuesday 6th April 2021, 11am-1pm, Research Meeting Room/Microsoft Teams.

Item 7
Board of Directors (in Public)

minutes

Minutes of the Meeting of the Board of Directors held on 30th March 2021 via MS Teams

Present :	**Neil Large**	**Chair**
	Jane Tomkinson	**Chief Executive**
	Nicholas Brooks	**Non-Executive Director**
	Bob Burgoyne	**Non-Executive Director**
	Karen Edge	**Chief Finance Officer**
	Julian Farmer	**Non-Executive Director / Deputy Chair**
	Mark Jones	**Non-Executive Director**
	Hayley Kendall	**Chief Operating Officer**
	Karen O'Hagan	**Non-Executive Director**
	Sue Pemberton	**Director of Nursing and Quality**
	Raphael Perry	**Medical Director/Deputy Chief Executive**
In Attendance:	**Jonathan Develing**	**Director of Strategic Partnerships**
	Lucy Lavan	**Director of Corporate Affairs**
	Karen Nightingall	**Chief People Officer**
	Kate Warriner	**Chief Digital and Information Officer**
Observers – Governors / Staff/ Members of the Public:	**Joan Burgen**	**Public Governor-North Wales**
	Dorothy Burgess	**Public Governor-Merseyside**
	Peter Brandon	**Public Governor-Cheshire**
	Allan Pemberton	**Public Governor- Cheshire**
	Trevor Wooding	**Senior Governor (Public – Merseyside)**
	Ian Haythornthwaite	**Member of the public**
Apologies for absence:	**Marga Perez-Casal**	**Director of Research & Innovation**

Action

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1 Opening Matters

The Board meeting was conducted via MS Teams.

The Chair welcomed all those present to the meeting.

1.1 Apologies for Absence

Apologies for absence were received from Marga Perez-Casal.

1.2 Declaration of Interests relating to agenda items

It was noted that Neil Large, Mark Jones and Julian Farmer each had an interest in Item 5.4 in relation to NED independence. They would remain present for the discussion, unless at any time during the discussion on this item, any Board member indicated a concern that they wished to raise without an individual being present.

As for the remaining agenda items, all Board attendees declared that they had no interests.

1.3 Patient Story

The Director of Nursing & Quality read a patient story.

1.4 Staff Story

The Chief People Officer read a staff story.

1.5 Chair's Briefing

The Chair reflected on the stories read and that these illustrated how moving the last 12 months had been for staff and patients and how humbling this had been to see. On behalf of the Board, he expressed sincere gratitude to all staff for their significant efforts in rising to the challenges brought by the coronavirus pandemic.

Congratulations were expressed to Dr Nigel Scawn who had recently been appointed Deputy Medical Director and the Trust's patient safety lead. He would take up these roles with effect from 1st April 2021.

2 Patient Safety and Quality

2.1 Infection Prevention and Control

2.1.1 Infection Prevention and Control (IPC) Board Assurance Framework (BAF)

The Medical Director took the Board through updates to the IPC BAF, noting that there had been a significant revision of the IPC BAF in February 2021, with inclusion of an additional 42 key lines of enquiry. The BAF had been updated accordingly, with further evidence to demonstrate compliance and to highlight a small number of gaps and mitigating actions. It was also noted that the CQC had put in place a new emergency support framework for IPC.

It was noted that whilst the third peak in hospitalisation as a result of the coronavirus pandemic had now eased considerably, IPC protocols remained robust and it was essential that meticulous

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IPC processes were maintained to ensure the safety of patients and staff as the Trust recovered its regular activity.

The Board discussed the ongoing gap in consultant microbiology cover for critical care and noted the mitigating arrangements in place.

It was noted that the actions in relation to mandatory training were now complete.

The Board noted the report.

2.1.2 Update on Nosocomial Outbreaks

The Board heard that there were no notifiable outbreaks within the Trust at the present time.

3 Strategy and Development

3.1 Sustainability Development Plan Update

The Board noted that good progress had been made in respect of investment in theatre ventilation systems (funded from a successful grant application to Mailforce), recycling of EP catheters and introduction of a new 'Bag to Bed' clinical waste management system. In addition plans were being progressed to install ten new Electric Vehicle Charging Stations, with support from the Charitable Funds Committee.

It was noted that many of the schemes had been self-generated by staff, a number of whom had shown keen interest in the green agenda.

The Board noted the report.

3.2 Digital Excellence Report

The Chief Digital & Information Officer presented the report and confirmed the announcement of LHCH's participation in the Digital Aspirant Programme with £1.1m funding received in respect of the first tranche of milestones. She outlined progress with the mobilisation of plans to support the delivery of the Digital Excellence Strategy, catalysed through this national investment; and in establishing effective governance arrangements to support the digital collaboration with Alder Hey.

The Board noted the completion of a number of improvements in relation to improved connectivity and rollout of new devices, along with progress of transformational projects including virtual consultation ('Attend Anywhere'), Office 365 and photo on discharge to support remote monitoring of wound care post-discharge. Further projects were on track for delivery later in the year.

A new 'Digital Excellence Committee' (to replace the preceding digital committee) chaired by the Chief Executive had been established and the Board noted its terms of reference.

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It was reported that Julie Roy had been confirmed as the Digital Lead Nurse.

The Board noted the report and excellent progress to date.

A discussion followed in relation to patient input into the plans in the context of inequalities around patient access to IT, including internet connectivity. It was noted that plans to date had been developed largely around existing condition groups such that digital enablement was aligned to the specific needs of individual conditions and the patient cohorts involved. In addition, digital access was now a key theme at regional level and LHCH would be actively engaged in this workstream going forward. The Chief Executive added that the planning guidance signalled the need for a real focus on facilitating access through both digital and non-digital means to ensure equality of access for all.

The Board went on to discuss how success would be monitored and heard that a Statement of Planned Benefits had been set out and would be used as a key tool for measuring realisation of financial and quality benefits. These would be tracked via the Digital Excellence Committee with quarterly reports provided for the Board of Directors. The tracking of benefits realisation was a key requirement for participation in the Digital Aspirants Programme.

It was noted that success would be driven by having the right people and that recent changes in leadership had seen the start of significant presence from Alder Hey colleagues with both organisations benefitting from the pooling of talent. The development of users was also key and excellent support and engagement from Divisional colleagues was acknowledged.

The Director of Nursing & Quality noted that the nursing workforce was already feeling the impact as a result of replacement of ageing devices and involvement in work underway to implement handheld devices which would support better interaction with patients; also significant safety benefits would accrue following implementation of technologies such as 'closed loop' which would support safer administration of blood products and medicines.

The Chief Digital & Information Officer was thanked for her leadership of this significant programme of work.

3.3 Health & Wellbeing Update

The Chief People Officer updated the Board on new health and wellbeing initiatives for staff including, wellbeing conversations with line managers, relaunch of the Health & Wellbeing Group and a clear strategy for the provision of psychological support. The launch of 'Vivup', a new staff benefit portal was planned for April 2021 and upcoming events including stress awareness month (April 2021), World Health Day (7th April 2021) and reopening of the staff gym from 12th April 2021 were noted.

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The Board recognised the importance of the health and wellbeing work and discussed the arrangements for rolling out wellbeing conversations for all staff. The Chief People Officer advised that whilst there would be training and a process and parameters around expectations for managers in leading these discussions, it was not intended that these would be recorded or linked directly to appraisal, except in the event of the requirement for occupational health involvement.

It was noted that the Health & Wellbeing Group had been refreshed and now comprised 16 champions from across the Trust who were motivated to move at pace in development and roll out of health and wellbeing plans.

The Board noted that there had been good uptake of the Wellpoint Kiosk which was underpinned by a robust information governance process to protect personal data but also provide generalised data on themes. For example it was noted that of the 565 users of the LHCH kiosk, 25% had high blood pressure. Whilst the Trust would not be able to identify those individuals, the information could be used to inform a wider health and wellbeing offer to staff, for example promotion of healthy lifestyle. It was noted that in addition to the reopening of the staff gym, the fruit and vegetable stall would be reopened in the coming weeks.

The Director of Strategic Partnerships noted that LHCH had one of 30 Kiosks that had been installed across Cheshire and Merseyside and that the scheme had been shortlisted for an HSJ award linked to rollout of community blood pressure testing.

The Board noted the report and recognised the strong emphasis that had been placed on staff health and wellbeing both throughout the pandemic and looking ahead to recovery and beyond.

4 Targets and Financial Performance

4.1 Board Dashboard period ended 28th February 2021

The Chief Operating Officer presented the performance dashboard and highlighted the continuation of non-compliance with access targets, due to the accumulation of a significant number of patients waiting following a third surge in Covid-related hospitalisation. In-month performance for RTT was 74.6% treated within 18 weeks for English commissioned activity and 76.9% for Welsh commissioned activity. There were 125 patients waiting longer than 52 weeks at the end of February and this was expected to increase further as the Trust continued to prioritise the most clinically urgent cases. The Board noted that consultant-led harm reviews continued to take place for patients waiting. The 6 week diagnostic performance remained below target but had increased to 89.8% compliance in-month. Backlog recovery plans were progressing well and diagnostic performance was expected to reach compliance from April 2021, subject to the

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successful installation of the new CT scanner, which was due for delivery within the next 24 hours.

The Board noted that sickness absence remained above target at 3.74% but this position was significantly improved compared to last month, and was strong in comparison to absence levels experienced across the region and wider NHS.

Other performance exceptions noted included delayed transfers of care, dementia referrals and infections.

Although the national targets had not been achieved, the Trust was in a strong position to deliver its elective recovery programme and the Board went on to discuss the impact on patients in respect of delayed treatment. The Board heard that all patients waiting had been clinically categorised for prioritisation, which meant that there would likely be a growth in patients waiting over a year, but would ensure that the most urgent clinical conditions were treated first. It was clarified that the clinical categorisation applied to all patients irrespective of commissioner and therefore patients from Wales and the Isle of Man were treated in exactly the same way as English patients as soon as their referral was received at LHCH. It was acknowledged that any delays in local primary care and secondary care systems could not be influenced by LHCH but once on the LHCH waiting list, there were robust processes in place to secure the safety of patients waiting. The Chief Operating Officer added that non-recurrent investment had been secured to enhance waiting list validation processes. The Medicine Division would be leading on the trust-wide processes for managing and monitoring waiting lists going forward.

The Board noted the financial position a £978k surplus to 28th February 2021 as a result of an additional share of national funds and lower non-pay expenditure linked to reduced activity during the winter Covid surge. A strong cash position had been maintained as a result of pre-payments by commissioners to support COVID related costs. The outturn was better than revised plans due to the receipt of further national allocations. There were no specific risks to highlight in respect of the Month 11 financial position.

The Chair summarised that overall performance was good in the context of prevailing circumstances; however long waiters and the elective backlog was of significant concern and would remain the key focus for recovery.

The Board noted the report.

4.2 Phase 4 Recovery Planning

The Chief Operating Officer took the Board through phased plans to increase elective capacity which would be allocated in accordance with greatest clinical need. The Board discussed the risks associated with the recovery programme including non-

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elective demand; staff resilience and morale; recruitment and retention; wider system demands in relation to mutual aid and in the event of a further Covid surge; and winter planning.

It was noted that there were approximately 4000 patients on the waiting list, of which 146 had waited over 52 weeks. Patients clinically categorised as 'P2' were the most urgent electives and needed to be seen within 4 weeks and capacity plans were currently focussed on this requirement. It was expected that all P2s would be dated and treated by the end of April 2021, though the 52 week trajectory was subject to potential significant fluctuations in demand. Based upon the assumptions underpinning the trajectory, it was anticipated that the waiters over 52 weeks would be seen by the end of January 2022 although every effort would be made to accommodate these patients earlier than this. It was noted that the waiting list would continue to grow and therefore the provision of additional capacity needed to be explored.

It was noted that the Trust continued to provide mutual aid in respect of capacity for liver surgery and for now this was committed until the end of April 2021. The Trust may need to adapt its plans as necessary to support wider system recovery in accordance with the clinical prioritisation of all patients.

The Board noted the draft activity pans and the reliance on positive staff engagement which underpinned all aspects of recovery. The plans assumed a core level of activity but there was opportunity to exceed this with additional funding and the ongoing willingness of staff. A number of schemes to increase capacity were set out and risk assessed as described on Page 6 of the report. Staff absence was a key risk that could quickly destabilise what was an ambitious recovery plan.

The Chief Executive highlighted that the Trust remained constrained in expanding its capacity both by the requirement to maintain rigorous infection prevention and control procedures and by the fact that the Trust was landlocked with no opportunity to expand its physical footprint on the Broadgreen site. She added that POCCU 3 was currently ring-fenced exclusively for COVID positive patients and at the present time there was only one such bed being utilised. Work was ongoing to consider how these beds might be released safely to enable more throughput of non-COVID activity. It was noted that there was still a great deal of uncertainty in respect of COVID transmission and impact on hospitalisation and there remained a risk of a further surge, particularly in the winter months.

The financial assumptions were discussed and it was noted that there would be greater clarity in the next few weeks regarding the cost of extra capacity and the likely level of national financial support. It was hoped that the capacity plans to support recovery could be firmed up by the end of April.

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The Board accepted the activity recovery plans and clarity of assumptions and risks underpinning the Trust's recovery journey.

5 Governance and Assurance

5.1 National Staff Survey Results 2020

The Chief People Officer delivered a powerpoint presentation and the following highlights were noted:

- Overall - LHCH ranked number 1 for overall positive scores compared to other Acute Specialist Trusts (using Picker)
- Top 'overall' score in Cheshire and Merseyside (78.4%)
- 64% response rate which was significantly higher than that of other providers
- LHCH results compared favourably with other Trusts with 46% of questions (36/75) scoring significantly better and 51% (40/75) comparable to average.
- There was no significant change to 91% of questions when compared with previous LHCH results, 2 questions scored significantly better, and 2 significantly worse.
- Significance testing showed a drop in the scores for 'Quality of Care' and 'Safe Environment - violence' themes
- LHCH achieved the top specialist trust score for 5 out of the 10 overall key themes, including;
    - Equality, diversity & inclusion
    - Immediate managers
    - Safety culture
    - Staff engagement
    - Team working

Trust-wide action planning would be focused on each Division identifying the two or three areas in greatest need of improvement. It was noted that a number of the themes for learning and improvement were generic but that each Division would scrutinise its own feedback for any specific follow up actions. The OD Manager would be focussed on driving improvement from the staff survey and also supporting Divisions and Departments to prepare for the next survey. It was also agreed that consideration would be given to standardisation of the staff survey provider across Cheshire and Merseyside to enable quicker and easier comparability of results.

The results would be disseminated via a variety of routes and it was noted that Picker had requested to work with the Trust as an exemplar in respect of its great results and excellent completion rate.

The Chief Executive advised that particular focus would be given to improving the response from staff in relation to 'Recommendation as a place to work'.

The Board noted the 2020 staff survey results and it was confirmed that the full slide deck would be circulated for

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reference. The Chair concluded that the staff survey results were an excellent tribute to LHCH staff.

5.2 Going Concern Report

The Chief Finance Officer presented the report, demonstrating the range of evidence used to assess the Trust's position as a Going Concern. The Board of Directors confirmed its reasonable expectation that the Trust had adequate resources to continue in operational existence for the foreseeable future; also that there were no material uncertainties that cast doubt on the Trust's ability to continue as going concern that required disclosure.

5.3 Consultant Appointments

The Board ratified the following consultant appointment:

- Mr Gopal Soppa – Consultant Surgeon

5.4 Annual Review of Board Director Disclosures:

- **Register of Interests**

The Board noted that all Directors had been formally requested to review and update their declarations of interest.
The Board reviewed the Register of Directors' interests and confirmed that there were no material conflicts with the business of the Trust.

- **Independence Test**

The Board received evidence that all Non-executive directors (NEDs) had recently reviewed their self-declarations of NED independence and determined the continued independence of all NEDs.

The Board noted that Neil Large was in his twelfth year of service as Chair and that careful consideration to his circumstances had been a key part of the latest re-appointment process.
The Board determined that he continued to be independent based on (but not limited to) the following points:
• No material conflicts of interest;
• Clear boundaries maintained between professional and personal relationships;
• No involvement in Audit Committee or Board Assurance committees;
• No involvement in Operational Board, Executive or management forums.

The steady turnover of NEDs had brought independence and fresh perspective to the collective Board and there continued to be strong evidence of constructive challenge as evidenced in the documentation of Board meetings, and endorsed through the CQC's assessment of leadership as 'outstanding'.

On this basis the Board determined that it had no concerns regarding the independence of Neil Large as Chair.

The Board went on to note that Mark Jones completed six years' service as a Non-Executive Director in 2020/21 and that the

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Council of Governors had re-appointed him for a further 12 months. Julian Farmer had also been re-appointed for a further 6 month period in view of his six year tenure expiring at the end of May 2021. The new terms meant that both NEDs would complete their tenures in late 2021, allowing Governors to consider the succession plan in early summer and plan a recruitment process in the context of the prevailing circumstances.

The Board was satisfied that Mark Jones and Julian Farmer continued to meet the independence requirements.

- **Fit and Proper Persons**

The Board received evidence that all Board Directors (voting and non-voting) had completed unqualified self-declarations in respect of the fit and proper persons criteria set out in Regulation 5 (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and as required by the Trust's Fit and Proper Persons Policy.

The Director of Corporate Affairs advised that the Chair had recently reviewed all supporting records held on Directors' personal files and had confirmed these to be up to date, including satisfactory documentation to support all new appointments made in 2020/21.

5.5 Code of Governance: Compliance Review and Disclosure Statement 2020/21

The Board noted the report and approved the proposed disclosure (at Appendix 2) for the 2020/21 annual report. This related to departure from the provisions of the Code in two areas – length of tenure of the Chair and one Non-executive Director; and the Board's decision not to commission a further independent review of Board leadership in 2020/21; the latest comprehensive review having been undertaken in March 2017.

The Director of Corporate Affairs advised that a new updated Code of Governance was expected to be published in the next few months.

5.6 Ratification of Use of Trust Seal-for approval

The Board ratified retrospectively, the application of the Trust seal on 3rd February 2021 to documentation concerning a Deed of Novation as described in the Board paper.

5.7 Wellbeing Guardian Role

The Board noted the recommendation within the People Plan for a Board level Wellbeing Champion and confirmed its support for Karen Nightingall, Chief People Officer, to fulfil this role. The remit of the Wellbeing Guardian as set out in the report, along with the nine principles surrounding the Wellbeing of our NHS People were noted. Karen Nightingall had attended a training course in relation to her role as champion and oversight of the wellbeing agenda would be provided to the People Committee with key issues reported to the Board of Directors.

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The Board noted the report.

5.8 **Annual Review of Disciplinary Cases 2020/21**

The Chief People Officer advised that the purpose of the report was to enable the Board to review disciplinary activity of the Trust for the year 2020/21, in the context of national recommendations around 'Improving People Practice' (IPP).

The Board noted that whilst there had been an overall increase in the number of disciplinary cases, the review of ongoing suspensions and timely lifting of suspensions had improved. The aim was to ensure that staff are not unnecessarily subject to procedures which are known to have a significant and detrimental impact on individual health and wellbeing. Continuous evaluation of the procedure in practice would be required to ensure consistency and application of lessons learnt.

It was noted that the Trust's disciplinary policy had recently been reviewed and updated to reflect IPP recommendations. An Employee Relations tracker had been developed to provide data on the number of cases and information on performance against timelines set for individual cases. The Board noted one case which due to unique circumstances had been prolonged for a period well beyond the normal timeframes.

In response to a question from the Board about learning, the Chief People Officer advised that IPP guidelines had facilitated the improvement of tracking and had prompted the challenge to managers that decision to suspend was the correct course of action. Importantly there had been a renewed focus on wellbeing support for staff undergoing disciplinary procedures. The Board heard that arrangements in place were now consistent with best practice but that there was more work to do on building relationships with Staff Side and working through process at a greater pace.

The Board noted the report.

5.9* ***Flu Campaign 2020/21 Summary Report****

The Board noted the report.

5.10* ***Gender Pay Gap Disclosure****

The Board noted the report.

6 **Board Assurance**

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

6.1.1 **Audit Committee: Approved Minutes of meeting held on 12th January 2021**

The Board received and noted the approved minutes of the Audit Committee meeting held on the 12th January 2020.

Chair's Initials _____

7 **Minutes of the Board of Directors meeting held (in public) on 26th January 2021**

The minutes of the meeting of the Board of Directors held on 26th January 2021 (in public) were reviewed for accuracy and approved by the Board.

8 **Action Log from Previous Meeting**

The action log was reviewed and updated as follows:
Actions 1 - completed and closed
Action 2 – removed as duplicated on private action log

All actions not listed above would carry forward per designated review dates.

9 **Legality of Board Documentation and Decisions**

Board members confirmed that the conduct of the meeting and decisions made by the Board, to the best of their knowledge, complied with the law. Board members confirmed they were satisfied with the format of the meeting.

10 **Date and Time of Next Meeting:**

Tuesday 27th April 2021, 10.00 hours

12 **Resolution to exclude the Public**

The Board resolved to exclude the public at this point by reason of the private nature of business to follow.

The Chair thanked Board colleagues and Governors / members of the public (observing), for their attendance.

Chair's Initials _____

Board of Directors (in Public)
Item 8

Action log

Updated 30.03.21

No.	Agenda Item	Action	By Whom	Progress	Board review	Note
March 2021						
1	5.1 Staff Survey Results	Circulate full slide deck to Board members	KN (JO'B)	completed	N/a	
March 2020						
2	4.2 Board Dashboard 2020/21-KPI Definitions and Performance Thresholds	Refresher training for the Board in use of SPC methodology would be provided as part of the 2020/21 Board Development Programme.	HK / LL		TBD	
November 2019						
3	5.3 Freedom to Speak Up Review of New Guidance	Self-reflection exercise to be repeated every 2 years	LL		Nov 21	