Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Meeting of the Board of Directors

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

Tuesday 28th September 2021
Microsoft Teams at 10.00am

Agenda

1	**Welcome and Opening Matters**		
1.1	**Apologies for Absence:** Lucy Lavan, Raph Perry	**Chair**	**Oral**
1.2	**Declaration of Interests Relating to Agenda Items**	**All**	**Oral**
1.3	**Chair's Briefing**	**Chair**	**Oral**
1.4	**Patient Story**	**Director of Nursing, Quality & Safety**	**Oral**
1.5	**Staff Story**	**Chief People Officer**	**Oral**
1.6	**Medical Devices**	**Interim Director of Research & Innovation**	**Presentation**
2	**Patient Safety and Quality**		
2.1	**Infection Prevention and Control:**		
2.1.1	**IPC BAF**	**Medical Director**	**Item 2.1.1(a)**
2.2*	***LHCH Monthly Nurse Staffing Report for Period: July and August 2021***	***Director of Nursing, Quality & Safety***	***Item 2.2***
2.3*	***Winter Preparedness Plan***	***Chief Operating Officer***	***Item 2.3***
3	**Strategy and Development**		
3.1	**New Quality Strategy**	**Director of Nursing, Quality & Safety and Deputy Medical Director**	**Item 3.1(a)**
3.2	**Research and Innovation Strategy Update**	**Interim Director of Research & Innovation**	**Presentation**
3.3*	***People Plan Delivery Report***	***Chief People Officer***	***Item 3.3***
4	**Targets and Financial Performance**		
4.1	**Board Dashboard – period ended 31st August 2021**	**Chief Operating Officer**	**Item 4.1(a)**
4.2	**Phase 4 Recovery**	**Chief Operating Officer**	**Item 4.2(a)**

5	**Governance and Assurance**		
5.1	**Consultant Appointments – for ratification**	**Medical Director**	**Item 5.1**
5.2*	***Governor Election Report***	***Chief People Officer***	***Item 5.2***
5.3*	***Emergency Preparedness Resilience Response (EPRR) Core Standards Self-Assessment***	***Director of Nursing, Quality & Safety***	***Item 5.3***
6	**Board Assurance**		
6.1	**BAF Key Issues Reports and Approved Minutes of Assurance Committee Meetings:**		
6.1.1	**People Committee:** • **BAF Key Issues** • ***Approved Minutes for meeting held on 8th June 2021 ****	**Chair of People Committee**	**Item 6.1.1** ***Item 6.1.1a***
6.1.2	**Integrated Performance Committee:** • ***Approved Minutes for meeting held on 26th April 2021****	**Chair of Integrated Performance Committee**	***Item 6.1.2***
7	**Minutes of the Board of Directors Meeting held (in public) on 27th July 2021 – for approval**	**Chair**	**Item 7**
8	**Action Log from Previous Meeting**	**Chair**	**Item 8**
9	**Legality of Board Documentation and Decisions**	**Chair**	**Oral**
10	**Date and Time of Next Meeting:** Tuesday 30th November 2021, 10.00 hours		
11	**Resolution:** To exclude the public from the meeting at this point by reason of the private nature of business to follow.		

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

Board of Directors (in Private)
Item 2.1.1

Subject: **IPC BAF**
Date of Meeting: **Tuesday 28th September 2021**
Prepared by: **Nicola Best, Lead IPN/Deputy DIPC**
Dr Raphael Perry, Medical Director/DIPC
Presented by: **Dr Raphael Perry, Medical Director/DIPC**
Purpose of Report: To Note

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

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

1. Executive Summary

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

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

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

The CQC have developed an emergency support framework for IPC.

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

2. Background

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

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

A revised version (V1.6) has been issues with some changes to previous versions. The infection prevention team have updated the framework to reflect these changes and actions have been completed.

The third peak of the coronavirus pandemic had eased considerably at the end of March with a national lockdown in place and excellent progress of the vaccination program. Since then the Delta variant of the Covid 19 virus has become highly prevalent in the population and cases have risen exponentially due to the increased infectivity/transmissibility. However, the numbers of cases requiring hospitalisation or intensive care remains low due to the effectiveness of the vaccine in preventing severe illness in those infected. The vaccination program has offered vaccines to cohorts down to the age of 18 and at present 71% of the adult population has had a double dose of vaccine. The focus of hospitals was the resumption of normal activity while managing any increase in Covid admissions. The planning for winter pressures including any increase in Covid cases is at an advanced stage.

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

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

Mask wearing, social distancing and hand washing are being reinforced and staff supported to challenge non compliance.

3. Update

The Board assurance is included as an attachment, with changes highlighted in yellow. The actions/gaps from July version 1.6 have been addressed. The updated BAF will be supported by a verbal update on Covid 19.

4. Conclusion

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

5. Recommendations

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

Item 2.1.1a

Infection Prevention and Control Board Assurance Framework v 1.6 (Reviewed July 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: • local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff; • the documented risk assessment includes: o a review of the effectiveness of the ventilation in the area; o operational capacity; o prevalence of infection/variants of concern in the local area. • triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways; • when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given; • There are pathways in place which support minimal or avoid patient bed/ward transfers	Risk assessments done for all areas previously 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 allocated areas according to their specialty. Some will require moves in line with their clinical	Assessments do not use the hierarchy of control format and have not been reviewed for 3 months	Rewrite assessments with new format Audit and reassess all areas (23/7/21 IPT). **All actions complete.**

for duration of admission unless clinically imperative • that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance. • monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice including • Staff adherence to hand hygiene • patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE; • Staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: a)clinical b)non-clinical setting • monitoring of compliance with wearing appropriate PPE within the clinical setting • implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in	pathway. Patients moved to cohort areas according to COVID 19 status and risk pathway. Positive patients tracked on ICNET Protocols in place All cohorted areas deep cleaned on inpatient discharge, records held with hygiene services. Matrons audits and Infection prevention audits performed Hand hygiene audit programme in place. Risk assessments for all work areas in place to maximize social distancing. PPE audits. Infection Prevention and Matron's audits to monitor compliance with IPC practices for patients and staff. In addition there is a daily safety huddle where all managers update on their compliance with IPC standards. Weekly LAMP testing now in place and compliance reported through Gold Command. Awareness		

place to monitor results and staff test and trace • Additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team. • 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 (clinical and non-clinical) are trained in; -putting on and removing PPE; -what PPE they should wear for each setting -and context; • all staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance; • there are visual reminders displayed communicating the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	campaign on intranet. Staff testing and isolation protocols in place. Liaison with staff testing and IPT when positives identified. Targeted testing of staff has been done in specific circumstances. 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 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. Posters and signs in public areas. Information within regular corporate communications and also displayed on screensavers All national guidance is received by the DIPC and processed and actions by silver command. The Trust holds gold and silver		

• 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 • 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	meeting weekly. PPE supplies and adherence are monitored through all these meetings . 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 receives reports on all other infections.		
• that Trust Chief Executive, the medical director or the Chief nurse approves and personally signs off all daily 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**.**	Data submissions signed off by Executive during the week and by on call manager at weekends.		
• The IPC Board Assurance Framework is reviewed, and the evidence of assessments are made available and discussed at Trust board.	IPC BAF is shared at all BoD meetings to update Board members.		
• ensure Trust Board has oversight of ongoing outbreaks and action plans	Outbreak summaries and actions presented to Gold Command as they occur.		
• there are check and challenge oppurtunities by the executive/senior leadership teams in both clinical and non-clinical areas	Walkarounds by members of the senior staff and executive team.		

	Regular discussions with all departmental heads at weekly bronze meeting.		
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 nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID 19 isolation or cohort areas. • designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance • assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	Teams assigned on a daily basis for COVID 19 isolation All staff working in areas caring for Covid patients receive appropriate training Hygiene services assign staff who are appropriately trained and maintain training records. Terminal decontamination carried out according to PHE guidelines and is logged on a database. Additional decontamination using UV-C of single rooms and HPV also used. Records held on an electronic system.		

• 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 and recommended 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 • electronic equipment e.g mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily • rooms/areas where PPE is removed must	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		

be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily) • reusable non-invasive care equipment is decontaminated: o between each use o after blood and/or body fluid contamination o at regular predefined intervals as part of an equipment cleaning protocol o before inspection, servicing or repair equipment; • 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 • 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	Matrons and infection prevention audits of equipment Cleaning schedules Policy and protocols in place. Certification of equipment prior to repair in place Linen policy in place, managed as infectious linen Included in disinfection policy Audits in place. Monitoring performed by Hygiene supervisors regularly. Data available Additional ventilation and air dilution provided when practicable. Windows cannot always be left open due to temperature control.		

dilution of air			
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 the pressures of Covid and a shortage of staff	To develop the role of Critical Care Nurse to assist in ward rounds on Critical Care and a plan for ward cover. Three times weekly antimicrobial rounds and held virtually if microbiologist is unable to be present. **Actions complete**. Increased microbiology cover commencing September 2021
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed COVID-19 patients are being treated are clearly displayed with appropriate signage and have restricted access • information and guidance on COVID-19 is available on all trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved • there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice. • Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Visiting advice available on intranet. Suspended at present apart from specific circumstances Signage in place where appropriate. Information is available on the website regarding precautions advice for visitors and patients. Discharge planning team note this on their referrals. Information boards and posters in all areas across the trust. Toolkit reviewed by Silver Command. Screen savers, posters and regular updates/reminders in place. Safety huddles Walkrounds and audits with feedback to areas. Staff wellbeing action plan in place		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
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 undertaken to enable early recognition of COVID-19 cases.	Emergency arrivals are screened for symptoms in the ambulance or on arrival and placed in the appropriate area. Elective admissions screened before admission		
• 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	Screens in place at all reception areas Patients with new symptoms are cohorted promptly and immediately tested.		
• staff are aware of agreed template for triage questions to ask	Questions in pre-admission template and admission document and also asked prior to day case admission		
• 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	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. Volunteers stationed at entrances to		

• individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation; • clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; • patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. • isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, 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	advise patients and visitors coming in. Posters displayed Patients prioritized for siderooms by the capacity management team Ward managers monitoring in clinical areas. Social distancing and screens in place. Contacts recorded and monitored in database. 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		

• There is evidence of compliance with routine patient testing protocols in line with Key:Actions infection prevention and control testing document. • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Patient testing protocol in place and regularly audited. Patients assessed and temperature checked on admission to Outpatients Screening questions asked of patients for scheduled appointments. prior to admission		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • 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 • 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	Signage in place. Restricted access to communal areas Training provided by education team and also by individual departments e.g. critical care education practitioners regarding PPE and correct donning/doffing. Donning and doffing videos on intranet and staff app.		

• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to 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 managed any 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 with actions in place to mitigate any identified risk • 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 - staff maintain physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care -staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to	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 Messaging on intranet and via corporate comms.		

	follow public health guidance outside of the workplace -frequent decontamination of equipment and environment in both clinical and non-clinical areas - clear visually displayed 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	Posters displayed 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.		

other if they or a member of their household display any of the symptoms • 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	Ongoing surveillance via ICNET and regular reports from laboratory. All cases recorded, monitored and tracked on database. 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		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff	Designated cohort areas separated from other areas. Access restricted to certain areas Signage used to indicate different zones at entrances.		

• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas • 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		
8.Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Competency tool for staff Testing protocols in place. Audits performed. Staff screening records held by test and trace team Priority levels designated in lab and		

• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data) • screening for other potential infections takes place • that all emergency patients are tested for COVID-19 on admission. • that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise. • that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission. • that sites with high nosocomial rates should consider testing COVID negative patients daily. • that those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	in testing protocolsTurnaround times monitored regularly. Data available Cases monitored by Infection prevention team. Records available Screening protocols in place for other infections in place. Audits performed Testing protocol in place, regular audits performed and fed back to clinical areas and through command structure.		

• that those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting where they should continue their remaining isolation • that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission			
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • 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 • PPE stock is appropriately stored and accessible to staff who require it	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		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
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		

• 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,	staff Records kept on central database that can be accessed by individual 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.		

the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	Fit testing results monitored regularly and reports shared with Silver and Gold Command		
• 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	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	Pathways for patients continually under review.	Every effort made to reduce patient and staff moves
• all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas	Monitored and reported regularly by managers		
• 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	Risk assessments undertaken for all workplace areas. Numbers limited in all communal areas.		
• staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	Monitored and audited by Matrons		
• staff absence and well-being are monitored and staff who are self isolating are supported and able to access testing	Monitored regularly. Reports available		
• staff who test positive have adequate information and support to aid their recovery and return to work	Staff testing guidance / FAQs produced by swabbing team Staff who test positive supported as		

	per normal sickness process by line managers with additional support provided by HR/OH as required		

Board of Directors (in Public)
Item 2.2*

Subject: **LHCH Monthly Nurse Staffing for Reporting Period for July & August 2021**
Date of meeting: **Tuesday 28th September 2021**
Prepared by: **Julie Roy, Head of Nursing & Quality for Medicine**
Fiona Altintas, Head of Nursing & Quality for Surgery
Kirsty Dudley, Critical Care Manager,
Presented by: **Sue Pemberton, Executive Director of Nursing, Quality & Safety**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
BAF 1	The paper provides assurance in respect of nurse staffing levels

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

1. Executive Summary

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

2. Background

In line with the recommendations detailed in 'Hard Truths – The Journey to Putting Patients First' (Department of Health, 2014), LHCH publishes staffing levels 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 July and August 2021 and the impact on nurse sensitive indicators.
This report details planned and actual nurse staffing levels for the months of July and August 2021, including any red flag concerns.

3.1. Vacancy Data

All RN vacancies across the Trust are reviewed regularly by the Director of Nursing with the senior nursing team. The Trust's Recruitment and Talent Lead within HR continues to work closely with the senior nursing team, to ensure oversight of all Trust vacancies and recruitment progress against each. This information continues to be validated by the senior nursing team to ensure accurate vacancy reporting data. A number of experienced RNs from across the Trust's clinical areas have been successful in securing promotion into posts created within the Targeted Lung Health Check programme and this has added to pressures within the ward areas. 67 band 5 vacancies have been appointed into with candidates at varying stages of the recruitment process (including 9 who qualify in 2022).

Table 1-Vacancy data July & August 2021 (all bands)

	JULY		AUGUST	
Unit	**RN**	**HCA**	**RN**	**HCA**
Acute Cardiac Unit	12.11	-0.72	11.22	-0.72
Birch Ward	8.97	0.74	10.77	0.74
Cath Lab	0.81	0	0.81	0
Cedar Ward	3.05	1.65	5.28	0.05
Cherry Ward	0.9	0.2	1.9	0.2
Holly Suite	1.32	0	5.03	0
Maple Suite	1.95	0.2	3.95	0.2
Oak Ward	2.73	0.15	3.94	0.15
Outpatients	0.69	0	0.69	0
Rowan Suite	3.77	-0.61	3.77	-0.61
SICU Clinical Roster	14.63	3.43	14.63	3.43
Theatres	11.7	0.05	11.7	0.05
Grand Total	**60.27**	**5.09**	**73.69**	**3.49**

The first two cohorts of international RNs (17) have arrived at LHCH, after delays to their travel and are now well into their OSCE training. They have received excellent pastoral support and are being supported with the OSCE process and the journey towards NMC registration, anticipated for October 2021. Further arrivals are expected in September 2021. Feedback from both clinical areas and the international recruits has been overwhelmingly positive. Approval for further international recruitment utilising the Cheshire International recruitment Collaborative (CIRC) has been approved and 20 RNs have been successfully recruited and are undergoing pre-employment checks.

A face to face recruitment open day is planned for 25th September 2021 with 50 registrations of interest received to date.

3.2 Sickness Absence

During July and August, several clinical areas continue to experience sickness absence, and this is detailed in the table below.

Table 2- sickness absence data

	JULY		AUGUST	
Unit	**RN WTE**	**HCA WTE**	**RN WTE**	**HCA WTE**
Acute Cardiac Unit	3.07	0.95	3.62	1.12
Birch Ward	0.96	2.07	0.29	1.86
Cath Lab	4.70	1.21	4.44	1.35
Cedar Ward	3.77	3.78	5.18	2.22
Cherry Ward	1.26	1.01	2.23	0.95
Holly Suite	2.27	1.23	1.53	0.95
Maple Suite	2.09	1.41	1.32	0.61
Oak Ward	0.33	1.35	0.94	1.71
Outpatients		0.65		0.77
Rowan Suite	0.94	0.00	0.92	0.08
SICU Clinical Roster	10.81	4.42	10.80	5.61
Theatres	**1.23**	0.36	**2.76**	0.31
Total WTE Unavailable	**31.43**	**18.44**	**34.03**	**17.53**

There is a Trust focus on sickness absence management with support for staff in terms of wellbeing conversations with line managers and additional provision, to support mental health wellbeing across the Trust. Divisional leads are working closely with HR business partners and managers to review all sickness absence, in particular long term sickness cases and support returns to work where possible. During August, national guidance changes for staff identified as close covid contacts has enabled the Trust to support staff back into work, following a risk assessment and regular testing.

3.3. Temporary Staffing

The temporary staffing team are actively recruiting to the LHCH nurse bank in order to support during this time. Agency staffing has been utilised during July and August 2021 within critical care and cath labs when required.

3.4. Exceptions

All planned staffing for nursing in LHCH is assessed as required for the ward to run at full capacity, if capacity is reduced then the planned staffing changes accordingly. In July and August 2021:

- There were no red flags on Cedar, Rowan and Maple wards. There were 3 staffing related incident reports for Cedar and 1 for Maple during this period.
- Oak ward reported 7 red flag shifts over the 2 months and 5 of these were reported via datix. No patient safety incidents or harm were reported, however there was a report that some patient medications were delayed, and these were challenging shifts for staff. All avenues of supporting staffing undertaken Trust wide. Advanced Nurse Specialist support also on ward.

- There were no red flags reported on ACU, Birch, Cherry and Maple wards in July and August 2021.
- There were 2 staffing related incidents reported on Birch and Cherry wards, There were no patient safety incidents reported during these shifts although they were challenging for the ward staff. These were escalated appropriately at the time.
- Following the ward reconfigurations, the Acute Cardiac Unit (ACU) continues to have a significant number of RN vacancies, although all are recruited into and several staff are starting in September and are being supported through their supernumerary period. The divisional matron works closely with the ward team to ensure appropriate levels of coronary care trained staff are available for each shift, working flexibly across the 2 areas of ACU and POCCU3.

4. Summary

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

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

5. Recommendations

The Board of Directors are asked to:

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

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

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

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

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

CHPPD for July 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 (%)
TOTAL	**4174**	**8.8**	**3.8**	**0.0**	**0.3**	**0.0**	**0.0**	**12.8**	**91%**	**101%**	**44%**	**66%**	**90%**	**99%**	-	-
BIRCH	752	3.6	2.6	0.2	0.2	0.0	0.0	6.7	86%	92%	63%	67%	96%	87%	-	-
ACU	575	9.5	3.5	0.0	0.5	0.0	0.0	13.4	81%	92%	-	185%	85%	88%	-	-
CHERRY	207	6.4	5.9	0.0	0.0	0.0	0.0	12.3	90%	103%	-	-	84%	87%	-	-
CRITICAL CARE	725	26.9	3.3	0.0	0.0	0.0	0.0	30.2	100%	76%	-	-	97%	76%	-	-
OAK	539	3.3	3.6	0.0	0.8	0.0	0.0	7.7	90%	106%	-	70%	71%	105%	-	-
CEDAR	900	4.4	5.5	0.0	0.2	0.0	0.0	10.1	82%	123%	-	17%	75%	151%	-	-
MAPLE	359	3.6	2.2	0.2	0.2	0.0	0.0	6.3	89%	113%	26%	32%	82%	97%	-	-
ROWAN	117	4.9	3.7	0.0	0.0	0.0	0.0	8.6	64%	100%	-	-	68%	88%	-	-

CHPPD for August 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 (%)
TOTAL	3992	9.2	3.7	0.1	0.2	0.0	0.0	13.2	88%	97%	47%	61%	90%	92%	-	-
BIRCH	732	3.7	3.3	0.1	0.2	0.0	0.0	7.3	80%	109%	39%	48%	100%	100%	-	-
ACU	590	9.7	3.7	0.0	0.4	0.0	0.0	13.8	83%	109%	-	-	87%	77%	-	-
CHERRY	224	5.6	3.4	0.0	0.0	0.0	0.0	9.0	87%	103%	-	-	76%	100%	-	-
CRITICAL CARE	734	27.1	2.8	0.0	0.0	0.0	0.0	29.9	99%	69%	-	-	100%	61%	-	-
OAK	434	4.0	4.4	0.0	0.8	0.0	0.0	9.1	80%	93%	-	66%	70%	102%	-	-
CEDAR	850	4.4	5.2	0.0	0.2	0.0	0.0	9.8	75%	117%	-	13%	73%	123%	-	-
MAPLE	280	4.1	1.6	0.5	0.2	0.0	0.0	6.4	80%	42%	55%	23%	69%	93%	-	-
ROWAN	148	3.8	3.2	0.0	0.0	0.0	0.0	7.0	56%	95%	-	-	58%	100%	-	-

Board of Directors (in Public)
Item 2.3*

Subject: **Winter Preparedness 2021/22**
Date of meeting: **Tuesday 28th September 2021**
Prepared by: **Hayley Kendall, Chief Operating Officer**
Presented by: **Hayley Kendall, Chief Operating Officer**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
BAF 2	There is a small risk that providing capacity to system partners during the winter period will affect the recovery of elective waiting times at the Trust but the options to provide mutual aid are in line with prioritising urgent and cancer patients across a system.

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

Planning for winter this year is more challenging than previous due to the change in demands on healthcare services following the Covid-19 pandemic and in particular the high levels of non-elective demands being experienced across all healthcare sectors.

The leadership team has been engaged with system partners to offer mutual aid options and collaborative proposals for services as the region approaches winter, as well as ensuring internal readiness for the challenges ahead. The paper sets out schemes implemented in previous years and the plan to do so again this year subject to securing non-recurrent funding.

The Board of Directors is asked to note the contents of the paper and the Trust's role and support the workstreams proposed.

2. Aims of the 2021/22 Winter Plan

Each year the Trust undergoes a process of reviewing the internal readiness for the winter period as well as engaging with Cheshire and Merseyside system partners to align programmes of work that focus on admission avoidance particularly in respiratory services. Overall, the aims of the Trust's Winter Plan are:

- To ensure patients receive uninterrupted safe plans of care whilst ensuring they obtain treatment in a timely and appropriate way
- Identify specific seasonal pressures with confirmed mitigation to ensure the impact on services is minimal
- Work with other health and social care partners to maintain services that impact on the health economy and support admission avoidance across CVD services
- To support the delivery of the wider health economy's winter plans for all areas that the Trust serves with healthcare partners and commissioning bodies
- To respond to any transitional requirements from reset and recovery to winter surges of respiratory virus/ gastrointestinal tract within the hospital
- To ensure that there is a robust flu campaign programme

3. 2021/22 Internal Winter Plan

Although the Trust is not exposed to the pressures experienced within Accident and Emergency Departments (A&E) historically the Trust has seen increases in non-elective admissions and increased pressures on patient flow and capacity. In addition, with the pressures of Covid the Trust has reconfigured its bed base to provide a safe pathway for patients from admission to discharge. Throughout the winter period changes may need to be revisited to meet the varying demands of patient presentation and this will be monitored through the Trust's Gold Command structure. The Trust is in a good position with early planning to ensure a seamless transition into the winter period.

4. Staffing and Capacity

Each day there is a daily bed and staffing meeting; during times of increased pressure these will be increased as necessary to ensure patient flow continues and beds are available for patients when needed. Internal command and control systems can be implemented when appropriate.

Situation reporting on bed occupancy will be instigated as necessary to ensure all senior managers are informed of any bed and staff pressures as they arise, this will be in the form of a revised and enhanced bed state automatically populated from the Trust IT systems. Daily senior nurse meetings consider staffing, skill mix, dependency of patients, discharges, delayed discharges and planned occupancy.

The consolidation and embedding of the ANP programme has been a great development and will enhance care across ward areas seven days per week, continuing through the winter also supported by a Band 7 manager on each weekend to support flow and support clinical teams providing increased resilience in times of pressure.

To allow for safe quality care, substantive staff move wards within their own speciality and cross divisionally to support colleagues at times of high acuity, this will continue through the winter months. Daily consultant ward rounds now occur within the Surgery and Medicine Divisions. This is pivotal in ensuring timely patient review and effective discharge at consultant level.

It is imperative to continue monitoring Estimated Date of Discharge (EDD) so that the Trust can plan effective discharges and maintain patient flow accurately and safely.

Patient flow will see support from the divisional matrons, communication within the clinical teams is essential to ensure timely discharge can occur. Take home medications will be prepared following every ward round when a decision to discharge has been made. This should also be the case for ambulance discharges and any discharge summaries required to expedite the time of discharge.

As in previous years non-essential training and leave will be managed carefully during the winter periods to ensure that LHCH has sufficient staff to react to surges in demand across the health economy.

5. Divisional Actions

5.1 Surgery

Prior to the Christmas period the division will ensure that urgent patient operating capacity during the Christmas holidays is maximised to reduce the number of inpatients awaiting surgery across the health economy. As part of the Covid reset and recovery plans Cardiac/Aortic Surgery introduced seven-day ward rounds which will ensure senior decision making across seven days with the aim of facilitating improved flow through surgical beds. Thoracic Surgery has long standing six-day ward rounds that will continue to aid improved flow and quality.

The Service Line Manager for Cardiac Surgery is the main contact point for referring units with regards to expediting urgent surgical dates which has been received well by referring units in previous years. Where possible the division will look to accommodate urgent transfers into the surgical bed base as soon as possible in a view to support the referring Trusts with patient flow and releasing capacity for emergency admissions in other units.

The surgical bed capacity will be flexed as required to ensure that bed capacity is available to meet the increase in demand for urgent patients as and when required, and where possible patients will be transferred over early prior to their urgent cardiac procedure to assist with relieving bed pressures across the region.

One of the systemwide pressures will be the challenge of continuing to provide elective services and those that support cancer services. In light of this the division has engaged with system partners to explore the option of reintroducing surgical mutual aid to a local DGH through the winter period. The implications for the Trust is that capacity being provided to another Trust will mean reduced capacity for cardiac or thoracic surgery for the winter months, but does focus on ensuring system wide focus on protecting cancer elective services and equality in access to services for patients.

5.2 Clinical Services

Private ambulances will be utilised during the increased pressure over winter to facilitate the transfer of inpatients from referring units to LHCH for procedures as well as being utilised for expediting discharges. The one added complexity for this winter is that the private ambulances are also being utilised to transfer ACS cases to LHCH from referring Trusts.

5.3 Medicine

An ACS Early Transfer Policy will be utilised again during the winter period which will see patients awaiting intervention transferred to LHCH as soon as possible after referral. Building on the successes of the respiratory admission avoidance specialist cardiology nurses will be able to fast track local A&Es patients to be transferred quicker. All early transfers must be discussed and accepted by the on-call Cardiologist, however building stronger relationships with two large referring units will facilitate early transfers and release of inpatient capacity at DGHs.

Utilisation of a Respiratory NWAS car was deployed 10 hours per day, seven days per week in the previous year, but funding has not yet been identified to support this initiative for 20/21. In addition,

there was a successful deployment of a Swiss nurse at a local DGH that focussed on rapid assessment and signposting to community services, avoiding unnecessary admission. Both of these schemes will be considered again for this winter subject to securing winter funds.

6. COVID and Flu Implications

As in previous years the Trust has a strong flu campaign that will be launched mid-September. Each division will have a peer vaccinator in each area along with Occupational Health providing good access to the vaccine. Every area in the Trust will be visited across all shifts to provide the maximum opportunity for staff to access a flu vaccine.

Based on information available through regional and national Covid forums winter is forecast to be a very challenging period with the presence of Covid, Influenza and increased RSV among children which may result in LHCH accepting older children as part of mutual aid provision. As per advice from NHSE/I, LHCH is preparing to launch a phase 3 Covid vaccination booster programme to all staff who received the first two doses of the vaccine. In order to support Primary Care partners, the offer to vaccinate HCW from Merseycare, NWAS and Alder Hey has been made. It is anticipated that the booster programme will commence 20th September and run concurrently with the flu campaign.

7. Economic Overview

In previous years the Trust has successfully secured funding for winter schemes that included the Swiss nurse role and the NWAS respiratory car but at present there are no regional funding streams to support winter pressures in this financial year. The Trust has a small amount of in year funds to support winter schemes and these will be prioritised in readiness for implementation from November.

8. Conclusion

The Trust has prepared its winter plan based on experiences from previous years and up to date knowledge of the regional pressures. With established command and control processes, LHCH will manage expected and unexpected situations as and when they occur, by ensuring good communications, detailed reporting of staffing, skill mix and capacity and ensure appropriate and timely escalation to the Executive Lead as appropriate. LHCH representatives engage with the Liverpool system wide winter plans and the Cheshire and Merseyside Hospital Cell to ensure partnership working is maximised to support the wider healthcare system.

9. Recommendations

The Board of Directors is asked to support the actions proposed within the plan providing a robust plan for the 2021/22 winter period.

Board of Directors
Item 3.1

Subject: **Quality and Safety Strategy**
Date of meeting: **Tuesday 28th September 2021**
Prepared by: **Susan Pemberton, Director of Nursing & Quality**
Presented by: **Susan Pemberton, Director of Nursing & Quality**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
BAF 1	The paper provides assurance in respect of the quality and safety strategy.

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 Quality Strategy 2021/2024 has been created to follow on from the Trusts previous strategy 2017/2020. The Trust has made significant quality improvements over the past three years which has contributed to the Trust being rated Outstanding in 2019.

The new National Safety Strategy was published in 2020 however, due to covid, progress with the implementation of this on a national level has been delayed. The trust has used the vision and strategy from a national perspective to inform the new quality and safety strategy for the Trust. In addition, a series of discussions have taken place with our people across the Trust to ascertain what the key priorities are for our staff and our patients to ensure we can deliver excellent, compassionate and safe care to our patients and populations.

The Board of Directors are asked to receive this strategy and to read it in conjunction with the Trusts overall strategy as the vison and way forward for the organisation to develop in improving quality and safety trust wide.

2.The Quality and Safety Strategy

The National Patient Safety articulates a vision to continuously improve patient safety. It states that to do this the NHS will build on two foundations: a patient safety culture and a patient safety system. LHCH has developed a new quality and safety strategy by listening to our workforce to understand what they believe we need to focus upon to improve.

In addition, the national priorities have been considered and encompassed. This is linked to our overall Trust strategy of ‘Patients, Partnerships and Populations’.

3. Summary

The past 18 months of the challenges of covid have been life changing for many staff who work in the Trust. This has also impacted greatly on our patients, who will have experienced delays in care and treatment, resulting in high levels of anxiety.

The safety culture is therefore paramount as we begin to recover from the impact of covid, while supporting our staff with their health and wellbeing, is critical in ensuring that we can meet the needs of our patients and populations. The updated version of our Quality and Safety Strategy is timely in light of the pandemic. It is an opportunity to reset and recover and ensure that our priorities for improving safety, reducing harm and improving quality are clearly articulated. Our vision is aligned to the national safety strategy and our ambition is to continuously improve the quality of care and safety for our patients and populations.

4. Recommendations

The Board of Directors are asked to approve this quality and safety strategy.

NHS
Liverpool Heart and Chest Hospital
NHS Foundation Trust

Item 3.1a

Quality & Safety
Strategy 2021-2024

Contents

FOREWORD

The National Safety Strategy was published in 2019. Due to covid, progress has been limited nationally. Organisations are now addressing the ambitions of this strategy.

The Secretary of State requested a patient safety strategy to be created as a golden thread running through healthcare. As quoted in the national safety strategy, Hogan *et al's* research from 2015 suggests we may fail to save around 11,000 lives a year due to safety concerns, with older patients the most affected. The extra treatment needed following incidents may cost at least £1 billion.

1 (Hogan et al (2015) using 2009 and 2012/13 data adjusted to include A&E, outpatients, day surgery. Adjustment uses ratio of inpatient to other deaths from incident reporting data (see Appendix 1).

Liverpool Heart and Chest Hospital has a good track record in assessment, and improvement, of its safety culture, evidenced in the two safety culture surveys conducted in 2014 and again in 2017 with a further survey conducted in June 2021.

LHCH implemented a care partner role for patients several years ago where they are supported to be involved in care if they wish to do so. We recognise that this needs to be further developed at the Trust to create "***patient safety partners***".

We also acknowledge the value of learning when things go wrong as well as the importance of sharing and embedding this learning, to prevent further issues and/or harm to patients.

Across the NHS, we must significantly improve the way we learn and involve patients to reduce harm. LHCH has an ambition to continuously improve our quality and safety of care for our patients and our populations.

INTRODUCTION

Over the past 8 years LHCH has developed an open and honest culture with total transparency of issues and incidents to encourage learning to improve care and practice for both patients and our staff.

In 2014 and again in 2017 we undertook a safety culture survey which suggested areas for improvement and confirmed areas of strength across the Trust.

This was repeated across the Trust recently, in June 2021.

The past 15 months of the challenges of covid have been life changing for many staff who work in the Trust. This has also impacted greatly on our patients, who will have experienced delays in care and treatment, resulting in high levels of anxiety.

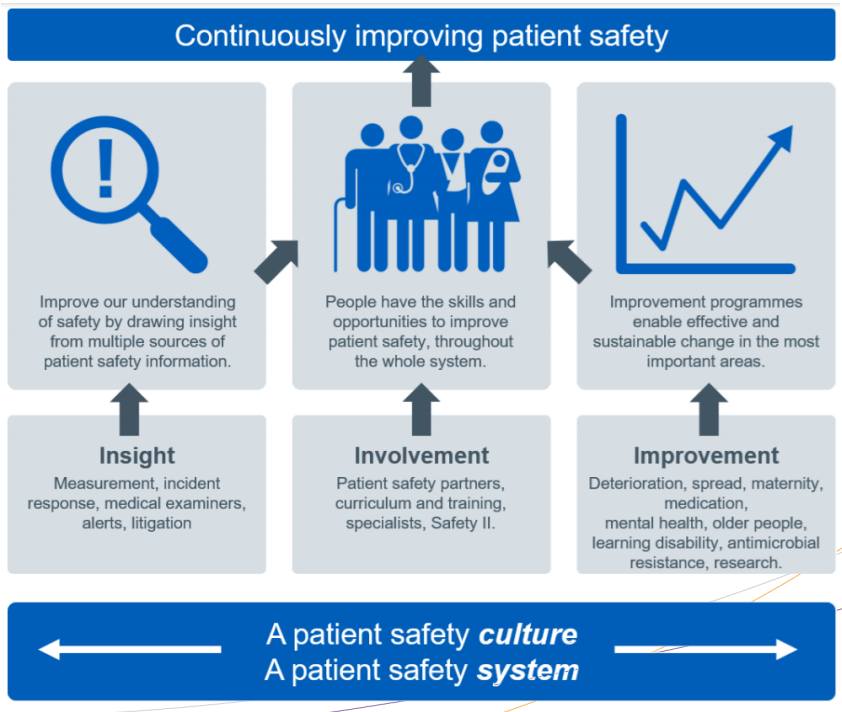
The safety culture is therefore paramount as we begin to recover from the impact of covid, while supporting our staff with their health and wellbeing is critical in ensuring that we can meet the needs of our patients and populations.

The updated version of our Quality and Safety Strategy is timely in light of the pandemic. It is an opportunity to reset and recover and ensure that our priorities for improving safety, reducing harm and improving quality are clearly articulated.

Our vision is aligned to the national safety strategy and our ambition is:

...to continuously improve the quality of care and safety for our patients and populations.

Following consultation across the organisation and with our governors, the priorities to deliver against our ambitions have been agreed and set for 2021and beyond.



Summary of the NHS Patient Safety Strategy

SUMMARY

The National Patient Safety articulates a vision to continuously improve patient safety. It states that to do this the NHS will build on two foundations: a patient safety culture and a patient safety system.

LHCH has developed a new quality and safety strategy by listening to our workforce to understand what they believe we need to focus upon to improve.

In addition, the national priorities have been considered and encompassed.

This is linked to our overall Trust strategy of *'Patients, Partnerships and Populations'.*

LINKS TO OUR 5 YEAR STRATEGY AND OUR DIGITAL EXCELLENCE STRATEGY

Patients, Partnerships & Populations

LHCH produced its new five year strategy in 2020 – ***Patients, Partnerships & Populations***.

The strategy was developed in partnership with all our clinical and corporate teams both internal and external to the organisation and reflects upon the role and ambitions of the organisation as well as the changing needs of our patients, partners and populations.

Our commitment to continuously develop and support our people is a central priority as highlighted in our strategic objectives as below:

1. Delivering world class care

2. Advancing quality and innovation

3. Increasing value

4. Developing people

5. Leading through collaboration

6. Improving our population health

Digital Excellence

LHCH also recently produced a five year ***Digital Excellence*** strategy, which sets out our ambition to deliver digital excellence for our patients, staff and populations.

Our aim is for digital technology, intelligence and innovation to enable excellent outcomes and safe care.

The strategy has three core themes:

1. Connecting digitally with patients and families

2. Digital safety and outstanding care

3. Insight led care

Read about our *Patients, Partnerships & Populations* and *Digital Excellence* strategies on the LHCH website - www.lhch.nhs.uk

OUR VALUES

To support the Trust's vision we have developed the following value based approach.

Our IMPACT is:

INCLUSIVE
We will create an environment where everyone is treated with dignity and respect and where the talents and skills of different groups are valued

MAKE A DIFFERENCE
We will ensure that what we do contributes to providing outstanding care for our patients

PEOPLE CENTRED
Value each person as an individual – our patients, their families, each other and our communities

ACCOUNTABILITY
Every member of staff takes personal responsibility for the services they provide, taking pride in the work they do

CONTINUOUS IMPROVEMENT
We will deliver the best service for our patients through continuously improving what we do and how we do it

TEAMWORK
We work together as one whole team to achieve our vision 'To Be The Best'

DEVELOPMENT OF OUR STRATEGY

In developing this Quality and Safety Strategy engagement with staff Trust wide has taken place and people from all disciplines attended and shared ideas and thoughts.

In addition we have captured the key national priorities. From this triangulation of information we have distilled the key priorities that the Trust must address to further develop its safety culture and safety of care for patients.

From the feedback there were three key areas that need focus and improvement.

COMMUNICATION

Much of the feedback from our staff was how communication needs to improve, for example plans of care being documented in the Electronic Patient Health Record and not been verbally passed onto the staff looking after the patients.

Medical staff seeing patients and not communicating when they have reviewed a patient and made changes to their plan of care. Handover of a patient's plan of care is a critical piece of the jigsaw when caring for patients.

There are three methods that we will implement to address this. We will name these **always events**.

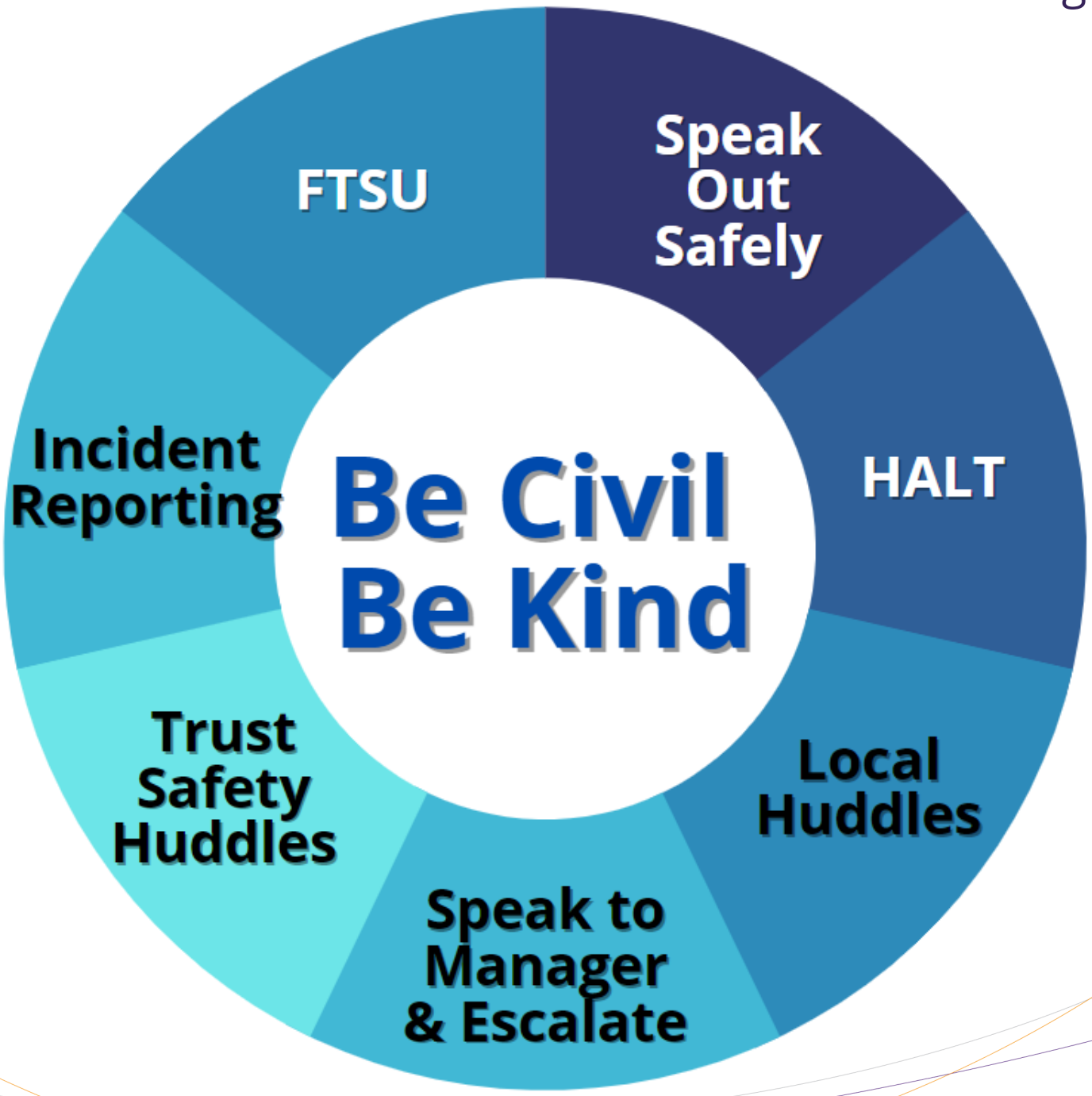
- We will **ALWAYS** use our Electronic Patient Record to document the handover of a patient's care.
- We will **ALWAYS** handover patients from area to area at the bedside to involve the patient where possible.
- We will **ALWAYS** communicate verbally with the responsible nurse in any clinical area when a patient review takes place, so that they are fully informed of any changes to a plan of care.

CCL
Communication
Culture & Learning

CULTURE

There are many ways that we support our staff in relation to the safety culture, as demonstrated in the chart below.

CCL
Communication
Culture & Learning



CULTURE

The Trust repeated its safety culture survey in June 2021. This highlighted three key areas for improvement.

Teamwork

- As we reset and recover from the acute phase of the covid pandemic we need to build on the Trust's safety climate and continue to strive to deliver the best care for our patients, ensuring that quality and safety are prioritised. Working as a team within local wards and departments and as part of the wider Team LHCH.

- LHCH is an inclusive organisation and welcomes each individual person as a member of its team.

Safety climate

- During covid our focus has been on infection prevention and risk assessments to prevent spread of infection for our patients and our staff. All infection prevention measures have been adhered to and regular assurance or compliance sought through our command structures and our local and Trust-wide safety huddles.

- Incident reporting is encouraged, as is speaking out, when there is concern regarding a patient or staff safety issue. There are multiple means of raising concerns, including escalation to local managers, via freedom to speak up champions and/or sharing at safety huddles.

- Attendance at our Trust-wide safety huddle has improved following the introduction of the virtual meeting, as this allows more people to join and engage in the safety discussion.

Working conditions

- Throughout covid, working conditions have changed for many staff with a requirement to work at home, where possible, in line with the national lockdown measures.

- Some people have found this to be challenging, whilst others have relished this way of working. As lockdown measures relax, all staff will have opportunity to review their ways of working, to meet the needs of the organisation and themselves with their line managers.

- It is important that staff who work at home are able to participate in Trust briefings and contribute ideas and thoughts, including at Team Brief and local and departmental meetings. This is to help keep up to date on key information and so that they continue to feel as connected to the Trust as they did prior to covid.

BE CIVIL, BE KIND, SPEAK UP

LHCH prides itself on the culture of openness and transparency which has developed over several years.

We expect all staff to *be civil* and *be kind* to each other at all times. Where this does not happen we expect that our staff will call it out.

This is not always easy to do for some, and therefore there are multiple methods of calling it out - either via a line manager or via our Freedom to Speak Up champions.

Jane Tomkinson, LHCH Chief Executive, has three pledges which are:

1. **I actively encourage staff to speak up about any concerns.**
2. **I will investigate fully, openly and transparently and will provide feedback wherever possible.**
3. **I will keep you safe and ensure you suffer no detriment.**

Dr Nigel Scawn, LHCH's Deputy Medical Director / Patient Safety Lead, is leading our Trust's *'Culture Club'* , which aims to:

- **Review how civility across the Trust can improve.**
- **Review how we embed the Trust values and behaviours.**
- **Develop a civility charter.**

LEARNING

We have many ways to share learning which have been in place for several years. The challenge is how to bring together all the learning to enable triangulation of themes.

The Trust has developed a Learning and Sharing database where all learnings will be triangulated to provide clarity on the themes for improvement.

CCL
Communication
Culture & Learning

NATIONAL SAFETY PRIORITIES

As part of the Trust's Quality & Safety Strategy, national safety priorities will also become embedded as follows:

- Develop the role of patients as safety partners.
- Implement the patient safety response Framework (will replace Steis and NRLS and will support mortality reviews and link with the medical examiners).
- Be aware of learning from the Healthcare Safety Investigation Branch (HSIB).
- Receive alerts from the National Patient Safety Alerts Committee.
- Learn from litigation.
- Implement the patient safety syllabus.
- Understand the learning from safety 1 (when things go wrong) and safety 2. (when things go right)
- Support safety improvement in priority areas such as the safety of older people and the safety of patients with learning disabilities.
- Adopt and promote key safety measurement principles and use culture metrics to better understand how safe care is.
- Develop the medicines safety improvement programme.
- Work with research and innovation to explore how they can support safety improvement.

OUR TRUST PRIORITIES WILL BE...

Build on and further develop the culture improvement work the Trust has undertaken by introducing ***Be Civil, Be Kind, Speak Up*** across the Trust (see page 6). ***2021/22***	To appoint a Patient Safety Lead for the Organisation. ***Completed May 2021***	Ensure our workforce is trained in patient safety – this is being implemented by the national team. We will equip our people with opportunities and skills to improve patient safety. ***2022/23***
Utilise the areas for improvement from our culture survey (2021) and the culture staff questions from the staff survey to drive improvement. ***2021/22***	Work with digital teams to implement innovations and ideas to improve safety – closed loop systems to support safety in medicine administration and handheld equipment to allow more time at the bedside. ***2021/22***	Utilise the Patient Safety Incident Response Framework to improve the response to an investigation of incidents. ***2022/23***
Share learning from litigation to improve care and use opportunities to learn when things go well, not just when they go wrong. ***2021/22***	Work with medical examiners to ensure we are utilising the learning opportunities from their reviews to improve care systems to scrutinise and learn from deaths. ***2021/22***	Improve the response to new and emerging risks, supported by the new National Patient Safety Alerts Committee. ***2022/23***
Improve the recognition and treatment of sepsis. ***2021/22***	Develop our patients as patients and families / carers as safety partners. ***2021/22***	Work with the workforce to look at how care can be improved for the deteriorating patient. ***2021/22***
Improve medication safety by involving patients in their care and treatment. ***2021/22***	Focus safety on the older person and those with learning disabilities understanding any enhanced care needs. ***2021/22***	Work to ensure research and innovation support safety improvement. ***2021/22***

OUR APPROACH TO PATIENT & FAMILY EXPERIENCE

Our Patient and Family Centred Model of Care sets out our expectations for patients and families at each step of their journey, commencing prior to admission and until after discharge.

In LHCH every decision we make is based on what is best for our patients and their families.

We recognise our responsibility in being aware of our patients' needs prior to admission and to ensure that we follow up their care after discharge.

We actively encourage carers and families to be involved in care as the patient wishes.

Our model of Patient and Family Centred Care - ensuring quality and safety

NHS Liverpool Heart and Chest Hospital NHS Foundation Trust

PRE-CARE "I knew what to expect when I came into hospital because communication had been clear."

ARRIVAL "My family and I were expected at the hospital and felt welcomed by all."

CONTRACT OF CARE "My family and I were involved in planning my care."

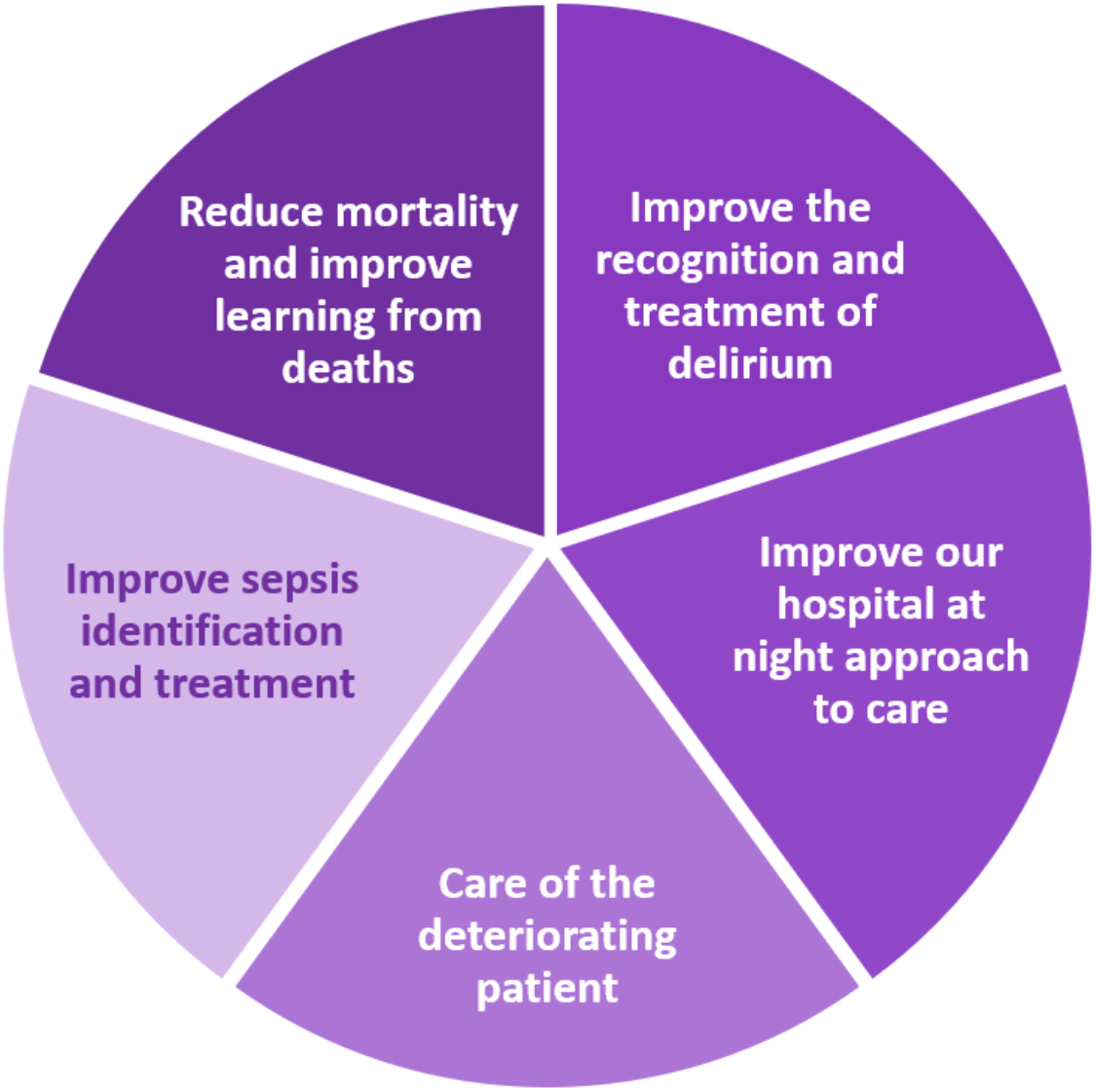
STAY "Compassionate, safe and personalised care was delivered with dignity and respect."

TREATMENT "I felt safe because staff communicated well and displayed the skills to deliver excellent care."

DISCHARGE & AFTER CARE "My family and I received ongoing support."

OUR CLINICAL CARE PRIORITIES

The following are the top 5 priorities for 2021/2022:



Our additional care priorities are as follows:

Improve mouthcare.

2022/23

Reducing harm and promoting safe and high-quality care for patients with swallowing disorders.

2021/22

To improve our patients' mealtime experience and overall nutrition.

2021/22

To prevent transmission of highly resistant organisms and healthcare associated infections (HCAI)

2021/22

To prevent nosocomial infections and outbreaks of Covid 19.

2021/22

To reduce levels of avoidable Trust attributable bacteraemias including MSSA.

2021/22

OUR CLINICAL CARE PRIORITIES

Our additional care priorities are as follows:

To reduce infections related to Intravenous Access devices.

Improving compliance to the consent policy.

Reducing patient harm associated with skin damage and Surgical Site Infections (SSI).

To monitor and further reduce incidences of hospital acquired pressure ulcers and Moisture Associated Skin Damage.

Reduce harm from falls.

To improve patient and staff safety through safe and effective moving and handling techniques.

To improve stroke care within LHCH.

Improve medication safety from patients.

To foster a safety culture in the Trust that ensures the use of medicines for patients is free from both actual and potential harm.

Ensure education regarding Human Factors for all staff.

Review benchmarking and triangulate with other information sources to understand where the Trust has the greatest opportunity to improve patient safety, quality and experience.

GIRFT, deliver the recommendations made by the national GIRFT team across all published reports, by adopting best practice at Trust and regional level.

Increase learning arising from complications, incidents, complaints, mortality reviews and other key learning sources such as CQC reports.

Measure complications baselines and track over time with the aim of reducing complication rates.

Develop an Organisational Learning Database.

HOW WILL WE MEASURE PROGRESS AGAINST OUR QUALITY & SAFETY STRATEGY AND BEYOND?

We will report our progress annually to the Board of Directors and 6 monthly to the operational Board. The way we will monitor our progress is by improvements as demonstrated in the annual staff survey.

The following questions will be used as a benchmark, and we would expect to see continuous improvement over the next 3 years.

Question	2020 result
The organisation treats staff involved in errors/near misses/incidents fairly?	68.3%
The organisation encourages reporting of errors/near misses/incidents	93.9%
The organisation takes action to ensure errors/near misses/incidents are not repeated.	86.3%
Staff are given feedback about change made in response to reported errors/ near misses/incidents.	74.3%
Staff know how to report unsafe clinical practice.	98.2%
Staff would feel secure raising concerns about unsafe clinical practice	79.5%
Staff would feel confident that the organisation would address concerns about unsafe clinical practice e	74.5%
I feel safe in my work	84.3%
I feel free to speak up about anything that concerns me in this organisation	73.5%

Safety Culture

The Trust has carried out its third safety culture survey. There are three key areas of focus identified from these results. This survey will be repeated in 18 months from the launch of the strategy (April 2023), where we would expect to see improvements in the three identified areas:

- Teamwork
- Safety
- Working conditions

The overall completion rate for the survey was 38% compared to a completion rate of 63% in 2017.

The scores show a small decrease in results across all domains with the most significant decrease being in teamwork, safety and working conditions domains.

HOW WILL WE MEASURE PROGRESS AGAINST OUR QUALITY & SAFETY STRATEGY AND BEYOND?

Teamwork

During the pandemic, in order to comply with the Government directive for home working, a number of teams were allocated to work from home. As the workplace has opened up, the Trust has reverted to agile working to ensure compliance with social distancing. This may have left some teams feeling distant from on-site teams. This is despite having regular meetings online as per the Agile Working policy. Clinical staff gave strong feedback following the pandemic of how they felt Team LHCH had pulled together and supported one another through a challenging time.

Safety

To ensure the safety of staff and anyone visiting LHCH during the pandemic, a number of safety initiatives were undertaken, including:

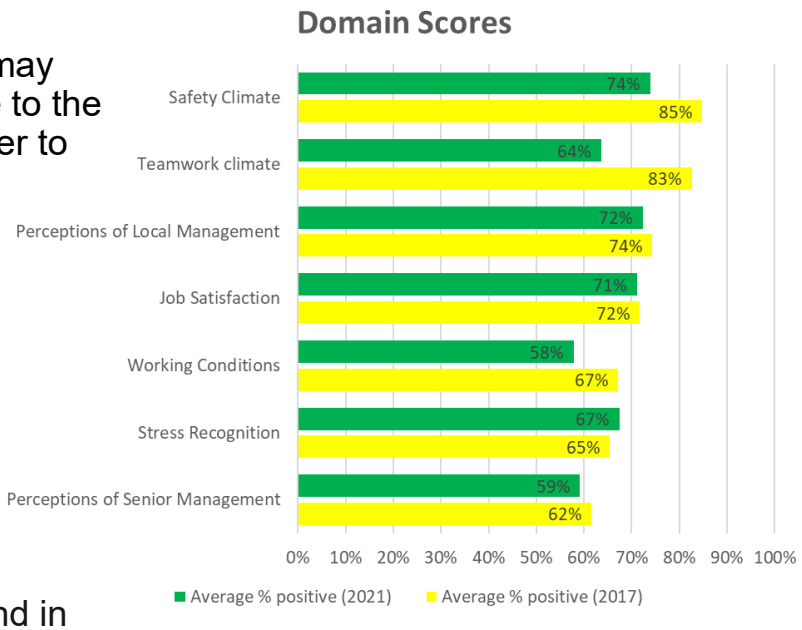
- safe working with PPE,
- fit testing
- signage for social distancing
- staff Covid testing
- patient covid swabbing,
- free meals and drinks for staff
- risk assessments for staff remaining on site
- risk assessments for agile working
- regular communication with staff was supported by thrice weekly Gold and Bronze meetings
- a major vaccination campaign was run to ensure all healthcare workers (and the wider public) had easy access to a Covid vaccination.

It is possible that staff working off site were not aware of the safety practices that were in place to enhance safety in spite of the regular communications.

Working Conditions

The decrease in scores for thisdomain may relate to staff having to work off site due to the restrictions placed on workplaces in order to comply with Covid social distancing regulations.

The graph illustrates the 2017 and 2021 survey results.



Patient experience

The Trust participates in the CQC national inpatient survey annually and has been rated top in the country for 9 from the last 14 years and rated second in the other years. The Trust always aims to be rated top in the country for overall patient care.

CONCLUSION & NEXT STEPS

This strategy serves to ensure the Trust delivers on its ambition. This has been co-created with our people who constantly strive to deliver their best for our patients.

The Trust has a track record of delivering high quality and safe care for our patients. This has been recognised by the CQC who have rated the organisation outstanding in 2016 and 2019.

The Trust's ambition is to continuously improve care for patients ensuring that they receive the quality and safe care they deserve.

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
Reducing harm and promoting safe and high-quality care for patients with swallowing disorders. To ensure all patients with swallow disorders are managed safely throughout their admission. To ensure all patients with swallowing disorders are offered the best quality assessment and intervention to aid their recovery and minimise distress.	**Reducing harm and promoting safe and high quality care for patients with swallowing disorders** A reduction in harm or potential for harm in patients with swallowing disorders. Improved compliance with Speech and Language Therapy (SALT) referral criteria and nutritional stroke guidelines. Increased training and education opportunities for staff and patients in swallowing disorders. Quicker recovery times and reduced distress for patients with swallowing disorders.	**Reducing harm and promoting safe and high-quality care for patients with swallowing disorders** Reduced errors in relation to SALT referrals and recommendations. Consistently being able to meet stroke targets in relation to swallow screening and swallow assessment. Consistently being able to meet GPICS guidelines in relation to swallow assessment in patients with tracheostomy.	**Reducing harm and promoting safe and high-quality care for patients with swallowing disorders** **Staff education:** SALT to deliver six-week trial of twice weekly 15 minutes ward training. This will specifically focus in referring and modified diet/fluids. Training sessions will be rotated around the wards. Feedback and confidence scores will be recorded. SALT to develop short video that can be uploaded to intranet. **Patient education:** SALT to ensure all patients are given specific patient plan, detailing what the recommendations are and why. SALT and catering will revise texture modified menus to include suitable snack options.	October 2022

LEAD: SPEECH AND LANGUAGE THERAPY

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
		Improved scores on stroke satisfaction survey in relation to support given for swallowing disorders. Increased confidence of staff in relation to referring to SALT and following SALT guidelines. Involvement in clinical research.	In future – SALT to trial pre-operative education and 'pre-habilitation'. **Staff engagement** SALT to complete training of ANPs and Outreach in 'Out of Hours Stroke Swallow Screening' to ensure stroke patients have access to swallow screening in the evening and at weekends. SALT to present of the function and value of FEES to ward staff at Learning and Sharing. **Research** SALT collaborate with cardiac surgery and aortic teams in research study.	October 2022

LEAD: SPEECH AND LANGUAGE THERAPY

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
Improving awareness, education, and delivery of mouth care To raise awareness of the importance of mouth care and ensure all clinical staff feel confident and equipped to safely deliver this.	**Improving awareness, education, and delivery of mouth care** Improved awareness of mouthcare for patient outcomes and general wellbeing. Increased access to training on mouth care. Ensuring that staff have the appropriate tools for effective mouth care. Helping staff identify who needs additional support with mouth care. Improved recording and documentation of mouth care.	**Improving awareness, education, and delivery of mouth care** Reduced incidents related to inadequate mouth care. Improved patient comfort and wellbeing scores on mouth care audit. Improved awareness, knowledge, and confidence in delivering mouthcare using pre / post training feedback scores. Improved range of mouth care products available to suit individualised needs. Consistent EPR documentation on mouth care flow sheets to help identify 'high risk' patients and individual care plans.	**Improving awareness, education, and delivery of mouth care** Develop mouth care working group to include Matron, nursing staff, Education, Dental nurse, SALT and Palliative Care. Implement mouth care policy. Develop and deliver training programme to new starters and current ward staff. Deliver mouth care campaign. Develop mouth comfort question-naire and use this to audit mouthcare on critical care. Research, trial and roll out increased repertoire of mouth care products to suit individual needs. Incorporate mouth care information in pre-operative information to ensure patients actively participate in mouth care during their admission where able.	October 2022

LEAD: SPEECH AND LANGUAGE THERAPY

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
Improving patient mealtime experience and overall nutrition To encourage patients and staff to view nutrition as a core part of treatment and recovery.	**Improving patient meal-time experience and overall nutrition** To improve patient's nutritional status and reduce clinical complications associated with malnutrition.	**Improving patient mealtime experience and overall nutrition** Improved patient experience (inpatient survey results). Improved PLACE Lite scores. Reduced number of incidents relating to nutrition. Improved compliance with appropriate nutritional monitoring (MUST).	**Improving patient mealtime experience and overall nutrition** Review of catering provision to ensure meeting the needs of our patients. Develop new patient education literature to highlight the importance of adequate nutrition. Staff education of the importance of using MUST tool appropriately. A Trust wide campaign to focus on the importance of food record charts for patients who are nutritionally vulnerable.	October 2022

LEAD: CRITICAL CARE MATRON

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
To prevent transmission of highly resistant organisms and health care associated infections (HCAI).	**To prevent transmission of highly resistant organisms and health care associated infections (HCAI).** Highly resistant organisms detected and monitored, and standards adhered to in order to prevent the transmission of HCAI.	**To prevent transmission of highly resistant organisms and health care associated infections (HCAI).** There will be no outbreaks. There will be greater compliance with the antibiotic policy. There will be good compliance with hand hygiene policy and standard infection prevention measures.	**To prevent transmission of highly resistant organisms and health care associated infections (HCAI).** To ensure there is a robust surveillance and reporting system for all highly resistant organisms. To ensure that anti-microbial stewardship programme is completed. To ensure the education and audit programme for compliance with hand hygiene and standard infection prevention precautions is maintained.	October 2022

LEAD: INFECTION PREVENTION LEAD

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
To prevent nosocomial infections and out-breaks of Covid-19.	**To prevent nosocomial infections and outbreaks of Covid-19.** All patients with Covid-19 are promptly identified, appropriate precautions are taken and there is no transmission to other patients. There are no outbreaks among patients and/or staff.	**To prevent nosocomial infections and outbreaks of Covid-19.** Compliance with screening programme will remain high throughout the patient's journey. There will be no outbreaks or nosocomial transmission. There will be compliance with national guidelines.	**To prevent nosocomial infections and outbreaks of Covid -19.** To review and ensure compliance with BAF, HSE checklist and Infection Prevention 10 Point Plan. To ensure a robust screening is in place which is regularly audited and fed back to all areas. Policies and protocols are regularly reviewed to ensure compliance with changes in the national guidelines. Regular PPE audits are completed. To ensure a staff testing programme is in place. To ensure all patients are tracked and contact tracing undertaken if positive.	October 2022

LEAD: INFECTION PREVENTION LEAD

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
To reduce levels of avoidable Trust attributable bacteraemias, including MSSA	**To reduce levels of avoidable Trust attributable bacteraemias, including MSSA** All bacteraemias are monitored and numbers of avoidable infections reduced.	**To reduce levels of avoidable Trust attributable bacteraemias, including MSSA** Reduced numbers of avoidable bacteraemias.	**To reduce levels of avoidable Trust attributable bacteraemias, including MSSA** To ensure a robust process for reviewing bacteraemias to ensure lessons learned. To develop action plans for separate working groups to tackle specific causes of the bacteraemias. 1. IV Access Group 2. SSI Group	October 2022

LEAD: INFECTION PREVENTION LEAD

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
To ensure there is a high level of environmental cleanliness in the patient environment	**To ensure there is a high level of environmental cleanliness in the patient environment** High levels of cleanliness of patient environment and equipment are maintained. The new national standards for cleanliness are introduced across the Trust.	**To ensure there is a high level of environmental cleanliness in the patient environment** 5-star hygiene ratings will be achieved across the Trust. Audit results will be available for all areas. Clean trace results will consistently be high across all areas. Environmental decontamination and a deep cleaning programme with alternative technology will be achieved in all areas across the Trust.	**To ensure there is a high level of environmental cleanliness in the patient environment** To review new national standards and implement actions. To establish a comprehensive multi -disciplinary adult programme. To upgrade the Clean Trace system and establish new monitoring programmes. To establish a cleaning group to ensure regular review and monitoring of all areas. To improve environmental decontamination and deep cleaning programmes using UVC systems and also hydrogen peroxide vapour. To trial decontamination methods for handheld devices.	October 2022

LEAD: FACILITIES MANAGER

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
To reduce Surgical site infections	**To reduce Surgical site infections** An effective surveillance programme for monitoring surgical site infections is in place. Surgical site infection rates are reduced.	**To reduce Surgical site infections** Regular reports will be produced via the electronic SSI system. SSI rates will be reduced. Compliance with SSI bundle, including decolonisation and prophylaxis will be increased. Improved collection of patient feedback will be established.	**To reduce Surgical site infections** To introduce a new electronic surveillance system to enable accurate and timely monitoring. The SSI group to develop and complete an action plan and audit programme for the SSI prevention bundle. To ensure patient involvement in the surveillance post discharge.	October 2022

LEAD: TISSUE VIABILITY LEAD & HEAD OF NURSING - SURGERY

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
To reduce infections related to Intravenous Access devices.	**To reduce infections related to Intravenous Access devices.** Increased adherence to standards of care of IV access and reduction in bacteraemias associated with IV access.	**To reduce infections related to Intravenous Access devices.** Increased compliance with documentation and review. Improved level of competence associated with IV care. Reduction in central line infections and bacteraeamias associated with IV access.	**To reduce infections related to Intravenous Access devices.** The IV working group to develop and oversee an action plan including: 1. An education programme relating to care for midlines and PICC lines. 2. A competency framework for insertion of midlines. 3. Surveillance of central line related infections. 4. Improvement of all documentation related to IV access devices. Update all policies.	October 2022

LEAD: INFECTION PREVENTION LEAD

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
Improving compliance to consent policy To review the consent audit process and ensure appropriateness of key audit parameters and take steps to improve compliance to those parameters.	**Improving compliance to consent policy** to involve patients in all aspects of care to reduce harm and promote safety.	**Improving compliance to consent policy** Improved outcomes in regular consent audits.	**Improving compliance to consent policy** Review the consent audit process. Ensure the parameters currently listed are fit for purpose, meaningful and achievable. Consider additional parameters if felt appropriate. Ensure frameworks are in place to facilitate compliance with the consent audit, e.g. consent forms fit for purpose, appropriate document templates available in EPR etc. Increase the frequency of the consent audits from the current internal audit. Increase the number of forms reviewed for each audit (this might require additional resources). Present consent audits in departmental business meetings, audit meetings and other relevant forums to increase awareness and educate clinicians on audit parameters. Explore potential for electronic consent forms in the future, which would make the audit process much simpler and less resource intensive.	October 2022

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
Reducing patient harm associated with skin damage and Surgical Site Infection (SSI) To monitor and further reduce incidences of hospital acquire pressure ulcers and Moisture Associated Skin Damage. To encourage our patients and their family/carers to support strategies effective in preventing skin damage. To lead in prophylactic use of PICO (Negative Pressure Wound Therapy) for high risk patients, to help reduce their risk of developing SSI. To lead in the implementation of Photo at Discharge for patients who have had cardiac surgery, to improve quality of information and to help them seek earlier advice and reduce their risk of readmission.	**Reducing patient harm associated with skin damage and Surgical Site Infection (SSI)** To monitor and further reduce incidences of hospital acquire pressure ulcers and Moisture Associated Skin Damage. To encourage our patients and their family/carers to support strategies effective in preventing skin damage. To lead in prophylactic use of PICO (Negative Pressure Wound Therapy) for high risk patients, to help reduce their risk of developing SSI. To lead in the implementation of Photo at Discharge for patients who have had cardiac surgery, to improve quality of information and to help them seek earlier advice and reduce their risk of readmission.	**Reducing patient harm associated with skin damage and Surgical Site Infection (SSI)** Continuous and accurate monitoring of hospital acquired pressure ulcer and MASD incidences. Monitoring and reporting on prophylactic PICO use and SSI rate. Monitoring and reporting on Photo at Discharge activity and readmission rates/ patient feedback. Positive patient experiences (via Tissue Viability Service patient surveys). Feedback from staff.	**Reducing patient harm associated with skin damage and Surgical Site Infection (SSI)** Promotion of new MASD prevention and care plan (EPR) and new MASD Patient Information Leaflet – regular feedback to staff. Sharing lessons learned from new hospital acquired pressure ulcer and MASD incidences in a timely manner with staff at all levels across the Trust. Patients will be actively encouraged to support strategies effective in preventing skin damage.	October 2022

LEAD: TISSUE VIABILITY LEAD

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
Reducing harm from falls To involve patients, family/carers and staff in reducing the number of inpatient falls.	**Reducing harm from falls** To reduce the risk of hospital falls by making patients, carers and staff aware of actions they can take to reduce harm.	**Reducing harm from falls** Reduced harm from falls. Reduced number of falls in totality. Reduced falls in bathrooms. Reducing the number of unwitnessed falls. Improved patient experience (measured through patient stories and shadows). Greater involvement of care partners in reducing the risk of falls. A better staff awareness of multifactorial risk assessment and care planning.	**Reducing harm from falls** Patients and carers will be provided with information and skills in reducing the risk of falls. Staff will be provided with knowledge and skills in falls risk assessment and prevention. Patient will receive a co-ordinated and planned multi professional approach to falls reduction. Staff will receive training on how to utilise technology to reduce harm from falls. Patients and staff will be involved in a trust wide launch focusing on the call don't dally initiative and will embed Bathroom Watch in their care planning.	October 2022

LEAD: MATRON FOR PATIENT EXPERIENCE

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
Moving and Handling To improve patient and staff safety through safe and effective moving and handling techniques.	**Moving and Handling** To ensure a consistent approach to moving and handling across the Trust to minimise safety incidents.	**Moving and Handling** Reduction in falls. Reduction in staff injuries reported on datix. An improvement in training compliance figures. Reduced MSK/injury related absence.	**Moving and Handling** Patients will be encouraged to be self-sufficient safely through the use of videos highlighting the issue around falls and mobility. Trust moving and handling focus group – led by the Education Team – to improve key trainer enthusiasm, knowledge and skills to cascade to col-leagues. Education sessions to be refreshed and become a more robust area of training delivery for all.	October 2022

LEAD: THERAPY LEAD

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
Stroke To improve stroke care within LHCH	**Stroke** To ensure all those with suspected stroke receive the timely and specialist care they require to maximise their potential.	**Stroke** Reduction in datix's around failure to follow process. Improved patient satisfaction scores. Have dedicated stroke champions Trust wide. Achieving actions on the stroke review completed in May 2021.	**Stroke** Review of the SLA with the Royal to ensure we are receiving the support we require. Explore having Stroke Specialist ANP in house. Develop more robust education package for stroke care. Explore follow up clinics for those who experience their stroke at LHCH.	October 2022

LEAD: THERAPY LEAD

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
The safe and effective recovery of Therapy services To ensure our staff are supported with the right environment and equipment to be able to deliver the new models of service provision.	**The safe and effective recovery of Therapy services** To ensure high quality care can be provided to patients by staff who have the space and equipment to do so.	**The safe and effective recovery of Therapy services** Staff survey results. Improved access to equipment for virtual services and meetings. Improved staff wellbeing.	**The safe and effective recovery of Therapy services** Assessed all services with regards to agile working. Complete department risk assessment with recommendations. Refurbish existing space to maximise access to necessary equipment – as funding allows. Higher level discussions around long term growth of therapies/change in service models and the estate required to house.	October 2022

LEAD: THERAPY LEAD

APPENDIX 1: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
Improving Medication Safety for Patients To foster a safety culture within the Trust that ensures the use of medicines for patients is free from both actual and potential harm.	**Improving Medication Safety for Patients** To increase reporting of medication incidents (including near misses). To ensure patients receive adequate information about their medicines and that any concerns are addressed. To focus on reducing incident trends (harm and potential harm), with particular focus on high risk medicines e.g. insulin, anticoagulants etc. To reduce dispensing and administration incidents/ near mises via introduction of closed loop medicine (CLM) system. To ensure medicine management training is undertaken for all nursing staff and new prescribers to the Trust. To improve reporting of delayed and omitted high risk medicines and seek to reduce incidence.	**Improving Medication Safety for Patients** Improved patient experience with regards to understanding medication and TTO process (inpatient survey results and via local audit). Quantify and monitor medication incidents, adjusted for bed days, to enable ward to ward comparison. Benchmark Trust incidents nationally. Quantify and monitor incident trends for high risk medicines (actual and potential harm). Quantify and monitor nurse and new prescriber medicines management training compliance. Develop better assurances that key medication safety information has been adequately received by relevant staff. Monitor numbers of delayed/omitted doses with focus on any ward area as required.	**Improving Medication Safety for Patients** Implementation of CLM system throughout the Trust to reduce dispensing and administration errors. Relaunch campaign to increase incident reporting. Engage ward managers and champions to drive. Pharmacy dept to increase near miss dispensing reporting (monitored via weekly stats). Engage ward managers and champions to ensure medicines information booklets and leaflets are deployed earlier in patient stay to; • Infirm patient of TTO process. • Signpost to pharmacy for help. • Give information on key common drugs. • This will enable patients to better absorb information and empower them to ask questions.	October 2022

LEAD: CHIEF PHARMACIST

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
	To review and seek to improve the cascade and learning from incidents throughout the Trust. To engage key areas identified within the National Medicines Safety Improvement. Programmes are reviewed and implemented across the Trust as appropriate.	Refresh QSEC quality slide to capture key metrics and provide better narrative on any action taken.	Develop automated EPR ward reports for omitted/delayed critical medicines to enable regular analysis and action. Continue to focus on high risk medicines e.g. insulin. Discuss common themes and required action at Safe Meds Practice Committee. Ensure data captured on QSEC quality side. Ensure nurse medicines management training compliance included in QSEC quality slide. Senior nurse and L&D to drive any improvement required. Review how wards and prescribers receive/cascade medicines safety information. Review likely effectiveness with a view to implementing a standard process if required. Periodic review of MedSIP to ensure action taken by the Trust.	October 2022

LEAD: CHIEF PHARMACIST

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
Human Factors To improve awareness of human factors/civility and their impacts on safe and quality care for all staff across LHCH ensuring that all staff incorporate the Trust's values of 'IMPACT'. Human Factors approaches underpin current patient safety and quality improvement science, offering an integrated, evidenced and coherent approach to patient safety, quality improvement and clinical excellence.	**Human Factors** To improve the safety and quality of care for our patients.	**Human Factors** Improved patient experience and satisfaction (inpatient survey results). Improved staff satisfaction (relevant questions on staff survey results). Human factors awareness training compliance. An increase in FTSU concerns related to incivility with teams. An increase in the reporting of human factors within incidents and near misses.	**Human Factors** To create a resilient system: we will appoint a Human Factors & Civility Champions at director level to enthuse and engage those they influence, and to authorise resources. To prove a qualified expertise/senior advisor: we will ensure there is enough Human Factor's expertise embedded within the organisation to provide specialist knowledge or advice to projects and training. To ensure competence: we will ensure all clinical areas have a Human Factors & Civility Champion with an intermediate level of theoretical knowledge of Human Factors underpinned with successful practical application. We will also develop and deliver leadership training to focus on inclusivity, civility, and compassionate leadership.	October 2022

LEAD: DEPUTY HEAD OF EDUCATION

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
			To improve awareness and basic education: we will ensure the completion of human factors e-learning modules which will encourage the positive actions that create patient safety that are relevant to all staff working in healthcare. All staff will complete Module 1: Introduction to Human Factors, and clinical staff, managers and leaders will also complete an additional module. To further promote civility within Freedom to Speak Up and raise awareness of the newly appointed FTSU Guardian and network of FTSU Champions. To further promote the impact on patient quality and safety of human factors and civility within forums such as Sharing and Learning and Team Brief.	October 2022

LEAD: DEPUTY HEAD OF EDUCATION

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
Benchmarking our Quality and Safety The main aim is to optimise the use of benchmarking to support our vision to be the best. In support of this, the aims are to: 1. Review benchmarking and triangulate with other information sources to understand where the Trust has the greatest opportunity to improve patient safety, quality and experience. We aim at a minimum to include the following resources: • GIRFT • NCBC • Dr Foster • National Institute for Cardiovascular Outcomes Research (NICOR) • ICNARC • Care Quality Commission (CQC) Insights	**Benchmarking our Quality and Safety** For GIRFT, deliver the recommendations made by the national GIRFT team across all published reports, by adopting best practice at Trust and regional level. For other benchmarking, develop improvement plans for areas where the data points to the greatest benefit to patients and or staff. Reduce complication rates. Increase learning arising from complications, incidents, complaints, mortality reviews and other key learning sources such as CQC reports.	**Benchmarking our Quality and Safety** Deliver programme grip on GIRFT recommendations through regular updates to Operational Board Measure complications baselines and track over time. Identify and agree other KPIs to track / establish baselines / measure progress over time.	**Benchmarking our Quality and Safety** Design and implement programme arrangements to ensure grip on delivery of GIRFT recommendations, reporting to Divisional Board, Operational Board and CVD Programme Board as required. Embed benchmarking in divisional governance and reporting through divisionally led benchmarking progress updates, supported by the Improvement team, to support decision making and to signpost improvement opportunities. Develop an Organisational Learning Database. **The Improvement Team Support Offer** The Improvement Team will support delivery of the above as follows:	October 2022

LEAD: HEAD OF IMPROVEMENT AND TRANSFORMATION

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improve-ment?	Actions we will take to improve are	Review date
2. Establish a programme of work to deliver GIRFT recommendations. 3. To promote benchmarking in decision making across the Trust, and as a tool to identify improvement opportunities. To support planning and delivery of those quality improvements.			1. Benchmarking – identification and triangulation of improvement opportunities arising in the benchmarking resources noted above. Training support to help service and clinical leads access and use benchmarking. 2. Developing links with Research and Innovation to identify improvement opportunities. 3. Provide programme support for key projects, including implementing appropriate governance arrangements. 3. Deliver improvement facilitation and diagnostic support using established improvement tools and methodologies. Generate improvement recommendations in partnership with the Triumvirates. Training in improvement methodology will be offered. The Improvement Team will deliver a programme of work to embed a Culture of Improvement.	October 2022

LEAD: HEAD OF IMPROVEMENT AND TRANSFORMATION

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improve-ment?	Actions we will take to improve are	Review date
Mortality improvement To ensure systems and processes are in place to reduce mortality risks	**Mortality improvement** To action the updated mortality improvement plan and achieve agreed mortality targets	**Mortality improvement** KPIs to be consistently with target range for risk adjusted mortality Reduction in avoidable deaths Improved bench-marking	**Mortality improvement** 1. Implement the new mortality improvement plan 2. Ensure consistent unified processes, poli-cies and pathways are followed and circulated regularly 3. Work with the Hospital at Night team to enhance handover and escalation 4. Implement IPC im-provements in sepsis management, SSI man-agement and UTI 5. Sharing learning from MRG, incidents and complaints through Learning Database, joint audit discussion and individual performance management.	October 2022

LEAD: MEDICAL DIRECTOR??

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improve-ment?	Actions we will take to improve are	Review date
Improve sepsis identification and treatment To improve sepsis screening both on the Critical Care and wards by improved systems and directed education	**Improve sepsis identification and treatment** Timely recognition of sepsis leading to prompt commencement of the sepsis bundle	**Improve sepsis identification and treatment** Improved sepsis screening KPIs and continued improvement of sepsis bundle KPIs	**Improve sepsis identification and treatment** **On Critical Care SOFA scoring:** 1. Discussed with intensivists and agreed to adjust the screening to make it more sensitive than national guidelines. Our new trigger would become a score of two or more above lowest recorded SOFA score (a change request has been made to EPR and approved) 2. Export the lowest and current SOFA score into the ICU daily reviews and have it as a mandatory field to be commented on and therefore it will be reviewed twice a day and actioned upon. (change request to be done) 3. Continue current feedback process for the triggers (currently this is only for MEWs trigger on the wards so an additional feedback system will be introduced for the SOFA screens on critical care as well	October 2022

LEAD:

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
			Improve sepsis identification and treatment **Screening on wards:** 1. Facility board review of mews scores/sofa scores could be added to the handover on wards/ critical care to ensure that before starting ward rounds, consultants are aware of which patients may be triggering for a sepsis screen. 2. Adding a column onto the facility board to state if a sepsis screen needs to be done and has been done in the last 24hrs. 3. World Sepsis Day (13th September) event for trust-wide information and education. This could include a competition with a scenario-based quiz for staff to fill out and return to us in order to identify if there are any specific areas for further education.	October 2022

LEAD:

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
Safety Ambassadors To drive our safety culture.	**Safety Ambassadors** To drive our safety culture across the organisation a network of safety ambassadors will work with and be supported by the Trust Patient Safety Lead.	**Safety Ambassadors**	**Safety Ambassadors** The role of the Safety Ambassadors will be to: 1. Meet with the Trust Safety Lead quarterly, to discuss safety issues and incidents and actions required 2. To be aware of the incident reporting culture in their area of work and to actively promote the need to report incidents and near misses to enable learning 3. To be involved in investigating incidents within their area of work and supporting the identification of learning 4. To share with their team learning from their own area and from across the Trust	October 2022

LEAD: HEAD OF IMPROVEMENT AND TRANSFORMATION

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
Improving the care of deteriorating patients and our hospital at night to improve safety for our patients and support for our staff To ensure the hospital at night service runs smoothly with clear communication and identification of patient who are deteriorating or at risk of deterioration. To ensure that the service is run by senior clinicians who work well as a team to ensure safety first for all patients and that staff are supported in care delivery.	**Improving the care of deteriorating patients and our hospital at night to improve safety for our patients and support for our staff** Safe care for all patients.	**Improving the care of deteriorating patients and our hospital at night to improve safety for our patients and support for our staff** A reduction of Incidents relating to poor escalation of deteriorating patients	**Improving the care of deteriorating patients and our hospital at night to improve safety for our patients and support for our staff** Review of the clinicians on site at night-time – both numbers and skill mix ensuring it is fit for purpose to treat the patients we care for. Review the escalation processes for staff to obtain help and assistance required for deteriorating patients. Ensure all Registered nurses receive training on escalation and sepsis identification and screening Review of the hospital handover at 8pm and 8am to ensure that the communication between teams is clear and concise and therefore ensures that all involved in care are aware of the sickest patients,	October 2022

LEAD: MATRON FOR CRITICAL CARE

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improve-ment?	Actions we will take to improve are	Review date
Improving safety and reducing risk of harm for patients with delirium The aim of this is to support patients who have delirium.	**Improving safety and reducing risk of harm for patients with delirium** A reduction in harm caused by delirium for patients and staff.	**Improving safety and reducing risk of harm for pa-tients with deliri-um** A reduction of Incident reporting of harm to patients A reduction of Incident reporting of harm to staff	**Improving safety and reducing risk of harm for patients with delirium** 1. Patients and their families will be informed of delirium preoperatively by the patient infor-mation leaflet 2. Continuation of follow up clinics for patients who have had delirium and review of learning/ themes from clinics 3. Targeted Patient shadows and stories 4. Development of the new mental health sup-port service 5. Training, development and champion role 6. Monthly review of inci-dents for both patients and staff 7. Review and update policy 8. Monitoring the delirium risk assessment compliance 9. Monitoring of delirium tailored interventions	October 2022

LEAD:

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
National Safety Standards for Invasive Procedures **Organisational Standards** A Trust wide commitment to ensure the organisational standards within the NatSSIP agenda underpin the safe delivery of procedural care	**National Safety Standards for Invasive Procedures** **Organisational Standards** A cycle of continuous quality improvement, a workforce that is appropriately trained, skilled and experienced, systems and processes for documentation and handovers of care are robust and they ensure key safety checks occur at the correct points in patient's journey That there is strong Governance and Audit to support, guide and demonstrate the effectiveness of our Safety Standards	**National Safety Standards for Invasive Procedures** **Organisational Standards** Governance and Audit of Organisational NatSSIPs and LocSSIPs Safe Staffing monthly review and annual report Trust Induction eLearning compliance Annual NatSSIP report to QSEC Staff Survey results MIAA inspection Patient Documentation Reviews Operational Planning – scheduling and cancellation of procedure rates Patient and Family feedback Deanery feedback Monthly review of Divisional Effectiveness / Audit at Divisional Board	**National Safety Standards for Invasive Procedures** **Organisational Standards** Themes from Staff Survey and subsequent actions Development of Trust Education Strategy Values based recruitment Incorporate Debrief feedback into the 'Be Civil, Be Kind' Trust agenda To continually review and develop Trust Induction for substantive and temporary staffing Drive improvements in eLearning compliance Regular Review of Documentation and EPR prioritisation Group To use the Datix reporting system for review of staffing incidents Organisational Learning Review of Exit Interviews Monthly review at Divisional Board and Operational Board of staff indicators	October 2022

LEAD:

APPENDIX: QUALITY & SAFETY PLANS

What is our aim?	What are we trying to achieve?	How will we demonstrate continuous improvement?	Actions we will take to improve are	Review date
National Safety Standards for Invasive Procedures A Trust wide commitment to educate, reduce variation and embed standardisation and harmonisation during invasive procedures within any clinical environment	**National Safety Standards for Invasive Procedures** To embed a culture within the Trust that can demonstrate a reduction in variation and a standardisation of the processes that underpin patient safety. To drive compliance regarding LocSSIP's and NatSSIP's within all clinical areas that undertake invasive procedures.	**National Safety Standards for Invasive Procedures** NatSSIP eLearning compliance Monthly monitoring of compliance at each Divisional Board Identifying areas of lower compliance and focus on improvement Annual NatSSIP report to QSEC MIAA inspection Reduction in incidents resulting in harm Monitoring themes from incidents Use of Debrief to identify areas for improvement Peer Reviews of each area – e.g. catheter labs/ theatres To develop fully ward and departmental LocSSIPS for all appropriate invasive procedures and monitor compliance	**National Safety Standards for Invasive Procedures** Themes from briefing and debriefing will be regularly collated and used for quality improvement work. Incorporate Debrief feedback into the 'Be Civil, Be Kind' Trust agenda To continually review and develop LocSSIPs that are required to improve the safety of care for patients following any safety incidents Drive improvements in eLearning compliance To use the Datix reporting system for significant deviations from LocSSIPs that have resulted in patient harm or could have resulted in patient harm (near miss). To monitor compliance of clinical procedural documentation that should be completed in the Patient's EPR medical record. Identification of de brief champions, engaging consultants to lead Training specifically on debrief, differences between Hot debrief and daily team debriefs. Sharing the learning from debriefs Organisational Learning	October 2022

LEAD:

NHS
Liverpool Heart and Chest Hospital
NHS Foundation Trust

Quality & Safety
Strategy 2021-2024

Board of Directors (in Public)
Item 3.3*

Subject: **People Plan Delivery Update**
Date of Meeting: **Tuesday 28th September 2021**
Prepared by: **Beth Williams-Lally, HR & OD Manager**
Presented by: **Karen Nightingall, Chief People Officer**
Purpose of Report: To Note

BAF Reference	Impact on BAF
BAF 4, BAF 5, BAF 6	Delivery of LHCH People Plan will directly contribute to the Trust's strategic workforce objectives.

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

1. Executive Summary

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

Delivery of the plan is on track and progress regularly reported through the People Committee. We do not envisage any risks in delivering the plan and will continue to monitor and assess the benefits and outcomes from the actions taken.

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. Key highlights from Q2 together with key actions for the upcoming quarter are shown below.

	20/21 Q2	20/21 Q3
Looking after our people	• Training sessions have continued to support the recording of HWB conversations with the appraisal process. • Development of 'the culture club' who have the remit of launching the 'Be Civil Be Kind' campaign in Q3. • The trust has now appointed an HWB guardian and the internal psychology team have now trained 7 mental health nurse advocates in CCU to enhance mental health support for employees which has proven successful. The team will be providing further training to Mental Health First Aiders. The trust has also engaged with Merseycare resilience hub, • All employees received 'thank you for their hard work during the pandemic' home delivery that included 3 cards to gift a day off for their birthday, an invite to our summer BBQ in July and an invite to a HWB conversation with their line manager as part of the appraisal process. • We have provided 152 Reiki sessions with staff citing benefits such as a reduction in stress and anxiety, improving relaxation and clarity of thinking. • To help promote a healthy work/life balance, employees were offered opportunity to 'buy' additional leave providing their additional leave would not negatively impact the service delivery of their department and is approved by their line manager. • During COVID many employee benefits were provided such as free lunches, free car parking, staff welfare visits (team of staff including FTSU champion visited hospital departments to check on staff welfare), on site 'listening room' specialist counselling and agile working in non-clinical areas. • Since August '21 we have introduced HWB into our daily practice with the launch of 'actions for happiness' calendars that includes kindness and positive mindset prompts/ideas.	• Full reports of % staff having conversations will be reported to December People Committee. Training sessions ongoing, including the Innovation Agency & Liverpool Health Partnership. • Launch 'Be Civil Be Kind' Campaign. • Launch annual, national staff survey October 2021. • Launch new HWB newsletter.. • Increase Equality, Diversity & Inclusion activities to build our community further. • Flexible working policy under review. • Agenda for change terms and conditions change on 13th September 2021 / revised Section 33: Balancing work and personal life was agreed as part of the wider NHS People Promise work strand on flexible working. The key changes to the framework for agreeing local flexible working policies are; ➢ new enhanced day one contractual right to request flexible working ➢ revised structure which is aimed at supporting managers to be more explorative in reaching mutually workable outcomes. ➢ Re-emphasis on the importance of monitoring flexible working requests at an organisational level, to ensure greater consistency of access to flexible working.

	20/21 Q2	20/21 Q3
Belonging in the NHS	• Leadership offerings reviewed in line with national offerings. Programme to be delivered at 4 levels, via modular access with ability to access a session as a stand-alone session if required. • Weekly Virtual HR support session in place to guide Managers on the application of policies and procedures in a fair and consistent manner.	• Leadership programmes to be launched September 21 across the Trust. • Improve candidate journey by introducing a new, welcoming, more informative welcome induction pack. • Introduce values-based recruitment to cultivate the trusts IMPACT behaviours.
New ways of working and delivering care	• Work experience has returned to site in small cohorts during Q2.	• Second cohort of Level 7 Cardiothoracic Skills module to start Sep '21. • Work Experience policy updated & to be processed for ratification • Work experience to run full programmes during Q3, ensuring any restrictions are adhered to • Careers events have been paused during pandemic, working with Schools & Colleges in the new term.
Growing for the future	• First cohort of Supported Internship with Project Search successful and to run annually at LHCH. • LHCH in partnership with LUFT and Project Search have won national award for continuing the work with People with Learning Difficulties & Disabilities throughout the pandemic. • Apprenticeship pathways continue to grow with new apprenticeship schemes being adopted. • 70 apprenticeships currently active (target is 72). • Registered Nurse Degree Apprentices started with Edge Hill on the 28th June. • LHCH has recruited to our first Physio apprenticeship.	• New cohort of traineeships to start September, this programme is now established at LHCH in partnership with Wirral Met & Liverpool at Work, to run 3 times a year. • Cadet Programme with Hugh Baird now established in it's second year, with process established for all cadets to become part of LHCH Bank. • A number of clinical apprentices - Healthcare Scientists, Nurses Associates, Nurse Degree Top Ups, Assistant Practitioner & Pharmacy Technicians planned for October 2021. • New cohort of Cadets will start on placement in Nov 21.

4. Conclusion

Additional resources invested into the team have enabled further progress to be made against the key actions of the People Plan. Final report against the actions for the People Plan will be presented to People Committee in December 21.

5. Recommendations

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

Board of Directors (in Public)
Item 4.1

Subject: **SOF, Regulatory and Operational Performance Overview Month 5**
Date of Meeting: **Tuesday 28th September 2021**
Prepared by: **Hayley Kendall, Chief Operating Officer**
Presented by: **Hayley Kendall, Chief Operating Officer**
Purpose: **To Note**

BAF Reference	Impact on BAF
BAF2	No negative impact on the BAF as performance against the statutory indicators remain in line with the risk appetite.

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

- Referral to treatment waiting times remain below target as expected due to the significant backlog accumulated during the Covid pandemic. Performance in month stands at 76.1% for English commissioned activity and 77.7% for welsh commissioners, a slightly improved position compared to the previous month.
- There were 78 patients waiting longer than 52 weeks at the end of August, a significant improvement compared to last month and still ahead of the recovery trajectories that

were developed in response to the pandemic. All 52 week waiting patients undergo a harm review by the consultant responsible for the patients care. Due to the challenges with non-elective demand and the focus on treating elective urgent patients first there is the possibility that the number of patients waiting longer than 52 weeks will increase which was predicted in the recovery trajectories previously shared with the Board and submitted to the regional recovery programme.

- Sickness increased in month to 5.1% with a couple of challenging areas across the Trust.
- One patient breached the 28-day cancellation target which was due to an emergency patient taking priority on the day of planned surgery.

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. The Board should be aware that services continue to face high levels of non-elective demand causing disruption to the elective programme particularly in surgery.

Strong performance should be noted across all cancer indicators and the diagnostic 6-week target achievement.

2. Financial Position

The Trust achieved a surplus of £167k in the period ending 31st August in line with the plan in place. This is reliant on the receipt of Elective Recovery funding (ERF).

The 2021/22 financial year has been split into two six month planning periods (H1 and H2). The national planning guidance focuses on H1, where many of the existing contractual arrangements have rolled forward from the second half of last year. The primary difference to last year is the ERF, and the way that system top-up funding has been distributed.

The Trust has planned to achieve a breakeven position in H1, with a high reliance on ERF. The threshold for ERF has been increased for Quarter 2 making it more difficult to achieve incentive payments. However, this risk has been significantly offset with Welsh commissioners confirming that a parallel scheme will be in place at an individual Trust level.

Expenditure in the month of August was in line with expectations with no significant variances to note.

The Trust is developing its Cost Improvement Plan with slippage noted resulting from the planning process being later than ordinarily achieved and a focus on recovery. There is some non-recurrent mitigation for slippage in the Trust plans, but the focus remains on identifying the target value recurrently.

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

The Trust retains a strong cash position.

3. Conclusion

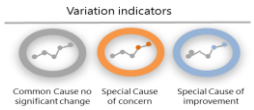
Considering the challenges faced throughout the COVID pandemic the Trust is performing well against the key statutory indicators and elective recovery plans are progressing well. There are a number of challenges with availability of workforce but there are strong mitigating plans in place to address these.

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%	76.1%	
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%	99.23%	
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%	2.4%	
Patients not booked in within 28 days (non clinical cancellations)	0	1	
Delayed Transfers of care	5.0%	2.8%	
Bed Occupancy	80.0%	74.31%	
Referral to treatment - Incomplete Pathways 52+ weeks	0	78	

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%	87.5%	
Welsh Patients: 26 weeks Referral To Treatment waiting times - Incomplete	95.0%	77.66%	
In-Hospital mortality	17	15	
Quantity of complaints	6	5	
Occurrence of any Never Events	0	0	
Mixed sex accommodation breaches	0	0	
Inpatient scores from Friends & Family Test - % positive	95.0%	98.86%	

Quality of Care

measure	target	in month	variation
Venous thromboembolism (VTE) risk assessment	95.0%	95.77%	
Clostridium Difficile	0	1	
MRSA Bacteraemias	0	0	
MSSA Bacteraemias	0	0	
Gram Negative Bacteraemias	0	1	
Hospital Standardised Mortality Ratio (HSMR) - basket diagnoses	100	83	
Hospital Standardised Mortality Ratio (HSMR) - all diagnoses	100	100	
Incidents - Serious incidents, Never Events, Adverse Events (Red)	1	0	
Clostridium difficile – infection rate	0	1	
Patient Safety Alerts not completed by deadline	0	0	
NHS Staff Survey - Staff recommendation of the organisation as a place to work	76.0%	76.0%	
NHS Staff Survey - Staff recommendation of the organisation as a place of treatment	96.0%	92.0%	

Organisational Health

measure	target	in month	variation
Staff Sickness (All Staff)	3.4%	5.07%	
Staff Turnover	10.0%	10.56%	
Executive Team Turnover	25.0%	56.15%	
Mandatory Training Compliance	95.0%	95.0%	
Appraisals Compliance	90.0%	63.0%	
Proportion of temporary staff - Agency staff costs	0.0%	0.4%	
Agency spend	1	1	
Capital service capacity - score	1	1	
Liquidity (days) - score	1	1	
Income and expenditure (I&E) Margin - score	2	1	
Distance from financial plan - score	1	1	
Overall use of resources rating	1	1	

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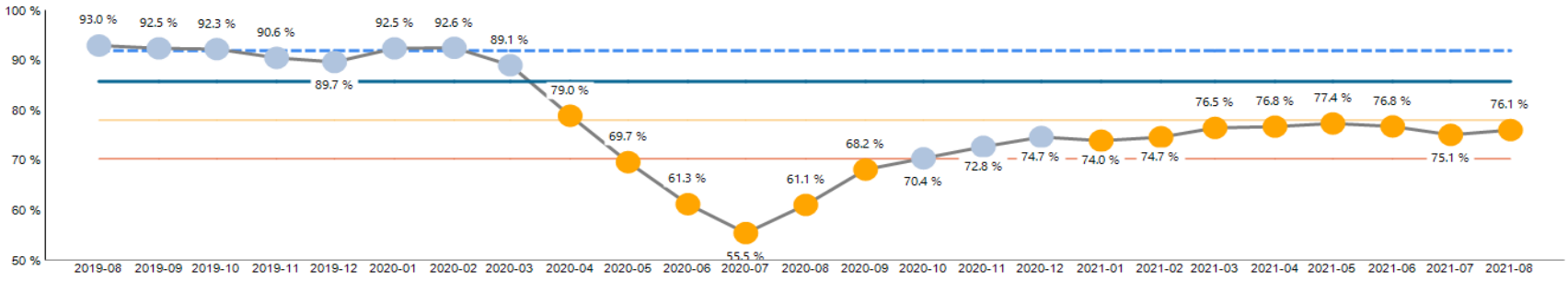
RTT 18 weeks in aggregate - Incomplete Pathways

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

Target	2019-08	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	2021-04	2021-05	2021-06	2021-07	2021-08
>=92%	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%	76.8%	77.4%	76.8%	75.1%	76.1%

Concern



ucl	85.84%
mean	78.09%
target	92.0%
lcl	70.33%

Commentary:

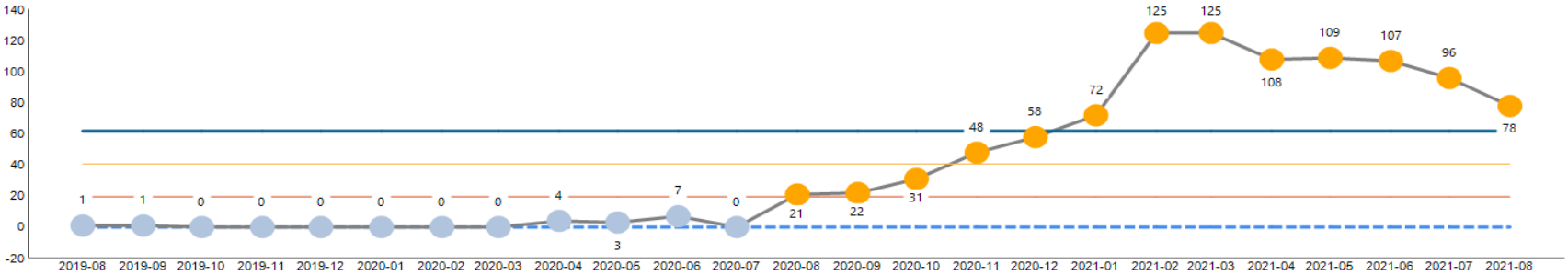
Performance continues in line with the Trust's recovery trajectories but there are still significant challenges with recovering the 18 week backlog.

Referral to treatment - Incomplete Pathways 52+ weeks

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

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
<0	1	1	0	0	0	0	0	0	4	3	7	0	21	22	31	48	58	72	125	125	108	109	107	96	78

Concern



ucl	62
mean	41
target	0
lcl	19

Commentary:

Good progress with reducing patients waiting longer than 52 weeks.

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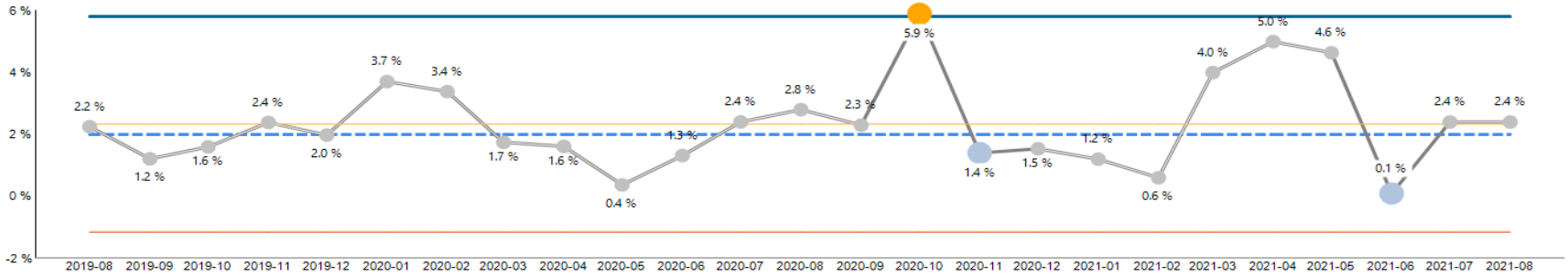
Cancelled Operations for non-clinical reasons

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

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
<=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%	5.0%	4.6%	0.1%	2.4%	2.4%

Common Cause



ucl	5.81%
mean	2.33%
target	2.0%
lcl	-1.15%

Commentary:

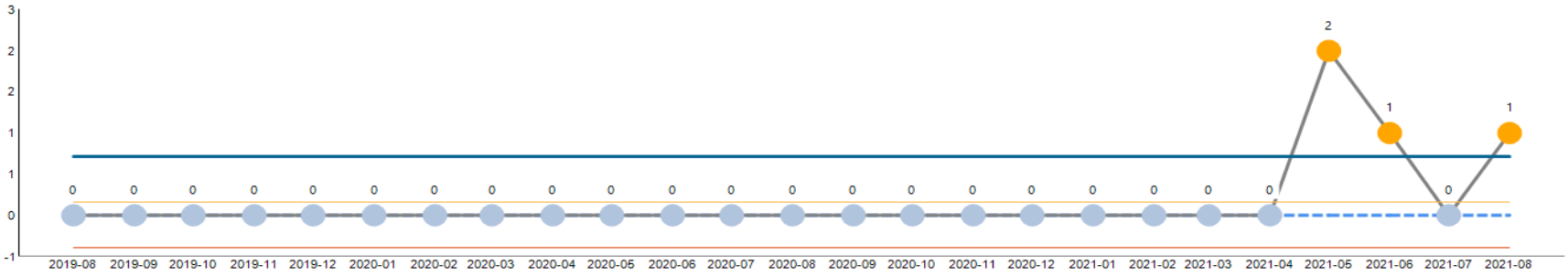
Further challenges in month with achieving the target with emergencies out of hours impacting planned elective cases and over runs also impacting.

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	2019-08	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	2021-04	2021-05	2021-06	2021-07	2021-08
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	1

Concern



ucl	1
mean	0
target	0
lcl	-0

Commentary:

1 patient cancelled due to an emergency patient taking priority for theatre on the day.

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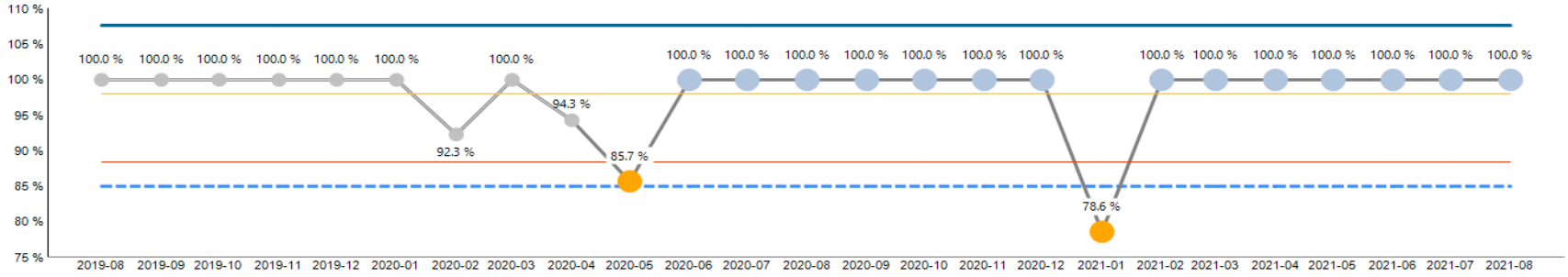
All cancers – maximum 62-day wait for first treatment from urgent GP referral for suspected cancer

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	2019-08	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	2021-04	2021-05	2021-06	2021-07	2021-08
>=85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	94.3%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	78.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Improvement

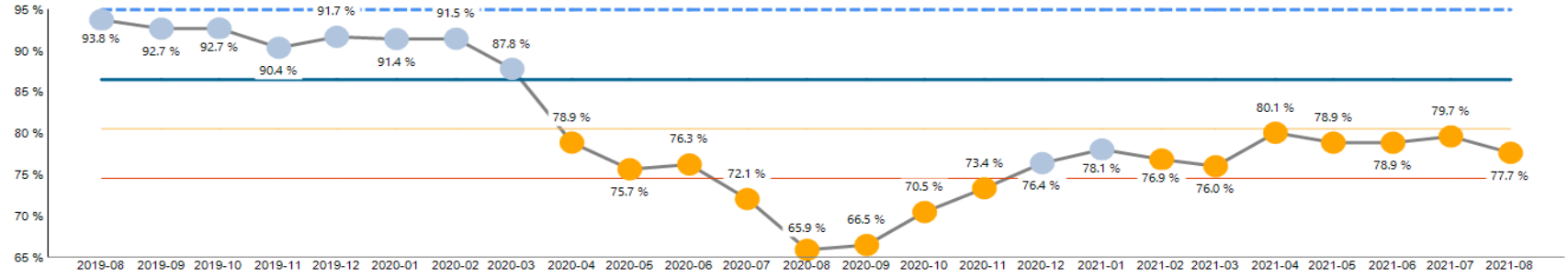
ucl	107.66%
mean	98.04%
target	85.0%
lcl	88.42%

commentary:

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

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

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
>=95%	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%	80.1%	78.9%	78.9%	79.7%	77.7%



Concern

ucl	86.54%
mean	80.55%
target	95.0%
lcl	74.57%

Commentary:

Slight decrease in performance in month but still in line with the recovery trajectories.

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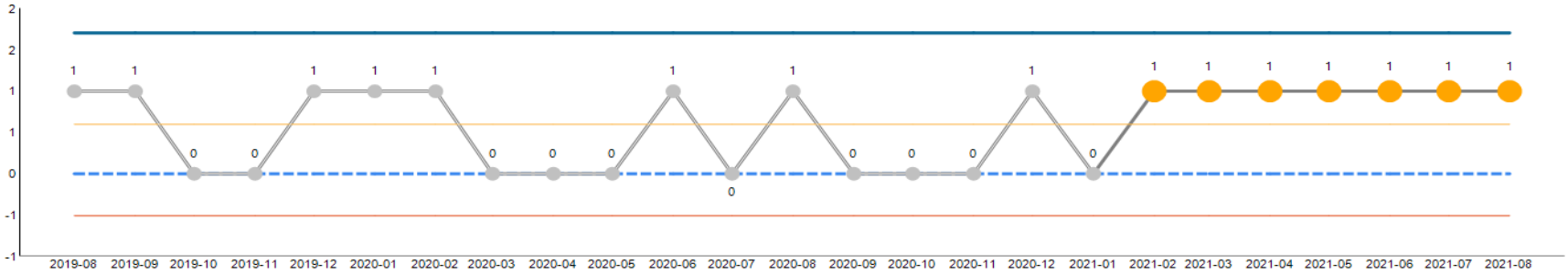
Clostridium Difficile

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

Target	2019-08	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	2021-04	2021-05	2021-06	2021-07	2021-08
	1	1	0	0	1	1	1	0	0	0	1	0	1	0	0	0	1	0	1	1	1	1	1	1	1



Concern

ucl	2
mean	1
target	0
lcl	-1

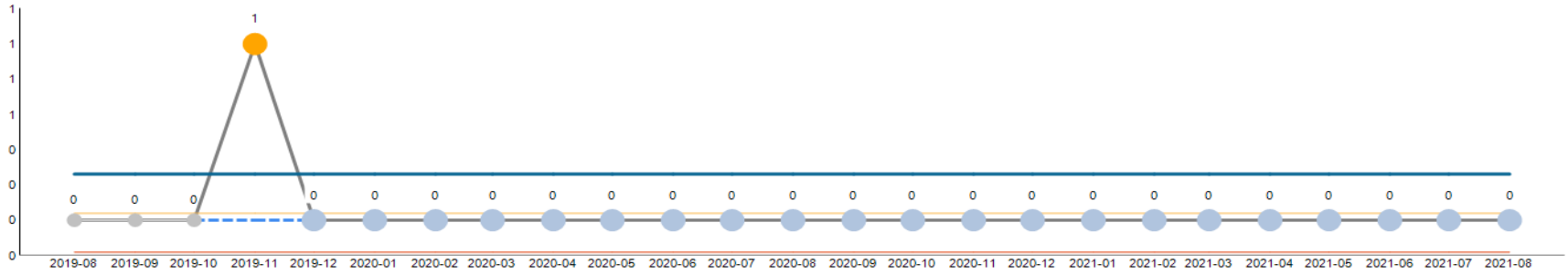
Commentary:

Annual target of 4 cases has been breached so will remain red for rest of year. Continued work with wards and divisions to avoid new cases.

MRSA Bacteraemias

Count of trust assigned MRSA infections

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
	0	0	0	1	0	0	0	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:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

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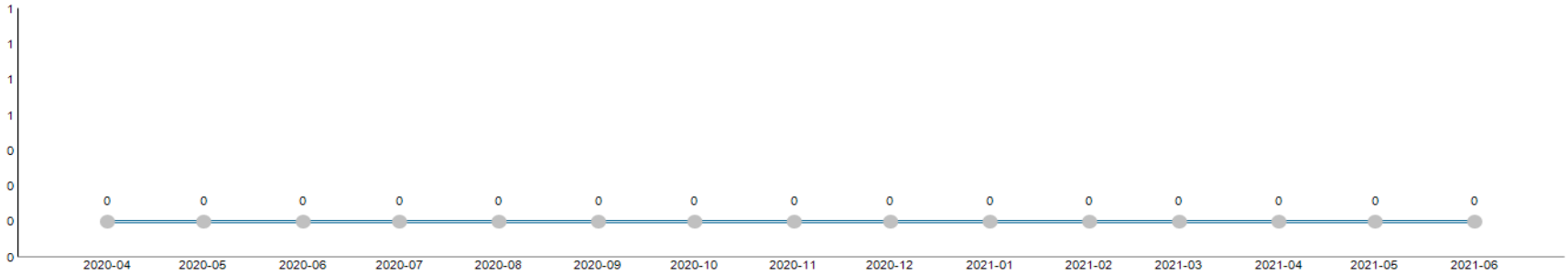
Patient Safety Alerts not completed by deadline

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



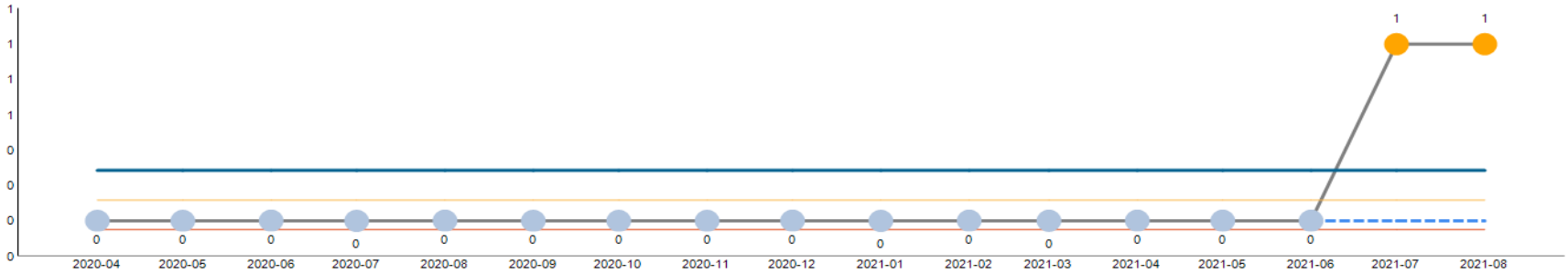
Common Cause

ucl	0
mean	0
target	0
lcl	0

commentary:

Clostridium difficile – infection rate

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



Concern

ucl	0
mean	0
target	0
lcl	-0

Commentary:

Annual target of 4 cases has been breached so will remain red for rest of year. Continued work with wards and divisions to avoid new cases.

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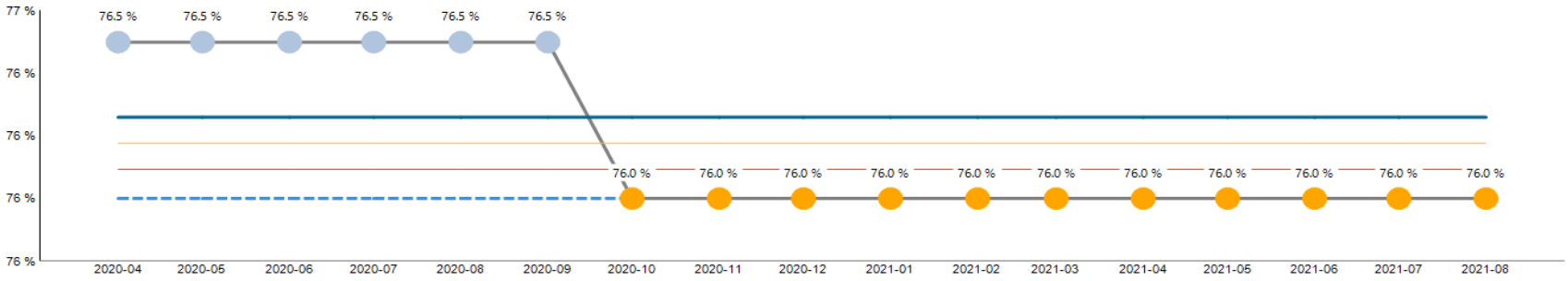
NHS Staff Survey - Staff recommendation of the organisation as a place to work

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



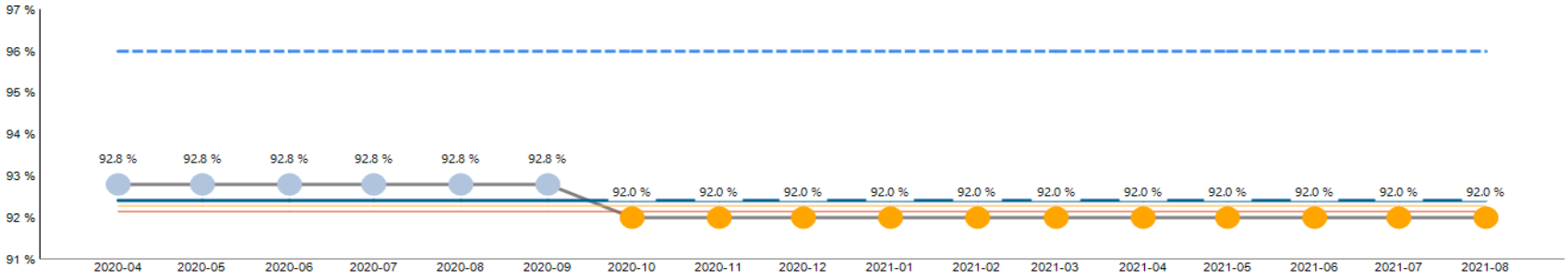
Concern

ucl	76.26%
mean	76.18%
target	76.0%
lcl	76.09%

commentary:

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

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



Concern

ucl	92.42%
mean	92.28%
target	96.0%
lcl	92.15%

commentary:

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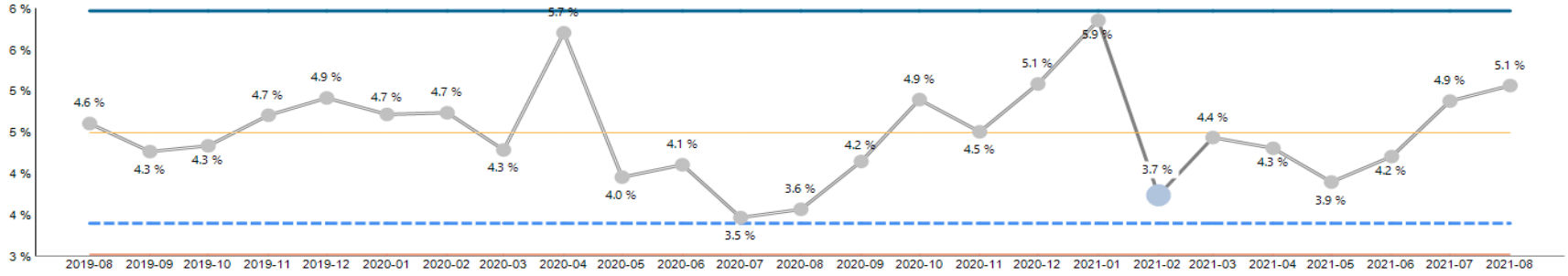
Staff Sickness (All Staff)

Rate of sickness across all staff

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
<=3.4%	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%	4.3%	3.9%	4.2%	4.9%	5.1%



Common Cause

ucl	5.98%
mean	4.5%
target	3.4%
lcl	3.02%

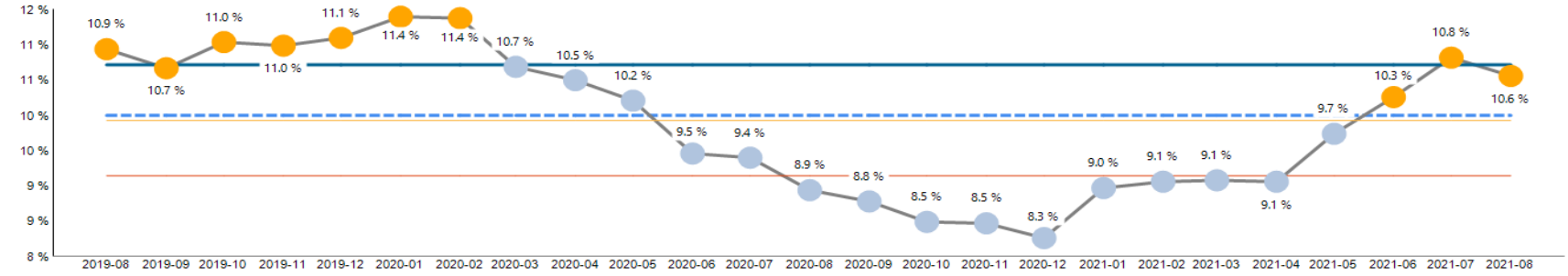
Commentary:

Stress and anxiety remains the leading reason for absence, this month C&M Resilience Hub has been launched. Close working ongoing between HRBPs and Heads of Departments.

Staff Turnover

Rate of turnover among voluntary leavers

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
<=10%	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%	9.1%	9.1%	9.1%	9.7%	10.3%	10.8%	10.6%



Concern

ucl	10.72%
mean	9.93%
target	10.0%
lcl	9.14%

Commentary:

Trustwide group established to review trends and develop actions with an initial focus on nursing due to the current high turnover.

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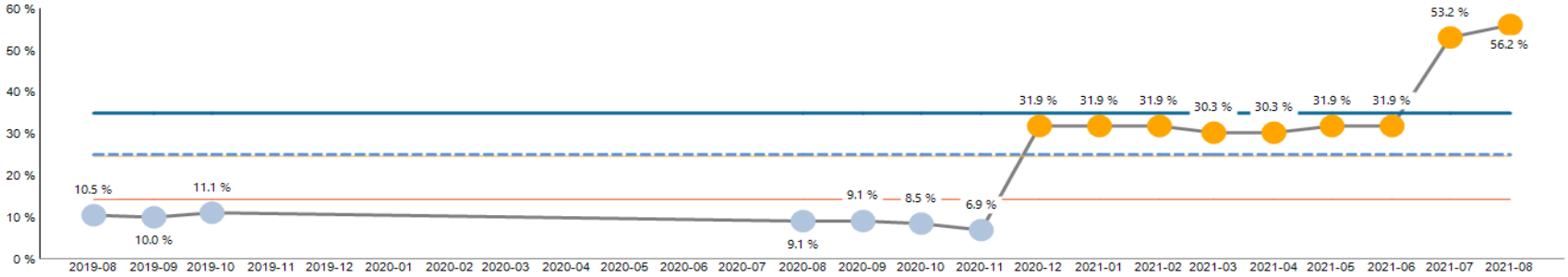
Executive Team Turnover

Rate of turnover among the executive team

Target	2019-08	2019-09	2019-10	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08
<=25%	10.5%	10.0%	11.1%	9.1%	9.1%	8.5%	6.9%	31.9%	31.9%	31.9%	30.3%	30.3%	31.9%	31.9%	53.2%	56.2%



Concern

ucl	34.98%
mean	24.66%
target	25.0%
lcl	14.35%

commentary:

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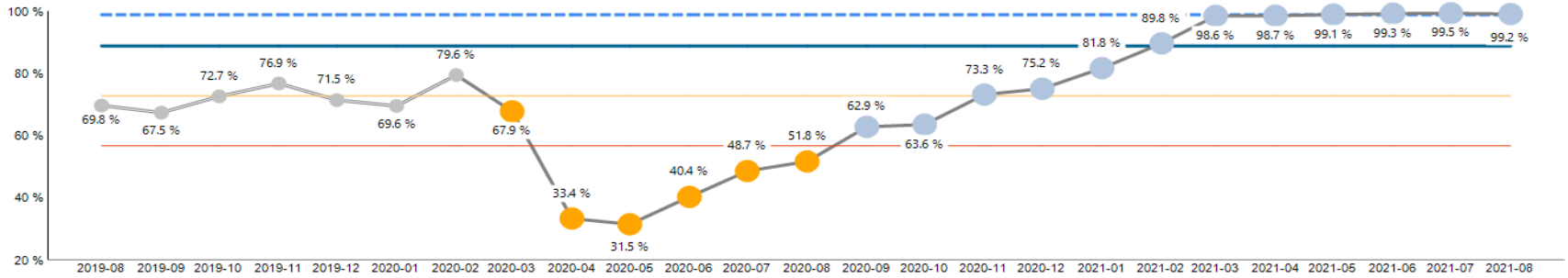
Maximum 6-week wait for diagnostic procedures

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

Target	2019-08	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	2021-04	2021-05	2021-06	2021-07	2021-08
>=99%	69.8%	67.5%	72.7%	76.9%	71.5%	69.6%	79.6%	67.9%	33.4%	31.5%	40.4%	48.7%	51.8%	62.9%	63.6%	73.3%	75.2%	81.8%	89.8%	98.6%	98.7%	99.1%	99.3%	99.5%	99.2%

Improvement



ucl	88.97%
mean	72.89%
target	99.0%
lcl	56.81%

commentary:

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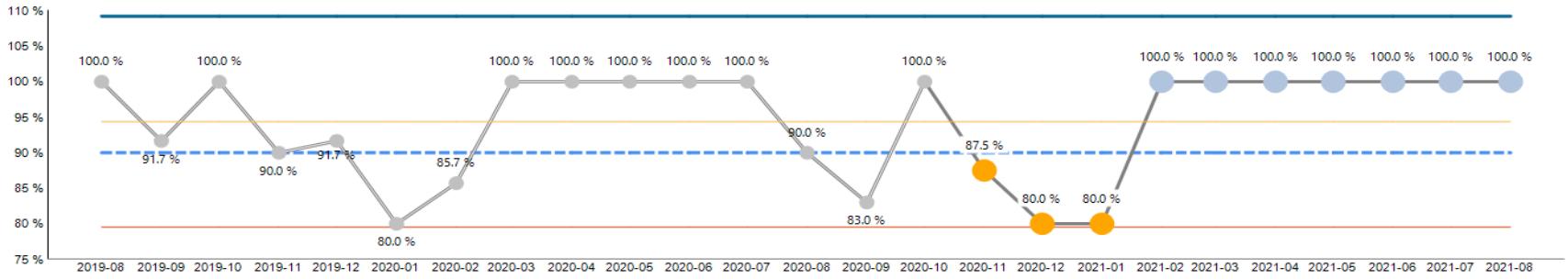
Dementia - Find

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	2019-08	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	2021-04	2021-05	2021-06	2021-07	2021-08
>=90%	100.0%	91.7%	100.0%	90.0%	91.7%	80.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	90.0%	83.0%	100.0%	87.5%	80.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Improvement



ucl	109.23%
mean	94.38%
target	90.0%
lcl	79.53%

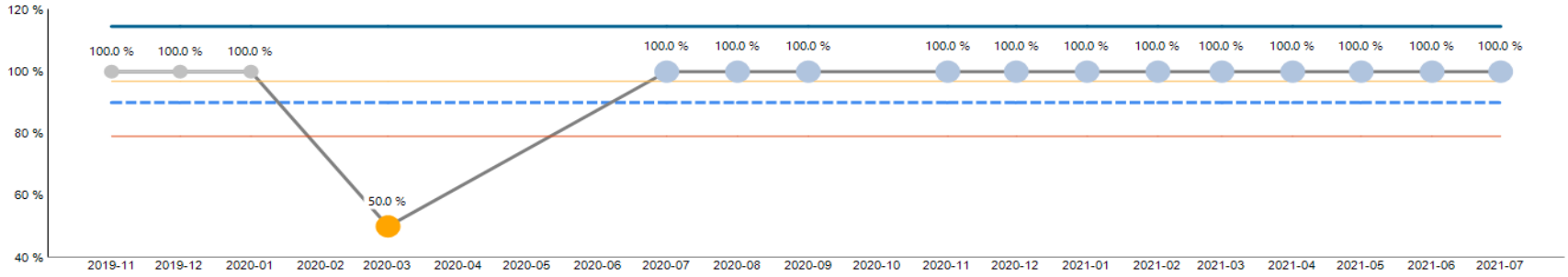
commentary:

Dementia - Assess

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

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

Improvement



ucl	114.61%
mean	96.88%
target	90.0%
lcl	79.14%

commentary:

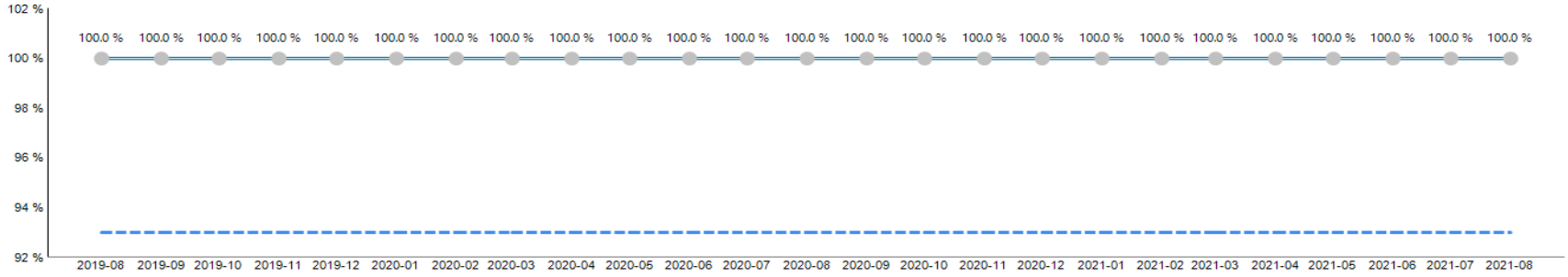
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Cancer: 14 day GP referral to 1st Outpatient Appointment

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

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
>=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%	100.0%



Common Cause

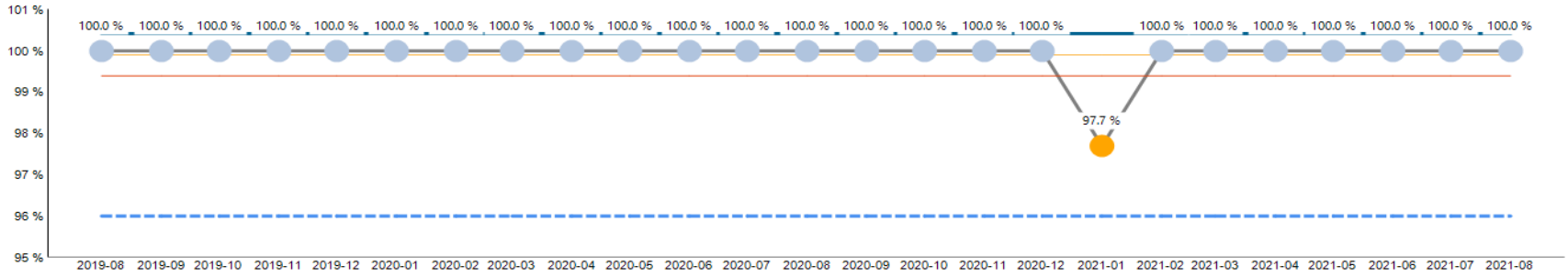
ucl	100.0%
mean	100.0%
target	93.0%
lcl	100.0%

commentary:

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

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

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
>=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%	97.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Improvement

ucl	100.42%
mean	99.91%
target	96.0%
lcl	99.4%

commentary:

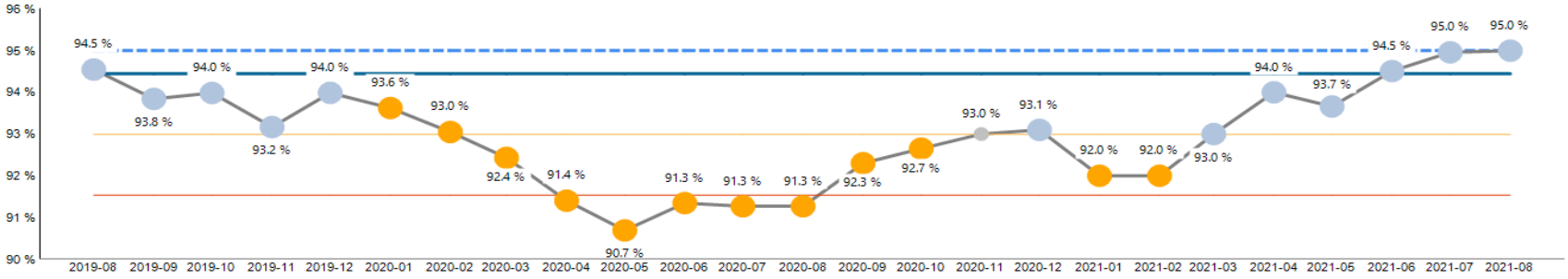
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Mandatory Training Compliance

Percentage of completed mandatory training

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
>=95%	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%	94.0%	93.7%	94.5%	95.0%	95.0%



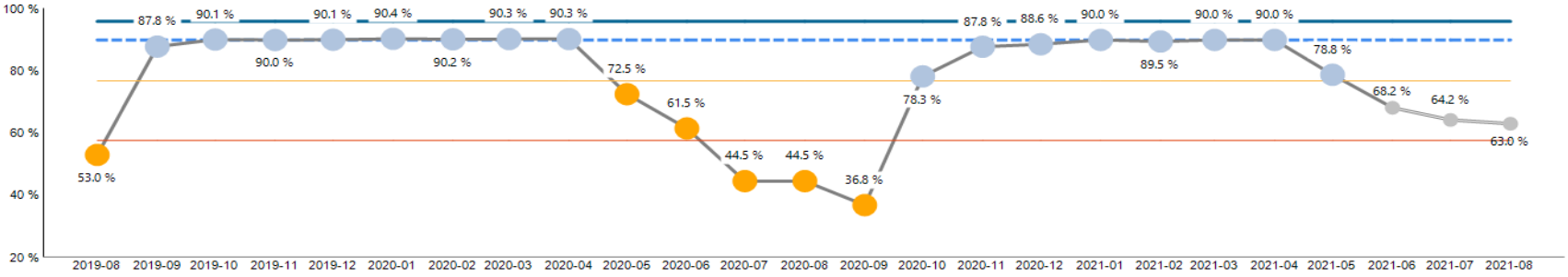
ucl	94.45%
mean	92.99%
target	95.0%
lcl	91.54%

commentary:

Appraisals Compliance

Percentage of annual appraisals completed

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
>=90%	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%	90.0%	78.8%	68.2%	64.2%	63.0%



ucl	95.94%
mean	76.81%
target	90.0%
lcl	57.68%

Commentary:

The appraisal window is open until the 30th September so performance should improve.

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
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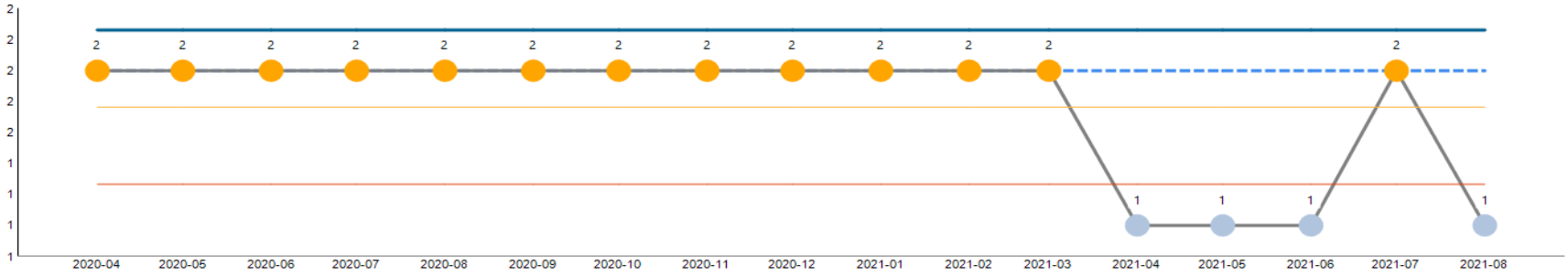
Income and expenditure (I&E) Margin - score

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

Improvement



ucl	2
mean	2
target	2
lcl	1

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

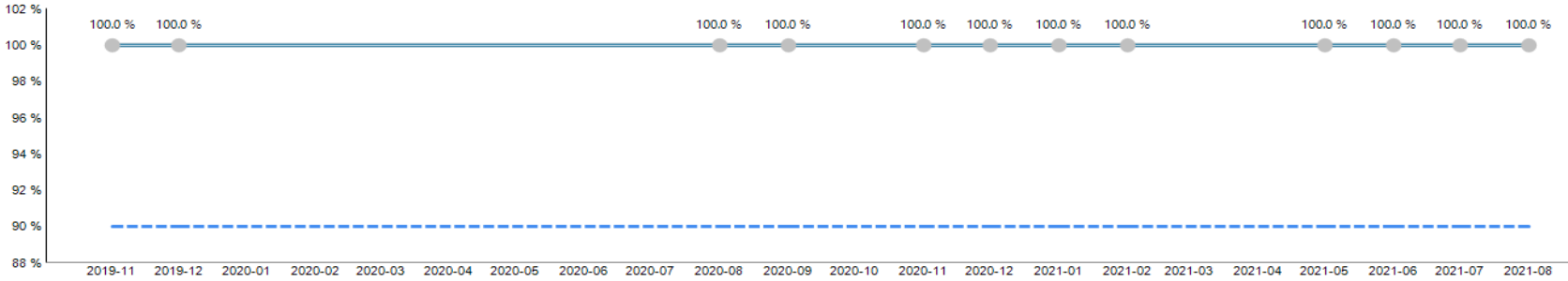
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Dementia - Refer

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

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

Common Cause



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

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

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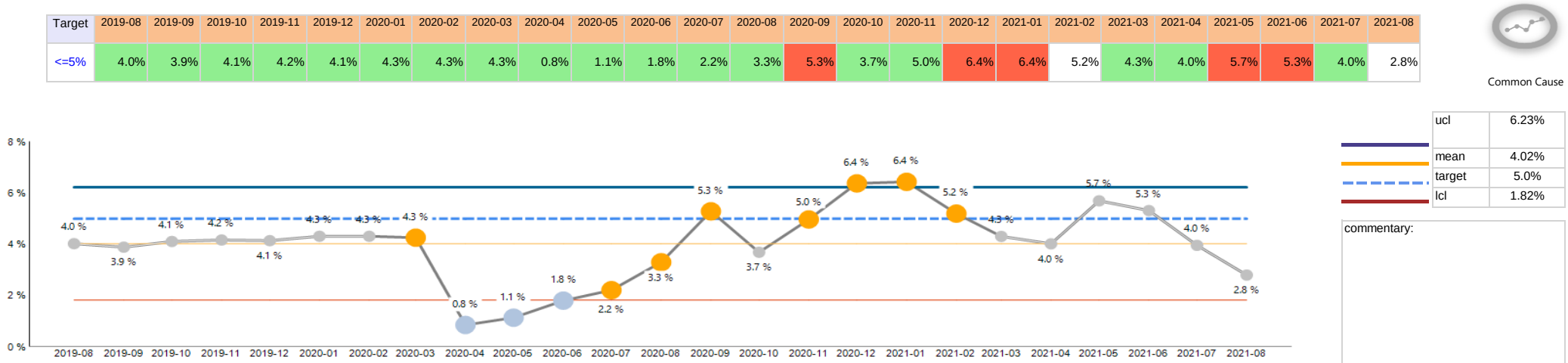
Delayed Transfers of care

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

Target	2019-08	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	2021-04	2021-05	2021-06	2021-07	2021-08
<=5%	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%	4.0%	5.7%	5.3%	4.0%	2.8%



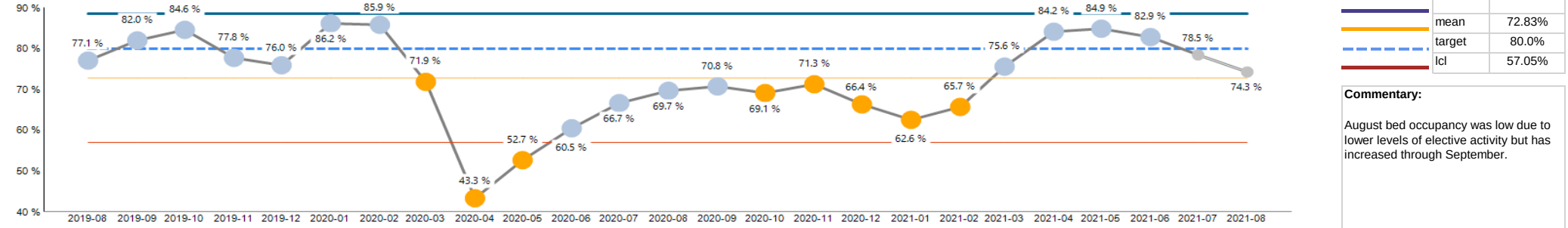
ucl	6.23%
mean	4.02%
target	5.0%
lcl	1.82%

commentary:

Bed Occupancy

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

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
>=80%	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%	84.2%	84.9%	82.9%	78.5%	74.3%



ucl	88.6%
mean	72.83%
target	80.0%
lcl	57.05%

Commentary:

August bed occupancy was low due to lower levels of elective activity but has increased through September.

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

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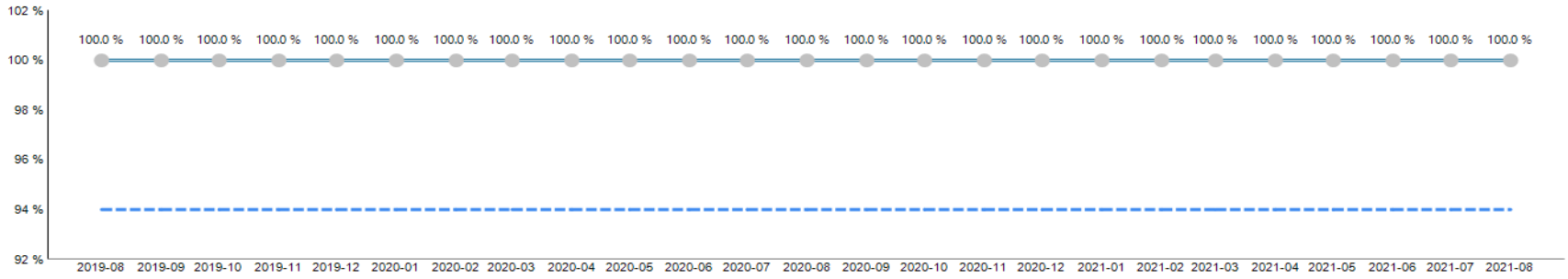
NHS Foundation Trust

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

Patients waiting a maximum of 31 days for all subsequent treatments

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
>=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%	100.0%

Common Cause



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

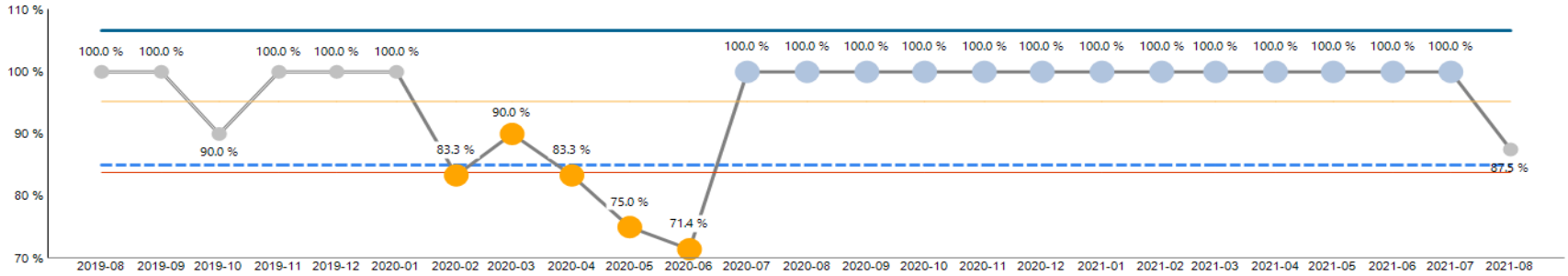
commentary:

Cancer: 62 day Consultant Upgrade

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

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
>=85%	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%	100.0%	100.0%	100.0%	100.0%	87.5%

Common Cause



ucl	106.64%
mean	95.22%
target	85.0%
lcl	83.81%

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

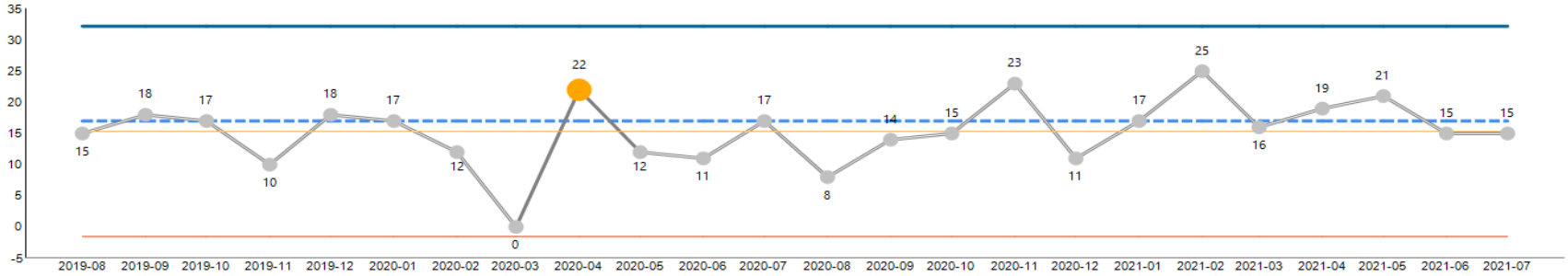
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

In-Hospital mortality

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

Target	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	2021-04	2021-05	2021-06	2021-07
<=17	15	18	17	10	18	17	12	0	22	12	11	17	8	14	15	23	11	17	25	16	19	21	15	15

Common Cause



ucl	32
mean	15
target	17
lcl	-2

commentary:

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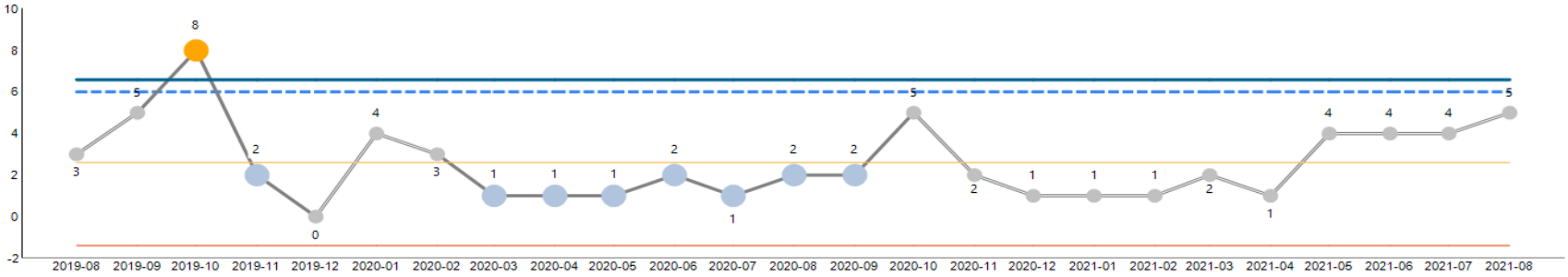
NHS Foundation Trust

Quantity of complaints

Quantity of complaints

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
<=6	3	5	8	2	0	4	3	1	1	1	2	1	2	2	5	2	1	1	1	2	1	4	4	4	5

Common Cause



ucl	7
mean	3
target	6
lcl	-1

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

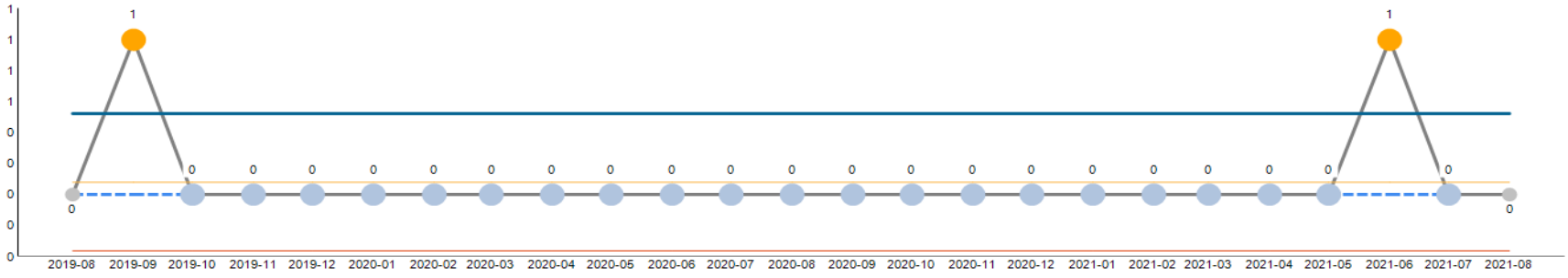
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Occurrence of any Never Events

Count of Never Events

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0

Common Cause



ucl	1
mean	0
target	0
lcl	-0

commentary:

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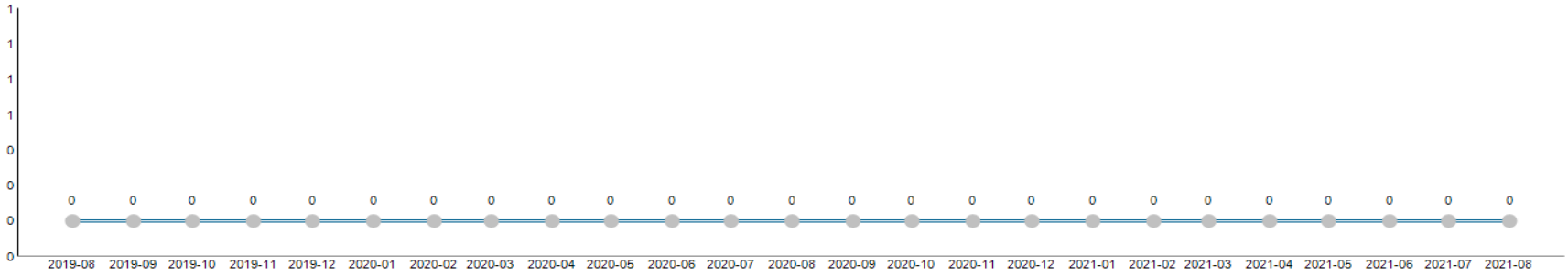
NHS Foundation Trust

Mixed sex accommodation breaches

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

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
	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



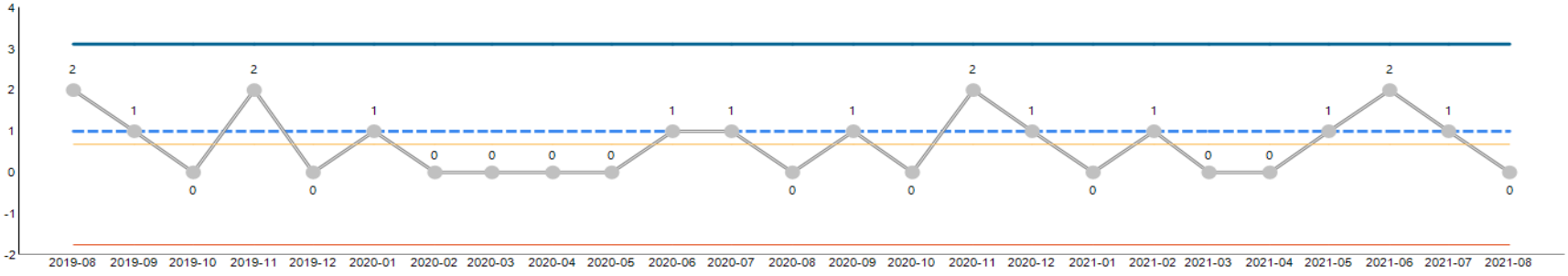
ucl	0
mean	0
target	0
lcl	0

commentary:

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

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
1	2	1	0	2	0	1	0	0	0	0	1	1	0	1	0	2	1	0	1	0	0	1	2	1	0

Common Cause



ucl	3
mean	1
target	1
lcl	-2

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

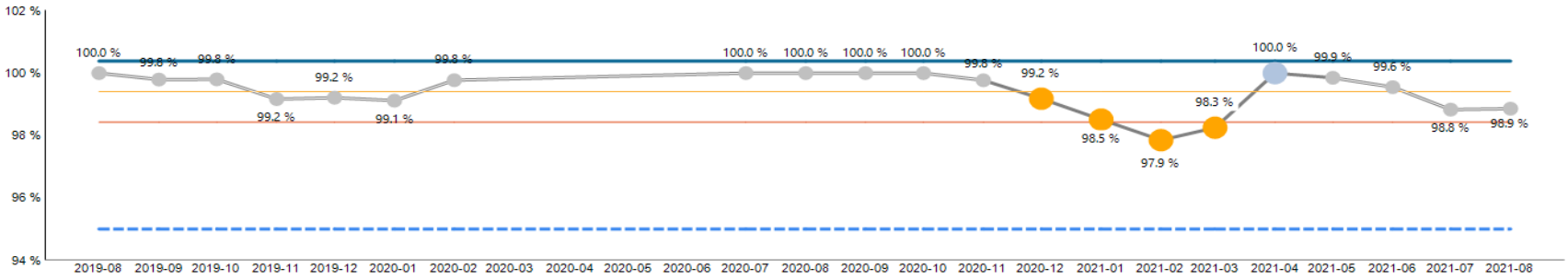
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Inpatient scores from Friends & Family Test - % positive

Percentage of inpatients rating the service good or very good

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
>=95%	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%	100.0%	99.9%	99.6%	98.8%	98.9%

Common Cause



ucl	100.39%
mean	99.41%
target	95.0%
lcl	98.43%

commentary:

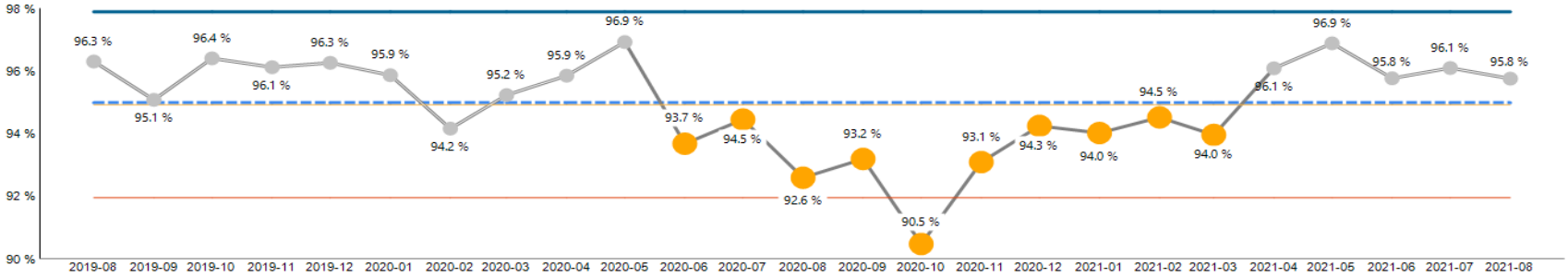
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Venous thromboembolism (VTE) risk assessment

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

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
>=95%	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%	96.1%	96.9%	95.8%	96.1%	95.8%



Common Cause

ucl	97.91%
mean	94.93%
target	95.0%
lcl	91.96%

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

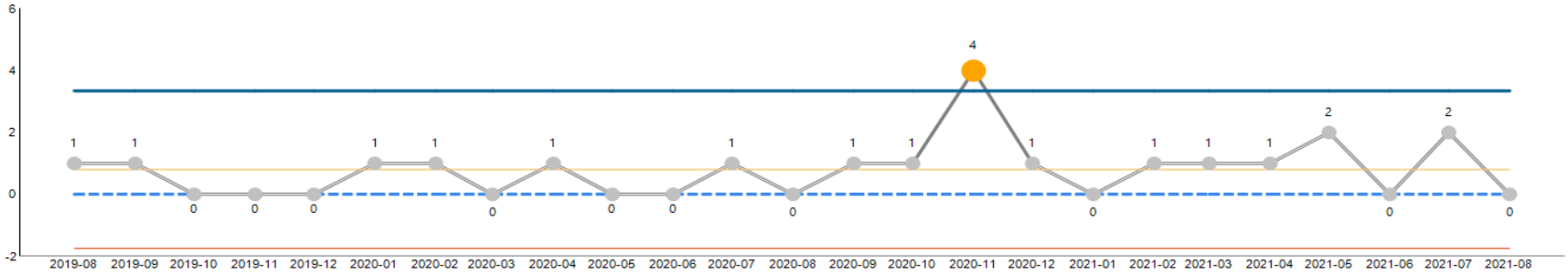
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

MSSA Bacteraemias

Count of trust assigned MSSA infections

Target	2019-08	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	2021-04	2021-05	2021-06	2021-07	2021-08
	1	1	0	0	0	1	1	0	1	0	0	1	0	1	1	4	1	0	1	1	1	2	0	2	0

Common Cause



ucl	3
mean	1
target	0
lcl	-2

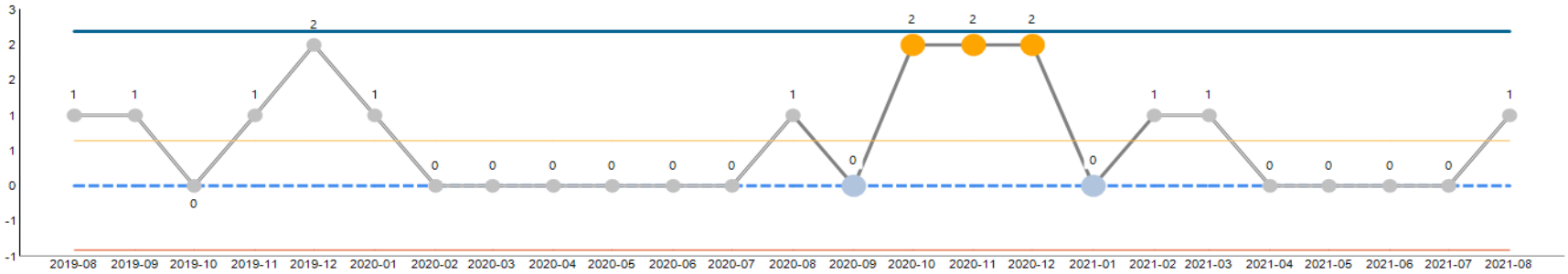
commentary:

Gram Negative Bacteraemias

Count of trust assigned Gram Negative Bacteraemias infections

Target	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	2021-04	2021-05	2021-06	2021-07	2021-08
	1	1	0	1	2	1	0	0	0	0	0	0	1	0	2	2	2	0	1	1	0	0	0	0	1

Common Cause



ucl	2
mean	1
target	0
lcl	-1

Commentary:

1 incident in month but within the yearly threshold.

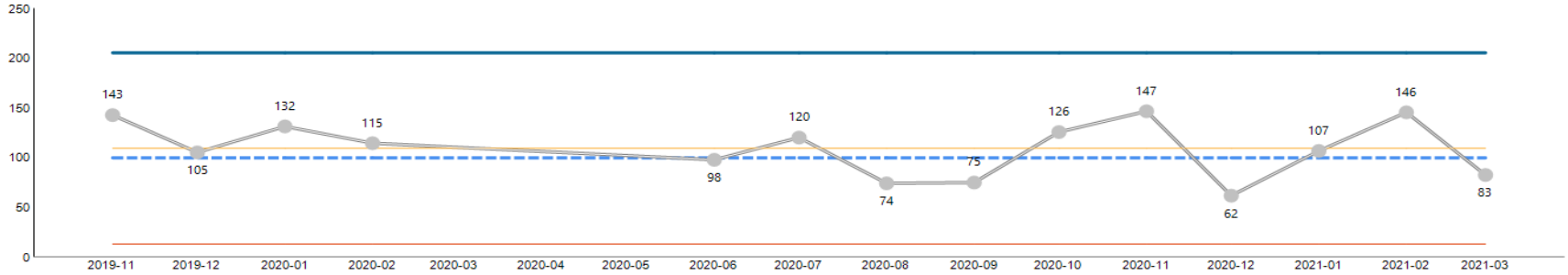
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Hospital Standardised Mortality Ratio (HSMR) - basket diagnoses

patient characteristics for those treated there.

Target	2019-11	2019-12	2020-01	2020-02	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
<=100	143	105	132	115	98	120	74	75	126	147	62	107	146	83



Common Cause

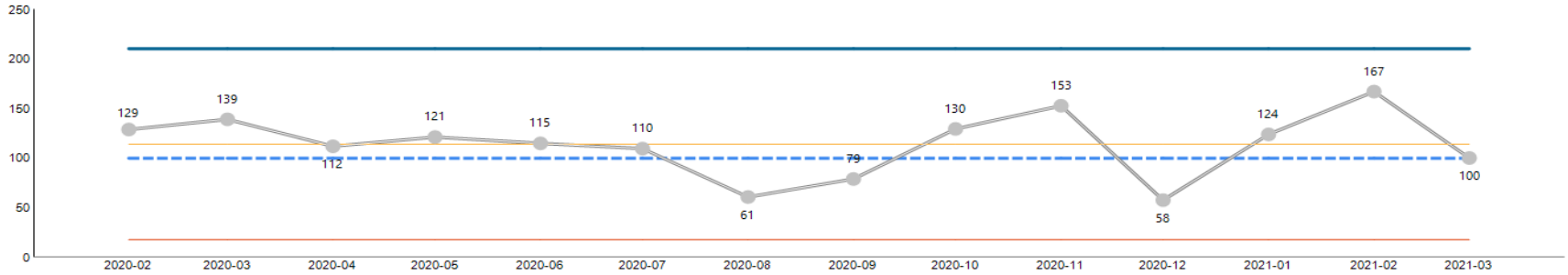
ucl	206
mean	109
target	100
lcl	13

commentary:

Hospital Standardised Mortality Ratio (HSMR) - all diagnoses

of patient characteristics for those treated there.

Target	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03
<=100	129	139	112	121	115	110	61	79	130	153	58	124	167	100



Common Cause

ucl	211
mean	114
target	100
lcl	18

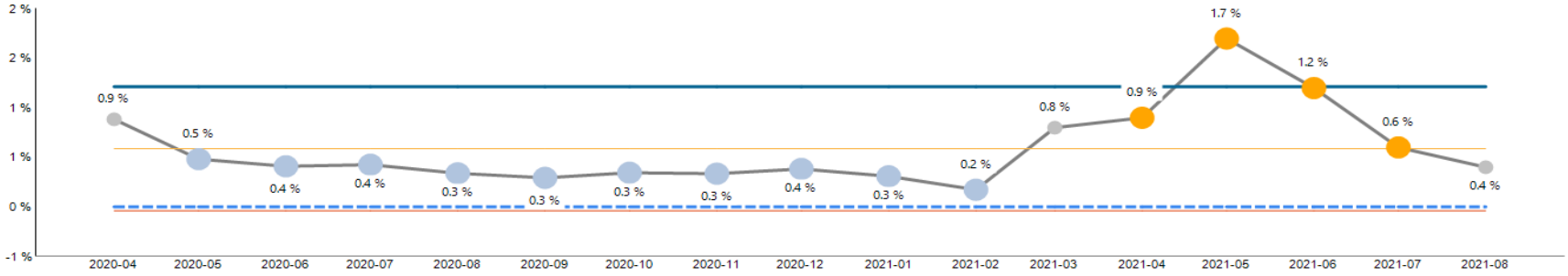
commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Proportion of temporary staff - Agency staff costs

Target	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08
0	0.9%	0.5%	0.4%	0.4%	0.3%	0.3%	0.3%	0.3%	0.4%	0.3%	0.2%	0.8%	0.9%	1.7%	1.2%	0.6%	0.4%



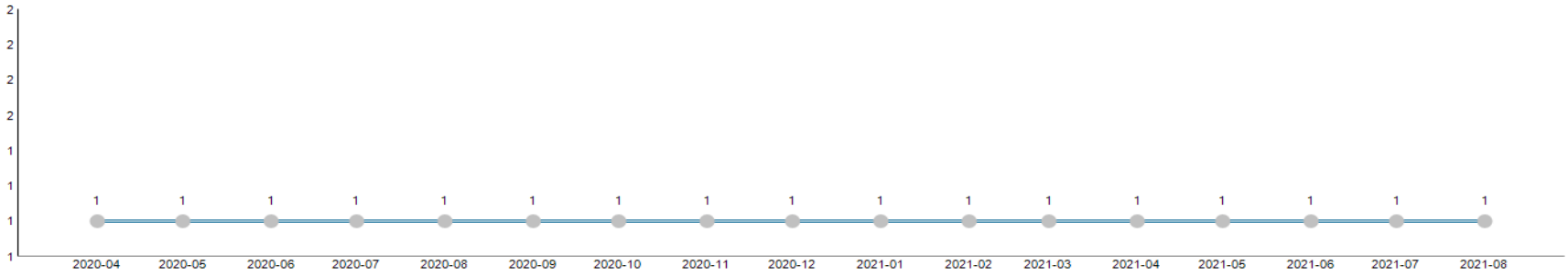
Common Cause

ucl	1.21%
mean	0.59%
target	0.0%
lcl	-0.04%

commentary:

Agency spend

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



Common Cause

ucl	1
mean	1
target	1
lcl	1

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

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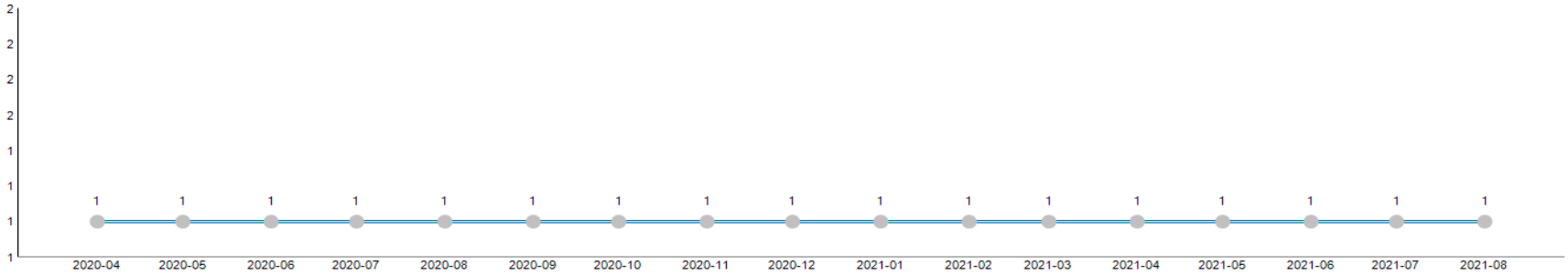
Capital service capacity - score

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



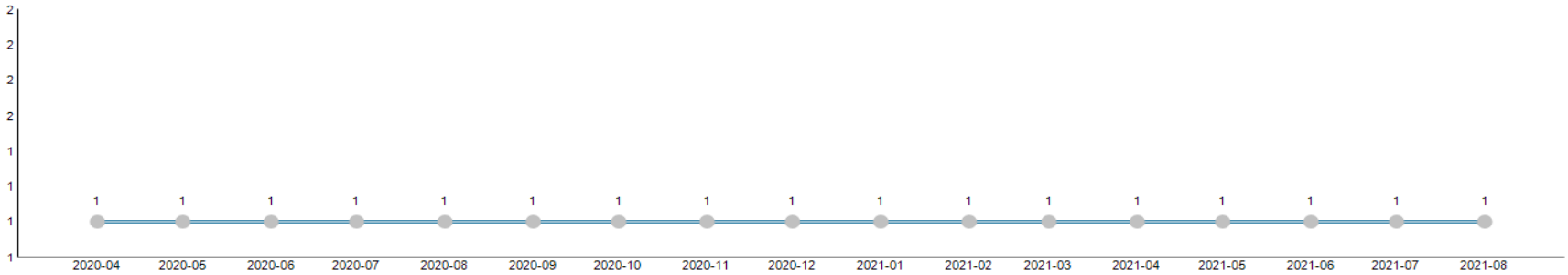
Common Cause

ucl	1
mean	1
target	1
lcl	1

commentary:

Liquidity (days) - score

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



Common Cause

ucl	1
mean	1
target	1
lcl	1

commentary:

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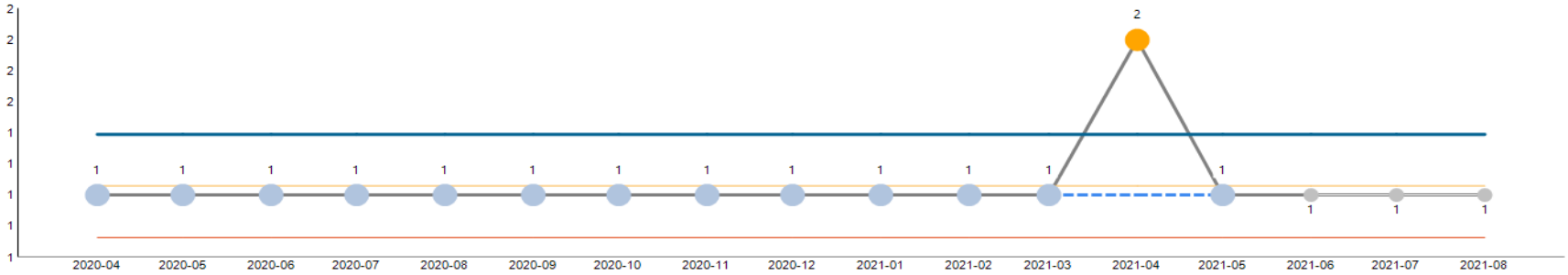
Distance from financial plan - score

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



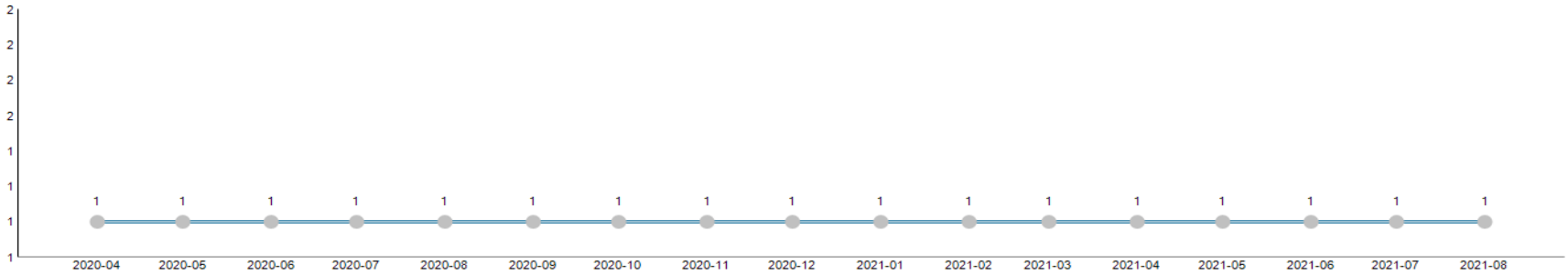
Common Cause

ucl	1
mean	1
target	1
lcl	1

commentary:

Overall use of resources rating

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



Common Cause

ucl	1
mean	1
target	1
lcl	1

commentary:

Board of Directors (in Public)
Item 4.2

Subject: **Phase 4 Elective Recovery Update**
Date of Meeting: **Tuesday 28th September 2021**
Prepared by: **Jonathan Mathews, Deputy Chief Operating Officer**
Presented by: **Hayley Kendall, Chief Operating Officer**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
BAF3, BAF7	Assurance that performance is in line with the recovery trajectories. Risk that national changes in ERF rules will reduce income recovery, impact assessment being undertaken by C&M ICS.

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

1. Executive Summary

The Covid-19 pandemic placed significant pressures on the healthcare system with mutual aid and high volumes of non-elective demand accentuating pressure on the ability to provide routine elective services through the Covid surges. In response to this the operational teams developed recovery trajectories for all elective services that focused on reducing the backlog of the most urgent patients awaiting treatment; these have previously been approved by the Board of Directors.

The restoration and recovery of elective services has progressed well with all services being fully restored, other than a small number of community outpatient settings, and performance against the recovery trajectories remains strong. Clinically urgent and long waiting patients have been a priority throughout the recovery phase and both patient groups have received timely access to care.

The Board of Directors is asked to note the strong performance against the elective recovery trajectories and receive future updates as required.

2. Background

In planning for recovery of elective services there was a drive to recover activity levels to pre-

Covid levels but in a safe and sustainable way being mindful of the challenging times that staff had experienced during the pandemic. Recovery trajectories were developed across the three clinical divisions and aggregated into one Trust level plan that the Board are sighted on each month.

3. Performance Overview

3.1 P2 Performance

Due to the nature of the specialties the Trust provides there will inevitably be a large proportion of surgical patients that fit into the P2 category with patients being prioritised for treatment within 4 weeks of the decision to treat. During June and July there were occasions whereby P2 patients had their procedure rescheduled due to the very high levels of non-elective demand that the Trust experienced, although this occurred less during August. All patients are clinically triaged to make sure it is safe for the procedure to be delayed and any patients waiting longer than one month has a harm review undertaken. The harm reviews are reviewed by the divisional leadership team and any harm reported will follow the Trust's risk management processes.

The table below shows the P2 performance across the Trust as at the 12th September 2021:

Indicator	No TCI			TCI			Total
	Not Dated Breach	Not Dated Not Breach	Total	Dated Breach	Dated Not Breach	Total	
Medicine	12	11	23	3	21	24	47
Heart Rhythm	3	2	5	0	4	4	9
Ebus	0	1	1	0	7	7	8
Intervention - Cardiology	3	7	10	3	6	9	19
Achd Medical	3	0	3	0	1	1	4
Structural Tavi	3	1	4	0	3	3	7
Surgery	5	2	7	9	17	26	33
Cardiac Surgery	3	2	5	7	4	11	16
Thoracic Surgery	1	0	1	0	12	12	13
Aortic Surgery	0	0	0	1	0	1	1
Achd Surgical	0	0	0	1	1	2	2
Aorto-vascular Surgery	1	0	1	0	0	0	1
Trust Total	17	13	30	12	38	50	80

In summary this shows that at present there are 17 patients that are not dated for their procedure that have waited longer than 4 weeks. Surgery have made excellent progress in reducing patients waiting longer than 4 weeks and all divisions are focused on ensuring P2 patients receive treatment within 4 weeks from decision to treat. There are a number of patients that require sub-specialist treatment that may sometimes mean waiting times are slightly more than the proposed 4 weeks.

3.2 52-week Position

Historically the Trust did not have a challenge with treating patients within 52 weeks, from referral to treatment, but because of the reduced elective activity through the Covid surges a

backlog of patients waiting longer than the statutory waiting times was accumulated. This was particularly a challenge across the surgical specialties as most of the operative capacity was focused on treating urgent patients first and then long waiting patients. Current performance against the recovery trajectory is detailed below:

52 Week	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	138	131	122	108	88	74	55	30	8	3	0	0
Actual	121	103	107	96	78							
Variance	-17	-28	-15	-12	-10							

Performance remains in line with expected levels but there are challenges in a number of sub-specialty areas namely, aortic surgery, LAAO, EP. This has also been compounded by the shortfall in anaesthetic capacity due to unplanned absence during the summer months. It is forecast that performance will remain in line with the trajectory subject to no further impact of Covid and any changes in patients opting to delay treatment.

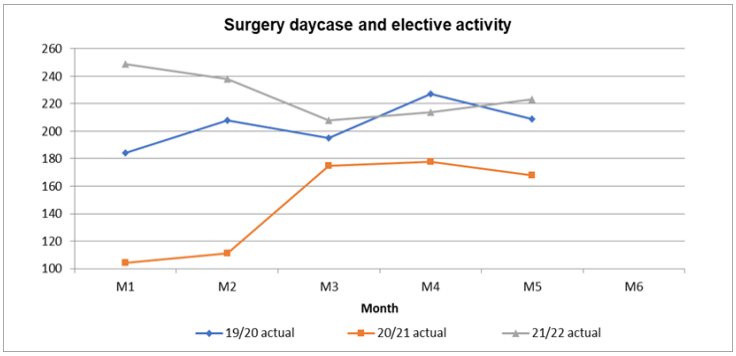
3.3 RTT Performance

As would be expected there is a significant backlog of patients waiting longer than 18 weeks as an output of the reduced elective programme and was previously in excess of 1,000. As capacity has been utilised for the most clinically urgent patients first and then longest waiting patients, managing patients through an 18-week pathway has not been achievable. The position at the end of August is demonstrated in the table below:

18 Weeks	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	952	863	879	844	804	772	740	700	668	628	596	564
Actual	869	839	829	877	790							
Variance	-83	-24	-50	+33	+14							

3.4 Activity

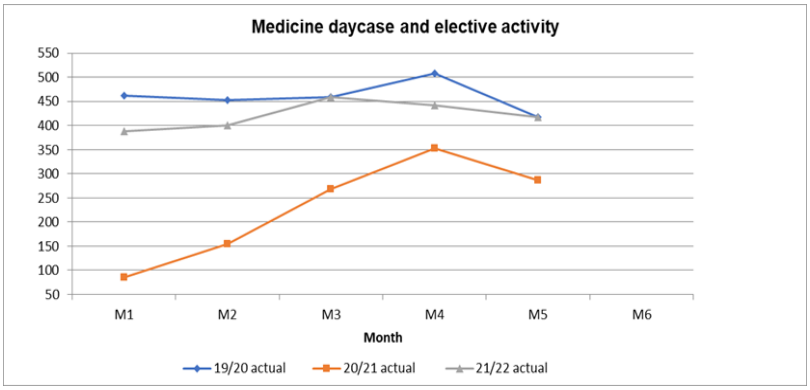
When developing the recovery trajectories, the focus was to ensure that activity levels reached pre-Covid levels as quickly and as safely as possible. The performance against the 2019/20 actual levels are shown in the graphs below:



Surgery has continued to perform well throughout the year with performance in month 5 above the 2019/20 actual activity levels.

Challenges were forecast in achieving the activity levels in July and August due to challenges with anaesthetic staffing.

It should be noted that whilst the above is actual activity the Elective Recovery Fund (ERF) is based on income and casemix, although activity is a good proxy for this.



Specialties within the Medicine Division have again performed well against the plan. There have been a number of challenges in achieving this with pressures in anaesthetic and ODP staffing. The Cath Lab refurb programme is also impacting activity when handover of phases is taking place.

In addition to achieving the required activity thresholds there is also the requirement for organisations and systems to demonstrate achievement of the ERF gateways. The Trust's RAG rated performance against the thresholds is attached at Appendix three.

4. Costs of Recovery

The Board approved the interim H1 financial plan with an expectation that ERF income would be achieved and flow to the Trust and in addition that the system top-up would be reduced for this contribution; noting the risk that ERF is earned at an aggregate Cheshire and Mersey level. This contribution would support the costs of recovery associated with the restoration and recovery plan.

The plan and actual cost against the key schemes associated with the plan are detailed in Appendix 1 for the period ending August 2021.

The budget for months 1-5 totaled £766k and costs to date total £543k, giving a favorable variance of £223k.

The primary cause of the underspend is less than anticipated additional session costs in surgery weekend working.

In respect of ERF income received, the table below shows the current income reflected in the month 5 financial position, compared to the original plan.

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Total
Original plan	1,315	1,241	1,058	996	852	5,462
Included in M5 position	1,861	1,494	681	28	28	4,092
Variance	**546**	**253**	**(377)**	**(968)**	**(824)**	**(1,370)**
Original thresholds	70%	75%	80%	85%	85%	85%
Revised thresholds	70%	75%	80%	95%	95%	95%

Key areas to note on the ERF income position are as follows:

- April and May income has been confirmed. June to August are indicative figures.
- ERF is managed at an aggregate system level across Cheshire and Merseyside. As a result, where performance across the system has not been strong, this has led to lower income for the Trust. This is particularly relevant for June to August, where ERF income is not commensurate to the activity delivered by the Trust because it has been constrained by lower system performance.

- The national thresholds above which ERF is earned were amended for quarter 2, increasing from 85% to 95%. This significantly reduced the income available to the Trust.
- The numbers presented above relate only to English patients. Welsh commissioners have recently announced that they will mirror the NHS England ERF arrangement. The shortfall in ERF income outlined in the table above has been offset by the income from the Welsh ERF, thus largely mitigating the risk in H1.

H2 projections

The original recovery plan was revisited in light of the significant financial risks in H2 and also the practical challenge of recruiting the staff necessary to implement the recovery actions. The revised forecast is outlined in appendix 2 and shows that spend is likely to be lower by £1,072k.

Recent announcements confirm that there will be an ERF in H2, but the details are yet to be finalised.

5. Overarching Risks to Delivery

Workforce has always remained a high risk in the delivery of the recovery programme with the challenges that Covid has placed on staff generally. Through July and August there were significant challenges with absence with the overall rate reaching 5.9% for a good proportion of the month to date. This prolonged period of high absence placed pressures on staff that remain in work and makes it very difficult to provide additional capacity over and above core to assist with reducing the backlog further. Recruitment continues daily for nursing and the risk will be mitigated somewhat with the arrival of the international nursing cohort.

There have been three unplanned consultant absences within anaesthesia that is causing a pressure with being able to provide enough general anaesthetic capacity to all required lists. It should be noted that the consultant workforce has worked flexibly to provide the maximum elective capacity whilst also ensuring on call rotas are safely staffed. A locum consultant has been appointed and an advert has been published for a substantive consultant.

6. Conclusion

Considering the challenges that were faced during the pandemic the Trust has restored its elective services to full capacity facilitating the reduction in waiting times for patients. Although waiting times are in excess of pre-Covid levels the Trust remains focused on reducing these to a reasonable level over the financial year and remains a strong performer in the region.

7. Recommendations

The Board of Directors is asked to note the strong performance against the recovery trajectories and the associated challenges that have and are being faced with achieving these.

APPENDIX 1: Recovery Actions - Year to date spend against plan

RECOVERY PLAN £	M1	M2	M3	M4	M5	TOTAL (M1-5)
POCCU 3	0	0	0	0	0	0
Expanding critical care	0	0	0	32,083	32,083	64,167
Hot lab	3,667	3,667	3,667	3,667	3,667	18,333
Remote monitoring - CF	0	0	0	9,583	9,583	19,167
Remote monitoring - Cardiac	20,000	20,000	20,000	20,000	20,000	100,000
Birch staffing	0	0	0	5,500	5,500	11,000
Private ambulance service	34,000	34,000	34,000	34,000	34,000	170,000
Expanded validation team	0	0	0	4,667	4,667	9,333
Surgery additional sessions	70,417	70,417	70,417	70,417	70,417	352,083
EP - additional capacity through org change	0	0	0	0	0	0
Spirometry	0	0	0	11,083	11,083	22,167
	128,083	**128,083**	**128,083**	**191,000**	**191,000**	**766,250**

ACTIONED IN MONTH £	M1	M2	M3	M4	M5	TOTAL (M1-5)
POCCU 3						0
Expanding critical care	(22,300)	(22,300)	(22,300)	(22,300)		(89,200)
Hot lab						0
Remote monitoring – CF			(4,382)	(1,200)	(1,200)	(6,782)
Remote monitoring - Cardiac			(60,000)	(19,500)	(24,900)	(104,400)
Birch staffing						0
Private ambulance service	(34,000)	(34,000)	(34,000)	(34,000)	(34,000)	(170,000)
Expanded validation team		(2,885)	(1,358)	(4,393)	(4,298)	(12,934)
Surgery additional sessions	(40,000)	(40,408)	(20,475)	(23,056)	(19,496)	(143,435)
Medicine additional sessions			(16,000)			(16,000)
EP - additional capacity through org change						0
Spirometry						0
	(96,300)	**(99,593)**	**(158,515)**	**(104,449)**	**(83,894)**	**(542,751)**

BALANCE - UNDER / (OVERSPEND)	**31,783**	**28,490**	**(30,432)**	**86,551**	**107,106**	**223,499**

APPENDIX 2: Recovery Actions – H2 Revised Forecast

Recovery Action	Original plan £'000	H2 Forecast £'000	Variance to plan £'000
POCCU 3	665	0	665
Expanding Critical Care	193	134	59
Hot Lab	22	22	0
Remote monitoring - CF	58	58	0
Remote monitoring - Cardiac	120	120	0
Birch Staffing	33	0	33
Private Ambulance Service	204	144	60
Expanded Validation Team	28	28	0
Surgery Additional Sessions	423	210	213
EP - additional capacity through org change	231	231	0
Spirometry	67	24	43
	2,042	**971**	**1,072**

Item 4.2a

ERF Gateway Position

Update to the Board of Directors – September 2021

Hayley Kendall on behalf of the Executive Team

ERF Gateways

5 overall principles to deliver the ERF Gateways:

1. **Clinical validation of waiting lists and long waits**
2. **Addressing health inequalities**
3. **Transforming outpatient services**
4. **System-led recovery**
5. **People recovery**

1. Clinical validation of waiting lists and long waits

Ref	Requirement	LHCH position	RAG
1.1	• Oversight and governance structures in place to enable effective monthly waiting list data review and validation. • Weekly submission to the national WL dataset.	• Trajectories of improvement in place across the Divisions, with weekly and monthly meetings in place to review and provide assurance. • Data submitted weekly signed off by the DCOO.	
1.2	• Regular processes in place to undertake clinical validation of patients and their ongoing need for treatment with evidence to support reviews of long waiting patients. • Evidence of shared decision making and treatment reviews between patients and clinicians keeping patients informed of next steps in treatment/waiting times.	• All PTLs are validated continuously with clinical harm reviews undertaken for any patient that exceeds 52 weeks. • A folder is kept centrally to document all clinically harm reviews and are managed via the weekly performance meeting. • P2 patients dated over 4 weeks are re-reviewed clinically at 8 weeks. • Letters are sent out to the patient & GP after every consultation to ensure robust communications.	
1.3	• Through the outputs of the national WL dataset monthly review mechanisms in place to balance waiting lists by prioritising urgent need and then addressing the longest waiting patients.	• LHCH utilise the P code national categorisation based on clinical urgency and P2 patients prioritised first along with caner and urgent cases. • 52 week patients are prioritised after the most clinically urgent patients have been treated.	

2. Addressing health inequalities

Ref	Requirement	LHCH position	RAG
2.1	Over the pandemic referrals from primary care have fallen, disproportionately greater in some population groups. ICS BI should: • Analyse the referrals since the start of the pandemic. • Estimating the shortfall against the estimated baseline and forecasting the projected rate increase. • Identify disparities between specific population groups particularly by deprivation and ethnicity. • Systems should adjust for the number of patients who may have died from Covid and other relevant factors.	Inequalities have been identified through analysis of access and referral rates. Whilst differential access is noted the `take` from waiting lists or referrals is always of the basis of clinical priority / risk. Issues of health inequalities are linked with the wider determinates of health and port of the system, wide conversations within the One Liverpool Integrated Health and Care Plan.	
2.2	As part of the design, implementation and expansion of Advice and Guidance, patient initiated follow-up and digital consultations providers are to collect activity data to outline uptake by age, disability status, ethnic minority groupings and bottom 20% by IMD for renal medicine, respiratory medicines, dermatology and ENT.	• Work has started to look at how we can automate this information collection as it is not currently available directly from a report. There are some data issues but the admin and information teams are working through it. • Issue with A&G as not all requested convert to a referral so specific patient characteristic information may be limited. • A&G only used for GP referrals so need to consider data collection for referrals not going through referral optimisation	

3. Transforming outpatient services

Ref	Requirement	LHCH position	RAG
3.1	• Increase uptake of Advice and Guidance (A&G) or other measures such as referral triage to avoid unnecessary first attendances where this does not add clinical value. • Implement Patient Initiated Follow-up (PIFU) in at least three major specialities. • Develop plans to increase virtual appointments and alternatives to traditional outpatients. • Implement clinical stratification methodology for follow-ups to reduce unnecessary attendances.	• A&G - LHCH performance has dropped to around 4% on the Outpatient Provider Transformation Network. Reconciliation being undertaken internally as A&G only in place for GP referrals to LHCH, not for tertiary/secondary. A&G performance for GP referrals is well established and has good uptake. • PIFU – number of potential groups identified and 3 now agreed, with options for further patient groups. Awaiting Cardiology specific guidance but working with other Trusts to share ideas.	
3.2	Deliver virtual or remote consultations for at least 25% of all outpatient activity. Where this had not yet been achieved, regional teams should agree a fair/realistic timeframe to reach 25% minimum. For those areas which have already reached this point, enhanced targets to further optimise remote outpatient consultations should be considered.	• LHCH above the target with 34% virtual appointments as at the beginning of August. but there are still opportunities for increasing the number of news held as virtual appointments. Creating monitoring tool to keep the focus on and target any areas where % may be dropping. Will also target areas not at the 25% yet to bring in line with others.	
3.3	Establish regular data and reporting processes to count the volume of PIFU and A&G services and the impact of local initiatives.	• In progress – information analyst for Clinical Services is establishing a dashboard to monitor all necessary information. Some issues with data quality but PAS recording method now identified and clinical streams agreed.	

4. System-led recovery

Ref	Requirement	LHCH position	RAG
4.1	Set out arrangements to share data and plans and to manage Patient Tracking Lists (PTLs), including for cancer patients at system level.	• LHCH has been part of the system mutual aid for cancer services and provided considerable capacity to partners in prioritising treatment for cancer patients (UGI, Liver). Further discussions to take place in relation to system winter planning.	
4.2	Plans outlining how systems will collaborate to provide mutual aid and establish initiatives such as joint clinical hubs, networks and partnerships in order to ensure equity for patients.	• LHCH engaged in the system wide discussions and in the main focus on LHCH supporting cancer recovery.	
4.3	Plans to ensure that local Independent Sector (IS) capacity contracted is fully utilised and aligned to contribute to wider system plans to meet the prioritised plans of the ICS.	Not applicable.	
4.4	• System plans to include confirmation of a named responsible Director for system-led recovery in the ICS. • Local systems establish monthly system-wide governance and oversight process including all NHS and IS providers to monitor waiting lists and priorities.	LHCH plays a leading role in the system wide elective restoration and engages and provides assurance on the elective programme at the Trust.	

5. People recovery

Ref	Requirement	LHCH position	RAG
5.1	• Wellbeing Guardian appointed and established. • "Wellbeing Warning System" agreed by Board.	Completed. Wellbeing group leading on several initiatives	
5.2	• Plans to increase rate of annual leave in Q1 and allow flexibilities such as buying back leave. • Monitoring to ensure leave is taken.	Completed – some buy back of annual leave was taken up by staff and continued monitoring of leave is being done.	
5.3	• Guidance, training and tracking established to monitor staff health and wellbeing at an employer level. • Process in place to track that all staff have Health and wellbeing conversations during Q1.	Wellbeing conversations have launched and are being tracked through a revision to the appraisal template. Wellbeing group is proactively working on employee initiatives to improve wellbeing. Pulse survey was launched in July 21 with some questions focussing on colleague mood and the impact of COVID.	
5.4	• Evidence of use of staff survey and channels in place to listen to staff. • Active engagement with staff networks.	Action plans by Division are focussing on areas for improvement within the staff survey. No appetite for individual networks so LHCH had agreed to have an Inclusion network. This will be launched in Sept 21. Pulse survey will concentrate on Employee voice. Be Civil; be kind campaign is being led by the Deputy Medical Director with a back to basics review of civility and behaviours of trust and respect.	
5.5	• Tracking staff availability, sickness and absence by staff group. • Assess cause of sickness to establish underlying drivers by area.	Absence tracked daily by staff group, with focus on areas of concern. Absence continued to increase in Q1 to above 5% and whilst not as high as other Trust average (6.6%), it has only started to get back to previous national targets (3.4%) excluding COVID.	
5.6	• Identify high risk staff groups, cohorts and services. • Develop retention plan for priorities. • Tracking staff leaver rate by staff group, service.	High risk groups have been identified and workforce planning carried out in these areas to mitigate longer term risk. Turnover is being monitored in all areas with a refresh for exit interviews. Nurse turnover continues to be high with a particular focus on retention in this area.	
5.7	• Develop improvement plans to address inequalities based on the latest WRES findings. • Consult staff networks to ensure a focus on equality, diversity and inclusion across requirements. • Set out plans for line manager training on inclusion	Gender balanced recruitment panels continue to be promoted and continued progress has been made on the EDI action plan. EDI is a key pillar of the 2021 people plan with a focus on improving the WRES findings. The staff survey which will inform the 2021 WRES has shown distinct improvements on last year.	

Board of Directors (in Public)
Item 5.1

Subject: **Ratification of Consultant Appointments**
Date of Meeting: **Tuesday 28th September 2021**
Prepared by: **Chris Dunn, Recruitment Officer**
Presented by: **Dr Raph Perry, Medical Director**
Purpose of Report: **For Ratification**

BAF Ref	Impact on BAF
N/A	N/A

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

1. Introduction

The following Consultants have recently been appointed:

Grade	Name	Recruitment Stage
Consultant Surgeon	Mr Amir Khosravi	Starting on 1st November.
Consultant Radiologist	Dr Linu Kuruvilla	Starting in October.

2. Recommendation

The Board of Directors is asked to ratify the above appointments.

Board of Directors (in Public)
Item 5.2*

Subject: **Governor Elections Report**
Date of Meeting: **Tuesday 28th September 2021**
Prepared by: **Gill Donnelly, Membership & Communications Officer**
Presented by: **Karen Nightingall, Chief People Officer**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
N/A	N/A

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

1. Executive Summary

The purpose of this paper is to present the results of the recent governor elections held for six Public Governor seats. All seats have been filled with four governors elected following contested elections and two uncontested.

The Board of Directors is requested to note the contents of the report and receive assurance that the elections were held in accordance with the Model Election Rules within our Trust Constitution.

2. Background

The Governor Elections concluded at 5pm on 6th September 2021. The Uncontested Report was received on 21st July 2021 and the Final Report of Voting received on 7th September 2021.

Civica Election Services (CES) was appointed to act as the independent electoral administrator for this election. The elections were held in accordance with the Model Election Rules contained within our Trust Constitution. This is confirmed in the Uncontested Report and Final Report of Voting.

The below table reflects the outcome of the recent election:

Seats	Elected	Turnout (if applicable)
1 Public Governor - North Wales	Joan Burgen (re-elected)	Uncontested
3 Public Governors - Cheshire	Allan Pemberton (re-elected) Ray Davis Roy Page	4 candidates for 3 seats 14.4% turnout
1 Public Governor - Merseyside	Linda Griffiths	3 candidates for 1 seat 16.8% turnout
1 Public Governor – Rest of England & Wales	Lynne Addison (re-elected)	Uncontested

All of the above elected Governors will commence their three-year term at the end of the Combined General Council of Governors and Annual Members' Meeting on Tuesday 12th October 2021.

3. Recommendations

The Board of Directors is requested to note the results of the recent elections outlined within this report.

Board of Directors (in Public)
Item 5.3*

Subject: **Emergency Preparedness Resilience Response (EPRR) Core Standards Self-Assessment**
Date of Meeting: **Tuesday 28th September 2021**
Prepared by: **Helen Martin, Risk and Safety Lead**
Presented by: **Sue Pemberton, Director of Nursing, Quality & Safety**
Purpose of Report: To Note

BAF Ref	Impact on BAF
All	Assurance regarding effective EPPR arrangements to ensure the Trust can continue to deliver services.

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 year, NHS England request that healthcare organisations self-assess their emergency preparedness against a core set of emergency preparedness and resilience response (EPRR) standards. The purpose of this is to highlight any weaknesses in systems and develop action plans to mitigate same.

An assurance deep dive is undertaken each year. For 2021, the emphasis is on piped medical gases.

The Board of Directors is requested to review and agree the results of the EPRR core standards self-assessment, and recommendations made.

2. Background

Attached is the completed core standard for Liverpool Heart and Chest Hospital. The standards relevant to LHCH are concentrated on EPRR core standards and business continuity.

The majority of the evidence of compliance is contained within the Major Incident Plan, which is subject to regular review to ensure it remains up to date. Other policies that link to the Major Incident Plan, comprise of the heatwave plan, cold weather plan, pandemic flu policy, Infectious disease policy, evacuation and lockdown policies.

A table top exercise is conducted on an annual basis as per the requirements of current national guidance. Learning from exercising is monitored via the Emergency Planning Group. The membership of the emergency planning group is multidisciplinary. An annual report for the emergency planning group is presented to the risk management committee.

Business continuity plans have been developed for all areas across the organisation and are reviewed at Divisional Governance at least annually.

Command and control training for relevant staff takes place on a 3 yearly basis, as per current national guidance. The last training was conducted in July 2021 and was delivered by the Head of Emergency Planning for NHSE/I.

3. Self-Assessment 2021

The NHS England Core Standards for EPRR are split into ten domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plans
4. Command and control
5. Training (removed)
6. Response
7. Warning and informing
8. Cooperation
9. Business continuity
10. Chemical Biological Radiological Nuclear (CBRN).

For the 2021 self-assessment of the relevant EPRR core standards, LHCH can demonstrate substantial compliance. An action plan (see appendix 1) to monitor and ensure completion of the standards, that are not fully compliant, has been developed. It will be reviewed in the emergency planning group until full completion is achieved.

Additionally, the deep dive review is concentrated on oxygen supply and comprises of the following:

Deep Dive Oxygen supply	LHCH Position	Action
The organisation has in place an effective medical gas committee.	Compliant	None
The organisation has robust and tested business continuity	Compliant	None

Deep Dive Oxygen supply	LHCH Position	Action
and/or disaster recovery plans for medical gases		
The organisation has used appendix H to the HTM 0201-part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	Compliant	None
The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	Compliant	None
The organisation has a clear escalation plan and processes for management of surge in oxygen demand.	Compliant	None
The organisation has an accurate and up to date technical file on its oxygen supply system, with the relevant instruction for use. (IFU)	Compliant	None
The organisation has undertaken a risk assessment in the development of the medical oxygen installation, to produce a safe and practical design and ensure that a safe supply of oxygen is available, for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	Compliant	None

The Trust will be declaring full compliance against the deep dive standards. The results of the deep dive are not included in the overall result of the EPRR assurance process.

4. Conclusion

The 2021 self-assessment of the EPRR core standards has been undertaken and LHCH can demonstrate substantial compliance with the relevant standards.

An action plan has been developed which will ensure the completion of the areas, where further work is required to demonstrate full compliance. The emergency planning group will monitor the action plan, until all actions are completed.

5. Recommendations

The Board of Directors to receive assurance that a self-assessment against the EPPR core standards has been completed and that the Trust has substantial compliance and an action plan to address the four outstanding areas for improvement.

Appendix 1

Action Plan for completion of EPRR standards - 2021

Date	EPRR standard	Evidence available	Action required	Progress	Action complete
8th Sept 2021	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident	63% of BCP's are in date on the intranet	The areas that require the BCP's to be updated have been contacted and progress monitored through EPG – **to be achieved by Dec 2021**		
8th Sept 2021	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	63% of BCP's are in date on the intranet	The areas that require the BCP's to be updated have been contacted and progress monitored through EPG**– to be achieved by Dec 2021**		
8th Sept 2021	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Business continuity testing reported to Risk Management and Corporate Governance committee and the Emergency Planning Group. EPRR standards reported to the Board	A rota of business continuity scenario testing scheduled to be developed and progress monitored through EPG– **to be achieved by Dec 2021**		
8th Sept 2021	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Business continuity scenario testing has lapsed during the Covid pandemic	A rota of business continuity scenario testing scheduled to be developed and progress monitored through EPG– **to be achieved by Dec 2021**		

Board of Directors (in Public)

Item: 6.1.1
Subject: People Committee BAF Key Issues Report
Date of Meeting: Tuesday 28th September 2021
Prepared by: Karen Nightingall, Chief People Officer
Presented by: Mark Jones, Chair of People Committee
Meeting Held: 8th September 2021 (E-Meeting)

Agenda Item	Lead Exec	Assurance Received	New/ Emerging Risks	Actions/Comments
5.1	KN	National Workforce Update		It was reported that there is a shortage of nursing on a national level, particularly registered nurses and as a result of that, the Trust has been involved in the big collaborative across Cheshire and Mersey for the overseas nurses of which LHCH has requested 50 initially, and have requested an extra 20 to help fill some vacancy gaps; 17 nurses currently appointed and the remainder scheduled to arrive throughout the rest of the year with 12 left to fill. In relation to well-being and general fatigue the Trust has experienced some pressures in areas across the Trust. It was reported that the Trust is doing everything it can to support staff and a Quality and Safety Strategy is due to be launched, with some measures relating to Staff Survey questions.
5.2	KN	Be Civil, Be Kind Campaign Update		Assurance was sought in relation to the monitoring and success of implementation in terms of the cultural element. It was stated that culture survey's take place every three years and 2021 results of that have been included in the Quality and

Agenda Item	Lead Exec	Assurance Received	New/ Emerging Risks	Actions/Comments
				Safety Strategy. It was also noted that there were relative questions within the Staff Survey, triangulated with Freedom to Speak Up (FTSU). Measurements were acknowledged and it was agreed that those measures could be consolidated into a culture focused dashboard. It was accepted that cultural change takes longer.
5.3	KN	Equality, Diversity & Inclusion, WRES data, ethnic minority group data and Inclusion Networks Update		Discussion took place in relation to Staff Survey results and actions taken. Discussion took place in relation to statistics and denominators and it was queried whether all questions had been answered to form a fair comparison. It was acknowledged that analysing data would be difficult from a statistical point of view as the number of people completing the survey each year is different and not all questions answered. It was suggested that data be triangulated to offer consistency and drive improvements.
5.4	KN	HR, OD & Education Quarterly Assurance Report		It was reported that many of the International Nurses have requested to work within Critical care. A rotation plan is underway to ensure retention within the Trust.
5.8	KN	Recruitment Challenges		It was noted that lots of support is available for International and Student nurses; following feedback and questions at induction, it was highlighted that more support may be required for newly qualified nurses on the wards. Whilst the Committee recognised and welcomed the structured approach to recruitment and retention. Ongoing, it was acknowledged that some of the measures in terms of support and education may require a review to gain full assurance; to be revisited at December's People Committee. The Chair requested this be revisited in December.
5.9	KN	Trainee Doctor Action Plan Update		The results of the GMC Trainee Doctor survey were shared which highlighted poor performance within some areas in

Agenda Item	Lead Exec	Assurance Received	New/ Emerging Risks	Actions/Comments
				specific sub-specialties. Concerns were expressed, especially as the Trust had previously made improvements and it was suggested that meetings with junior doctors take place in a formal capacity to monitor conversations and support. It was also suggested that support from Practice Educators may be beneficial in scoping support Framework. The Committee were informed that an action plan had been implemented with some already addressed. Although a full report would be presented at September's Board of Director's meeting, the Chair requested this be addressed again at December's People Committee meeting.
5.10	KN	Variable Pay Audit		A clear report was provided to the Committee which provided assurance that the risks identified and documents within the paper had been addressed.
5.11	KN	Disciplinary Policies and Procedures		A paper was provided which sighted the People Committee on the ongoing Disciplinary activity within the Trust and the actions taken to ensure that the pastoral care is strengthened for any employees that are subject to a formal process. The report highlighted that in line with Improving People Practice recommendations, mechanisms had been established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Concerns were raised in relation to identification of individuals upon reporting; discussion took place and the Committee agreed that the information provided to the Board should be on an anonymous basis as a consensus report. The Committee were pleased to see the emphasis on Pastoral

Agenda Item	Lead Exec	Assurance Received	New/ Emerging Risks	Actions/Comments
				Care.
7.1	KN	Board Assurance Framework		The 3 corporate people risks (BAF 4, 5 & 6) remain within the risk tolerance but with further progress being made in each area. The Committee were assured that items highlighted within the BAF report were being addressed and moving in the right direction, particularly with BAF 4 and 6 and therefore recognised the actions in place to provide assurance.

Item 6.1.1a*

minutes

E- Meeting of the People Committee

Minutes of the People Committee Meeting scheduled on Tuesday 8th June 2021

Meeting Participants:	**N/A**	
Committee Members:	**Mark Jones (Chair)**	**Non-Executive Director-Chair**
	Bob Burgoyne (BB)	**Non-Executive Director**
	Nick Brooks (NB)	**Non-Executive Director**
	Sue Pemberton (SP)	**Director of Nursing, Quality and Safety**
	Karen Nightingall (KN)	**Chief People Officer**
	Ruth Dawson (RD)	**Head of Learning, Education & OD**
	Beth Williams-Lally (BW-L)	**HR & OD Manager**
Committee Attendees:	**Laura Williamson (LW)**	**Executive Assistant (Minutes)**
	Dr Nigel Scawn (NS)	**Deputy Medical Director**
	Rachael McDonald (RMc)	**Senior HR Business Partner**
	Laurence Flannagan	**Senior HR Business Partner**
	Sarah Smith (SS)	**Head of Resourcing & Employee Services**
Apologies:	**Dr Raphael Perry (RAP)**	**Deputy CEO and Medical Director**

In accordance with the Trust's response to Covid-19, it was decided that face to face meetings were to be limited and therefore a system to enable business to be conducted by remote working was devised. The papers were produced as usual and in accordance with the business cycle and distributed on 1st June 2021 by e-mail. A template was produced for each meeting participant to complete individually if they wished to make any comments following the review of papers.

A two-hour Microsoft Teams meeting was convened on 8th June 2021 between Committee members to discuss the comments and questions presented by e-mail. A summary of key issues raised, and decisions made are documented below as minutes of the meeting, and individual participant's comments have been retained on file in support of the minutes.

The Chair opened the meeting by welcoming members and attendees to the Trust's People Committee meeting and reminded colleagues that the last meeting scheduled for March 2021 was stood down due to Covid pressures.

1. Apologies for Absence
All meeting participants were included in the e–meeting and in attendance at the Microsoft Teams meeting.
Apology was received for Raphael Perry and the Chair welcomed Nigel Scawn as deputy. The meeting was deemed to be quorate.

2. Declarations of Interest
All meeting participants had been asked to declare any interests in respect of items listed on the agenda. No participants declared that they had any interests.

3. Minutes of the Meeting held on 8th December 2020
The minutes were approved as a true and accurate record of the meeting.

4. Action Log
Action 1 Q2/3 Strategic Update
KN to revisit the objectives to update and reflect what is being carried out in alignment with the People Plan.
08.06.21 update: Taken from the 3 P's Corporate Strategy to incorporate within the People Plan with integrated objectives which was presented at Board during Q4 of 2020/21.

Action 2 - Q2/3 Strategic Update
Include initials of lead in the WHO column to reflect who is responsible for each action/objective.
08.06.21 update: Strategic objectives were updated and leads assigned to actions within the plan. Action complete.

Action 3 - Equality and Inclusion Update
Convert WRES data into Dashboard as numbers, in addition to percentages.
08.06.21 update: Agenda item

Action

Action 4 – Outline Plans for revised People Committee Dashboard
Draft Dashboard to be circulated to provide an opportunity for feedback to assist with the final version.
08.06.21 update: Dashboard complete and listed as an agenda item.

5. Draft Business Cycle 2021/22
The Chair introduced the Business cycle for Committee members to review and approve.

The Chair sought clarification in relation to the Staff Survey results as to whether Divisional Action Plans were still planned to take place or whether they would be incorporated into the People plan. It was confirmed that Divisional Action Plans were in place, driven by the Triumvirates with the support of HR Business Partners and escalated through Governance meetings.

It was suggested that high level assurance could be presented to People Committee if required.

It was agreed that action plans would remain on the Business Cycle for September as a high-level action plan to document assurance. It was noted that it was important for the Committee to know that issues had been identified, addressed and resolved.

ACTION: High level Divisional Action Plans to be shared at September's People Committee. **KN**

ACTION: LF to work with HR Business Partners and Triumvirates to ensure high level action plans are presented for September's People Committee. **LF**

It was noted that the Trainee Doctor Action plan was scheduled as an agenda item for June 2021, however as Dr Perry had given apologies, this item was deferred to September.

ACTION: Trainee Doctor Action Plan update – agenda item for September's People Committee. **RAP**

The Committee approved the Business Cycle for 2021/22 subject to the proposed changes.

6. Strategy
6.1 National Workforce Update
The Chief People Officer, Karen Nightingall (KN) provided the Committee with a verbal update which informed colleagues of the following areas of focus: -

International Nurse Recruitment – Recruitment had been delayed until June 2021. It was reported that 24 nurses were in the pipeline; 7 delayed from April, 13 delayed from May and 4 recruited for June. Information on further cohorts would be confirmed soon.

Nurse Advocates - The national training programme for Nurse Advocates has now commenced with 250 places available for band 5 employees and above with a degree.

Pulse Survey - It was anticipated that the Pulse Survey would be re-introduced on a quarterly basis, rolled out nationally; the Staff Survey would remain on an annual basis. Further information to follow. Positive move in terms of

Health & Wellbeing - Business as usual was reported in relation to wellbeing, resilience, ability to react to recovery and what that would mean for recruitment and retention.

LHCH Vaccination Programme - due to end on 23rd June 2021. It was reported that LHCH had vaccinated 40,000 individuals, which included more than 90% of staff in line with the national position.

Refugee Recruitment - colleagues were informed that five refugees had applied to LHCH and three had been appointed and in post. It was stated that there was some challenge due to a language barrier.

Apprenticeships – there has been a big focus nationally, it was reported that the teams were linking in with regional groups and it was expected that LHCH would surpass the national target of 72% by the end of the year as 69% had already been achieved.

The Chair requested information in relation to Apprenticeship posts within the Trust and a full update was provided as follows: -

- The Trust has a number of Apprentices ranging from level 2 up to level 7, including NBAs.
- The clinical HCA programme has taken 10 on in September 2020 at level 2 and were set to progress straight onto level 3. It was reported that due to the success, another 10 were being recruited and the Trust was looking at migrating the trainee programme and developing a 'grow your own' programme.

Discussion took place in relation to the quarterly pulse survey and it was explained that the pulse survey was national request to provide a temperature check which would be a positive input.

The chair raised concerns in relation to survey responses and acknowledged that it may be a challenge.

Reference was made to news updates in relation to staff burn out and staff leaving the NHS and assurance was sought in relation to LHCH's position. It was stated that a couple of areas in the Trust had seen a high turnover which had been due to staff being moved around a lot as a result of Covid. It was reported that the Trust had seen examples of staff feeling tired and burnt out which had contributed to a rise in poor behaviours in some groups of staff; despite the Trust's activity in relation to health and wellbeing, the impact on staff had begun to emerge and a meeting had been scheduled to engage with the Triumvirates to discuss, address and take appropriate action. It was noted that communication had been to a good standard throughout the pandemic and now that activity had risen, continuous re-evaluation was required to reach a balance.

The Chair acknowledged concerns in relation to staff fatigue and behaviours and requested that an update be presented at September's meeting.

ACTION: Update in relation to staff fatigue to be presented at September's meeting. **SP**

KN continued with the remainder of the national update and informed colleagues of the case of flowers which had been introduced to incorporate overtime into annual leave, nationally by September 2021.

Pay progression – time served pay progression was removed from 1st April 2021 which meant that staff under Agenda for Change would not automatically receive a pay increment, staff will have to meet five criteria such as an up to date Appraisal, all Mandatory Training completed, signed off by manager.

Concerns were expressed in relation to the possibility of the change impacting staff engagement and it was reported that the incentive was there for staff to take ownership and for HR to ensure criteria had been met for compliance and auditing purposes. Colleagues were informed that the five criteria have been in place for all new staff since 2019.

Winter Incentives – each year the Trust prepares for winter incentives which links into the variable pay audit undertaken by MIAA for HR. An extra incentive was added this year due to Covid and the complications that presented.

NHS jobs – A full launch of the website will take place in July 2021. It was reported that the piolet had been well received and presented a much slicker recruitment process.

Effective workforce planning – is underway with the Director of Nursing, Quality and Safety and Heads of Nurses around registered nurses and a virtual nurse event scheduled with the aim to recruit 15 HCA vacancies and become less dependent on bank.

RPA approach – digitising forms broadly across the NHS and a project is underway across the People service within the Trust.

WRES and DES - Distinct improvements have been identified following the WRES and DES last year. Preparation were underway for June and the Committee were informed that the 2020 staff survey would be used to feed into this year's WRES and DES; a full update had been included as an agenda item.

National HR, Education & OD - currently in its second phase of the national consultation, made up of 8 key statements as part of consultations. Further updates at future meetings were requested.

6.2 Bullying, Harassment & Discrimination
Senior Business Partner, Rachael McDonald (RMc) Provided a paper which sighted Committee members on the current status in relation to bullying, harassment and behavioural issues across the organisation.

Concerns were expressed in relation to the data presented and colleagues were informed that during a recent Board of Directors meeting, one Governor had raised concerns. It was felt that the data had been open to interpretation and therefore clarity was important within this meeting.

It was noted that the number of Grievance cases did not correlate with the Staff Survey results and clarification was sought in relation to context of information. It was acknowledged that there was a gap between Grievances and Staff Survey results and it was stated that there was a significant level of under reporting within the Trust; a presentation was shared with colleagues which provided more detail in relation to percentages and numbers and it was noted that intelligence with FTSU correlated well with Grievances.

In addition, WRES recruitment numbers were shared which showed a decline in 2020 against 2019 results; of the 28% Black, Asian, Minority Ethnic (BAME) staff applications, 6.37% were appointed. It was reported that 2021 WRES results would be available in August 2021 and presented at People Committee in September.

ACTION: RMc present 2021 WRES data at the next People Committee. **RMc**

The Chair stated that it would be useful to have a breakdown of Black, Asian, Minority Ethnic (BAME) staff from ESR in relation to grouping. Concerns were expressed in relation to the low application and recruitment for Black, Asian, Minority Ethnic (BAME) staff, which captures a number of different cultures and ethnicities. Assurance was given that the Model Hospital goals were behind adhered to within the Trust, a recruitment strategy in development and an EDI action plan; it was confirmed that actions were in place to close the gaps to drive improvement and understanding.

ACTION: RMc to provide a breakdown of Black, Asian, Minority Ethnic (BAME) staff from ESR in relation to grouping. **RMc**

Further discussion took place and it was stated that staff experience abuse from patients and don't always report it as quite often involves patients with delirium whereby abuse is not intentional. It was acknowledged that some areas do not report anything and there were opportunities to improve, which the Risk Management team have begun looking into.

The Chair acknowledged a recurring theme in relation to staff survey numbers being greater than FTSU numbers and it was noted that intelligence provided richness to the data; the Committee recognised the difference and triangulation of data. It was also recognised that under reporting within the system was in some cases in relation to acceptance of abuse due to the clinical profile of the patients. It was agreed that work was needed to encourage reporting and the Committee would expect to see an increase next time.

The Chair highlighted the increase in staff experiencing harassment, bullying or abuse from staff within the white population and sought clarity as to whether the figures were in relation to managers and colleagues

witnessing but not reporting. Discussion took place and it was acknowledged that a lot of focus had been given to Black, Asian, Minority Ethnic (BAME) staff and it was acknowledged that promoting a positive culture should be organisationally led, not targeted to one staff group. The signal in relation to the white population was recognised and concerns were expressed that as white staff groups were predominant within the Trust, the culture may be affected and should be addressed in its entirety.

ACTION: RMc to provide an update on organisationally led civility / positive culture across all staff groups at September's meeting. **RMc**

6.3 Equality, Diversity & Inclusion Networks Update
Senior Business Partner, Rachael McDonald (RMc) provided a verbal update on one of the national priorities in relation to setting up staff networks, to provide assurance to the Committee of progression.

Colleagues were informed that an engagement session had taken place with staff who were keen to drive the agenda forward. Numbers were lower than expected and further communication and engagement were underway, to include support from the regional team.

The intention was to have three separate engagement groups: Black, Asian, Minority Ethnic (BAME), LGBT plus, disability and health group. However, the feedback received was that people didn't want to be part of an individual group and felt it should be more inclusive. Therefore, it was suggested that the Trust was likely to move more towards an Inclusion Network which would focus on specific issues within those staff groups and attract engagement.

It was reported that the first group was expected to take place in quarter two and would be able to provide an update at the next People Committee Meeting.

ACTION: RMc to provide an update on the Inclusion group at the September meeting. **RMc**

6.4 HR, OD & Education Quarterly Assurance Report
The Head of Learning, Education & OD, Ruth Dawson (RD) provided an assurance report invited feedback and questions.

Appreciation was expressed for the quality report with excellent assurance received in all areas.

Further information was sought in relation to the Robotic Process Automation and the difference between conventional processes. It was stated that the electronic process would reduce human factors to speed up processes and reduce human error, as automatic updates would be enabled.

Clarification was sought in relation to medical student training and feedback from the quality visit from University of Liverpool. The Committee were informed that the virtual visit took place in May which was a robust audit and Dr James Greenwood (JG) gave a presentation

which outlined how the Trust deliver education and support to third year and fifth year students and how clinical supervisors are supported. The University were impressed with the information presented and the Trust's ability to recognise areas for improvement.

Dr James Greenwood was acknowledged for the great input in terms of the Clinical Education Lead; Dr Nigel Scawn agreed to feedback to JG.

Clarification was sought as to whether there were any plans to re-introduce work experience and access to medical programme. It was stated that work experience had been paused due to Covid, and the work experience policy was being reviewed with plans to re-introduce with the utilisation of Highfield House.

6.5 People Plan Delivery Update
The Chief People Officer, Karen Nightingall (KN) provided a paper which outlined the key priorities in relation to People Plan delivery.

The Chair acknowledged positive movement forward from Q4 last year to Q1 this year and recognised that there were a number of new or revised processes referred to in the report and requested further understanding of was entailed and that the Committee should be aware of from an assurance perspective: -

- Revised appraisal template
- New recruitment strategy.
- New Leadership offerings.

It was stated that the Leadership Offering had not been presented to the Executive Team and had been streamlined to offer a more tailored experience for leaders.

It was reported that the Appraisal template had been adapted to include a tick box to enable the team to measure whether wellbeing conversations had taken place.

It was stated that the development of the Recruitment Strategy and Education Strategy would underpin the People Plan and Workforce Strategy and the local population; Black, Asian, Minority Ethnic (BAME) should be at 11% as a minimum.

ACTION: Present Recruitment and Education Strategies at next People Committee. **RD/KN**

Assurance was sought as to what level of record is retained of individual processes; should the Trust be audited would it be able to demonstrate that rules had been followed and no discrimination was present. The Committee were informed that gender mixed panels had recently been introduced; assurance was received in terms document retention and accountability.

6.6 Disciplinary, Policies & Procedures
HR Business Partner, Laurence Flanagan presented a paper which sighted the People Committee on the proposed changes to the Disciplinary Policy.

It was noted that a request had been received from NHS E for the policy to be presented and discussed at a Public Board, and although not open for discussion at People Committee, had been presented s respect to acknowledge as it would be debated at the next Public Board of Directors Meeting on 27th July 2021.

Colleagues were informed that the Policy had been updated following the Dido Harding findings, and the Trust had assessed the policy, made appropriate changes with the overall aim to manage cases is a fair and appropriate manner.

Discussion took place and concerns were expressed in terms of wellbeing and timing. The assurance to the Committee was that the Policy was fit for purpose, relevant and correct HR support would be provided and that the Trust would work to an agreed standard with every case.

It was noted that the template provided did not include tracking in relation to wellbeing. The importance of having an appointed person of contact for suspended employees was stressed.

ACTION: LF to provide a template in terms of tracking for assurance purposes to include wellbeing. **LF**

7. Dashboards – Workforce Intelligence
7.1 Team LHCH Dashboard
The Chair introduced this item and highlighted the importance of the report in anticipation of the weekly update being phased out as Covid restrictions ease.

Clarification was sought in relation to 'Vol leave' and 'All leavers'. It was explained that vol leave was voluntary leavers; those who had taken alternative positions by choice. All leavers related to all turnover of staff such as retirement, dismissal, end of Fixed Term contracts which would cover all reasons for turnover. The information was broken down to understand reasons, particularly in relation to voluntary resignation.

The Committee welcomed the information within the report and look forward to future updates.

8. Workforce Risks
8.1 Variable Pay Audit
The Chief People Officer, Karen Nightingall, provided a verbal updated and proposed that this item be brought back to September's meeting to look at management responses and actions.

Colleagues were informed that a variable pay audit was carried out by MIAA in relation to shift pay and bank pay which was centred around six areas: -

- Policy non-compliance - sickness
- Policy non-compliance – requested to work bank annual hours approval
- Bank and agency shift requests and KPI reporting

- Working time directive opt-out forms
- Temporary staff policy
- Annual leave - working bank shifts whilst on annual leave

It was reported that the HR and Rostering team had commenced a great piece of work in following up on actions. Actions found by MIAA had been completed or part completed. Actions partially complete were noted as follows: -

- Non-compliance - sickness
- Bank agency shift request
- Annual Leave

In order to provide the Committee assurance it was agreed that the variable pay audit be presented in its entirety, yet high level detail, at the at the next People Committee meeting.

ACTION: Variable Pay Audit presented at the next meeting (high level detail). **KN**

8.2 Board Assurance Framework (BAF) 2021/22
The Chief People Officer, Karen Nightingall presented the Board Assurance Framework which highlighted the following risks: -

BAF 4 - In relation to wellbeing
It was reported that lots of progress had been made in relation to wellbeing, but some residual risks remained.

BAF 5 – In relation to training and development
It was reported that Covid had slowed down progress significantly. Talent management and education strategy – still some residual risk although lots of progress.

The Committee acknowledged the risk and commented on the well managed area. Recognition was given to the fit testing team for their hard work and dedication throughout Covid.

BAF 6 – In relation to recruitment and retention
Engaged with recruitment team and international nurse recruitment working actively on Workforce plans, virtual event. Felt appropriate to leave risk at amber.

The Committee recognised the actions in place to provide assurance.

9. Evaluation of Meeting
It was stated that the meeting went well with good discussion.

12. Date and Time of Next Meeting:
Tuesday 7th September 2021, 12.00 – 14.00, MS Teams

Item 6.1.2*

Integrated Performance Committee

minutes

Minutes of the Integrated Performance Committee Meeting Monday 26th April 2021

Present:	Karen O'Hagan	Non-Executive Director (Chair)
	Bob Burgoyne	Non-Executive Director
	Mark Jones	Non-Executive Director
In Attendance:	Karen Edge	Chief Finance Officer
	Hayley Kendall	Chief Operating Officer
	James Bradley	Deputy Chief Finance Officer
	Carl Richardson	Head of Income and Costing
	Jennifer Ohlsson	Senior Executive Assistant (Minutes)
Apologies for Absence:		

1. Apologies for Absence — **Actions**

None to note.

2. Declarations of Interest

None declared.

3. Minutes of meeting held on 26th October 2020

No meeting took place in April 2021 due to change in priorities as a result of the Covid-19 pandemic, but all critical decisions were made.

Minutes from the meeting of 26th October 2020 were noted and approved.

4. Action Log

Item 1: New strategic performance dashboard has been presented to Chairman and NED colleagues. Action closed

Item 2: Follow up DNAs within the Medicine Division to be reviewed as part of the outpatient transformation work stream and an update will be provided at the next IPC meeting. — **HK**

Item 3: Long terms capital programme is now on the IPC work plan. Action closed.

5. Financial / Performance Reporting
5.1 Finance Strategy and Annual Plan review
CFO presented an update on the Cheshire and Merseyside ICS H1 finance regime to IPC colleagues. CFO noted that the planning guidance was released in March 2021

Each system funding envelope will be rolled forward for the first six months of 2021/2022 (H1) and comprises of baseline CCG allocations, Covid-19 funding, top-up funding and additional funding for new pressures and priorities. The block payment arrangements remain in place for providers and new pressures and priorities. Systems also have access to new funding to support Elective Recovery. To start with NHSEI calculated provider plans as the default position for H1 to support budget management based on Q3 actions. NHSEI expects each system to reach a break-even system position.

The default position for H1 is subject to system change. In Cheshire and Merseyside there is a c£40m deficit predicted based on Q3 actuals and there is a requirement to plan within the principles. Planning principles have been issued, however have not yet been signed off. These principles use the Q3 actuals as a starting point and include an application of 1.4% CIP to contract values to achieve breakeven, redistributing surplus to deficit organisation so every system and every provider has a break-even plan and further development of the ERF outside of planning processes at provider level. CFO informed colleagues that the deadline for the ICS return was Friday 23rd April 2021.

CFO presented the different 2020/21 scenarios as outlined in the financial plan update circulated prior to the meeting as item 5.1. Scenarios include 'scenario 1 – underlying budget', 'scenario 2a – 85% activity budget', 'scenario 2b – 100% activity budget' and 'scenario 2c – 100% plus recovery'.

In summary, scenario 1 is the trust underlying budget based on PnR contracts and underlying capacity. Scenario 2a, 2b and 2c assume a level of fixed income from the ICS based on Q3 performance and flexing costs dependent on activity. Scenario 2c is the maximum capacity the Trust can deploy with recovery actions. The scenarios all reflect the planning horizon of 'H1' April – September 2021 and planning guidance only covers this period. Assuming this continues to H2, a further deficit of £3.5m would arise resulting in a maximum deficit of £5.9m in the financial year assuming no ERF is received. The Trust cash position excluding future Cath Lab commitments is c£30m and the deficit will reduce cash and resilience.

CFO also provided IPC colleagues with an overview of Elective Recovery Funding. The ERF is in place to incentivise providers to increase activity and reduce waiting times. Access to the ERF is contingent on both system level performance and achieving some transformational change. Neither of these are within the control of the

Trust so ERF is not guaranteed. Where the criteria are met, the funding available is based on PbR tariffs. For activity delivered between the target threshold and the estimated funded activity within envelopes set at 85%, systems will receive an additional payment at 100% of tariff. Additional activity above 85% will receive the equivalent of 120% of tariff. The thresholds of the 2019/20 activity will be 70% for April 2021, 75% for May 2021, 80% for June 2021 and then 85% from July to September 2021. If the activity thresholds were achieved by all providers in the system and ERF was allocated in line with where additional activity was delivered, the allocation for LHCH for 100% of pre-COVID activity would be c£4.5m for H1.

IPC colleagues are asked to recommend to the Board of Directors the approval of the interim H1 budget outlines in scenario 2c, with a deficit of c£2.4m excluding receipt of ERF monies.

IPC colleagues are also asked to note the current uncertainties regarding income including the system income distribution, the application of efficiency and the achievement of system break-even position and are also asked to note the risks and mitigations to delivery of the financial plan including non-NHS income, CIP identification, limited new investment, except digital and recovery and ERF and non-recurrent reserves presenting mitigation opportunities.

CFO agreed to provide an update as the H1 system income is confirmed and for H2 as planning guidance becomes available. **KE**

Comments are questions were welcomed from colleagues and an outline of the major changes between version 1 and version 2 of the financial plan paper were requested and CFO confirmed the costs of recovery were defined in terms of absolute cost and profile in version 2.

Concerns were raised regarding staffing levels required for recovery, in particular asking staff to work additional sessions, after working through a pandemic. COO confirmed that the plan would be to recruit into additional posts as part of recovery and there is no assumption that staff would want to work extra hours. This led to a discussion around the risk related to relying on recruitment and COO stated that international recruitment would fill a number of these posts and there has been no issues recruiting into theatres. COO reassured colleagues that any risk can be mitigated.

A query was raised on how the increase in private patient work would impact the waiting list. COO confirmed that the demand for private care is increasing and additional sessions have been put in place in order to aid the balancing of elective recovery and retain Private patient care. There is a risk that surgical private practice will migrate to Manchester Private Hospitals in the short term. CFO added that there will be some level of elective recovery funding and COO reassured colleagues that there is confidence in delivering 85% of activity across the C&M system. It was agreed that COO would provide a system wide update on the activity and forecast against the thresholds. **HK**

Further detail was requested on what the phrase transformational means. COO confirmed that transformation focuses mainly on Outpatient

transformation which includes Attend Anywhere, virtual consultations and remote monitoring. There is an expectation that 25% of outpatient activity will be delivered remotely.

5.2 Finance Reporting including CIP

Deputy CFO provided an overview of the finance report. The financial performance for the year ending 31st March 2021 is a £421K surplus. This position is £1,708K better than the forecast submitted to NHSI. The primary reasons for the variance to the forecast include NHSE/I distributing significant additional funds to providers in February and March, PDC was also lower than forecast as the cash balance remained high all year, depreciation is also lower than prediction as the capital expenditure has been pushed back to the final months of the year and no increase was needed for annual leave accrual as this has been proactively managed.

Questions were welcomed from colleagues on the year end position and Chair noted the positive position considering the year we have had.

Deputy CFO also presented a CIP update. The 20/21 CIP target was £1.932m. The Trust delivered £1.846m against the target. The delivery of this consisted of a significant level of non-recurrent schemes and this puts additional pressure on the 21.22 CIP requirements, as the total undelivered 20/21 recurrent gap has been added to the 21/22 CIP targets.

Given the significant pressure caused by the winter surge in Covid, a staged trajectory for 21/22 planning was agreed at FISG, which consists of an end of May target of 100% identified of which 80% will be developed to level 3 and an end of June target of 100% identified of which 100% will be developed to level 3. The progress to date made on CIP identification for 21/22 against the above trajectory is set out in a weekly tracker and will be monitored through the FISG.

Concerns were raised around Corporate and Clinical Services recurrent CIP and the ability to deliver the 21/22 CIPs. CFO noted that non-delivery of recurrent schemes and delivery of non-recurrent were a product of the financial regime that the Trust has been working in and these schemes will be available to re-visit in the future. COO added that Clinical Services is a challenge and is the highest risk out of the Divisions in terms of CIP and will require focus and support.

5.3 Capital Report

IPC colleagues were asked to note the capital schemes report.
The electrical works generally continues to progress well and the focus of attention is now moving to load migration which begins in May. Regular load migration meetings are being held with Trust operational staff to plan this work

Issues have been identified by TDL regarding the load bearing capacity of an existing Cath Lab roof and have required Sudlows to alter their plans for the routing of containment and cabling and this has delayed the Suldows programme by c. 2 weeks. The cost delay on the Sudlows scheme has been contained within the overall cost forecast for the scheme.

COO noted that Philips had originally indicated that they could install the first two labs concurrently however due to backlog in equipment installations nationally they are unable to get the resource to accommodate this, meaning that the equipment will be installed consecutively giving a c.7 week installation as opposed to a c.4 week installation as anticipated. However currently it seems that this could be accommodated and the target date of July/August for completion of the first phase of the labs achieved.

The potential delays and mitigation costs were noted and it was queried whether there would be cost scoping and COO confirmed that prelim costs are being managed as part of the contingency at present and reassured colleagues that Propcare have a strong background in mitigating costs and delays in programmes and no additional costs are flagged at present.

5.3.1 5 Year capital plan

CFO provided an overview of the 5 year capital plan to IPC colleagues. The proposed Capital budget for 2021/22 is in line with the 5 year programme and includes the 2nd year of the Catheter lab development. IPC colleagues are asked to note the risk to the capital programme as a result of limitation of Cheshire and Mersey ICCS allocations and note the mitigation actions required by the Capital Management Group to manage within the resource envelope.

5.4 SLR & Costing update

Carla Richardson, Head of Income and costing attended IPC to provide colleagues with an SLR and costing update.

The vision for Service Line Reporting is to widen the use of PLICS intelligence to engage clinical, divisional and finance colleagues in supporting patient care improvements, productivity and improved value for money. Essentially, to have accurate patient and service level data that is trusted by clinicians and divisional colleagues and is therefore widely used to support decision-making.

In order to achieve this vision the following approach is used; 'Plan, Listen, Investigate, Collaborative, Support'. This approach will drive improvements and inform colleagues about patient level performance of their services and embed PLIXS as a tool to support decision-making.

Underpinning this approach are three interlinking work streams; engagement and roll out of PLICS, data quality and continuous improvement and national requirements. All of which are interdependent and key in supporting the delivery of high quality costing information for LHCH.

A query was raised on whether there would be any issues with the data requirements across the multiple disciplines and CR reassured colleagues that work is being done with the information team to identify a gap analysis and time frame.

5.5 National Cost Collection Submission 2019/20

CR also provided an overview of the national cost collection submission and IPC colleagues are asked to note the successful submission of the mandatory NCC and also note the recent audit, system upgrades and upcoming collection window.

CR noted the recent audit and noted that the initial draft report has been shared with the Costing team for feedback and overall a substantial assurance rating was achieved, and CR agreed to bring an updated paper back to the next IPC meeting including update on the development of timelines **CR**

5.6 Q4 Performance Report
COO presented an overview of the regulatory and operational performance overview for month 12. The six week diagnostic performance has narrowly underperformed in month with a position of 98.4% 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.

A query was raised as to whether the new scanner was installed and COO confirmed that it is installed and in use and informed colleagues that there had been a slight technical issue which meant that the technicians needed to be called out to reboot the scanner however no further concerns were noted.

Clarity was sought on the delayed discharges and COO reassured colleagues that the discharge team are proactive and this is not a concern at present.

Mandatory training target of 93% against 95% was noted and COO agreed to look into this further and request an update from the divisions. **HK**

A request was made for the trajectories to be included in the performance report and COO confirmed that this will be included from April onwards. **HK**

5.6.1. Strategy report

IPC colleagues were asked to note the strategy report.

There were no further comments or questions.

5.6.2. Target performance report

IPC colleagues were asked to note the target performance report.

There were no further comments or questions.

5.7 Covid Recovery & Performance against phase 3 recovery trajectories

COO presented an update on the 2021/22 trajectories and IPC colleagues were asked to note the significant work undertaken to date to ensure that the Trust has a robust and resilient approach to recovering elective services.

IPC colleagues are asked to support any additional cost of recovery, understanding the financial impact this will have on the Trust.

Clarity was sought around the Spirometry backlog and the option of using a van in the community and whether this would impact the funding received for community provision and COO confirmed that Spirometry is a small part of the community services and both services would still be required.

Voluntary working for Anaesthetists was also noted and it was asked whether this would be a risk. COO confirmed that there is good engagement from staff around additional sessions and weekend working.

5.8 ACHD backlog and waiting times update

COO requested that colleagues note the position statement of the ACHD service including progress with reducing the backlog. It was agreed that further updates will be provided as required for assurance.

6. Governance

6.1 IPC Work Plan Review

It was agreed to continue with the COVID recovery as per the previous workplan.

IPC colleagues also agreed to consider what meeting would be most appropriate for the Reference cost submission review and review the NCBC benchmarking

It was also agreed that the Cancellation improvement plan would come to IPC only as an exception.

6.2 Annual Report prior to submission to Audit Committee

It was noted that the annual report was circulated to IPC members before presenting to the Audit committee in March 2021.

6.3 Review Terms of Reference

No comments on the Terms of Reference

6.4 Finance and Improvement Steering Group Approved minutes & Issues for escalation for the IPC
Finance and Improvement Steering group minutes were noted and there was nothing to escalate.

7. Evaluation of Meeting
IPC colleagues were informed that Level of assurance tick box will be used for all assurance committees and Board of Directors going forward.

8. Date and Time of Next Meeting:
Monday 26th July 2021, 09.30am – 11.30am, Microsoft Teams

Item 7
Board of Directors (in Public)

minutes

Minutes of the Meeting of the Board of Directors held on 27th July

Present:	**Neil Large**	**Chair**
	Jane Tomkinson	**Chief Executive**
	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, Quality & Safety**
	Raph Perry	**Medical Director/Deputy Chief Executive**
In Attendance:	**Jonathan Develing**	**Director of Strategic Partnerships**
	Karen Nightingall	**Chief People Officer**
	Kate Warriner	**Chief Digital & Information Officer**
	Karan Wheatcroft	**Interim Chief Governance Officer**
	Jay Wright	**Clinical Lead for Research**
Observers- Governors/ Staff/ Members of the Public:	**Lynne Addison**	**Public Governor – Rest of England and Wales**
	Eliot Forster	**Chair, Liverpool Health Partners**
	Peter Humprey	**Public Governor - Merseyside**
	Dr Mark Jackson	**Director of Delivery and Performance, Liverpool Health Partners**
	Allan Pemberton	**Public Governor- Cheshire**
	Trevor Wooding	**Senior Governor (Public -Merseyside)**
Apologies for absence:	**Nicholas Brooks**	**Non-Executive Director**
	Lucy Lavan	**Director of Corporate Affairs**

Action

Chair's Initials

1 Opening Matters

1.1 Apologies for Absence

Apologies for absence were received from Nicholas Brooks and Lucy Lavan.

1.2 Declaration of interests relating to agenda items

All meeting participants were asked to declare any interests in respect of items listed on the agenda. All participants declared that they had no interests.

1.3 Chair's Briefing

The Chair formally announced that he will be stepping down in March 2022. Chair recruitment is planned to commence in September 2021 to support a period of handover.

The Chair provided an update on the ongoing developments of the Cheshire & Merseyside (C&M) ICS and the interim appointments of David Flory (Chair) and Sheena Cuminsky (Chief Officer).

Nationally we await governance clarifications including provider collaboratives and updates to the Foundation Trust Code of Governance.

The Chair expressed his thanks to everyone in terms of their continued hard work in challenging circumstances.

1.4 Staff Story

The Chief People Officer provided a collective staff story from the recent international nurses 'reflection on their journey from India to Liverpool'.

1.5 Patient Story

The Director of Nursing, Quality and Safety provided a patient story from an acute transfer patient who continues to remain in the Trust's care.

1.6 LHP Annual Report and Forward Plan

The LHP Chair reflected on starting with LHP a few months ago, the context of C&M landscape, and the focus on long term patient outcomes.

The LHP Director of Delivery and Performance provided an overview of the LHP annual report, which reflected on the impact of Covid-19 in delivering their strategy, the contribution to research priorities, SPARK, continued delivery of programmes, and adoption of specialty research centres to work in partnership. The brand refresh and organisation development have been a key feature to prepare for the future.

Chair's Initials

The strategy refresh, including the focus on being the Academic Health Science System for C&M and the priorities in the business plan.

Discussion followed in terms of the geographical spread in the context of historic focus on the Liverpool City Region and now a wider strategy across C&M with the ICS recognised as a key partner.

The Chief Executive recognised the strength of the relationship with LHP and was pleased to hear the focus on health inequalities and population health aligned to Trust priorities.

The LHP Chair expressed his thanks to the Trust for continuing to host LHP.

The Board **noted** the report and forward plan.

2 Patient Safety and Quality

2.1 Infection Prevention and Control:

2.1.1 IPC BAF

The Medical Director provided an update in terms of the IPC assurance report. The Covid 19 pandemic has led to a review of all IPC measures with strengthening of IPC processes.

It was noted that the risk around microbiology cover is not a new risk, but an update was provided regarding appointments and actions being taken. Within the other sections of the report there were no significant issues to highlight to the Board.

The Board **noted** the report.

2.2 Learning from Deaths Dashboard Q1 2021/22

The Medical Director introduced the dashboard. There have been 55 deaths in the Trust between April and June 2021. In Quarter 1 2021/22 one death has been classified greater than 50:50 chance of avoidability by the mortality reviewer. Mortality reviews continue for all deaths to ensure learning is sought.

The Board **noted** the report.

2.3 Director of Infection and Control (DIPC) Q1 Update

The Medical Director confirmed that standards continue to be applied. During Quarter 1 2021/22 there have 3 MSSA and 3 Clostridium Difficile infections. The Medical Director confirmed that teams receive feedback from all infections. It was noted that a cannula group had also been formed following identification of a specific theme.

Chair's Initials

The Quality Committee received the sepsis annual report last week and there is ongoing work to improve sepsis figures. The paper also noted the MIAA report with actions to improve structures and governance around sepsis.

Discussion included the importance of record keeping. There was also assurance that the Quality Committee continued to have oversight and surveillance of the areas reported, and the Audit Committee were sighted on this as well.

The Director of Nursing, Quality and Safety confirmed that sepsis is one of the top 3 priorities in the Quality Strategy this year.

The Chief Executive also referred to a discussion with the Head of Innovation at Alderhey about potential tools including AI that could be used in areas such as sepsis.

The Board **noted** the report and the actions being taken.

2.4* ***LHCH Monthly Staffing Report for Period May to June 2021***
Discussion took place regarding specific outliers in the figures. It was recognised that there had been some of vacancies (now recruited) and the impact of track and trace. There was confirmation that the Trust has been proactive in implementing testing to reduce the impact from staff isolating through track and trace.

The Chief People Officer also confirmed daily and weekly monitoring of all staff absences, the continued focus on psychological welfare, and early intervention support from HR.

The Board **noted** the report.

2.5* ***Guardian of Safe Working Quarterly Exception Report Q1***
The Board **noted** the report.

2.6* ***Deprivation of Liberty (DoLs) Quarterly Report Q1***
The Board **noted** the report.

2.7* ***Safeguarding Annual Report 2020/21***
Discussion included an update on training figures. It was also agreed that outcomes would be added to future reports.

The Board **noted** the report.

3 Strategy and Development

3.1 **Strategic Objectives KPIs Quarterly Update**
The Director of Strategic Partnerships presented the update, setting out the context and importance of aligning the strategic objectives. A more detailed update will be provided for Quarter 2. **JD**

Chair's Initials

The Board **noted** the report.

3.2* ***Membership Strategy***
The Board **noted** the strategy.

4 Targets and Financial Performance

4.1 **Board Dashboard period Ended 30th June 2021**
The Chief Operating Officer presented the high level messages within the Board dashboard.

The report reflected the continued difficulties in meeting statutory waiting times (RTT and 52 week wait) as an impact of the Covid pandemic. Performance is in line with the planned trajectory for recovery, with some caution going forward in respect of capacity and non elective pressures.

Discussion included hospital mortality and the nature of the patients over the last year. The Chair asked if the target was reasonable and it was agreed that this would be considered. The Chair asked for a report to come back to the board in order to explain the variance from plan. **RP**

An update was requested on delayed transfer of care. It was confirmed this is slightly above target in the context of challenges across the system, this will continue to be monitored.

An update was also provided on national Covid cases and the local situation. Confirmation was received that the Trust is linked into regional conversations around pressures and potential mutual aid requests (priority remains for urgent and cancer patients).

The Board **noted** the contents of the paper and associated risks.

4.2 **Phase 4 Recovery**
The Chief Operating officer set out the performance against the trajectories. The restoration and recovery of elective services has progressed well with all services being fully restored, other than a small number of community outpatient settings and performance against the recovery trajectories remains strong.

There have been some challenges in achieving P2. All patients are clinically triaged to make sure it is safe for the procedure to be delayed.

52 week wait performance remains in line with expected levels but there are challenges in a number of sub-specialty areas namely; aortic surgery, LAAO, EP. This has also been compounded by the shortfall in anaesthetic capacity due to unplanned absence. It is forecast that performance will remain in line with the trajectory subject to no further impact of Covid.

Chair's Initials

RTT performance is ahead of trajectory.

Overall activity levels are good for quarter 1 but with some challenges noted for quarter 2.

Along with the capacity challenges, it was recognised there were challenges with the financial regime and elective recovery fund (ERF) in particular.

Discussion included the potential impact of annual leave with confirmation that lower levels of activity had been profiled in August to reflect this.

The Chief Operating Officer and Chief Finance Officer had begun work to profile recovery for 2022/23 with a view to forecasting when the Trust would be in a position to meet statutory targets. It was agreed that the Board would receive a further recovery paper looking ahead for 2022/23. **HK/KE**

Board **noted** the performance and risks within the paper.

5 Governance and Assurance

5.1 Consultant Appointments

The Board noted that there were no new consultant appointments to ratify.

5.2 Freedom to Speak Up Quarterly Report Q1

Apologies had been received from the FTSU Guardian and the Chief Executive presented the report.

There is an increase in the number of speak ups in quarter 1 which is positive. The Trust is continuing to monitor the number of anonymous reporting routes, as we are keen that people feel they can speak up in confidence. There are a range of issues being discussed and these are all logged and followed up.

It was noted that the Trust continues to be the top Trust in Cheshire and Merseyside and the top specialist trust nationally for FTSU.

Confirmation was provided regarding clinician involvement with the Deputy FTSU Guardian being a consultant as well as representation across the FTSU champions, alongside examples of issues being raised by consultants.

The Chief Executive also confirmed that the cultural work is ongoing with the Deputy Medical Director leading a culture club and progress of the Be Civil, Be Kind, Be inclusive campaign. The Trust has also launched a quarterly pulse survey in July 2021.

Chair's Initials

Confirmation of the completion of the FTSU training modules to be reported in quarter 2. **PW**

The Board **noted** the report.

5.3 Annual Review of Corporate Governance Manual

The Corporate Governance Manual had been reviewed and updated. There were no significant changes to bring to the attention of the Board. The Audit Committee had reviewed the changes and had recommended these for Board approval.

The Board **approved** the Corporate Governance Manual.

5.4 Ratification of the Use of the Trust Seal

The Board **approved** the use of the Trust Seal.

5.5 Mock CQC/EECS Process

The Director of Nursing, Quality and Safety updated the Board on the approach to mock CQC and EECS processes. These are due to recommence in quarter 3. The paper also included reference to the new CQC strategy including focus, ratings, speak up and working with other organisations. The CQC also have ambitions around assessing local systems as well as tackling inequalities.

An update was provided of the CQC inspections of the Trust during Covid with virtual reviews of both medicine and surgery over the past year. The one area that was highlighted for improvement was the robustness of an action plan from a serious incident, which was duly reviewed, and improvements made and fed back to the CQC.

The Chair praised the leadership role of the Director of Nursing, Quality and Safety and recognised the amount of work involved.

The Board **approved** the programme and changes to EECS.

5.6 Disciplinary Policy

The Chief People Officer set out the responsibility for the Trust Board to be sighted on and accountable for ensuring effective people management processes as referenced through both the Improving People Practices (IPP) recommendations in 2019 and more recently the letter from Prerana Issar, NHS Chief People Officer to all Trust Chief Executives and HR Directors in December 2020.

The Trust Board received an annual review of disciplinary activity for 2020/21 at the March 2021 meeting, and work continues to review and embed disciplinary processes.

The revised Disciplinary Policy has been reviewed by the People Committee following ratification through the Partnership Forum.

Chair's Initials

Confirmation was provided of the legal support in developing the policy and incorporation of key points which align with the approach of London Imperial College, shared nationally as best practice.

Discussion included reference to the People Committee discussions around making sure the committee focusses on process without becoming involved in process.

The Board **approved** the disciplinary policy.

Premises Assurance Model

5.7 The Chief Operating Officer explained it was mandatory to submit the Premises Assurance Model. This had been a rigorous process, led by the Head of Estates. Overall a strong submission, with the only area to bring to the Board's attention being the business continuity for decontamination with new arrangements in place and this risk being monitored through the risk register. The acquisition of land and property was also amber and this would be actioned if the Trust were to do this.

There was also work in progress to develop an Estates Strategy which would be brought to a future Board meeting. **HK**

The board **noted** the report.

Trust Insurance Arrangements

5.8 In line with SFIs, the Board needs to be informed of the insurance arrangements in place and any changes to these. In the main the paper sets out the arrangements in place with NHS Resolution. There was some duplication of board liability in terms of private insurance and this has now been removed. The Chief Finance Officer confirmed that this was consistent with other NHS Foundation Trusts.

The Board **approved** the insurance arrangements.

Communications Report Q1 2021/22

5.9* Discussion included the importance of communicating charity funded investments to continue to raise the profile of the charity.

The Board **noted** the report.

Emergency Preparedness and Business Continuity Annual Assurance Report 2020/21

5.10* The Board **noted** the report.

Health & Safety Committee Annual Report 2020/21

5.11* The Board **noted** the report.

Complaints Process Annual Review

5.12* The Board **noted** the report.

Chair's Initials

6 Board Assurance

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

6.1.1 Audit Committee: BAF Key Issues and Approved Minutes for Meetings held on 23rd March and 11th June 2021

The Audit Committee Chair commented on closure of incidents, and reviews of the effectiveness of internal and external audit.

The Board **noted** the BAF key issues report (July 2021).

The Board received and **noted** the approved minutes of the Audit Committee meetings held on the 23rd March and 11th June 2021.

6.1.2 Quality Committee: BAF Key Issues and Approved Minutes for Meeting held on 13th April 2021

The Director of Nursing, Quality and Safety referred to the reports already covered on the agenda, as well as a presentation on Stroke which may be useful for Board to see as well.

The Board **noted** the BAF key issues oral update (July 2021).

The Board received and **noted** the approved minutes of the Quality Committee meeting held on the 13th April 2021.

6.1.3 Integrated Performance Committee: BAF Key Issues and Approved Minutes for Meeting held on 26th October 2020

The Integrated Performance Committee Chair provided an update including assurances and updates on recovery.

The Board **noted** the BAF key issues oral update (July 2021).

The Board received and **noted** the approved minutes of the Integrated Performance Committee meetings held on the 26th October 2020.

6.1.4 People Committee: BAF Key Issues and Approved Minutes for Meeting held on 8th December 2020

The People Committee Chair recognised the focus on culture including bullying and harassment and was impressed by the actions being taken to address this. Reference was also made to the Disciplinary Policy discussions.

The Board **noted** the BAF key issues report (July 2021).

Chair's Initials

The Board received and **noted** the approved minutes of the People Committee meeting held on the 8th December 2020.

7 **Action Log (Public) from Previous Meeting**
All actions were for future meetings.

8 **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.

9 **Date and Time of Next Meeting:**
Tuesday 28th September 2021

10 **Resolution to exclude the Public**
The Board resolved to exclude the public at this point by reason of the private nature of the business to follow.

The Chair thanked Board colleagues and Governors / members of the public (observing), for their attendance.

Chair's
Initials

Board of Directors (in Public)
Item 8

Action log

Updated 27.07.21

No.	Agenda Item	Action	By Whom	Progress	Board review	Note
July 2021						
1.	3.2 Strategic Objectives KPIs Quarterly Update	Detailed quarterly update against Strategic Objectives for Q2	JD		Nov 21	
2.	4.1 Board Dashboard period ended 30th June 2021	Hospital mortality target to be reviewed	RAP		Sept 21	
3.	4.2 Phase 4 Recovery	Present a further recovery paper looking ahead for 2022/23	HK/KE		Nov 21	
4.	5.2 Freedom to Speak Up Quarterly Report Q1	Confirmation of the completion of the FTSU training modules to be reported in quarter 2.	JT/PW		Nov 21	
5.	5.7 Premises Assurance Model	Develop an Estates Strategy	HK		TBD	
April 2020						
6.	2.2 DIPC annual report	Develop new IPC strategy	RAP		Sept 21	
7.	3.1 Strategic objective – quarterly update	Present new R&I strategy	JT/JW		TBD	
March 2020						
8.	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						
9.	5.3 Freedom to Speak Up Review of New Guidance	Self-reflection exercise to be repeated every 2 years	LL		Nov 21	