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 30th November 2021
Microsoft Teams at 10.00am

Agenda

1	**Welcome and Opening Matters**		
1.1	**Apologies for Absence:** Lucy Lavan	**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	**Organ Donation and Transplantation**	**Tim Ridgway-Clinical Lead for Organ Donation in attendance**	**Presentation**
2	**Patient Safety and Quality**		
2.1	**Infection Prevention and Control:**		
2.1.1	**IPC BAF**	**Medical Director**	**Item 2.1.1(a)**
2.1.2	**New IPC Strategy**	**Medical Director**	**Item 2.1.2(a)**
2.1.3	**DIPC Quarterly Report**	**Medical Director**	**Item 2.1.3**
2.2	**Learning from Deaths Quarterly Update**	**Medical Director**	**Item 2.2(a)**
2.3	**Patient Survey Results**	**Director of Nursing, Quality & Safety**	**Item 2.3**
2.4*	***LHCH Monthly Nurse Staffing Report for Period: September and October 2021***	***Director of Nursing, Quality & Safety***	***Item 2.4(a)***
2.5*	***Deprivation of Liberty and Safeguarding (DoLS)***	***Director of Nursing, Quality & Safety***	***Item 2.5***
2.6*	***Guardian of Safe Working Quarterly Exception Report***	***Medical Director***	***Item 2.6***

3	**Strategy and Development**		
3.1	**Green Plan Update**	**Director of Strategic Partnerships**	**Item 3.1**
3.2	**Strategic Objectives Update**	**Director of Strategic Partnerships**	**Item 3.2**

3.3	**Digital Excellence Report**	**Chief Digital & Information Officer**	**Item 3.3**
4	**Targets and Financial Performance**		
4.1	**Board Dashboard – period ended 31st October 2021**	**Chief Operating Officer**	**Item 4.1(a)**
4.2	**Phase 4 Recovery**	**Chief Operating Officer**	**Presentation**
5	**Governance and Assurance**		
5.1	**Consultant Appointments – for ratification**	**Medical Director**	**Item 5.1**
5.2	**Ratification of Use of the Trust Seal- for approval**	**Chief Governance Officer**	**Item 5.2**
5.3	**SORD: Liverpool Health Partner Updates**	**Chief Finance Officer**	**Item 5.3**
5.4	**Report of Freedom to Speak up Guardian Q2**	**FTSU Guardian in attendance**	**Item 5.4**
5.5*	***Communications Report Q2***	**Chief People Officer**	***Item 5.5***
6	**Board Assurance**		
6.1	**BAF Key Issues Reports and Approved Minutes of Assurance Committee Meetings:**		
6.1.1	**Audit Committee:** • **BAF Key Issues** • ***Approved Minutes for meeting held on 6th July 2021 ****	**Chair of Audit Committee**	**Item 6.1.1** ***Item 6.1.1a***
6.1.2	**Quality Committee:** • **BAF Key Issues** • ***Approved Minutes for meeting held on 20th July 2021 ****	**Chair of Quality Committee**	**Item 6.1.2** ***Item 6.1.2a***
6.1.3	**Integrated Performance Committee:** • **BAF Key Issues** • ***Approved Minutes for meeting held on 26th July 2021****	**Chair of Integrated Performance Committee**	**Item 6.1.3** ***Item 6.1.3a***
7	**Minutes of the Board of Directors Meeting held (in public) on 28th September 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 25th January 2022, 10.00 hours		
11	**Resolution:** To exclude the public from the meeting at this point by reason of the private nature of business to follow.		

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

Board of Directors (in Public)
Item 2.1.1

Subject: **IPC BAF**
Date of Meeting: **Tuesday 30th November 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 initially presented at the May 2020 Board of Directors meeting and updates included at subsequent meetings.

There have been a number of revisions and new versions have been published, the latest was released in June 2021. An assessment against this has been previously presented to the Board of Directors. The assessment has been reviewed again by the Infection Prevention team to ensure the assurances remain in place, and there have been no significant changes. However new Infection Prevention and Control guidelines have just been published (November 2022) and this may lead to changes in future assessments.

The CQC have developed an emergency support framework for IPC.

In addition, there is an HSE checklist of IPC measures according to the hierarchy of controls structure and this has been completed and evidenced by the Trust.

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.

The latest BAF was published by NHS England in June 21 (V1.6) and the assessment against this version has previously been submitted to the Board of Directors. There have been no further changes to the published version but the framework has been reviewed again to ensure assurances remain in place.

Processes in place to keep patients and staff safe and prevent cross infection continue, including staff vaccination and testing, patient testing, isolation precautions and enhanced cleaning

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

Patients continue to test positive for Covid, there have been 30 patients identified between July – October 2021 but the majority of these have tested positive prior to admission, on admission or shortly afterwards or they have been known to be positive in another Trust prior to transfer here.

There has been 1 outbreak in September which was reported via the national system.

New Infection Prevention and Control guidelines in relation to Respiratory Viruses were published on 22nd November 2021 by the UK Health Security Agency.

3. Update

The Board assurance is included as an attachment, which has been reviewed again recently by the Infection Prevention team although there have been no significant changes from previous versions.

4. Conclusion

The IPC BAF is being managed proactively and will be updated in line with any new versions and with new Infection Prevention and control guidelines.

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			
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. Reassessed using hierarchy of controls format in July 21.. 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		

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	their specialty. Some will require moves in line with their clinical 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 or twice weekly lateral flow test now in place and		

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	compliance reported through Gold Command. Staff testing is now mandated and non compliance reported to managers 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.		

• 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 • 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. • The IPC Board Assurance Framework is reviewed, and the evidence of assessments are made available and discussed at Trust board. • ensure Trust Board has oversight of ongoing outbreaks and action plans • there are check and challenge oppurtunities by the executive/senior leadership teams in both clinical and non-clinical areas	The Trust holds gold and silver 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. Data submissions signed off by Executive during the week and by on call manager at weekends. IPC BAF is shared at all BoD meetings to update Board members. Outbreak summaries and actions presented to Gold Command as they occur.	New IPC guidelines released 22/11/21	To be reviewed by IPT and Silver Command and Trust policies changed to align where required (17/12/21)

	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;	Matrons and infection prevention audits of equipment Cleaning schedules Policy and protocols in place. Certification of equipment prior to repair in place		
•	linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Linen policy in place, managed as infectious linen		
•	single use items are used where possible and according to single use policy	Included in disinfection policy		
•	reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	Audits in place.		
•	cleaning standards and frequencies are monitored in nonclinical areas with actions in place to resolve issues in maintaining a clean environment	Monitoring performed by Hygiene supervisors regularly. Data available		
	• ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the	Additional ventilation and air dilution provided when practicable. Windows cannot always be left open due to		

dilution of air	temperature control.		
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. Cover has been increased.
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;	advise patients and visitors coming in. Posters displayed Patients prioritized for siderooms by the capacity management team		
• 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;	Ward managers monitoring in clinical areas.		
• 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.	Social distancing and screens in place.		
• isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative	Contacts recorded and monitored in database.		
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly retested and contacts traced promptly	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 2.1.2

Subject: **Infection Prevention & Control Strategy 2022-25**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by **Dr Raphael Perry, Medical Director,**
IPC Team - Nicky Best, Danielle Brady, Lynn Trayer Dowell, Madelaine Whelan, Dr Jon van Aartsen, Dr Omar Al-Rawi, Felicity Kempson
Presented by **Dr Raphael Perry, Medical Director/DIPC**
Purpose of Report: To Note

BAF Reference	Impact on BAF
BAF 1	Potential for patient harm

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

1. Executive Summary

- Historically LHCH has had an excellent record in maintaining high standards of Infection Prevention & Control.
- There has been some deterioration in specific areas and action plans have been developed to address gaps and ensure optimal outcomes
- The IPC team have developed a three-year strategy to maintain continuous improvement and map out how services can be developed

2. Background

While excellent IPC measures have been achieved for several years there have been some areas where results and targets have not been met.

The areas include MSSA numbers and surgical site infection, C. Diff numbers, IV line infection management and sepsis screening.

The attached strategy lays out the vision for developing and maintaining an outstanding IPC service and will be a three-year strategy.

3. IPC Strategy

The IPC strategy 22022-2025 is attached.

4. Conclusion

The IPC team have addressed all the areas of IPC and infection management and will implement the strategy and report progress through the quarterly board reports

5. Recommendations

The Board of Directors is asked to note the strategy.

Item 2.1.2a

LHCH IPC Strategy 2022-2025

Executive Summary

The prevention and control of healthcare associated infections (HCAI) remains a high priority on the government agenda with a continued focus to reduce HCAI's, improving and sustaining the quality of care provided by NHS Trusts. The Covid 19 pandemic has led to enhanced infection prevention and control (IPC) measures across the entire healthcare system.

The provision of a robust Infection Prevention Strategy is an essential element in continuing the Trusts focus on reducing HCAI's and in ensuring compliance with Cleanliness and Infection Control standards and national and regional targets. The strategy has been developed for 2022 – 2025 and the objectives outlined in the strategy will be supported by the annual IPC Programme of work.

LHCH has had an excellent record in maintaining a high standard of infection prevention and control. There remain some areas of concern and gaps in provision and the strategy outlines continuous and ongoing improvements.

The objectives focus on continuing to reduce HCAI, to embed infection prevention in everyday practice and sustain improvements in order to keep patients, staff and visitors safe. In doing so the Trust will develop existing work and projects and initiate new developments for new challenges, aspiring, in keeping with trust's vision to be the best in reducing further all HCAI's.

The Trust will continue to monitor compliance and in doing so will ensure the enhancement of existing surveillance systems and introduce new systems where required ensuring learning from action takes place.

Introduction

Nationally the acquisition of a healthcare associated infection remains a major cause of avoidable patient harm and has been shown to pose a serious risk to patients, clients, staff and visitors in a health and social care setting. They are seen to directly affect the patient and their carers in several ways, such as severe or chronic illness, pain, anxiety, depression, longer stay in hospital, reduced quality of life and loss of earnings.

They also impact on the health service in terms of extended lengths of stay of affected patients, the costs of diagnosis and treatment of the infections and their complications, and the costs of specific infection control measures.

Although nationally and locally significant progress has been made year on year in the number of patients developing serious infections such as Methicillin Resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (C.Diff) the reduction of HCAIs remains a key priority for the NHS.

The emergence of an increasing trend of antimicrobial resistance is seen as a global priority and one where the prevention of infection is paramount to support reducing the global demand for antibiotics. It is therefore imperative that clinically effective measures are adopted within all health care settings to minimise the risk of transmission of any organism which has the potential to cause harm.

Liverpool Heart & Chest NHS Foundation Trust (LHCH NHSFT) recognises that the prevention of infection is fundamental to the quality of care delivered and is committed to ensuring that a consistently high standard of infection prevention and control practice is seen as an essential requirement of assuring high quality patient safety and care within the services they deliver. The public, patients and visitors expect to have a safe stay and receive a high standard of care when admitted to the hospital setting.

This document sets out the strategy for infection prevention and control activity for the next three years. It identifies the way the Trust will continue to reduce HCAI, to embed infection prevention in everyday practice, sustain improvements in order to keep patients, staff and visitors safe and in doing so comply with National initiatives such as the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance (2015).

Scope

LHCH NHSFT is committed to ensuring the safety of patients, staff and visitors. Patient safety the key priority for the Trust. The new trust quality and safety strategy has been developed by the Director of Nursing and Safety in conjunction with the Trusts Patient Safety Lead. The provision of a robust Infection Prevention Strategy is an essential element in achieving these safety objectives and in ensuring compliance to the Code of Practice and to national and local targets. This strategy reflects the Trusts vision to be a leading centre of clinical and academic excellence by providing patients with the best possible care through continuous improvement and innovation. The strategy is essential for the achievement of these corporate objectives as well as achieving the priorities laid out in the Trust Safety Strategy.

This document sets out the strategy for infection prevention and control activity for the next three years building on present high standards. It identifies the way the Trust will continue to reduce HCAI, to embed infection prevention in everyday practice, sustain improvements in order to keep patients, staff and visitors safe and in doing so comply with National directives such as the NHSE/I standards, risk management standards and meet national and local targets.

Liverpool Heart & Chest Hospital NHSFT

Liverpool Heart & Chest Hospital NHSFT is an acute specialist trust providing a wide range of cardiothoracic and respiratory tertiary services, secondary and community cardiorespiratory services. There is a quaternary service for aortic surgery as one of two supraregional centres and a national cardiac robotic service for mitral valve repair. Services are commissioned by specialised commissioning and clinical commissioning groups. LHCH serves a population of approximately 2.8 million across Cheshire and Merseyside, North Wales and the Isle of Man.

The patient population includes a significant proportion living in areas of high deprivation

The trust strategy underpinned by the following objectives

1. Delivering World Class Care
2. Advancing Quality and Outcomes
3. Increasing Value
4. Developing People
5. Leading through Collaboration
6. Improving our Population Health

- Infection prevention and control plays a key role within the hospital and is intrinsically related to the objectives.
- In addition to the contribution to objectives 1 & 2 the cost savings of high-quality IPC can be considerable.
- The IPC team are involved in education / audit, and encouraging development to maintain high standards in developing people
- To achieve high standards requires close collaboration with those at the front line both internally and across the wider health economy
- Antimicrobial stewardship and education minimising HCAIs reduced morbidity/mortality at a population level as well as an individual level

LHCH has a well-developed annual IPC plan which reflects routine ongoing processes and is driven by emerging need for improvement and maintaining local and national standards. (See appendix)

Areas of present concern have been highlighted and plans developed to address gaps. They include

- staffing pressures within the Infection Prevention Team (IPT) and microbiology support
- MSSA cases exceeding agreed targets; C. Diff target reached and likely to be exceeded before year end
- UTI treatment and alignment to NICE guidance
- Intravenous and central line infections

- Sepsis metrics – in particular screening rates
- Age of some areas of estate buildings and ventilation
- Responding to new and emerging pathogens

Key Challenges

The key challenges the Trust faces, and this strategy must overcome are:

- Level of hospital activity and capacity – staffing
- Meeting national & local targets
- Emerging infections and new strains i.e. pandemics
- Instilling public confidence
- Educating workforce, patients and the public
- Ensuring a clean and appropriate environment
- Motivating staff and the engagement of staff
- An increase in antimicrobial resistant organisms

- The IPT resources will need to develop to match any increased activity in the next three years and any expansion of services. Investment in the education and training of the IP nursing team will be required to aid professional development and to enable succession planning. Investment in staff and in digital resources for more effective data handling will require support in business case development.

- Meeting the KPIs across all areas will need appropriate educational support for staff, informatics and BI support

- Much has been learned from the Covid pandemic and systems will need to be maintained and staff available to respond rapidly to future emerging infections. Continued education and information for patients relatives and the public

The strategy document will outline the trust's response to improving these areas.

The Trust will: -

Continue to provide divisional level data, identifying divisional gaps in compliance

Divisions will continue to monitor compliance and address non-compliance through their governance processes.

Continue to enhance and improve cleanliness within the Trust.

Improve isolation facilities and compliance within the Trust.

We will continue to monitor gaps in assurance through exception reporting, striving to consistently achieve full compliance

IPC Vision and Objectives

1. Minimise the risk to patients from healthcare-associated infection and aim to prevent all avoidable HCAI's.

2. Maintain compliance with all requirements of the Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and related guidance.

3. Continued commitment to working in partnership with other healthcare providers. Patients moving within the healthcare system require good communication between IPC teams and agreed pathways.

4. Continued delivery of education and training on prevention and control of infection so that staff understand their responsibilities and action to take.

5. Review and improve internal processes and systems with a focus on digital system support.

6. Enhance surveillance of infections and learning through action.

7. Support proactive antimicrobial stewardship within the Trust.

8. Ensure appropriate information relating to infection risks is communicated to relevant parties.

9. Ensure collaborative working within the Trust to ensure the maintenance of a clean and appropriate environment.

10. Ensure policies are in place and reviewed when required to fulfil the requirements in the hygiene code and NHSE/I.

11. Continued commitment to an approach whereby prevention and control of infection is viewed as integral to service delivery and development:

12. Enhance patient and public involvement in infection prevention in order to improve patient experience

13 Develop a programme of research and quality improvement to underpin the delivery of high-quality infection prevention practice with the potential to foster improvements in experience, safety

Roles/Responsibilities

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

The effective prevention of HCAI requires the commitment and active involvement of all employees. It is therefore vital that the IPC process is communicated and embedded throughout the organisation.

As an employee of the Trust, everyone has a responsibility for and a role to play in managing infection prevention and control. This includes:

- Being aware of Trust IPC policies and procedures.

- Adhering to IPC standards as required within their job description/role.
- Alerting managers to any IPC risks or environmental deficits that require urgent attention.
- Participation in mandatory IPC training and hand hygiene assessments (where appropriate).
- Maintaining a clean and safe environment at all times.

The **Chief Executive**, **Medical Director/DIPC and Director of Nursing** have overall responsibility for IPC, on behalf of the Trust Board of Directors. In addition, they are responsible for ensuring that the Trust is in a position to provide overall assurance that the organisation has in place necessary controls to manage infection prevention and control.

All the other **Executive Directors** share in the overall corporate responsibility to support the implementation of the IPC Strategy.

The **Director of Infection Prevention and Control** (**DIPC) & Infection Prevention Team (IPT)** have specific responsibilities to advise the Board on all issues relating to Infection Control.

The DIPC/IPT will;

- Oversee the production and implementation of local IPC policies.
- Oversee the work of the IPC Team within the Trust.
- Report directly to the Chief Executive and the Board and not through any other officer.
- Have the authority to challenge inappropriate clinical practice, poor standards of hygiene and antibiotic prescribing decisions.
- Assess the impact of all existing and new policies and plans on IPC and make recommendations for change.
- Be a part of the Trust's clinical governance and patient safety teams and structures.
- Produce an annual report on the state of HCAI in the Trust and release it publicly.
- Have overall responsibility for creating a culture of safe and effective practice to reduce HCAI and to ensure that infection prevention and control is accepted as an individual and Trust-wide responsibility

Matrons/Clinical Lead/Service Manager

Matrons and Clinical Leads/Managers within the Trust have responsibility for;

- Leading and driving a culture of cleanliness in clinical areas.
- Monitoring standards of cleanliness in clinical areas.
- Ensuring implementation of Trust HCAI prevention and control policies and procedures.
- Ensuring that there is promotion of HCAI prevention and control awareness responsibilities amongst employees, services users, contractors, and partners.
- Participation in root cause analysis where required to promote learning and practice improvement.

• Ensuring all IPC aspects of clinical practice are implemented as per IPC policies and procedures, through the use of mandatory hand hygiene assessments, the Trust approved infection prevention and control audit programme and the Trust's clinical competency framework.

All staff are responsible for establishing, maintaining and supporting a coordinated approach to infection prevention in all areas of their responsibility. All staff have responsibility for complying with Trust Infection Prevention policies and procedures and attending mandatory infection prevention training

Infection Prevention must be a key component of business plans and building/estates plans.

Infection Prevention Staff

The IPT was increased shortly after the onset of the Covid pandemic. The infection prevention nurse establishment currently is 2.6 WTE having previously been 1.8 WTE. A full-time administrative support role has now been established.

There is no specific budget for Infection Prevention.

The staffing of the IPC nursing and admin team would be

- A band 8B Lead IPN/Assistant DIPC
- A 0.6 WTE Band 7 IPC post.
- A band 6 nursing post to initially a secondment, but now a substantive post
- A band 4 administrative role to support increased surveillance and monitoring

The main activities of the IP nurse specialists currently are:

- To provide specialist nursing input in the identification, prevention, monitoring and control of infection and provide readily available information and advice to staff, patients and visitors
- To review national guidelines and policies and advise the Trust on their impact on infection control.
- To be responsible for the development, implementation and review of Trust wide of guidance and policies relating to infection prevention & control.
- To develop and deliver educational programmes for nursing, medical, allied health professional and ancillary staff, identifying specific learning needs.
- To lead in the development of a structured audit programme related to infection prevention & control practices, including setting standards for best practice, developing audit tools, and implementing the programme
- To develop an annual programme
- To develop and lead on infection control surveillance programmes for the Trust, using recognised methods of data collection and to collate and disseminate the relevant data
- To report to all relevant National surveillance and data collection systems
- To provide specialist nursing input and contribute to the programmes of Trust committees and working groups including: Infection Prevention Committee, Decontamination group, Antimicrobial group, Water Safety Group, Surgical Site Infection Group, Emergency planning Committee, PPE group, Health and Safety Committee, Cleaning group
- To conduct post infection reviews

In order to ensure development of the team and allow for succession planning it is important that the IPNs can access educational opportunities, including the resources and the time to enable this

The aim is that there will development opportunities for the team so that the Band 6 nurse will complete an accredited infection prevention specialist course and the lead nurse will complete a masters programme and develop the role of assistant DIPC.

The team also has a new administrative and surveillance officer post. This role will be developed to increase efficiency of the team and improve the data collection and

information related to all aspects of the audit and surveillance programme in general, but specifically related to SSI.

The team will explore opportunities to participate in research and identify and promote quality improvement programmes to prevent healthcare associated infections.

Consultant Microbiology support is provided by an SLA with Liverpool Clinical Laboratories microbiology department. The consultant microbiology staff were hard pressed during the pandemic and pressure worsened by a series of resignations. The previous cover had been equivalent to 11PAs of consultant time shared between two clinical microbiologists and an Infection Prevention Microbiologist. The cover during the pandemic was down to 2-4 PAs of consultant time.

There has been additional recruitment and at present there is a new consultant providing 6PAs of clinical microbiology and IPC. The Medical Director/DIPC is in further discussions with LCL Clinical Director to re-establish the previous 11PA service and is working with Dr Jon van Aartsen (Medical Microbiology Consultant) on the future responsibilities and roles that need support.

In April 2021, the British Infection Society and Royal College of Pathologists published Best Practice Standards for the delivery of NHS Infection Services in the UK. The Trust aspires to have specialist infection input to support achieving its IPC visions and objectives, aligned with the best practice standards in each IPC strategy area.

- **Infection Prevention and Control** – 6 PAs. This is in addition to the daily operational IPC service provided by other members of the infection service including DIPC, Assistant DIPC and IPC nurses. Duties would include:
    - Oversight of alert pathogens e.g. C. difficile, MRSA, SARS-Cov2, and provision of advice when appropriate, identifying and advising on outbreaks and transmission and prevention.
    - Oversight of HCAI surveillance
    - Detection, investigation and management of HCAI outbreaks
    - Technical microbiological expertise in relation to:
        - Water management e.g. attending water safety group
        - Specialist ventilation systems
        - Decontamination
        - Personal protective equipment
    - Contribute and support surgical site infection surveillance systems
    - Contribute and support intravenous access device infection surveillance systems
    - Overview of local control of infection policies and their implementation
    - Working with the IPT within the Trust
    - Challenging inappropriate clinical hygiene practice as well as antibiotic prescribing decisions;
    - Become an integral member of the Trust's clinical governance and patient safety teams and structures
    - Become an integral member of the organisation's Infection Control Committee
    - Contributing to the DIPC annual report on the state HCAI within the Trust and involvement in its public release
    - Training and education.
- **Antimicrobial Stewardship**
    - **Lead:** 2-4 PAs

        - Working with Pharmacy and clinical teams to ensure prescribing is in line with local guidance, including audit and quality improvement
        - Oversees the development of local antimicrobial guidelines based on local antibiotic resistance data
        - Training and education
    - **Review of patients with complex infection**: 2-4 PAs.
        - ITU / POCCU Ward Rounds, three times per week
        - Cardiothoracic Surgery Infection MDT, three times per week
        - Telephone, email and/or bedside consults for::
            - Bacteraemias
            - Endocarditis
            - Surgical Site Infections
            - C. difficile

In the absence of enhanced clinical microbiologist staffing, other avenues will be explored to support and develop a world-class infection service, including embracing the roles other allied health professionals including specialist infection pharmacists and nurses.

Governance

Governance structures within the Trust are key to ensuring that information on infection prevention, areas of concern and risks are fed back and discussed within the governance framework and relevant committees. Governance structures are key to ensuring infection prevention and control is integral to service delivery and development and that actions implemented where necessary and monitored within the divisions. It is also key for the identification and escalation of risks.

The Infection Prevention & Control committee meets quarterly and oversees all aspects of the infection prevention agenda. It is chaired by the Medical Director in their role as DIPC. There are three subgroups reporting to it; Water & Ventilation Safety, Decontamination and Antimicrobial Stewardship. There is also a sepsis update at each committee meeting by the sepsis lead and/or DIPC. The sepsis group has been formalised into a regular committee following an MIAA audit and has clear TORs, standing agenda items, action log and an annual meeting plan.

The IPC committee reports to the board of directors by means of a quarterly DIPC report. An annual report with a forward plan and audit programme is presented to the April Board of Directors outlining priorities for the coming year. Reports are written by the IPT and monitored by the IPC committee

The IPT will ensure that policies and procedures are reviewed and updated within the review dates. New policies will be developed in consultation with key committees and staff members. Additional resources to support policies will be produced where required with effective communication across the Trust of new and updated policies. Trust policies will be in accordance with the Code of Practice for health and adult social care on the Prevention and Control of Infections and related guidance and will meet NHSLA requirements.

The Trust will monitor non-compliance to the policy criterion in the Code of Practice and CQC Outcome 8, through the CQC assurance framework. Noncompliance and out of date policies will be reported as exceptions to the Infection Prevention Committee, Quality Governance Steering Group.

The IPC strategy will be implemented by the Infection Prevention Committee, led by the Director of Infection Prevention and Control. The Infection Prevention Committee will co-ordinate delivery plans in order to implement the strategy. Members of the Infection Prevention Committee link to other groups and committees to ensure that actions to achieve this strategy are included as part of all departmental and divisional annual programmes of activity. Committee members will act as a conduit for information; so that divisional plans can be coordinated and will provide

The investigation into and learning from key infections
Seeking specialist Infection Prevention and Microbiology advice where required Working with Bed Managers, Heads of Nursing, Senior Clinical Nurses, Matrons and other clinical leaders to ensure patients with infections are placed appropriately to meet their care needs and in order to protect other patients.
Ensuring that staff are trained in hand hygiene, ANTT and infection prevention
Working with hygiene services to ensure the clinical environment is clean and safe for patients

The Infection Prevention Committee will seek assurance from all Divisions to ensure the strategic aims in this document are achieved.

Progress of the implementation and monitoring of this strategy and the annual work programme will be reported to the Quality Safety Committee. The Quality committee will also receive updates from the Infection Prevention Committee and any areas of concern/risks for inclusion on the Corporate Risk Register.

This strategy and the Trust infection prevention annual programme is approved and reviewed quarterly by Trust Board. Trust Board is responsible for ensuring the Trust has appropriate infection prevention and control systems and resources in place to enable the Trust to deliver the objective.

Water Safety

The Water and Ventilation Safety Group is a sub-group of the Infection Prevention Committee.

This is well established and external consultants are present to provide expert advice.

The group provides oversight and management of the water safety plan which includes; planned maintenance and monitoring of the water system, monitoring of usage evaluation and flushing in all departments and regular audits of all aspects of

the plan. A testing schedule has been developed and the group monitors the results and any remedial actions required. In addition, water safety related to specific equipment used within the Trust e.g. heater coolers is monitored.

The aims for the future are to improve the administration of the electronic reporting system and to have a robust audit programme covering all aspects of water safety. Also, to ensure that water safety guidelines and the appropriate documentation is incorporated into all capital and refurbishment programmes

Antimicrobial stewardship

The antimicrobial group is subgroup of the Infection Prevention Committee. This comprises of DIPC, Microbiologist, Antimicrobial Pharmacist plus Infection prevention team, Clinical and medical representation. They will continue to meet quarterly and ensure that the plan for antimicrobial stewardship is fulfilled, which will include:

- Completing necessary audits including quarterly prescribing audits. Completing reactive audits as required when concerns are raised. Plus improve data collection tools for audit purposes.
- Regular attendance on ward rounds and utilise the electronic prescribing systems to enhance ward round review.
- Facilitate training when necessary and help develop a suitable training programme with differing staff grades and specialities.
- Review relevant guidelines and recommendations from external bodies when necessary e.g. NICE
- Facilitate data collection for national surveillance including prescribing and usage data and provide to the relevant bodies as requested e.g. (PHE, CCG and CQUINN).
- To review and maintain the trust antimicrobial formulary.
- To engage with groups that produce policies that make recommendations on antimicrobial therapy

There is currently one antimicrobial pharmacist 0.71WTE. In order to fulfil the plan, the antimicrobial pharmacist will be required to have protected time to do this apart from other pharmacist roles. This will be accomplished by exploring additional avenues of support such as

- Utilising band 6/7 pharmacists for support when required.
- Review of audit processes to encourage all clinical pharmacists to take part
- Liaison with audit to improve data collection
- Cover for antimicrobial ward round by band 7/ critical care pharmacist
- Ring fenced time aiming for 1 day per week minimum

Further actions for improving stewardship will include

- Liaison with Allscripts to improve stewardship related documentation and reporting and utilisation of digital systems to improve stewardship- i.e. ward round note, pharmacy care plan and antibiotic order sets
- Assist in training and development relating to stewardship.
- Maintenance of links with microbiologist/Critical care nurse specialist/infection prevention teams and Sepsis Group
- Development of Antimicrobial information home page on intranet as source of information for prescribing, stewardship and feedback
- To implement the use of define/refine to aid in the reporting of usage and prescribing data.
- To develop robust feedback mechanism for stewardship across the trust to prescribers.

In order to fulfil the plan, the antimicrobial pharmacist will be required to have protected time to do this apart from other pharmacist roles.

Currently there is 1wte nurse on a secondment as a Critical Care Infection nurse specialist to assist with the antimicrobial prescribing and stewardship agendas.

This role encompasses multiple elements to assist the microbiology and IPC team:
<u>Microbiology</u>
- Liaise with the laboratories and feedback advice to the ITU team
- review patients with existing or suspected infections 5 days a week
- Audit antimicrobial use and identify areas for improvement in conjunction with pharmacy

<u>Sepsis</u>
- Promoting the trust Sepsis Policy and providing education for new staff
- Provide direct feedback to sepsis first responders as part of a quality improvement project

<u>Infection Prevention and Control within CCA</u>
- Review all bacteraemias within the critical care area and report back on these to the Matron and IPC team
- Initiate Central line and Peripheral Vascular access surveillance as part of a quality improvement project

This post will need to be made permanent to continue supporting AMR and Sepsis

Decontamination.

The Decontamination group is a subgroup of the IPC committee. This group will implement all the recommendations from the MIAA audit and ensure that there is robust annual audit programme. Also that that there is a comprehensive review of the decontamination of all endoscopes across the Trust, with a move to automatic reprocessing wherever possible.

Decontamination is led by estates and has addressed the key issues in the last audit.

Addressing the Gaps/Concerns/Areas for improvement

Surgical site infection (SSI) Prevention and Surveillance

Information on SSI related to cardiac surgery is currently collected using an access database and aspects of this are completed retrospectively.

A new module for SSI is currently in development and the aim is that this will be utilised to ensure a robust real time surveillance system for cardiac SSI and that monthly reports will be generated and circulated to relevant forums.

The surveillance system will also be extended to also include thoracic surgery.

The surveillance programme will be carried out by the infection prevention team, unlike other centres who have dedicated surveillance teams. Ideally data should be collected and submitted to the national SSI system, to inform the national picture and allow ongoing comparison between centres however there is not the capacity within the team currently to contribute to this. The allocation of personnel to participate in this programme will be explored with the surgical division

Additional actions will be implemented, including

- post infection patient reviews for all patients who develop a severe SSI post cardiac or thoracic surgery and
- the collation and analysis of data as part of the surveillance programme to inform practice and address any learning points with the Surgical division.

Benchmarking with other cardiac centres will be performed to provide assurance improve practice where necessary.

Patients at high risk of infection post-surgery will be identified and a programme of targeted interventions to reduce the risks will be introduced as a project with the Tissue Viability team.

Universal decolonisation of patients undergoing cardiac surgery has already been implemented as part of a surgical site bundle. Actions to improve application for emergency admission patients will be introduced.

The use of a mobile phone app. to improve compliance with universal decolonisation by patients in the community prior to cardiac surgery will be trialled.

Prevention of Urinary Tract Infections

As a result of the audit process where gaps were identified, a comprehensive action plan to improve both prevention of UTI and the diagnosis and treatment has already been developed. The actions will be embedded across the Trust and a more comprehensive surveillance programme developed. New treatment and diagnosis guidelines will be introduced across the Trust with a multi-disciplinary education programme

A Trust wide survey of all products associated with the care of catheters will be performed as a lack of standardisation has been identified. Products, training and competencies to enable best practice and reduce catheter associated infections will be introduced across the Trust.

A catheter passport will be introduced for patients discharged/transferred with a catheter in situ to enable seamless care.

Prevention of Intravenous (IV) access device infections

The Trust currently does not have a specialised IV service or nurse. An IV working group has been established to develop action plans to ensure that there is an education and training programme for the insertion and care of all devices, including midlines and PICC lines. That national guidance is reviewed and implemented and that a robust surveillance programme for monitoring infections associated with devices is in place and these are recorded and reviewed.

Actions include:
Development of a new IV access policy
Review of all IV devices available in the Trust and introduction of new devices where relevant
Development of training programme and competency framework for midline insertion
Development of competency framework for midline and PICC line dressings
Audits and monitoring of dressings and care for midlines and PICC lines
Introduction of new documentation in the EPR system
Surveillance of line related infections

An IV passport will be introduced for patients discharged/transferred with a device in situ to enable seamless care.

Environmental Hygiene

The Trust has had monitoring systems in place to ensure high standards of cleanliness and environmental hygiene are maintained. High scores are consistently achieved and the Trust scores very highly on standards of cleanliness in patient surveys. The monitoring and audit systems have traditionally been paper based with hygiene services, infection prevention and the matrons using different audit tools.

The aim will be to implement the National Cleaning Standards across the Trust, rationalise all the audits and develop a comprehensive audit programme with multi-disciplinary involvement. The audit programme will be on a digital platform and results will be shared regularly with the divisions

The results will also be available to staff, patients and visitors and on display as a star rating, within the different areas across the Trust.

New technologies for improving environmental decontamination will be trialled and a Trust wide deep cleaning programme developed, in conjunction with Hygiene services.

Respiratory Viruses

New national guidelines and recommendations for the prevention and control of respiratory viruses, (including COVID-19) have been released for consultation and the final version will be released imminently. These guidelines will be reviewed and incorporated a new Trust wide Respiratory Virus policy and plan. Patient pathways will be developed with the relevant divisions. Infection prevention standards, PPE guidance, testing, monitoring and surveillance strategies will be incorporated into the new policy.
The Infection Prevention Committee and Emergency planning committee will oversee the policy implementation and monitoring and all preparations needed to enact the new plan.

A PPE working group has been established and will continue to oversee supplies and provision of PPE and relevant training programmes. A new training programme using artificial intelligence to monitor application of PPE will be evaluated.
programmes.

Sepsis

While sepsis in general acute hospitals can frequently present in the Emergency Department as well as on the wards, sepsis at LHCH it invariably occurs in the in-patient population who have undergone investigation, treatment or interventions. HCAIs not infrequently are the underlying cause of the bacteraemia causing sepsis and septic shock.

Sepsis management and control does not strictly fall into the category of Infection Prevention and Control is over seen by the Sepsis Lead and the multi-disciplinary sepsis group. The sepsis group report to the main IPC committee and the Quality Committee. Strict infection control measures play a significant role in reducing sepsis. There has been a significant improvement in the principal KPIs over the last three years. Sepsis screening remains a challenge and is part of the sepsis improvement plan presented to quality Committee.

Key actions are:

- Incorporation of sepsis screening and treatment in the newly developed trust's MET team protocol
- Development of a live sepsis compliance data platform to facilitate early recognition of incomplete sepsis treatment to improve current individual feedback programme
- Introduction of sepsis triggers into the Facility Board platform on EPR to provide timely information about patients at risk of developing sepsis on routine ward rounds, hand over and snapshot checks
- Perform snapshot audits looking at other elements of the sepsis bundle delivery.
    - IV fluid administration
    - Lactate levels

Summary

The IPC team have developed a comprehensive strategy to ensure continuous improvement in all aspects of IPC

Recommendations

The strategy will be shared with all relevant parties and monitored by the IPC committee reporting back through quarterly reports

Infection Prevention and Control – 2021/22			
Aim	**What we are trying to achieve**	**Actions**	**How will we demonstrate improvements**
To prevent transmission of highly resistant organisms and health care associated infections (HCAI).	Highly resistant organisms are detected and monitored and standards adhered to in order to prevent the transmission of HCAI.	• To ensure there is a robust surveillance and reporting system for all highly resistant organisms. • To ensure the antimicrobial stewardship programme is completed. • To ensure the education and audit programme for compliance with hand hygiene and standard infection prevention precautions is maintained	• 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 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 review and ensure compliance with BAF, HSE checklist and Infection Prevention 10 Point Plan. • To ensure a robust screening programme 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 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.	• 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 reduce levels of avoidable Trust attributable bacteraemias, including MSSA	All bacteraemias are monitored and numbers of avoidable infections reduced.	• .To ensure a robust process for reviewing all 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	• Reduced numbers of avoidable bacteraemias.
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 review new national standards and implement actions. • To establish a comprehensive multi-disciplinary audit 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.	• 5-star hygiene ratings will be achieved and displayed 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 reduce Surgical site infections	An effective surveillance programme for monitoring surgical site infections is in place. Surgical site infection rates are reduced.	• 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	• 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 infections related to Intravenous Access devices.	Increased adherence to standards for care of IV access and reduction in bacteraemias associated with IV access.	• The IV working group to develop and oversee an action plan including: An education programme relating to care for midlines and PICC lines. A competency framework for Insertion of midlines Surveillance of central line related infections. Improvement of all documentation related to IV access devices. Update all policies	• Increased compliance with documentation and review. • Improved level of competence associated with IV care. • Reduction in central line infections and bacteraemias associated with IV access.

Audit Programme 2021 - 22			
Audit	**Person(s) Responsible**	**Schedule**	**Reporting to**
Hand hygiene (1) Observational (2) Facilities and standards	Ward managers	Weekly	Infection Prevention Committee (IPC)
Isolation	IPT	Annually	IPC
Cleanliness (Domestic)	Cleaning Group	According to Cleaning Schedules	IPC/Cleaning Group
Clean Trace	IPT/Ward Staff	Monthly	IPC/Cleaning Group
Environmental decontamination – Use of Ultraviolet -C	IPT	6 monthly	IPC/Cleaning Group
Waste disposal Sharps disposal Linen handling Decontamination of equipment Environmental cleanliness	IPT/Link staff	6 monthly	IPC
Antimicrobial prescribing for UTIs	Antimicrobial pharmacist/IPT	Monthly	Drugs and Therapeutic Committee and IPC
Urinary catheter insertion and care	Ward managers/Matrons	Monthly	IPC
COVID 19 Screening	IPT	Fortnightly	IPC/Gold Command
PPE	IPT	Monthly	IPC
Critical Care Weekly Screening	IPT	Quarterly	IPC
CPE screening	IPT	Quarterly	IPC
MRSA screening	Clinical Audit /IPT	Quarterly	IPC
MRSA pathway	IPT	Annually	IPC
Clostridium difficile policy	IPT	Annually	IPC
Decolonisation prior to cardiac surgery	IPT	Quarterly	IPC/SSI Group
Surgical Prophylaxis	IPT/Pharmacy	6-monthly	IPC/SSI Group
Patient Hair Removal	IPT	6-monthly	IPC/SSI Group
Peripheral Line Insertion and Care	Matrons	Monthly	
Transfer of patients with alert organism	IPT	Annually	IPC
Water safety	Estates manager	6 monthly	IPC and H&S committee

Audit Schedule												
Audit	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Hand hygiene												
Isolation												
Cleanliness												
Clean Trace												
UVC												
IP Audits												
UTI												
Urinary catheter insertion and care												
COVID Screening												
PPE												
CCA Screening												
CPE screening												
MRSA screening												
MRSA pathway												
C Diff policy												
Decolonisation												
Surgical Prophylaxis												
Patient Hair Removal												
Peripheral Line Insertion and Care												
Transfer of patients												
Water safety												

Board of Directors (in Public)
Item 2.1.3

Subject: **Director of Infection Prevention and Control (DIPC) Quarterly Report**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by **Nicola Best, Infection Prevention Nurse Specialist**
Presented by **Dr Raphael Perry, Medical Director/DIPC**
Reason for Report: To Note

BAF Ref	Impact on BAF
BAF 1	Potential for patient harm

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

1. Executive Summary

This paper provides information and an update on infection prevention and control issues for the 2nd quarter of this financial year, 1st July until 30th September 2021. Previous reports have covered the period up to 30th June 2021.

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

2. Background

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

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

3. Issues

3.1 Surveillance

There is a requirement that bacteraemias (blood stream infections) caused by certain bacteria and also Clostridium difficile infections are monitored and reported to Public Heath England on a monthly basis. These cases are also reported to the Clinical Commissioning Group monthly. In addition the infection prevention team monitor other resistant organisms or organisms of concern.

Mandatory Reporting – Bacteraemias (Blood cultures)

	Attributable cases July-Sept 21 **(Year to Date-Trust attributable)**	Threshold
MRSA bacteraemias	0 **(0)**	0
MSSA bacteraemias	3 **(6)**	7
E coli	3 **(3)**	5
Klebsiella sp.	1 **(1)**	5
Pseudomonas aeruginosa	0 **(0)**	3

Post infection reviews have been undertaken for all these patients to identify the probable sources, and any lapses in care or learning points.

Probable sources the MSSA bacteraemias included intravascular device related infections and lower respiratory tract chest infection. The learning points regarding the intravascular line infections will be addressed by the IV-line group.

Probable sources for the gram negative bacteraemias were urinary tract infections and intrabdominal infections. Also, one patient had hepatobiliary infection which related to a procedure performed at another Trust whilst an inpatient her, this has been feedback to the other Trust.

The relevant clinical area and any issues and actions required have been discussed with the relevant areas and will also be discussed at the divisional governance meetings.

CPE cases

There were three cases of trust attributable CPE within this time period. Although none of the patients overlapped in any area, they had all been cared for at some point in POCCU. These cases were discussed, an action plan identified to provide assurances that any additional cases would be detected and any onward transmission prevented. Details are included in Appendix 1.

All MRSA cases (non-bloodstream)

A number of patients were identified as MRSA positive in this time period. 2 appeared to be Trust acquired, these were screening swabs and the patients were colonised and not infected. There was no connection between the patients

C. difficile Infection

	Attributable cases July - Sept 21 **(Year to Date)**		Threshold for 21/22
Clostridium difficile infection (C. difficile **toxin** positive)	3 **(6)**		6

3 patients were identified in this time period and a link was identified between 2 of the patients on one particular ward. A meeting was held to discuss these patients and any additional actions and assurances that were required. Attendees included the infection prevention team, hygiene services representative, the matron, the ward manager and Head of Nursing.
An action plan was developed (see appendix) Individual patient reviews were completed with the relevant wards. A number of issues were identified, and these will be discussed at the relevant committees.

SARS CoV-2

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

COVID 19 Patients July- Sept 21	**Numbers of Patients**
Community-Onset – First positive specimen date <=2 days after admission to trust.	10
Hospital-Onset Indeterminate Healthcare-Associated – First positive specimen date 3-7 days after admission to trust.	7
Hospital-Onset Probable Healthcare-Associated - First positive specimen date 8-14 days after admission to trust.	2
Hospital-Onset Definite Healthcare-Associated – First positive specimen date 15 or more days after admission to trust.	4

There was 1 outbreak in this period. This included 5 of the hospital probable or hospital definite attributed infections and also 1 member of staff. The infections all occurred within a 5-day period. This outbreak was discussed at various forums within the Trust and a number of actions instituted, including deep cleaning of areas, contact tracing and additional screening of staff and patients. Additional audits of the patient screening protocol and PPE compliance were undertaken.

Staff compliance with asymptomatic screening was audited and the protocols changed to allow staff to use LAMP or lateral flow testing. It was decided at that staff participation in the asymptomatic testing would be made mandatory and this has been communicated to all staff and is monitored weekly

3.2 Audits

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

- Decolonisation prior to surgery
- COVID- 19 swabbing compliance
- Compliance with MRSA pathway
- Urinary tract infection treatment
- Compliance with MRSA pathway
- PPE compliance

Audits have been performed by ward staff assessing compliance with hand hygiene, IV care and care of catheters. Results and action plans have been feedback to wards and relevant areas and through the Infection Prevention committee

3.3 Cleanliness

The standard monitoring tool used by the Hygiene supervisors to assess environmental cleanliness has continued to be used. The target is an overall Trust score of 95%, with an individual score for clinical areas of 95% or above.

Hygiene services have been under renewed pressure because of the increased frequency of cleaning and the number of areas requiring deep cleaning. Also additional cleaning has been required in certain areas due to building works and capital planning projects.

	July	August	September
Results overall of Compliance Audits	98%	96%	96%

A group has been established to introduce the new National Standards for Cleanliness across the Trust which has reviewed all areas across the Trust, developed a new audit tool and a multi-disciplinary audit programme and has commenced inspections. Work is ongoing to develop the electronic audit tool amd reporting system.

3.4 Surgical Site Infection

A working group has been convened to introduce a new surveillance module to improve data collection, monitoring and reporting of surgical site infections. Development work is ongoing, and the aim is that this will be functional by January 2022.

4. Sepsis

The 20/21 annual sepsis report was presented at Quality Committee on 20th July 2021. There has been an improvement in the management of sepsis with the principal KPIs either achieved or significantly improved.

There has been a review of the service and systems by MIAA. The gaps in provision are being addressed by the sepsis group working with the divisions. This table outlines ongoing work and as part of the annual sepsis report.

The sepsis group has been formalised with TORs and regular meetings planned with a standard agenda and minutes. An action plan has been developed and gps are being addressed.

5. Summary

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

6. Recommendations

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

Appendix 1

Background
2 patients identified recently with CPE in clinical samples (Enterobacter OXA-48). 1 probably Trust acquired, 1 unknown acquisition as not previously screened.

Patients did not overlap and were not actually present in the Trust at the same time. However had both been cared for in POCCU and within the same bedspace, approximately 2 weeks apart. Patients had been isolated when results received, in line with Trust policy. General background levels of CPE within the Trust are low. There is a concern that this may be an indication of a future issue for Critical Care in terms of transmission of infection and ability to effectively treat infections that may arise.

A meeting was convened by the IP team to review cases, assurances and agree actions ,. Representatives included the Infection prevention nurses, Critical Care Matron, Microbiologist, Hygiene services manager, Critical care nurses.

The following actions were discussed and agreed:

Action	Responsible person	Target date	
Further microbiological testing of samples. To be sent to reference lab for typing	JVA	15/10/21	Completed
Review of previous CPE positive patients to look for additional overlap	IP team	4/10/21	Completed
Review of all Enterobacter clinical isolates for previous 6 months	NB/JVA	8/10/21	Completed
Increase screening to include short stay patients in the weekly screening programme on Mondays. In addition, all patients to be screened on Wednesday mornings Commencing Monday 4th October and to be reviewed weekly	JS/Band 7 leads/FK	Commence 4/10/21 then review weekly	Ongoing
Identification of immediate contacts (to be noted in ICNET for future reference in the event of an outbreak)	IP team/PAS team	5/10/21	Completed
Review of Hygiene scores for previous 2 months to identify any gaps	SH	6/10/21	Completed
Review of Matrons audits for previous 2 months to identify any gaps	JS	6/10/21	Completed
Deep clean of bedspace 32 and			Completed

curtain change when patient currently in has been moved/transferred	Hygiene assistant/Band 7 lead	4/10/21	
All shared equipment stored in corner bedspaces to be cleaned and tagged	Band 7 lead	4/10/21	Completed
Equipment in corner bedspaces to be added to cleaning schedule	RL/JS	4/10/21	Completed
All chairs stored in the corridor to be cleaned and moved to patient bedspaces so that they will be regularly cleaned	RL/JS	4/10/21	Ongoing issues with storage space
Clean Trace audit to be performed on shared equipment	IP team	8/10/21	Completed
Holes in backboard of sink to be covered (Bedspace 32)	Estates dept	15/10/21	Completed
Pendant arms (high level) to be cleaned	Hygiene assistant	4/10/21	Completed

Appendix 2

Actions for Cedar Ward September 21

Action	Responsible	Target Date	Progress & comments
Audit of environment – clinical	Infection prevention nurse Matron	7/7/21	Completed
Audit of environment – non clinical	Hygiene supervisor	8/7/21	Completed
Cleanliness of equipment – random swabbing using Clean Trace system	Infection prevention nurse	7/7/21	Completed
Review of recent matrons audits to identify if any areas for improvement	Matron	7/7/21	Completed
Enquire if samples can be sent for ribotyping	Infection prevention team	7/7/21	Lab advised -this has not been done but will reassess if more positive samples
Check other patients on the ward to ensure no others have symptoms	Ward manager	7/7/21	No other patients
Review of staff sickness	Ward manager	7/7/21	No issues
Deep clean and UV-C decontamination of sluice area	Hygiene services/Cedar ward staff	9/7/21	Completed
Deep clean of bay (14-17) including bathroom	Hygiene services/Cedar ward staff	9/7/21	Completed
Change products to use chlorine impregnated wipe, specifically for commodes and bedpans	Infection prevention team Supplies department	10/7/21	Completed
Review time taken for sample to be processed and why there was a delay	Infection prevention team Ward manager	10/7/21	Result took 4 days to be released. There appeared to be a delay in transit from LHCH to LCL but unable to ascertain why.
Include infection prevention and C difficile in new training pack for bank staff	Education team Infection prevention team	30/9/21	Completed
Provide additional training sessions on ward	Infection prevention team	24/9/21	Completed

Board of Directors (in Public)
Item 2.2

Subject: **Learning from Deaths Dashboard Q2 21/22**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by: **Dr Raphael Perry, Medical Director**
Presented by: **Dr Raphael Perry, Medical Director**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
BAF 1	Possible avoidable patient harm

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

1. Executive Summary

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

Deaths are categorised as to the likelihood of being avoidable or not (on balance of probability >/< 50:50) and the data collected centrally each quarter. This quarterly report presents the mortality dashboard for Q1 21/22 (Appendix 1)

2. Background

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

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

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

3. Dashboard Q1 2021/22

There have been forty-two deaths in the trust between July and September 2021. For comparison the total number of deaths in the trust for Q1 2021/22 was fifty-five. In Q2 thirty-nine of the deaths have been through the mortality review process. There have been no deaths in patients with an identified learning disability.

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

In Q2 21/22 two deaths has have been classified greater than 50:50 chance of avoidability by the mortality reviewer and the MRG. One death was definitely avoidable - RCP1 and one death strong evidence of avoidability – RCP 2.

Of those less than 50:50 in Q2 four deaths (10.3%) were classed probably avoidable but not very likely (RCP4); two deaths (5.1%) were classed as slight evidence of avoidability (RCP5); thirty - one deaths (80.6%) were classed as definitely not avoidable (RCP6).

Annual Deaths

The YTD figures for this year to date are a total of 106 deaths, eight of which are yet to complete the full MRG process. There are three avoidable deaths year to date two of which are as above and one from Q1 that was RCP3 – probably avoidable (>50:50)

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

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

In 19/20 there were eight potentially avoidable deaths.

4. Conclusion

The Trust complies with national guidance and populates the mortality dashboard. There are two with evidence of avoidability during Q2 21/22.

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

5. Recommendations

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

Item 2.2a

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

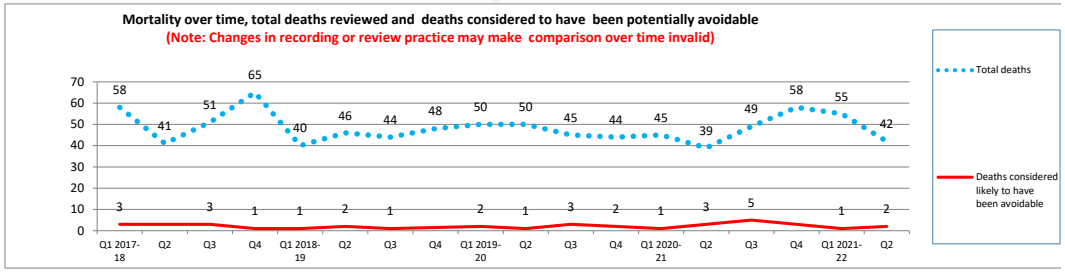
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
11	16	8	16	1	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
42	55	39	52	2	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
106	191	98	190	3	9

Time Series: Start date 2017-18 Q1 End date 2021-22 Q2



Total Deaths Reviewed by RCP Methodology Score

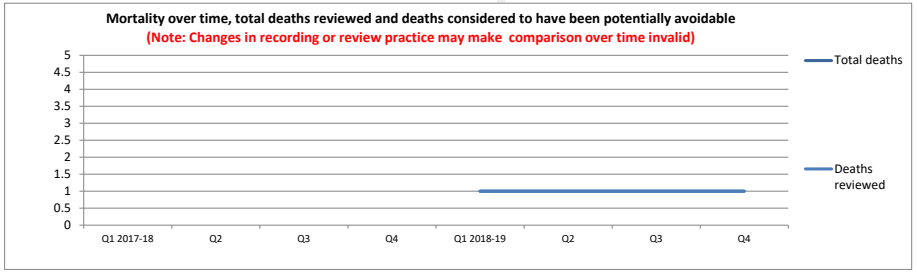
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	1	12.5%	This Month	0	0.0%	This Month	0	0.0%	This Month	2	25.0%	This Month	0	0.0%	This Month	5	62.5%
This Quarter (QTD)	1	2.6%	This Quarter (QTD)	1	2.6%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	4	10.3%	This Quarter (QTD)	2	5.1%	This Quarter (QTD)	31	79.5%
This Year (YTD)	1	1.0%	This Year (YTD)	1	1.0%	This Year (YTD)	1	1.0%	This Year (YTD)	9	9.2%	This Year (YTD)	7	7.1%	This Year (YTD)	79	80.6%

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

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

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

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



Board of Directors (in Public)
Item 2.3

Subject: **Care Quality Commission – National Inpatient Survey 2020**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by: **Sue Pemberton, Director of Nursing, Quality & Safety**
Presented by: **Sue Pemberton, Director of Nursing, Quality & Safety**
Purpose of Report: To Note

BAF Reference	Impact on BAF
All	Assurance on patient experience

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

1. Executive Summary

The purpose of this paper is to provide the Board of Directors with an overview of the results of the National Inpatient survey for 2020. (Appendix one) There are 10 sections within the national inpatient survey 2020 compared to 12 sections from the previous year. In addition, there are several new questions and some questions have been removed. It is noted in the survey that trend data is not available, and these results are not comparable to previous years due to the changes that were made.

Within the data from the survey, patients are counted as a medical or surgical case based on the treatment function code assigned to them during their time as an inpatient. Surgical care includes most surgical activity in a hospital. This includes cardiac and vascular surgery. Medical care includes services that involve assessment, diagnosis, and treatment of adults by means of medical interventions rather than surgery. Core service results have been included to give Trusts an indication of where improvement is required. For LHCH medical care has been rated much better and surgical care about the same. This indicates that surgery is the main area where improvements are required.

Overall LHCH has been rated the top hospital in the northwest for overall care and fourth nationally. In addition, the Trust is listed as one of four Trusts who have been classed as better than expected across the entire survey.

Whilst this is positive, there are six Trusts who were classified as much better than expected across the entire survey. Therefore, improvement work is required to understand where LHCH needs to improve to achieve much better than expected. There are three key areas that require improvement highlighted within this paper and articulated within the action plan (Appendix 2)

2. Background

871 Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH) patients responded to the survey. The response rate for LHCH was 70.81% compared to a national response rate of 46%. The 2020 survey of adult inpatients' experiences involved 137 NHS acute trusts in England. The patients asked had spent at least one night in hospital during November 2020.

3. Findings

All Trusts are rated as below - these results being for LHCH.

Banding

Better
Your trust's results were much better than most trusts for 12 questions.
Your trust's results were better than most trusts for 19 questions.
Your trust's results were somewhat better than most trusts for 5 questions.

Worse
Your trust's results were much worse than most trusts for 0 questions.
Your trust's results were worse than most trusts for 0 questions.
Your trust's results were somewhat worse than most trusts for 0 questions.

Same
Your trust's results were about the same as other trusts for 9 questions

The results for each of the ten categories within the survey are listed below highlighting the comparison with 2019– (although it must be remembered that some questions have changed or rephrased, and some have been removed and new questions added).

Section	Category	Score 2020 (2019)	Rating (compared to other hospitals)
One	Admission to hospital	8.7	Better
Two	The hospital and ward	8.6 (8.8)	Much Better
Three	Doctors	9.3 (9.4)	Better
Four	Nurses	9.0 (9.0)	Somewhat better
Five	Care and Treatment	8.7 (8.9)	Much Better
Six	Operations and procedures	8.7 (8.6)	Better
Seven	Leaving Hospital	8.0 (7.7)	Much better
Eight	Respect and dignity	9.6 (9.6)	Better
Nine	Overall experience	9.1 (9.1)	Better
Ten	Feedback on quality of care	2.0 (1.8)	Much Better

4. Analysis

From the survey it is difficult to compare results from 2019 to the current results 2020. However, there are three key areas that the Trust needs to improve which are:

1. Explaining the reasons for changing wards during the night
2. Getting enough help from staff to wash or keep yourself clean
3. Getting enough help from staff to eat your meals

An action plan has been devised as to how the Trust will approach improvements in these areas. (Appendix two)

The Overall results for medicine and surgery are highlighted below.

	Overall results				Core service		Overall CQC rating
	2020	Most Positive (%)	Middle (%)	Most Negative (%)	Medical care	Surgical	
Trust average		**67**	**22**	**11**			
Liverpool Women's NHS Foundation Trust	B	75	18	7	MB	N/A	G
Liverpool Heart and Chest Hospital NHS Foundation Trust	B	75	18	7	MB	S	O
The Walton Centre NHS Foundation Trust	B	75	17	8	B	B	O
Royal Brompton and Harefield NHS Foundation Trust	B	73	19	8	B	S	G

Key:					
	Trust performance	About the same (S)	Better (B)	Much better (MB)	
	CQC rating	Inadequate (I)	Requires Improvement (RI)	Good (G)	Outstanding (O)

The question which is used to compare Trusts is in relation to overall care – below is the position for LHCH comparing Surgery and Medicine.

Question	Unadjusted medical score	Unadjusted surgical score
Q46: Overall, how was your experience while you were in the hospital?	**9.1**	**8.9**

The chart below shows the position of LHCH (4th) nationally for overall care.

Trust Name		Rank
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	9.54	1
Queen Victoria Hospital NHS Foundation Trust	9.42	2
Royal Papworth Hospital NHS Foundation Trust	9.17	3
Liverpool Heart and Chest Hospital NHS Foundation Trust	9.07	4
The Walton Centre NHS Foundation Trust	9.03	5
The Christie NHS Foundation Trust	9.02	6
The Clatterbridge Cancer Centre NHS Foundation Trust	9.01	7
The Royal Marsden NHS Foundation Trust	9.01	8
Royal Brompton and Harefield NHS Foundation Trust	9.00	9
Liverpool Women's NHS Foundation Trust	8.90	10

5. Summary and Conclusion

LHCH has always been rated highly by its patients in the national inpatient survey being rated top in the country for 9 out of the last 14 years. In 2020 LHCH has been rated 4th from 167 hospitals which is extremely positive. There are however some areas that require improvements in 2021/22 and beyond which need focus.

6. Recommendations

The Board of Directors to receive the national inpatient survey results and associated action plan.

Appendix 1

2020 Adult Inpatient Survey: Early release of CQC benchmark results for Liverpool Heart and Chest Hospital NHS Foundation Trust

This report provides benchmark results for Liverpool Heart and Chest Hospital NHS Foundation Trust, in advance of national publication of the 2020 Adult Inpatient Survey in October 2021. It contains the same scoring and 'banding' (how your trust performed compared to other trusts across England), but does not include national scores. These national results can only be shared at official publication of the survey results in October.

By sharing results now, you will be able to see how your trust performed on individual questions in advance of the national publication.

This year we have amended our analysis and reporting in an attempt to provide trusts with more granular feedback from the survey. Previously all questions were banded as either 'better', 'about the same' or 'worse', for 2020 we now also report where trust results are 'much worse', 'somewhat worse', 'somewhat better' or 'much better'.

If you require any assistance, have any queries, or would like to provide feedback on the format of this report, please contact the CQC Surveys Team at: patient.survey@cqc.org.uk.

2020 Adult Inpatient Survey

The 2020 survey of adult inpatients' experiences involved 137 NHS acute trusts in England. We received responses from 73,015 patients, a response rate of 46%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital during November 2020 and were not admitted to maternity or psychiatric units. Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between January and May 2021.

CQC will use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Survey data will be used in CQC's monitoring tools, which provide inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be used to support CQC inspections. NHS England and Improvement will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health and Social Care will hold them to account for the outcomes they achieve.

Making fair comparisons between trusts

People's characteristics, such as age and sex, can influence their experience of care and the way they report it. For example, males tend to report more positive experiences than females. Since trusts have differing profiles of people who use their services, this could potentially affect their results and make trust comparisons difficult. A trust's results could appear better or worse than if they had a slightly different profile of people.

To account for this, we 'standardise' the data, i.e. we apply a weight to individual responses to account for differences in demographic profile between trusts. For each trust, results have been standardised by age, sex and method of admission (emergency or elective) of respondents to reflect the 'national' age-sex-admission type distribution (based on all respondents to the survey). This helps to ensure that no trust will appear better or worse than another because of its respondent profile.

Scoring

For each question in the survey that can be scored, individual responses are converted into scores on a scale of 0 to 10. For each question, a score of 10 is assigned to the most positive response and a score of 0 to the least positive. The higher the score, the better the trust's results.

It is not appropriate to score all questions because some of them do not assess a trust's performance. For example, the primary purpose of some questions is to filter out ineligible respondents.

Interpreting your data

The better and worse categories, displayed in the column with the header '2020 Band' in the tables below, are based on an analysis technique called the 'expected range'. It determines the range within which your trust's score could fall without differing significantly from the average score of all trusts taking part in the survey. If the trust's performance is outside of this range, its performance is significantly above or below what would be expected. If it is within this range, we say that its performance is 'about the same'.

Where a trust's survey results have been identified as better or worse than the majority of trusts, it is very unlikely that these results have occurred by chance. If your trust's results are 'about the same', the '2020 Band' column will be empty.

If fewer than 30 respondents have answered a question, a score will not be displayed for this question. This is because the uncertainty around the result is too great. Where a question that contributes to a section score has fewer than 30 respondents, a score will not be displayed for the section.

Trend data

The Adult Inpatient 2020 survey is significantly different to previous years' surveys with regards to methodology, sampling month and questionnaire content. This year's survey was conducted

using a push-to-web methodology (offering both online and paper completion). The questionnaire was amended significantly, with changes to both question wording and order. The 2020 results are therefore not comparable with previous years' data and trend data is not available. In future years, trend data will be incorporated into these reports.

Further information

The full national results will be available on the CQC website in October, together with the technical document which outlines the survey methodology and the scoring applied to each question: www.cqc.org.uk/inpatientsurvey

Results for Liverpool Heart and Chest Hospital NHS Foundation Trust: Executive Summary

Respondents and response rate

- 871 Liverpool Heart and Chest Hospital NHS Foundation Trust patients responded to the survey
- The response rate for Liverpool Heart and Chest Hospital NHS Foundation Trust was 70.81%

Banding

Better

Your trust's results were much better than most trusts for **12** questions.

Your trust's results were better than most trusts for **19** questions.

Your trust's results were somewhat better than most trusts for **5** questions.

Worse

Your trust's results were much worse than most trusts for **0** questions.

Your trust's results were worse than most trusts for **0** questions.

Your trust's results were somewhat worse than most trusts for **0** questions.

Same

Your trust's results were about the same as other trusts for **9** questions.

Tables of results

Table 1: Admission to hospital

Question	Respondents	2020 Score	2020 Band
Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?	405	8.5	Better
Q3. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	844	8.9	Much better

Table 2: The hospital and ward

Question	Respondents	2020 Score	2020 Band
Q4A. There were restrictions on visitors in hospital during the coronavirus (COVID-19) pandemic. Were you able to keep in touch with your family and friends during your stay?	782	8.4	Somewhat better
Q5.1. Were you ever prevented from sleeping at night by noise from other patients?	758	8.1	Much better
Q5.2. Were you ever prevented from sleeping at night by noise from staff?	758	8.9	Much better
Q5.4. Were you ever prevented from sleeping at night by hospital lighting?	758	8.7	Better
Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?	92	7.5	
Q8. How clean was the hospital room or ward that you were in?	845	9.6	Somewhat better
Q9. Did you get enough help from staff to wash or keep yourself clean	547	8.6	
Q10. If you brought medication with you to hospital, were you able to take it when you needed to?	500	8.2	
Q11. Were you offered food that met any dietary requirements you had?	377	9.0	Better
Q12. How would you rate the hospital food?	829	8.1	Much better
Q13. Did you get enough help from staff to eat your meals?	164	7.9	
Q14. During your time in hospital, did you get enough to drink?	834	9.8	Much better

Table 3: Doctors

Question	Respondents	2020 Score	2020 Band
Q15. When you asked doctors questions, did you get answers you could understand?	811	9.2	Better
Q16. Did you have confidence and trust in the doctors treating you?	854	9.7	Much better
Q17. When doctors spoke about your care in front of you, were you included in the conversation?	848	9.0	Better

Table 4: Nurses

Question	Respondents	2020 Score	2020 Band
Q18. When you asked nurses questions, did you get answers you could understand?	811	9.2	Somewhat better
Q19. Did you have confidence and trust in the nurses treating you?	853	9.3	
Q20. When nurses spoke about your care in front of you, were you included in the conversation?	849	9.0	
Q21. In your opinion, were there enough nurses on duty to care for you in hospital?	853	8.5	Better

Table 5: Your care and treatment

Question	Respondents	2020 Score	2020 Band
Q22. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?	775	8.7	Much better
Q23. To what extent did staff looking after you involve you in decisions about your care and treatment?	833	7.8	Better
Q24. How much information about your condition or treatment was given to you?	855	9.4	Much better
Q25. Did you feel able to talk to members of hospital staff about your worries and fears?	755	8.4	Better
Q26. Were you able to discuss your condition or treatment with hospital staff without being overheard?	815	7.7	Better
Q27. Were you given enough privacy when being examined or treated?	859	9.8	Better
Q28. Do you think the hospital staff did everything they could to help control your pain?	730	9.3	Better
Q29. Were you able to get a member of staff to help you when you needed attention?	784	8.8	Somewhat better

Table 6: Operations and procedures

Question	Respondents	2020 Score	2020 Band
Q31. Beforehand, how well did hospital staff answer your questions about the operations or procedures?	712	9.3	Better
Q32. Beforehand, how well did hospital staff explain how you might feel after you had the operations or procedures?	768	8.0	
Q33. After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?	781	8.7	Better

Table 7: Leaving hospital

Question	Respondents	2020 Score	2020 Band
Q34. To what extent did staff involve you in decisions about you leaving hospital?	848	7.8	Better
Q35. To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?	700	8.1	Better
Q36. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	271	8.4	
Q37. Were you given enough notice about when you were going to leave hospital?	863	7.8	Better
Q38. Before you left hospital, were you given any written information about what you should or should not do after leaving hospital?	845	8.8	Much better
Q39. Thinking about any medicine you were to take at home, were you given any of the following [information about medicines]?	782	6.1	Much better
Q40. Before you left hospital, did you know what would happen next with your care?	830	7.3	Better
Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	827	9.2	Much better
Q42. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	549	8.8	Somewhat better
Q44. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?	573	7.3	Better

Table 8: Respect and dignity

Question	Respondents	2020 Score	2020 Band
Q45. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	860	9.6	Better

Table 9: Overall experience

Question	Respondents	2020 Score	2020 Band
Q46. Overall, how was your experience while you were in the hospital?	857	9.1	Much better

Table 10: Feedback on quality of care

Question	Respondents	2020 Score	2020 Band
Q47. During your hospital stay, were you ever asked to give your views on the quality of your care?	673	2.0	

Table 11: Section Scores

Section	2020 Score	Band
Section 1. Admission to hospital	8.7	Better
Section 2. The hospital and ward	8.6	Much better
Section 3. Doctors	9.3	Better
Section 4. Nurses	9.0	Somewhat better
Section 5. Care and treatment	8.7	Much better
Section 6. Operations and procedures	8.7	Better
Section 7. Leaving hospital	8.0	Much better
Section 8. Respect and dignity	2.0	
Section 9. Overall experience	9.6	Better
Section 10. Feedback on quality of care	9.1	Much better

Table 12: Demographic Information

Characteristic	Percent
Total respondents	871
Response rate	70.8
Sex	
Male	65.9
Female	33.6
Intersex	0.0
Prefer not to say sex	0.5
Gender	
Gender same as sex at birth	99.5
Gender different than sex at birth	0.1
Prefer not to say gender	0.4
Age	
16-35	2.4
36-50	8.3
51-65	32.7
66+	56.6
Ethnicity	
White	96.6
Multiple ethnic groups	0.9
Asian or Asian British	0.9
Black or Black British	0.5
Arab or other ethnic group	0.2

Table 13: Demographic Information (Continued)

Characteristic	Percent
Religion	
Not known	0.9
No religion	20.1
Buddhist	0.2
Christian	76.2
Hindu	0.3
Jewish	0.1
Muslim	0.3
Sikh	0.0
Other religion	1.2
Sexuality	
Prefer not to say religion	1.5
Heterosexual	97.6
Gay/lesbian	0.7
Bisexual	0.2
Other	0.3

Appendix 2

Areas for Improvement

Area for improvements	Rationale	Improvement required	Action by
Explaining the reasons for changing wards during the night in a way that the patient can understand	Patients who are asked to change wards during the night are most commonly in the medical division – CCU/ACU and Birch ward.	The movement of patients during the night is only used where it is an urgent situation and bed capacity needs to be found in a high care area. This needs to be considered as part of the patient flow improvements work which is in place currently. In addition, there needs to be a clear process of who a patient is asked to change wards and how this is explained to them	December 2021
Did you get enough help from staff to wash or keep yourself clean?	It is basic standard practice that all patients are offered help with washing daily and more often if required.	This has been discussed and shared with ward managers and matrons and forms part of the matrons' weekly audits to ensure the set standards are maintained	December 2021
Did you get enough help from staff to eat your meals?	The Trust has a robust nutrition group led by the matron in critical care. All wards have mealtime coordinators and regular observations are conducted by nutritional leads in areas to ensure that patients receive the help when required. The volunteering lead is also exploring how the use of volunteers	The Trust has been without relatives/carers for a considerable length of time now and often it is the visitors who support their family members with mealtimes. The Trust staff need to ensure the needs of patients and the support they require is in place to provide the help needed.	December 2021

Board of Directors (in Public)
Item 2.4*

Subject: **LHCH Monthly Staffing for Reporting Period for September 2021**
Date of meeting: **30th November 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	No impact.

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

1. Executive Summary

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

2. Background

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

The National Quality Board (NQB) publication Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable, and productive staffing

(2016) outlines the expectations and framework within which decisions on safe and sustainable staffing should be made to support the delivery of safe, effective, caring, responsive and well-led care on a sustainable basis. It builds on National Institute for Health and Care Excellence (NICE) guidelines on safe staffing for nursing in adult inpatient wards and is informed by NICE's comprehensive evidence reviews of research, and subsequent evidence reviews focusing specifically on staffing levels and outcomes, flexible staffing, and shift work.

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

3. Information

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. 97 band 5 posts have been recruited into with candidates at varying stages of the recruitment process (including 41 who qualify in 2022).

Table 1-Vacancy data September 2021 (all bands)

	SEPTEMBER	
Unit	**RN**	**HCA**
Acute Cardiac Unit	10.5	-0.72
Birch Ward	11.51	0.74
Cath Lab	0.81	0
Cedar Ward	5.33	0.05
Cherry Ward	2.1	0.2
Holly Suite	5.03	0
Maple Suite	4.15	0.2
Oak Ward	4.09	0.15
Outpatients	0.69	0
Rowan Suite	3.16	-0.61
SICU Clinical Roster	18.06	3.43
Theatres	11.75	0.05
Grand Total	**77.18**	**3.49**

The first two cohorts of international RNs (17) have successfully completed their OSCE training and all 17 passed the OSCE exam on 5th October 2021. These staff are now working in their clinical areas in a band 4 capacity whilst their NMC registration is processed. Further cohorts have arrived during September 2021 with another 10 nurses planned to arrive in October through the Cheshire International recruitment Collaborative (CIRC).

A hugely successful face to face recruitment open day took place within the Trust on 25th September 2021 with 42attendees, 34 were interviewed on the day with offers to 33, 27 of whom are students due to qualify in 2022.

Members of the senior nursing team and recruitment team colleagues also represented LHCH at a Nursing Times careers event in Manchester in October with over 20 contacts being followed up.

3.2 Sickness Absence

During September 2021, clinical areas continue to experience sickness absence, and this is detailed in the table below.

Table 2- sickness absence data

	SEPTEMBER 2021	
Unit	**RN WTE**	**HCA WTE**
Acute Cardiac Unit	**2.64**	1.26
Birch Ward	**0.66**	1.61
Cath Lab	**5.79**	0.52
Cedar Ward	**4.27**	3.52
Cherry Ward	**1.88**	0.80
Holly Suite	**1.66**	0.37
Maple Suite	**0.55**	0.45
Oak Ward	**0.38**	2.29
Outpatients	**0.09**	1.52
Rowan Suite	**0.36**	0.03
SICU Clinical Roster	**8.90**	3.93
Theatres	**4.53**	0.76
Total WTE Unavailable	**31.70**	**17.05**

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. 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 although short term absence whilst staff await PCR teat results following household contacts, continue to impact staffing levels.

3.3. Temporary Staffing

The temporary staffing team are actively recruiting to the LHCH nurse bank to support during this time. Agency staffing has been utilised during September 2021 within critical care and Cath lab recovery 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 September 2021:

- There were no red flags on Cedar, Rowan, and Maple wards. There were 2 staffing related incident reports for Cedar and 3 for Maple during this period.
- Oak ward reported 3 red flag shifts in September. 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. The ward did have several supernumerary staff on shift also supporting, but staff had been moved to support other areas in the

trust. All avenues of supporting staffing undertaken Trust wide. Advanced Nurse Specialist support was also present on the ward.

- There were no red flags reported on ACU, Birch and Cherry wards in September 2021.
- There were 2 staffing related incidents reported on Cherry ward, there were no patient safety incidents reported during these shifts and these were due to short notice sickness impacting on the support and cross-cover from Maple Suite. These were escalated appropriately at the time.
- Acute Cardiac Unit (ACU) continues to have a significant number of RN vacancies, although all are recruited into with several staff 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 POCCU and working through a staffing plan to enable an increase in beds opened across the 2 areas.1 staffing related incident was reported on ACU in September.
- There is a current pressure within the anaesthetic nursing/ OPD team across both Cath lab and theatres which is being managed utilising temporary staffing, ensuring cross-divisional flexibility and with a longer-term plan to merge the 2 teams being presented at operational board.

4. Summary

This continues to be a particularly challenging period for all staff working with reduced staffing levels at times. The Trust has experienced an increase in staff absence during the covid pandemic which has contributed to increased staffing pressures, experienced across the NHS. As reported by the Institute for Public Policy Research (IPPR, 2021) 29% of nurses and midwives report that they are more likely to leave the sector than 1 year ago, and as such retention of current staff and recruitment of future staff remains a Trust priority.
Recent national press coverage has highlighted a national nursing ‘crisis’, impacted particularly by a significant reduction in recruitment from Europe. LHCH is experiencing significant nurse staffing challenges but has taken robust action to avert a staffing crisis. A successful international recruitment programme is hoped to stabilise the staffing position across the clinical areas.

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, in accordance with covid recovery and escalation plans.
- Receive assurance that a robust recruitment plan continues, including an extended overseas recruitment plan.

- Receive assurance that revised models of nursing care, utilising Registered Nursing Associates and apprentices continue to be implemented.
- Receive assurance that alternative temporary staffing options are being explored.
- Receive assurance that staffing escalation plans are in place to be enacted when significant staffing pressures are seen during the covid pandemic.

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

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

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

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

CHPPD for September 2021

	Care Hours Per Patient Day (CHPPD)							Day				Night			
	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)
TOTAL	8.0	3.4	0.1	0.1	0.0	0.0	11.7	92%	112%	70%	58%	93%	97%	-	-
BIRCH	3.0	2.7	0.3	0.2	0.0	0.0	6.2	69%	106%	110%	57%	96%	78%	-	-
ACU	8.5	4.0	0.0	0.3	0.0	0.0	12.8	92%	121%	-	-	85%	102%	-	-
CHERRY	1.7	1.0	0.0	0.0	0.0	0.0	2.7	90%	95%	-	-	63%	103%	-	-
CRITICAL CARE	22.1	2.8	0.0	0.0	0.0	0.0	24.9	101%	75%	-	-	100%	76%	-	-
OAK	3.7	4.2	0.0	0.3	0.0	0.0	8.2	81%	104%	-	32%	71%	95%	-	-
CEDAR	10.6	11.3	0.0	0.0	0.0	0.0	21.8	86%	159%	-	-	103%	143%	-	-
MAPLE	3.1	2.2	0.2	0.1	0.0	0.0	5.6	85%	138%	30%	20%	87%	90%	-	-
ROWAN	4.4	3.2	0.0	0.0	0.0	0.0	7.6	62%	96%	-	-	68%	90%	-	-

Board of Directors (in Public)
Item 2.4a*

Subject: **LHCH Monthly Staffing for Reporting Period for October 2021**
Date of meeting: **Tuesday 30th November 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	No impact

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

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2. Background

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

The National Quality Board (NQB) publication Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable, and productive staffing

(2016) outlines the expectations and framework within which decisions on safe and sustainable staffing should be made to support the delivery of safe, effective, caring, responsive and well-led care on a sustainable basis. It builds on National Institute for Health and Care Excellence (NICE) guidelines on safe staffing for nursing in adult inpatient wards and is informed by NICE's comprehensive evidence reviews of research, and subsequent evidence reviews focusing specifically on staffing levels and outcomes, flexible staffing, and shift work.

The purpose of this report is to provide detail of the care hours per patient day (CHPPD) delivered to inpatient areas in LHCH. It will also detail, exceptions to planned staffing levels for the month of October 2021 and the impact on nurse sensitive indicators.
This report details planned and actual nurse staffing levels for the month of October2021, including any red flag concerns.

3. Information

3.1. Vacancy Data

All RN vacancies across the Trust are reviewed regularly by the Director of Nursing with the senior nursing team. A new recruitment lead within HR has been appointed 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. There are currently 40.85 band 5 RN vacancies and 59 band 5 candidates at varying stages of the recruitment process with a further 42 students who qualify in 2022

Table 1-Vacancy data October 2021 (all bands)

	SEPTEMBER	
Unit	**RN**	**HCA**
Acute Cardiac Unit	11.22	-0.72
Birch Ward	10.77	0.74
Cath Lab	0.81	0
Cedar Ward	5.28	0.05
Cherry Ward	1.9	0.2
Holly Suite	5.03	0
Maple Suite	3.95	0.2
Oak Ward	3.94	0.15
Outpatients	0.69	0
Rowan Suite	3.77	-0.61
SICU Clinical Roster	14.63	3.43
Theatres	11.7	0.05
Grand Total	**77.18**	**3.49**

The first two cohorts of international RNs (17) have successfully completed their OSCE training and all 17 passed the OSCE exam and are now registered with the NMC. These staff have been moved into band 5 positions, but this is not reflected in the end of month vacancy figures in table 1. Further cohorts have arrived during October 2021 through both the Pan-Mersey collaborative and the Cheshire International Recruitment Collaborative (CIRC), and these nurses are currently undergoing their OSCE training.

Considering the current rate of band 5 turnover and the information regarding recruitment challenges nationally, a proposal for further international recruitment to take place in 2022 has been developed. The Trust is also beginning to model the potential impact of mandatory covid

vaccination for all patient facing staff with the risk of further vacancies across clinical areas as a result.

The recruitment team continue to work to process all successful candidates from recent recruitment events and are in the process of planning events for 2022, including engagement with local universities and current students within the Trust.

3.2 Sickness Absence

During October 2021, clinical areas continue to experience sickness absence, and this is detailed in the table below.

Table 2- sickness absence data

	OCTOBER 2021	
Unit	**RN WTE**	**HCA WTE**
Acute Cardiac Unit	**3.67**	4.15
Birch Ward	**1.25**	1.92
Cath Lab	**4.08**	0.21
Cedar Ward	**1.63**	5.93
Cherry Ward	**0.57**	0.62
Holly Suite	**1.13**	0.42
Maple Suite	**0.00**	0.79
Oak Ward	**0.55**	2.50
Outpatients		0.97
Rowan Suite	**0.30**	1.29
SICU Clinical Roster	**12.02**	1.70
Theatres	**6.01**	1.48
Total WTE Unavailable	**31.21**	**21.98**

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. The Trust continues to support covid close contact staff back into work, following a risk assessment and regular testing, although a number of staff have tested covid positive and have been required to isolate, impacting upon staffing levels.

3.3. Temporary Staffing

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

3.4. Exceptions

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

- There were no red flags on Cedar, Rowan, and Maple wards. There were 2 staffing related incident reports for Maple during this period. There were no patient safety incidents reported during these shifts and these were due to short notice sickness impacting on the support and cross-cover from Cherry ward. These were escalated appropriately at the time.

- Oak ward reported 1 red flag shift in October. No patient safety incidents or harm were reported, however there was a report that some patient medications were delayed. Advanced Nurse Practitioner support was present on the ward.
- There were no red flags reported on ACU, Birch and Cherry wards in October 2021 and no staffing related incidents were reported via the datix system for these areas.
- Acute Cardiac Unit (ACU has a reducing number of RN vacancies, with several staff 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 (CCU) and working through a staffing plan to enable an increase in beds opened across the 2 areas.
- There is a current pressure within the anaesthetic nursing/ OPD team across both Cath lab and theatres which is being managed utilising temporary staffing, ensuring cross-divisional flexibility and with a longer-term plan to merge the 2 teams being implemented following approval at operational board.

4. Summary

This continues to be a particularly challenging period for all staff working with reduced staffing levels at times. The Trust has experienced an increase in staff absence during the covid pandemic which has contributed to increased staffing pressures, experienced across the NHS. As reported by the Institute for Public Policy Research (IPPR, 2021) 29% of nurses and midwives report that they are more likely to leave the sector than 1 year ago, and as such retention of current staff and recruitment of future staff remains a Trust priority.
Recent national press coverage has highlighted a national nursing 'crisis', impacted particularly by a significant reduction in recruitment from Europe. LHCH is experiencing significant nurse staffing challenges but has taken robust action to avert a staffing crisis. A successful international recruitment programme is hoped to stabilise the staffing position across the clinical areas. T

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, in accordance with covid recovery and escalation plans.
- Receive assurance that a robust recruitment plan continues, including an extended overseas recruitment plan.
- Receive assurance that revised models of nursing care, utilising Registered Nursing Associates and apprentices continue to be implemented.
- Receive assurance that alternative temporary staffing options are being explored.

- Receive assurance that staffing escalation plans are in place to be enacted when significant staffing pressures are seen during the covid pandemic.

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

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

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

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

CHPPD for October 2021

	Cumulative count over the month of patients at 23:59 each day	Care Hours Per Patient Day (CHPPD)							Day				Night			
		Registered Nurses/Midwives	Non-registered Nurses/Midwives	Registered Nursing Associates	Non-registered Nursing Associates	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nursing Associates (%)	Average fill rate - Non-Registered Nursing Associates (%)
TOTAL	**4183**	**8.8**	**3.5**	**0.0**	**0.3**	**0.0**	**0.0**	**12.6**	**90%**	**96%**	**26%**	**84%**	**93%**	**89%**	-	-
BIRCH	717	3.7	3.0	0.1	0.4	0.0	0.0	7.2	76%	102%	26%	116%	100%	87%	-	-
ACU	609	9.1	3.2	0.0	0.2	0.0	0.0	12.4	91%	93%	-	-	92%	74%	-	-
CHERRY	221	5.5	3.1	0.0	0.0	0.0	0.0	8.7	90%	84%	-	-	68%	103%	-	-
CRITICAL CARE	756	26.0	3.7	0.0	0.0	0.0	0.0	29.7	99%	94%	-	-	100%	80%	-	-
OAK	462	3.9	4.3	0.0	1.1	0.0	0.0	9.2	78%	101%	-	79%	78%	103%	-	-
CEDAR	901	4.4	4.1	0.0	0.4	0.0	0.0	8.9	80%	98%	-	26%	80%	101%	-	-
MAPLE	338	4.0	1.4	0.0	0.0	0.0	0.0	5.4	85%	48%	-	-	97%	87%	-	-
ROWAN	179	3.8	3.9	0.0	0.0	0.0	0.0	7.8	52%	133%	-	-	65%	87%	-	-

Board of Directors (in Public)
Item 2.5*

Subject: **Deprivation of Liberty Safeguards (DoLS) Update for Q2 21/22**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by: **Terri Marshall, Safeguarding/Risk Management Co-Ordinator**
Presented by: **Sue Pemberton, Director of Nursing, Quality & Safety**
Purpose of Report: To Note

BAF Reference	Impact on BAF
BAF 1	Assurance regarding application of Deprivation of Liberty Standards

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

1. Executive Summary

The purpose of this paper is to update the Board of Directors on the number of applications made for Quarter 2 – 2021/22 in relation to the Deprivation of Liberty Safeguards (DoLS).

2. Background

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

3. Current Position

MCA Assessments and DoLS Applications – Q2 (2021/22)

For Q2 a total of 51 Deprivation of Liberty Applications have been received by the Safeguarding Team for 12 different local authorities across the catchment area. This is a 10% increase in applications received since the previous quarter.

Of the total 51 applications received by the team, all were standard and urgent applications.

- 6 urgent applications were issued, and the standards were not required as the patients were discharged/transferred within the 14-day urgent period.
- In 2 cases an urgent and standard were requested but no decision was given by the local authority. The urgent application expired but the patient continued to be treated within best interests.
- In 43 cases, the applications were reviewed, and the patients were assessed by the safeguarding team, but the applications were not sent. This was due to a number of reasons, either the patients confusion had settled, the patient passed away, the patient met the criteria for a critical care patient and were to be managed under the best interests principle and would be reviewed again once they were ready to be transferred to the ward or the patient was transferred or discharged.

MCA and DoLS Mandatory training is currently at 94.8% across the trust.

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

4. Recommendations

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

Board of Directors (in Public)
Item 2.6*

Subject: **Guardian of Safe Working Q2 Report 21/22**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by: **Laura Brittles, HR Business Partner**
Presented by: **Dr Raphael Perry, Medical Director**
Purpose of Report: To Note

BAF Reference	Impact on BAF
BAF 6	Trust compliant with exception reporting. No change to risk rating. Potential financial risk and risk of losing junior posts if not compliant

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

1. Executive Summary

This is the 21/22 Q2 report on safe working hours following introduction of the 2016 contract for Junior Doctors.

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

2. Background

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

Number of Doctors / Dentists in training (total):	54
Number of Doctors / Dentists in training on 2016 TCS (total):	54
Amount of time available in job plan for guardian to do the role:	0.25 PAs
Admin support provided to the guardian (if any):	To be reviewed
Amount of job-planned time for Educational Supervisors:	0.25 PAs per trainee

3. Update

a) Exception Reports (with regard to working hours)

There have been no exception reports in Q2. Only one exception has been received since August 2016.

b) Issues Arising

- Current gaps in Tier One rota for both Surgery and Cardiology are causing problems with on call cover.
- A WAST Doctor's start date was delayed due to illness. OH report recommended phased return and reasonable adjustments.
- There is currently a long list for car parking permits.
- A Trust Doctor on Tier One is due to leave before the end of their contract.

c) Actions Taken

- Weekly reminders are sent every Monday morning to key stakeholders, including ICU, Anaesthetics, Cardiology, of any gaps in the rota for the upcoming 3 weeks to allow time to cover.
- When gaps arise, an email is sent to all Doctors to ask for support, either as a swap or paid time.
- We are piloting a text message service as an additional function to request covering gaps.
- New starters are allocated empty slots to bridge gaps and to ensure all shifts are covered.
- The WAST Doctor should be back to full capacity within the next 3 weeks.
- A car parking waiting list process is currently in place. Doctors will need to pay for their tickets initially, however, can then claim the funds back via the general office.
- Recruitment process about to commence for two new Tier One Doctors.

4. Junior Doctor Forum

The last forum was scheduled for October 2021 however, it was delayed due to annual leave and other commitments. The JDF has been re-scheduled for 25th November.

5. GSW Annual Meeting

Dr Holemans will be attending the 2021 GSW Annual conference organised by NHS employers on 9th December

6. Recommendations

The Board of Directors are asked to note the report.

Board of Directors (in Public)
Item 3.1

Subject: **Green Plan Update 2021**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by: **Tom White, Interim Sustainability Lead**
Presented by: **Jonathan Develing, Director of Strategic Partnerships & Green Executive Lead**
Purpose of Report: **To Note**

BAF Ref	Impact on BAF
BAF 9	Demonstration of Progress in the delivery of the Trust Green Plan

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

1. Executive Summary

The purpose of this report is to review Liverpool Heart and Chest Hospital's (LHCH) approach to sustainability – as agreed in the March 2020 Green Plan - and produce appropriate recommendations to further our Green Ambition.

In summary this report demonstrates progress made against the Trusts Green Plan and savings, environmental and financial, that have been realised through our October Green Month Initiative.

Environmental Savings

- 1,073,217 kg CO2e is being saved from being released into the atmosphere every year, the equivalent of powering 1,233 homes for a whole year.[1]

[1] Average Electricity Usage in the UK: How Many kWh Does Your Home Use? | OVO Energy KWH-to- CO2 (rensmart.com)

Financial Savings

- LHCH is saving £163,710 per annum due to the range of sustainability initiatives outlined in this paper.

2. Background

In October 2020 the NHS Chief Executive said "…as the largest employer in Britain, responsible for around 4% of the nation's carbon emissions, if this country is to succeed in its overarching climate goals the NHS has to be a major part of the solution. It is for this reason that we are committing to tackle climate change by reducing our emissions to 'net zero'. In doing so, our aim is to be the world's first 'net zero' national health service."[2] Two clear and feasible targets are outlined in the Delivering a 'Net Zero' National Health Service report:

- The NHS Carbon Footprint: for the emissions we control directly, net zero by 2040
- The NHS Carbon Footprint Plus: for the emissions we can influence, net zero by 2045.

In March 2020, the LHCH Board agreed to a Sustainable Development Management Plan (Green Plan). Since that date initiatives have been brought forward but not coordinated and captured in a systematic way.

At the request of the Director of Strategic Partnerships, a Graduate Management Trainee was recruited for a short-term flexible placement as a Sustainability Lead, with three clear objectives:

- Produce an initiative repository which documents the green, sustainable projects the Trust has undertaken following the approval of the March 2020 Green Plan and calculate their cost and environmental impacts.
- Review and refresh the Trust's Green Plan.
- Run a 'Green Awareness Month' in October to coincide with the Conference of the Parties (COP26) and the anniversary of the NHS' pledge to net-zero (October, 2020).

3. Context

The March 2020 Green Plan had several objectives which can be summarised as follows:

- reducing energy costs
- improving waste management and recycling
- sustainable procurement
- active and efficient travel
- developing links within the community and other NHS organisations.

These provided the structure for the October 2021 Green review, recognising that some of these activities are direct interventions – that is, within the scope of the Trust and some indirect interventions – that being external interventions such as reduced travel arising from the Trust approach to agile working.

[2] https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf
Delivering a 'Net Zero' National Health Service. delivering-a-net-zero-national-health-service.pdf (england.nhs.uk). 2020.

3.1 October Green Awareness Month

In October 2021, we facilitated a Green awareness month.

The purpose was to celebrate the sustainability initiatives that LHCH have undertaken in the last two years, discuss the NHS' role in climate change, and highlight our responsibilities in achieving the NHS' net-zero ambition.

It consisted of daily communications on different topics, incorporating LHCH's green projects as well as key climate dates, such as, but not limited to: The UN Biodiversity Conference, Conference of Parties (COP26), World Mental Health Day and the International Day of Climate Action.

In summary the following initiatives took place during October 2021:

- The hospital was lit Green.
- Two webinars took place on Electric Vehicles and the Cycle to Work scheme, facilitated by our salary-sacrifice partners: NHS Fleet Solutions and Cyclescheme. We had over 50 viewers across the two events, demonstrating LHCH's passion for sustainability.
- To increase biodiversity, staff members volunteered to plant wildflowers and install bird boxes during their lunch break (pictured below). The ambition is to create a 'Green Space' for patients and staff to enjoy, sit and reflect.
- A pod cast was also presented through 'Heart and Chest Matters' so as to align with the COP 26 and the anniversary of the NHS' 'One Year On' NHS net-zero pledge.
- A sustainability initiative competition was held, where staff were encouraged to submit sustainability ideas. The best idea was selected by a panel and the winner was awarded an electric bike (donated through our associated charity). 49 submissions, containing nearly 70 ideas from 31 different areas across the Trust were received. The winning idea challenged the Trust to swap metered-dose inhalers to dry-powder inhalers which have a lower carbon footprint.
- The Trust registered for the Queens Green Canopy (Tree planting initiatives celebrating Her Majesty the Queens Platinum jubilee in 2022). This will result in 20 new trees and shrubs being planted on the LHCH site, with tree varieties being aligned to the respective names of each of our clinical/ward areas. (Elm, Birch, Maple, Rowan, Cherry etc.)
- A recurrent emergent theme from staff was the subject of recycling and waste segregation initiatives. Currently, our waste is recycled off-site by Veoila, however only 11% is graded as appropriate to be recycled.
- Successful applications for Grants have been realised through the Low Carbon Skills Fund (£30k) and Salix (£57k) which have funded projects such as reviewing heat decarbonisation with theatres and plant rooms.

<u>Specific Green Initiatives</u>

Energy

• Low level energy lighting.

- The replacement of LED lighting has been ongoing, and LEDs are included in the development of any new building program, such as the catheter labs. However, there

are still areas using older lighting that should be considered as part of the Trust's capital plan.

• Reduction in energy usage.

- Passive infrared sensors (PIR) light sensors have been installed in office areas to reduce energy use, automatically switching lights off unless motion is detected. These sensors will soon be expanded to the theatre air-filtration systems, which currently run 24 hours a day. This is expected to yield a significant reduction in energy use.
- Personal accountability - all laptop, desktop and personal computer screens are fitted with protocols to power down to standby mode when not in use.
- Energy alternatives. Exploration of alternative power sources (solar and wind) required a bespoke survey as this is an area of intent that is highly specialised. This was included within the Six Facet Surveys (property appraisal).
- The installation of smart meters to better understand, monitor and reduce energy consumptions and costs does not currently feature in capital plans due to the prioritisation process. Whilst there is a potential long-term return on investment the capital cost of installation is circa £44k inclusive of VAT. This is an important monitoring tool, as it is not currently possible to monitor the geographical use of our energy, and thereby target areas to improve efficiency. This should be considered as a priority for future capital programmes.

  LHCH achieved energy efficiency savings of 804,099 kWh when compared to the 2018/19 period. Based on a price of £0.12p per kWh, this resulted in a cost-saving of £96,491 and prevented 187,468kg CO2e from being released into the atmosphere.

• Reduction in gas usage.

- Improvement to building management systems, installation of new boilers, smart system upgrades and a replacement protocol boiler system (heat-synchronisers).
- This work was partly supported by £30k from the Low Carbon Skills Fund to support the development of a Heat Decarbonisation Plan.

- **LHCH achieved efficiencies resulting in a 765,909 kWh savings when compared to the 2018/19 period. Based on a price of £0.12p per kWh, this resulted in a cost-saving of £91,909 and prevented 178,564kg CO2e from being released into the atmosphere.**

<u>Recycle</u> – [indirect emissions]

• New waste systems.

- The introduction of Clinismart a waste segregation system includes specifically designed procedures, education tools and products to ensure optimisation of waste disposal processes at point of care. This provides cost effective, compliant, and safe management of healthcare waste whilst contributing to a cleaner patient environment. Typical results following installation of the Clinismart system would provide 50-80% reduction in clinical waste volumes and between 20-30% reduction in waste management costs. This will be implemented at the end of October.

• Recycling initiatives.

- Reduction in single use plastic items. Known as the `Steady cycle` initiative the use of single use items has increased during the covid-19 period because of the demand

for personal protective equipment (PPE). Data provided by the Broadgreen Sustainability team indicates that only 11% of our waste is recycled by Veolia, with 89% being incinerated to produce energy.

- Whilst there will be a benefit of incineration to produce energy, quantifying this for LHCH within a wider agreement of waste provider across site has not been feasible at the time of this report. There is a widespread appetite to introduce recycling bins in all areas, this option should be explored with a cost and environmental appraisal.

• Waste Reduction.

- Intent to undertake an audit following the disposal of waste on and off site so providing assurances that recycling off site is fully complaint with standards.

- **LCHC achieved efficiencies when compared to 2019/20, of £22,708 saving in waste costs. However, with increased use of PPE and other single use plastics during Covid there have been an additional 1,995kg CO2e per annum.**

• Re-usable gowns

- From 1st April 2021 (following a successful trial) LHCH operating theatres signed a deal with Elis to provide re-usable gowns. This has reduced Trust clinical waste by approximately 8 tonnes a year. The Catheter labs intend to follow this pilot.

- **This has resulted in total savings of £22,200 and 23,520kg CO2e per annum.**

• Intranet Based eBay system

- The WARP IT pilot, a system by which surplus items can be sold to staff rather than put into landfill has been implemented but has not yet reached its full potential.

Procurement – [Direct emissions]

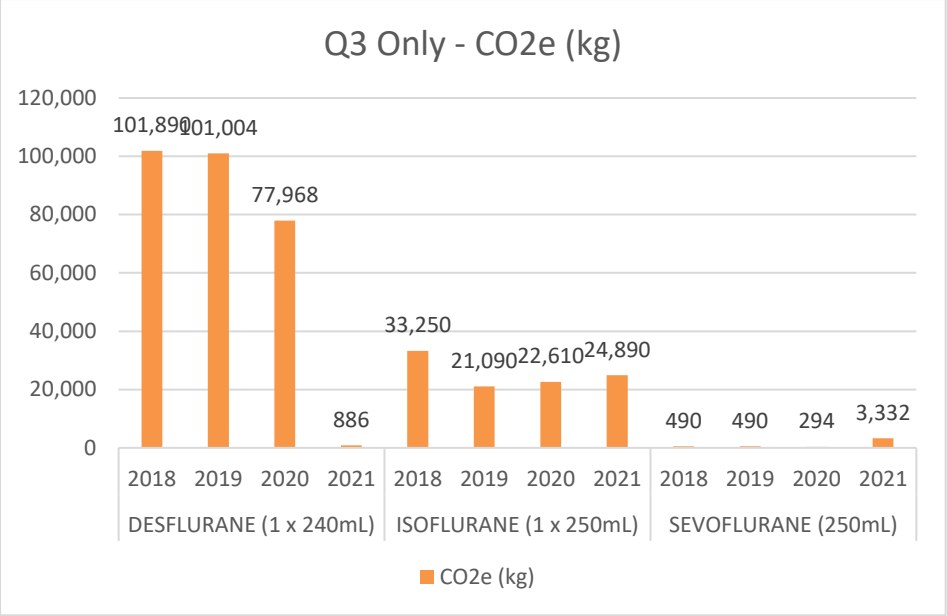
• Approvals and Procurement

- Specialised provider alliance. Harmonisation of approach across the four specialist providers to ensure that Green policies are developed as the first principle of procurement. This will evolve policy and approach in sourcing goods locally, which will reduce LHCH's carbon footprint and support the local economy.

• Anaesthetic gases – Desflurane

- The Anaesthetic team recently removed Desflurane vaporisers from use in June 2021. This has resulted in a significant impact and accounts for a quarter of our success to date. In Q3 alone, this has saved 71,764kg CO2e.

- **The projected per annum saving is 287,056kg CO2e and an estimated recurring cost-saving of *at least* £17,283.**



Travel – [indirect emissions]

It is worth noting as background that approximately 3.5% (9.5 billion miles) of all road travel in England relates to patients, visitors, staff, and suppliers to the NHS, contributing around 14% of the system's total emissions.[3] This includes approximately 4% for business travel and fleet transport, 5% for patient travel, 4% for staff commutes and 1% for visitor travel.

• Agile working

- Staff survey indicated opportunities for more agile working, thereby reducing the overall carbon footprint of the Trust. Cycle work to work policies have been updated following the latest guidance. New walking routes across the trust planned as part of a charitable funds application. Overall, Agile working policies have resulted in a significant decrease in staff commuting miles.

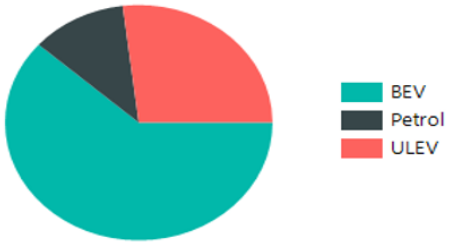
- **On average, 1,185,018.9 commuting miles are saved per year, resulting in a 367,360kg CO2e reduction per annum.**

• Electric Vehicle Charging Stations

- Ten new electric vehicle (EV) charging stations were installed this year which supports staff, encourages sustainable travel, and generates income. 62% of staff that have outstanding orders with the salary sacrifice scheme have selected EV cars, with 13% opting for hybrids, for a total of 75% of staff choosing a battery powered or supported vehicle (below). This demonstrates that there is an increasing trend towards battery-powered vehicles.

[3] NHS Sustainable Development Unit. *Reducing the use of natural resources in health and social care*. 2018.

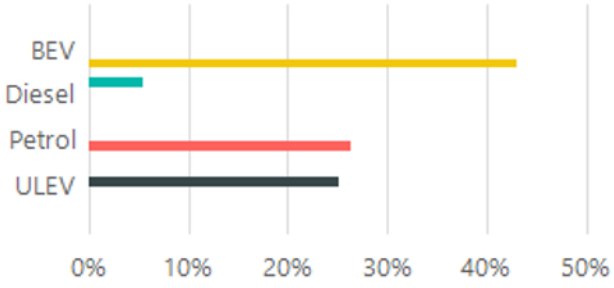
Vehicles On Order		
Battery Electric Vehicle	16	62%
Petrol	3	12%
Ultra Low Emission Vehicle (ULEV)	7	27%
Total	**26**	



- Based on the period July to September and extrapolated, the Trust can expect a **recurring income of *at least* £3,278 with 23,244kg CO2e saved per annum** (when compared to combustion engines).
- There is a willingness to expand electric-vehicle parking to other areas on-site.
- The Trust will review tariffs for EV charging on a regular basis to track current energy prices and ensure competitive rates for staff.
- The Trust recently hosted a webinar, run by our provider NHS Fleet Solutions to discuss the benefits of the salary sacrifice scheme, as well as to discuss the advantages of battery-powered vehicles.
- The table below shows the breakdown of staff who have engaged with the salary sacrifice scheme, which constitutes 10% of all staff (163). Combining battery electric vehicle and ultra-low emission vehicles, 68% of staff on the scheme chose an electrically powered (or supported) vehicle. Considering the table above which shows current orders, of which 89% of staff chose an electric or hybrid, there is a general trend towards battery-powered vehicles amongst LHCH staff. This should be considered when reviewing the amount of electric charging stations available to staff.

Figure 10:

All Orders Fuel Type		
Battery Electric Vehicle (BEV)	70	43%
Diesel	9	6%
Petrol	43	26%
Ultra Low Emission Vehicle (ULEV)	41	25%
Total	**163**	



<u>Go Green – Corporate and Culture</u> – [indirect emissions]

All aspects including community engagement, veteran's covenant, championing personal accountability opportunity and awareness raising will be taken into consideration within the People Strategy.

The Trust is currently applying for the Social Value Award (Social Value Business), with the long-term aim of developing LHCH into an anchor institution.

<u>Green Space</u>

- The last 18 months have demonstrated the importance of being out, and exercising in, nature. Research has shown that being in nature can reduce stress levels, boost our mood, as well as be beneficial for our social relationships. The evidence is so strong that spending time in nature can be medically prescribed for its wellbeing

benefits, and science continues to try to understand what it might do for our physical health.[4]

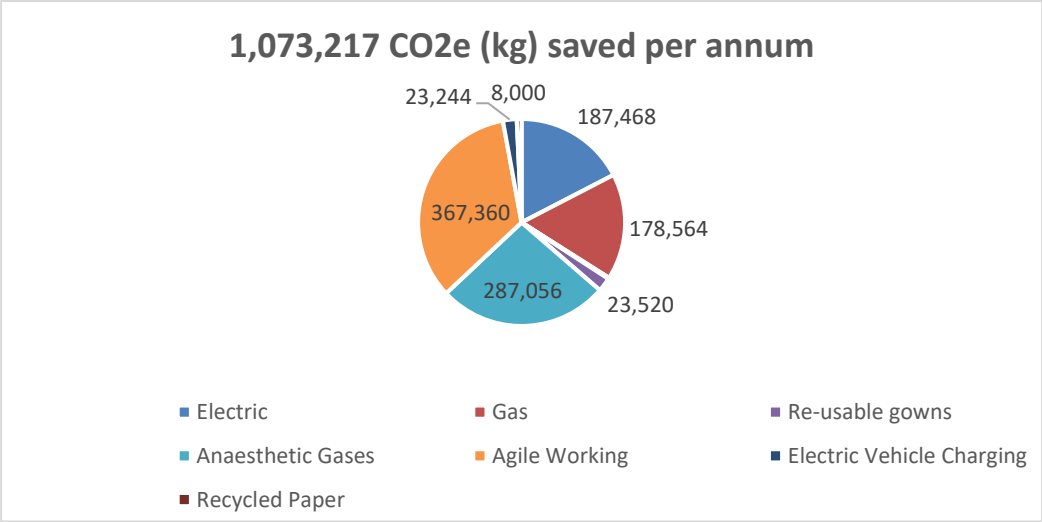
- The Trust is creating a 'Green Space' for staff by planting up to twenty new trees and shrubs, three wildflower patches and installing four bird boxes to increase biodiversity and create a wellbeing centre for staff to enjoy.

- The trees will be a part of the NHS Forest Project (Welcome | NHS Forest) and the Queen's Green Canopy initiative (The Queen's Green Canopy (queensgreencanopy.org)). The species have been selected to coincide with the names of our clinical areas. The carbon offset of these new trees, and how it benefits the local air pollution, are yet to be explored.

4. Conclusion

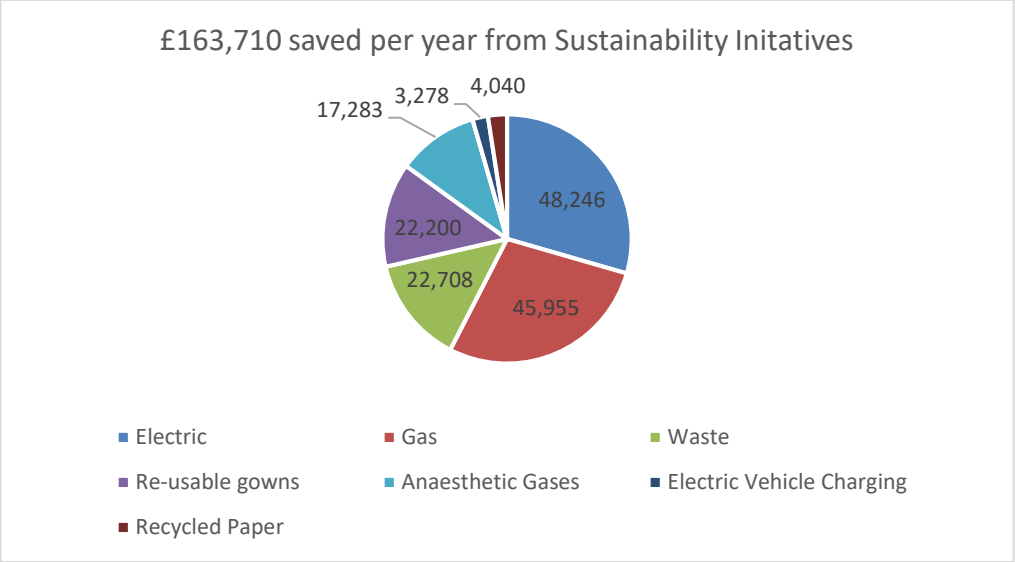
- **LHCH is saving £163,710 per year when compared to 2018** due to the range of sustainable initiatives outlined in the review.

- **LCHCH is saving 1,073,217 kg CO2e** from being released into the atmosphere. If converted back into electricity, that could power **1,233 homes for a whole year.**[5]



[4] Visiting green space is associated with mental health and vitality: A cross-sectional study in four European cities. Visiting green space is associated with mental health and vitality: A cross-sectional study in four european cities - ScienceDirect, 2016.

[5] Average Electricity Usage in the UK: How Many kWh Does Your Home Use? | OVO Energy KWH-to- CO2 (rensmart.com)



5. Recommendations

As we aspire to improve population health and become an anchor institution the Trust will continue to accelerate our Green plan. For information, Appendix 1 provides a summary of further ambitions and opportunities for further consideration.

The Board of Directors are asked to note the progress and success of the Green Plan review and October awareness raising initiative during October 2021.

Appendix 1

Energy – [direct emissions]

- Additional low energy lighting rollout to older areas of the estate, PIR sensors installed in all areas (including in the theatre air-filtration systems)
- Installation of SMART meterage across the full site circa £44k
- Reduction of site footprint – improved cycling facilities and showers to encourage active commuting, continuing virtual outpatient follow-ups and cementing agile working practices wherever appropriate
- Continued improvement to building management systems
- Green energy procurement (100% of energy used would be from a renewable source)
- Personal accountabilities – turning off equipment at source, estimated to save £0.7p per device, per night.
- Energy alternatives – solar and wind survey bespoke site survey of alternative power usage. If not included within the six-facet site survey, then it would cost circa £5k.
- Further utilisation of the Salix Public Sector De-Carbonisation scheme.

Recycle & Waste – [indirect emissions]

Waste takes many forms across, and it is an aspect that most staff seem to focus and anchor onto. LHCH has enthusiastic and willing staff, but the infrastructure does not support their ideals. During Green Awareness month, recycling was the most common idea cited in the sustainability competition, with 21 submissions asking for recycling or better waste segregation. It is clearly an area that staff are passionate about and requires further examination.

- Single use plastics – requires investigation to determine what must be single-use and what could be recycled. Procurement should then seek reusable items where possible
- Recycling bins – currently Veoila recycles 11% of waste and incinerates 89% to create green energy. Broadgreen have recently changed contracts to a new provider. This should be followed-up and a lifecycle of our waste should be recorded and audited. If the new provider does not recycle in sufficient quantities, then LHCH should work with Broadgreen to procure a new, sustainable provider. Installing recycling bins in all areas should be considered as a viable and visible waste strategy, but this is only feasible if a provider is willing to collect recyclable material. I recommend that a full waste review be conducted and shared with staff, to alleviate their concerns and investigate the most appropriate, effective green waste solutions.
- Recycling of Medical Devices – the same investigation could examine which devices could be washed, cleaned, and reused. The water and energy cost of this process should be assessed against the potential benefits.
- Anaesthetic Gases – continue to utilise sevoflurane instead of desflurane and isoflurane. No recommendations necessary.
- Recycled Paper – from the 1st November, 2021, the Trust will move to only procuring recycled paper. This is projected to save £4,040 recurrently and 8,000kg CO2e. This has been included in the overall calculations provided in the conclusion.

Procurement – [indirect emissions]

Procurement is one of the biggest influences on how the NHS produces carbon, and it needs to be embedded across the whole of the hospital.

- An Environmental Impact Assessment akin to an Equality Impact Assessment should be a priority for every procurement decision. This must be done as part of changes to services / major projects.
- The new Specialist Provider Alliance joint-procurement team should demand sustainable methods of production and supply, for example for reduction in plastics, to reduction in vehicle emissions for delivery, to sourcing sustainable and environmentally friendly components. There is also further opportunity to explore a medium-term joint vision

Travel – [indirect emissions]

An LHCH Travel Plan should be devised that seeks to reduce the health and environmental impact of fossil-fuelled vehicles to-and-from LHCH by providing better alternatives, incentives to reduce car travel and a switch to greener, cleaner, and healthier forms of transport.

The main benefits that can be expected from an associated Travel Plan are:

- Help make LHCH an environmentally responsible institution
- Deliver on sustainability commitments by reducing CO2 emissions
- Deliver health benefits to staff, children, young people, families, and visitors, through an increase in exercise and reduced conflicts between traffic and pedestrians.

The objectives of the Green Travel Plan should be:

- Increase the level of walking, cycling and public transport use to our sites.
- Reduce the Trust's environmental impact and the impact upon the local community by encouraging alternatives to driving alone.
- Promote electric and hybrid vehicles including an expansion of electric-vehicle parking on-site.
- Encourage staff to lead a healthy lifestyle by promoting active travel modes such as walking and cycling.
- Offer an improved choice of travel options to all patients, staff, and visitors.

In implementing this plan, LHCH need to not only concentrate on the hospital and associated buildings, but also other sites outside of the immediate main footprint. Everywhere that LHCH staff are required to travel to work to should be considered for its implications on its contribution to becoming net zero.

Additionally, there is a wider opportunity to collaborate with local NHS partners, e.g., from the Broadgreen and Alder-Hey sites, to develop a vision for travel for the whole area, that improves access to the local rail station, public transport services, walking and cycling routes in a fundamental way. This should be a medium-term view of what travel and the environment could look like that fundamentally challenges assumptions and practices around car usage, in favour of delivering a green alternative that changes the space we work and commute in permanently and radically.

Resources

There needs to be a clear shared programme for LHCH to follow with a regular steering group led by a Sustainability Lead. It should be noted that there are funds and grants available to NHS organisations that could support this work. LHCH has been successful in two grants funded by the Low Carbon Skills Fund and Salix's Public Sector Decarbonisation Scheme (Public Sector Decarbonisation Scheme [now Phase 1] | Salix Finance). The £30k

from the Low Carbon Skills Fund was used to support the development of a Heat Decarbonisation Plan in 2020, and £57k from the Public Sector Scheme is being used to conduct a full energy survey in 2021.

This paper has outlined the potential savings and environmental impact of accelerating the Green Plan. To achieve this, we will explore a specific role dedicated to pursuing sustainability initiatives that focuses on project management, administrative support, and acquiring funds and grants to support workstreams.

Crucially, the Sustainability Manager would benchmark the Trust's carbon footprint. This is important so that all future improvements can be assessed against that baseline. This would allow the Trust to create a long-term map to net-zero carbon emissions. Completing this project internally will save on external professional fees.

Useful Reading:

1. NHS England and NHS Improvement. Greener NHS campaign to tackle climate 'health emergency'. 2020.
2. Delivering a 'Net Zero' National Health Service. delivering-a-net-zero-national-health-service.pdf (england.nhs.uk). 2020.
3. NHS Net Carbon plan https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/
4. Royal College of Physicians. *Breaking the fever: Sustainability and climate change in the NHS*. 2017.
5. NHS England. *The NHS Long Term Plan*. 2019.
6. NHS Sustainable Development Unit. *Reducing the use of natural resources in health and social care*. 2018.
7. NHS Sustainable Development Unit. *Workforce insights study*. 2018.
8. NHS England and NHS Improvement. *We are the NHS: People Plan for 2020/2021 – action for us all*. 2020.
9. Defra. *UK's carbon footprint*. 2020.
10. Department for Transport. *National Travel Survey*. 2020.
11. A4S Chief Financial Officer Leadership Network. *CAPEX: A practical guide to embedding sustainability into capital investment appraisa*l.
12. https://www.mycarbonplan.org/post/uk-carbon-offset-providers-and-schemes
13. https://www.iucn-uk-peatlandprogramme.org/funding-finance/introduction-peatland-code
14. https://www.woodlandtrust.org.uk/partnerships/how-our-partnerships-work/
15. https://environmentagency.blog.gov.uk/2021/05/10/carbon-offsetting-reviewing-the-evidence/

Board of Directors (in Public)
Item 3.2

Subject: **Strategic Objectives Update**
Date of meeting: **Tuesday 30th November 2021**
Prepared by: **Jonathan Develing, Director of Strategic Partnerships**
Presented by: **Jonathan Develing, Director of Strategic Partnerships**
Purpose of Report: **For Approval**

BAF Ref	Impact on BAF
ALL	A review of Strategic Objectives has been undertaken so to ensure that the Strategic Goals as described within the Trust overall strategy Patients Partnerships and Populations is aligned to the White Paper, ICS Design Framework, ICS Strategy and the development of Place Based Systems.

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

1. Executive Summary

This paper proposes a refresh of the Trust Strategic Objectives as described within Patients, Partnerships and Populations.

2. Background

The publication of the White Paper `Integration and Innovation`, development of Integrated Care Boards and Partnerships, Provider Collaboratives, Place Based Partnerships and the abolition of Clinical Commissioning Groups are all features in a newly designed Integrated Care System.

Other features including, system control totals, duties to collaborate and a focus on prevention and improving health equality will place new responsibilities upon NHS Trusts at a time when Providers are making progress against recovery targets and clearing backlog from the impact of the COVID pandemic.

These influences, improvements and innovations will impact on the delivery of the Trusts strategic objectives which have been refreshed to take account of this new landscape.

The Six Key Strategic Goals within Patients, Partnerships and Populations remain our overall intent with new objectives refined to reflect new circumstance.

3. Strategic Goals (High Level Ambitions)

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

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

Strategic Goal 1 Delivering World Class Care

Original Objectives

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

Proposed objectives

- Implementation of quality and safety strategy
- Development of a Research and Clinical Strategy for the Trust
- Develop World Class Facilitate
- Deliver Operational Excellence

Strategic Goal 2 Advancing Quality and Innovation

Original Objectives

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

Proposed objectives

- Develop Trust academic expertise
- Develop a recognised learning and academic facility (The LHCH Institute
- Deliver the digital strategy
- Engage with Provider Collaboratives

Strategic Goal 3 Increasing Value

Original Objectives

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

Proposed objectives

- Finance Strategy
- Develop capacity for Program and Quality Improvement
- Utilise benchmarking and performance data to drive quality, productivity, efficiency and improvement
- Implementation of the Green Strategy

Strategic Goal 4 Developing People

Original Objective

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

Proposed objectives

- Recruitment and Retention Strategy
- Education and OD Strategy
- Equality, Diversity, Inclusion & Belonging Strategy

Strategic Goal 5 Leading Through Collaboration

Original Objectives

- Lead the Cardiovascular Disease programme, and deliver the NHS Long Term Plan and CVD Ambitions for Cheshire and Merseyside
- Become a proactive and collaborative partner of choice
- Work collaboratively to develop integrated cardiac, stroke and respiratory services.
- Offer mutual aid to partners to support whole system resilience (critical care/diagnostics/winter pressures).
- Explore new relationships with Public Health, industry and academia

Proposed Objective

- Lead Cardiac Board and CVD Prevention Group
- Take a leadership role within the new ICS and provider collaborative
- Develop a Strategy for Innovation
- Take leadership role in clinical Networks
- Explore new relationships with Public Health, industry and academic

Strategic Goal 6 Improving Our Population Health

Original Objective

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

Proposed Objective

- Develop an approach for health inequalities
- Support improved primary and secondary prevention and detection of cardiac and respiratory disease. (Lead, Orchestrate Deliver approach)
- Develop ourselves as an Anchor Institution

Each Objective will have a named Director who will bring forward specific delivery targets akin to operational delivery. This will ensure alignment of Strategic Goals, Strategic and Personal Objectives and delivery objectives for respective divisions within the Trust.

Delivery targets will be developed by respective Directors and informed by enabling strategies in place as well as trajectories and targets outlined within the Planning Guidance and Constitutional standards.

For Audit Purposes the attached Appendices outline each Strategic Goal and that proposed together we examples of measurable deliverable improvement targets.

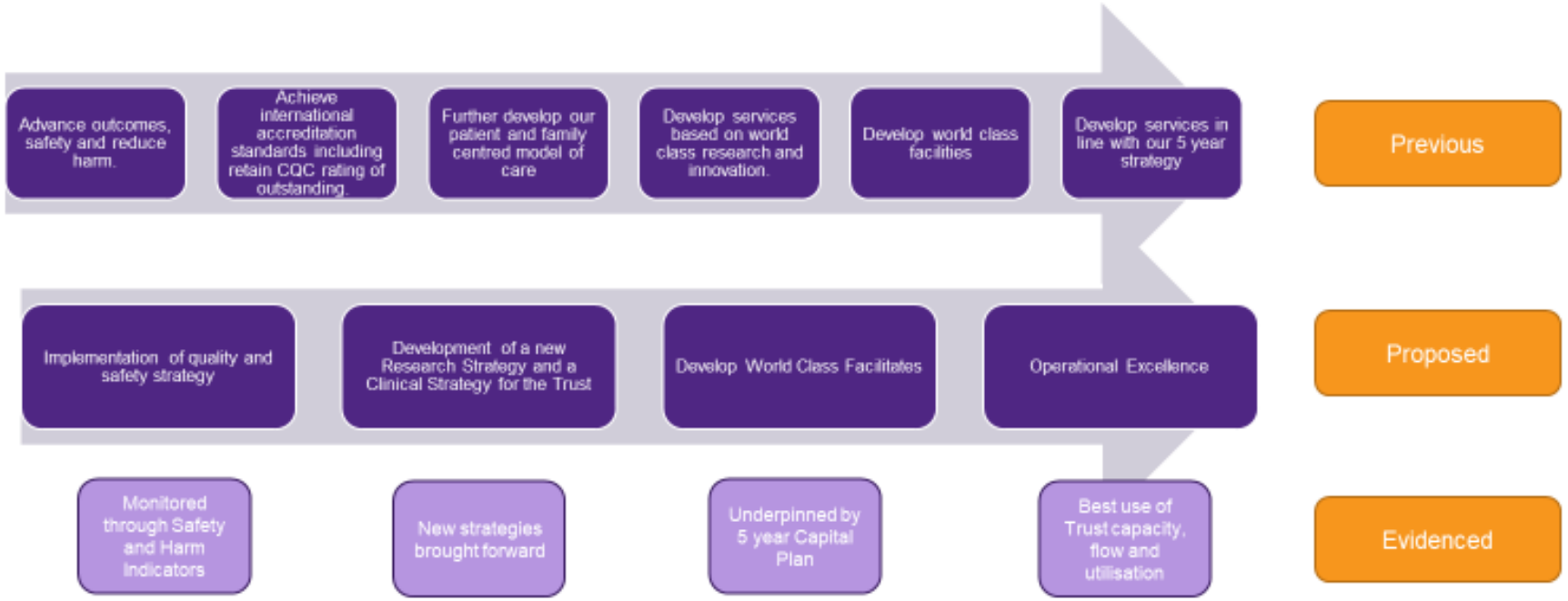
A progress update against the new objectives and KPI’s will be reported in January 2022.

4. Recommendation

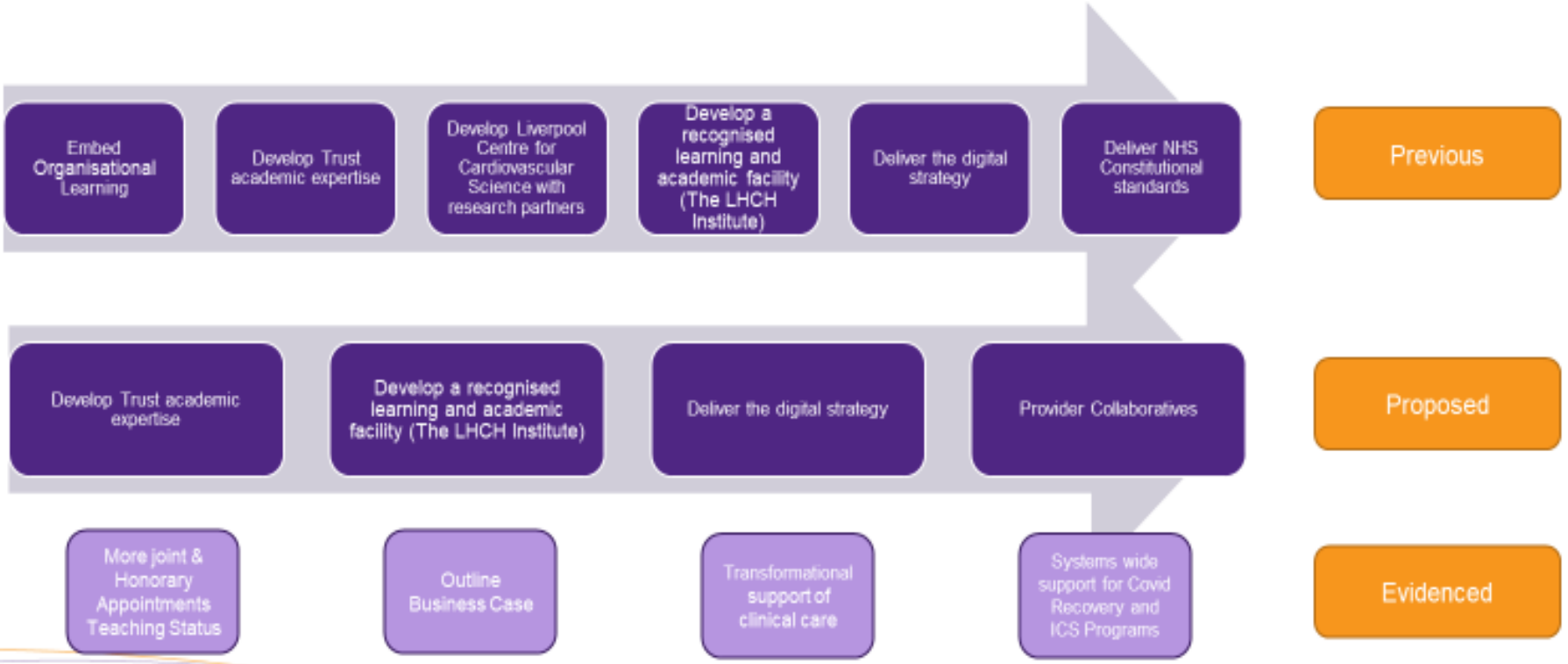
The Board of Directors is asked to approve the refresh of Strategic Objectives.

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

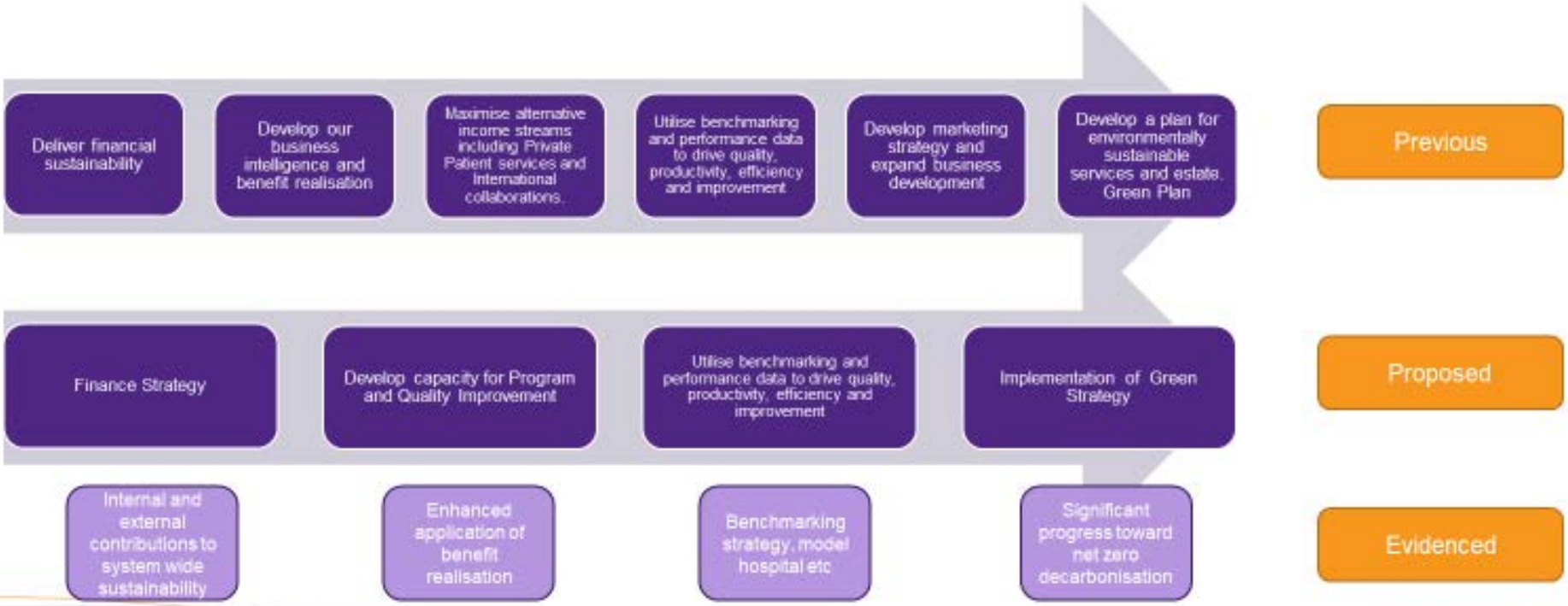
Strategic Objective 1 : World Class Care



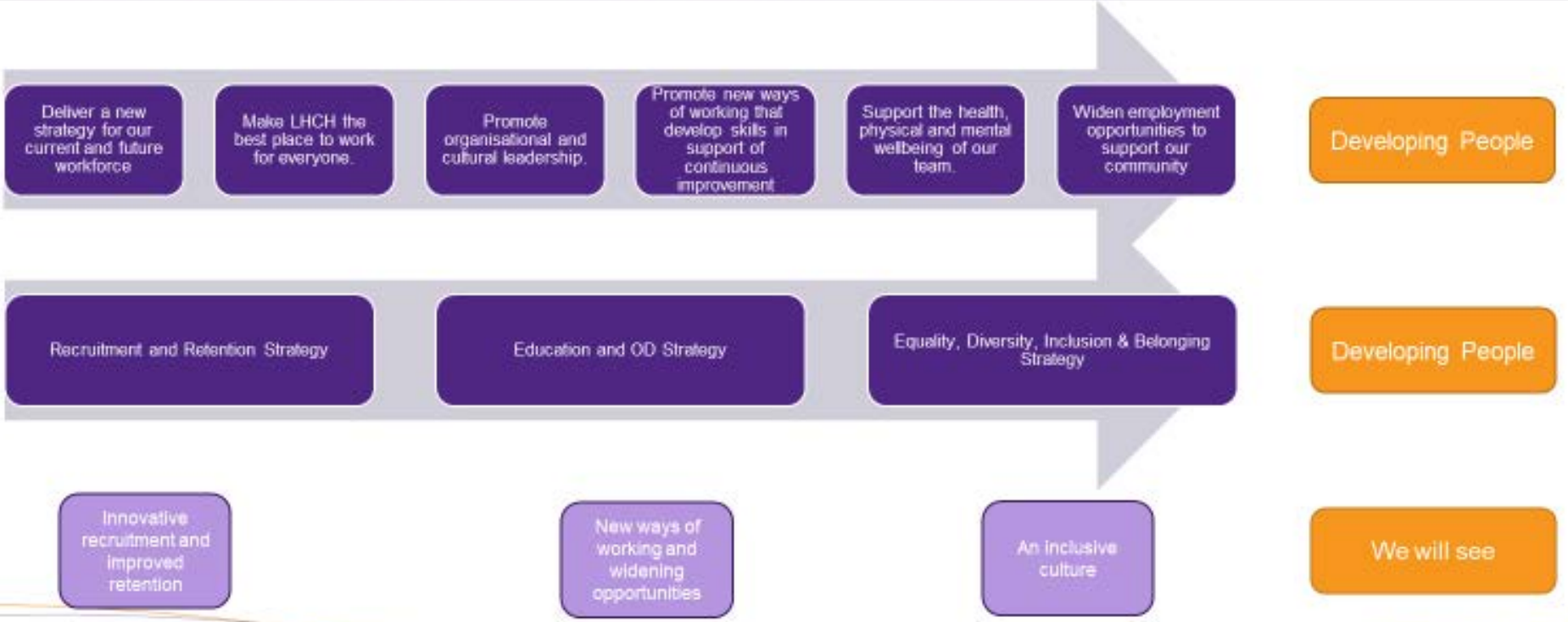
Strategic Objective 2 : Advancing Quality and Innovation



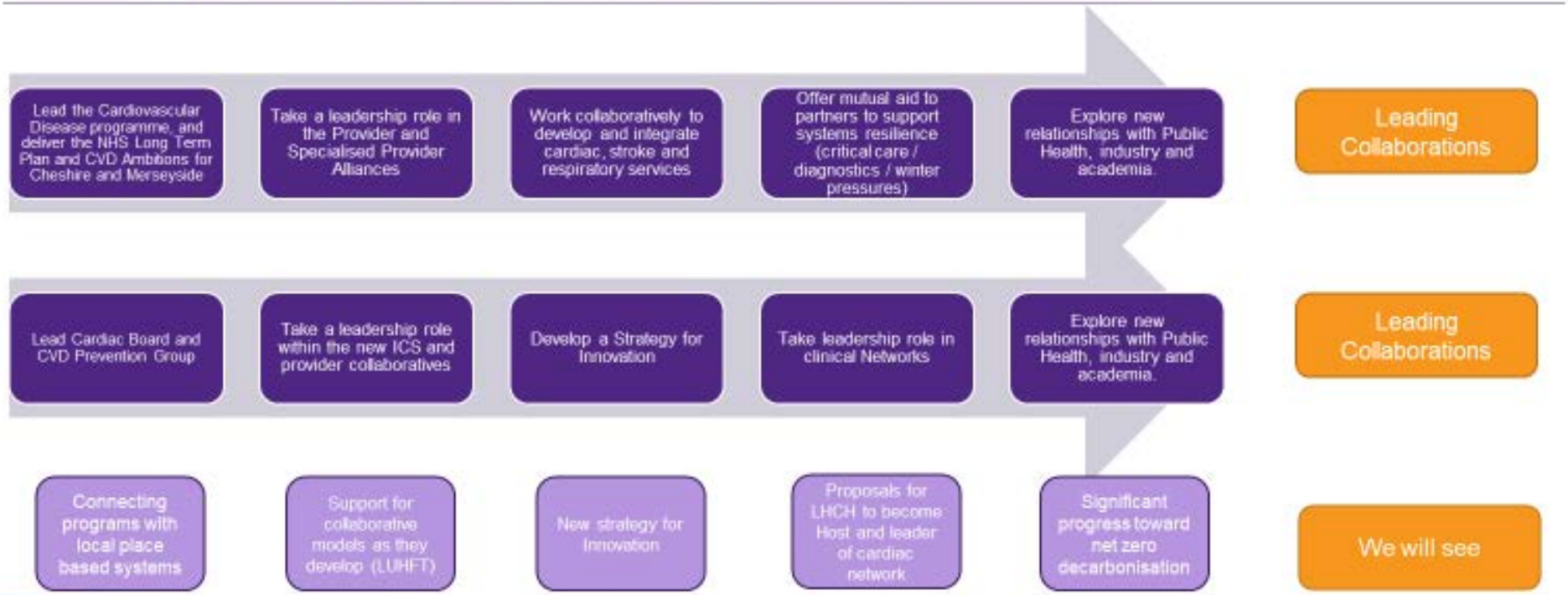
Strategic Objective 3 : Increasing Value



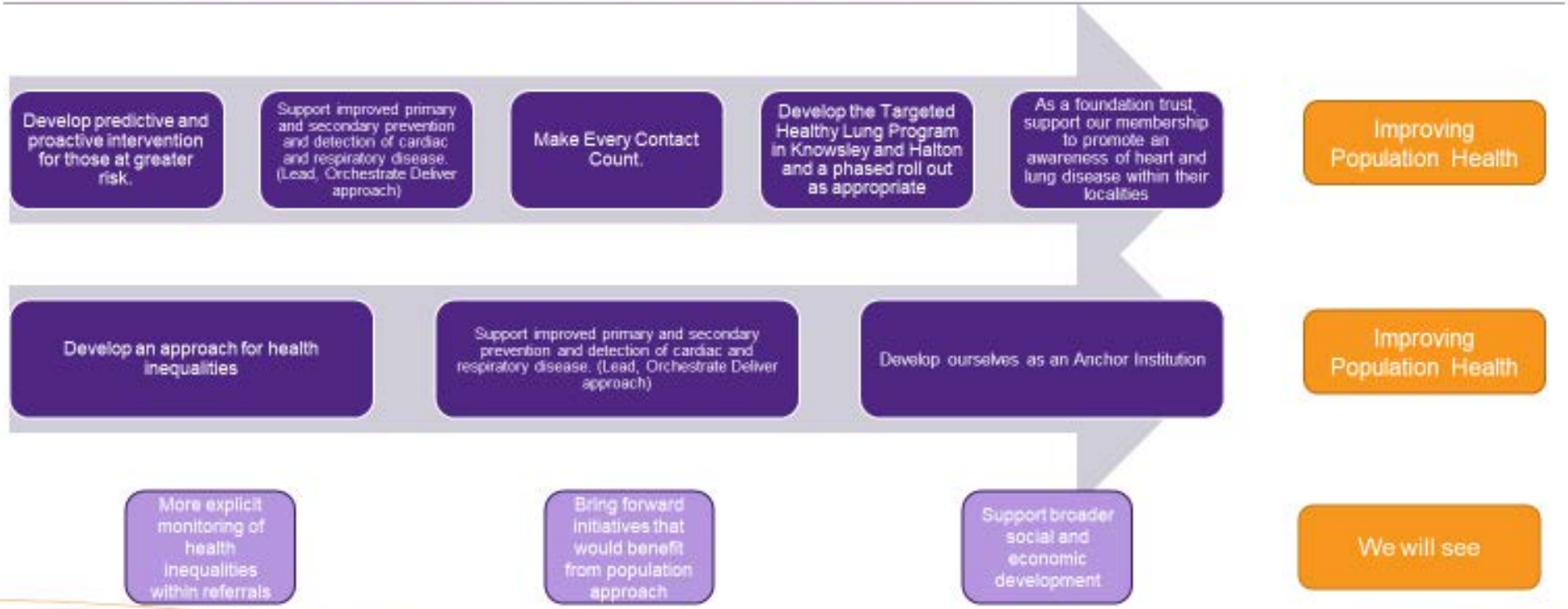
Strategic Objectives 4: Developing People



Strategic Objective 5 : Leading Collaborations



Strategic Objective 6 : Population Health



Board of Directors (in Public)
Item 3.3

Subject: **Digital Excellence Report**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by **Robin Clout, Deputy CDIO, Kate Warriner, Executive CDIO**
Presented by **Kate Warriner, Executive CDIO**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
BAF 12	The paper provides assurance in respect of Digital transformation and operational IT delivery.

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

1. Executive Summary

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

Key headlines include:

- National digital developments
- Engagement with new regional ICS digital lead
- Submission of initiatives for national Unified Tech Fund resources
- Good progress with Digital Excellence delivery
- Good progress with digital clinical and safety developments

- High levels of operational performance against agreed key performance indicators
- Developments with the iDigital service

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

2. National & Regional Digital Update

2.1 NHSX Strategy

The NHSX strategy for technology in health and care is to digitise services, connect them to support integration and, through these foundations enable service transformation. These themes are intended to guide Integrated Care Systems in their local digital plans. To support clarity in terms of national expectations, NHSX have a range of publications as listed below.

- NHS Data Strategy - published July 2021
- 'What Good Looks Like' Framework (WGLL) – published August 2021
- 'Who Pays for What' (WPfW) – proposals published August 2021
- Unified Tech Fund – prospectus published August 2021

2.2 What Good Looks Like Framework

The WGLL Framework (https://www.nhsx.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/) sets out a clear set of expectations for local systems and organisations with regards to good digital practice across health and care. Its aim is to provide clear guidance for leaders to digitise, connect and transform services safely and securely.

The framework is based around seven success measures aligned to the top line themes of digitise, connect, transform.

WGLL Success Measures

1. Well led
2. Ensure smart foundations
3. Safe practice
4. Support people
5. Empower citizens
6. Improve care
7. Healthy populations

An initial assessment against WGLL success measures has been undertaken. Progress against key criteria is good, any gaps are understood and included as part of the digital programme and future plans. As an ICS, providers in Cheshire and Merseyside are to trial the early prototype of the national assessment system.

2.3 Who Pays for What and Unified Tech Fund

The WPfW (https://www.nhsx.nhs.uk/digitise-connect-transform/who-pays-for-what/who-pays-for-what-proposals/) proposals are currently draft and requesting feedback. WPfW has been developed to support

health and care organisations by streamlining the way in which digital funds are coordinated and distributed. The ultimate aim is to facilitate more local control over funding distribution placing a lot of emphasis on ICS leadership.

For 21/22, the proposals are to:

1. Consolidate national funding for some areas into a single 'Unified Tech Fund' in order to support ICS's to make better investments
2. Enable applications for funding through a single portal
3. Improve metrics for benchmarking
4. Provide tools and case studies to help with benefits realisation
5. Review national policies

A range of bids have been submitted through the Unified Tech Fund Progress against a number of key areas to further develop our frontline digitisation in line with the published criteria. The outcome of these bids are awaited as they are reviewed nationally. Additional investment for cyber security investments has been supported by NHSX across the NHS.

2.4 Regional/ICS Developments

From a C&M ICS perspective, the new Chief Digital and Information Officer for C&M commenced in post in October 2021. Work is underway in partnership to review the digital strategy, governance and priorities within the ICS. LHCH is playing an active role in these developments with local digital leaders.

3. Digital Excellence Update

3.1 Digital Excellence / Digital Aspirant Programme Progress

The Digital Excellence programme is on track and progressing well. The governance arrangements are now well established, and the Digital Excellence Committee (DEC) is convening every 6 weeks. This is chaired by the Chief Executive and the meeting receives reports on progress, risk, key decisions and benefits realisation. The programme milestone for the second funding envelope of £2M has been successfully achieved by the programme and delivery team.

A range of business cases have been supported through the appropriate internal governance to date as outlined below:

- Closed Loop Medication – Nov 20
- Additional Programme Resources – March 21
- Digital Communications – August 21
- ISLA – September 21
- Robotic Process Automation – September 21
- Closed Loop Bloods – September 21
- EDMS Upgrade – October - 21

Further business cases are planned for this financial year as follows:

- E-Consent – November 21
- Digital Dictation – February 22

Business cases supported to date are entering deployment phases with delivery managed through the DEC with external programme support from NHS Digital.

A key component of the programme and LHCH's digital journey is the achievement of the next level of Healthcare Information and Management Systems Society (HIMSS) Stage 6 international digital accreditation. A date has been set for the formal accreditation on 9th December 2021. This accreditation demonstrates how electronic patient records and technology is used to improve patient care and safety and is a prestigious internationally recognised award. There are currently three UK HIMSS Stage 6 hospitals and three HIMSS Stage 7 hospitals.

3.2 Back to Basics Workstream

As outlined in the strategy, the fundamental technology must be in place to provide a solid platform to deliver and support the more innovative initiatives. The 'back to basics' workstream has delivered some key solutions in the last reporting period. The device refresh programme has now reached many new devices across the organisation, providing a better experience for staff. A plan has now been agreed to replace a number of Pharmacy carts across ward areas. To complement this, there have been improvements made to the Trust Wi-Fi, for both patients and staff, ensuring better connectivity when interacting with the technology.

The Trust has successfully migrated all staff onto the Office 365 platform, providing a more modern, enhanced experience when accessing Microsoft applications and enabling staff to work flexibly from any location. Given that more staff are now working remotely, alongside an increase in cyber-attacks, the need for a more secure infrastructure has never been more prevalent. There has been significant investment and delivery recently in tools and technology that help further protect the information of staff and patients at LHCH.

3.3 Clinical and Nursing Digital Developments

Further to the back to basics and service improvement work, there has been good progress within the digital transformation element of the Digital Excellence Programme. The team worked collaboratively with the Community Staff to transition the clinical and operational data capture, for the Knowsley Respiratory Service to a new digital platform earlier in the year.

To support nursing teams working closer to the patient's bedside when completing tasks and recording clinical information in the EPR, over 40 mobile devices have been delivered across all Inpatient wards. Staff have reported a 50% increase in user experience through using these devices following a short survey across the nursing teams. Scoping of remaining services included Theatres, Critical Care and personal clinician devices is underway.

Concurrently, further solutions have been progressed as outlined in the Digital Excellence Strategy. From a technical perspective, there is a significant piece of work underway around improving the internet connection and infrastructure, which will help provide a better performance for staff accessing clinical systems and when interacting with external organisations. The device refresh programme will continue, as more devices become in scope they will be refreshed and replaced accordingly. This includes a bespoke, focussed plan on the Community Staff who have slightly different workflows.

To further improve clinical workflows, the Trust has invested in 'Single Sign On' technology, which assists staff in accessing Trust devices and systems through a tap of their ID badge. This will speed up the process and release more time for direct patient care alongside, reducing the number of different passwords staff have to remember. Key clinicians have completed testing successfully and a deployment plan is being established, which is aimed to deliver from December.

3.4 Digital Safety Programmes

From a Digital Safety perspective, great strides have been made in relation to closed loop technology for bloods and medication. Both solutions deliver supporting technology to help nurses positively identify patient and product before administration or collection.

In early November, the rollout of Closed Loop Medication commenced. This has been positively received by staff. Pharmacy, Digital and Nursing Teams have worked together to support the wards through a floorwalking programme.

In relation to Closed Loop Technology for Blood Products, the future processes have now been approved by the Senior Nursing and Transfusion Team, as well as Liverpool Clinical Laboratories. Work is underway to establish a test environment, which will enable the clinical and nursing staff to practically assess the system, before formally signing off the solution.

It is widely evidenced that the implementation of these solutions will reduce human errors and decrease the risk of patient harm. Anticipated safety benefits have been baselined and will be tracked to monitor the impact of these new technologies.

3.5 Digital Innovations

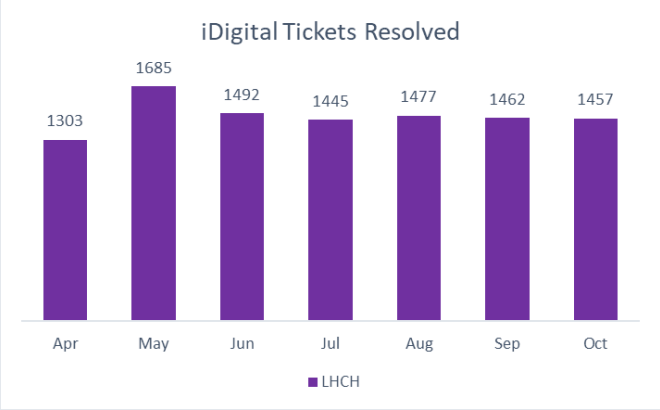
The Digital Team has worked in tandem with Human Resources to transform the current platform for receiving and managing HR Submissions across LHCH. The new platform provides a modern, easy to use, single point of access for staff at LHCH to log their HR requests. Not only will it improve the experience for the staff logging the requests, but its automated features will help save time and improve the efficiency and performance of the team. The first phase of the solution was launched in November 2021.

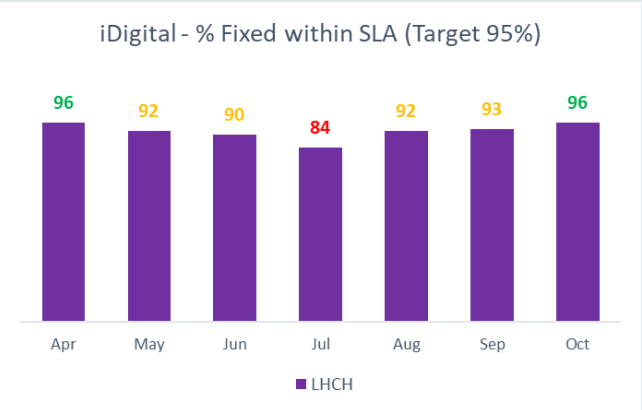
4. Operational Performance

Performance against key performance indicators has improved over the last 2 months and trending towards the target of 95%. The number of incidents or requests reported via the service desk is relatively consistent each month, however, the activity is around 10% higher than the same period last year.

Nearly 50% of all tickets each month are resolved at the first line level by the service desk. Resolution through the service desk demonstrates quicker resolution and better experience for staff. Nearly 70% of all tickets reported via the service desk are fixed within 1 working day, be it the service desk or local iDigital support teams.

Most incidents & requests reported by trust staff to the service desk is via telephone. Plans are being developed to promote self-service and live chat to further modernise this approach, as this would improve the efficiency of the service and increase the first level fix % and tickets resolved within target.





5. Digital Partnership – iDigital

The iDigital partnership with Alder Hey was launched in June 2021. This reporting period has seen the acceleration in collaboration and integration of teams and services. Workgroups have been established for shared learning, delivery, personal and service development.

Work continues to review other services to share and integrate and this includes the recently approved decision to establish a new data quality team across both organisations, and this follows the approval to integrate the two Information Governance and Freedom of Information teams.

The iDigital governance group is in place with representation from both Trusts to oversee the partnership development and service delivery.

In terms of staff engagement, bi-annual all-staff development sessions have been scheduled. The first of these was held in summer 2021 and the next is planned for December 2021. The summer development session included a range of presentations, staff development, team building, an EDI presentation and service celebration through the inaugural staff awards. The winter development time will have a theme on talent, celebration and sharing best practice.

As approved by the trust executive team and the iDigtal partnership group the integrated digital service will be expanded to a joint Data Quality service which is aimed to be live for the end of the year and onboarding of the LHCH Training Team into the iDigital Service.

6. Summary

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

7. Recommendations

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

Board of Directors (in Public)
Item 4.1

Subject: **Month 7 SOF Performance Report**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by: **Executive Directors**
Presented by: **Hayley Kendall, Chief Operating Officer**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
BAF2	Strong performance against recovery plans and BAF updated to reduce the risk

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

1. Executive Summary

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

- Six week diagnostic performance has narrowly underperformed in month with a position of 97.55% against a target of 99%. This was due to specific challenges on staffing additional sessions, significant work has gone into planning for the rest of the year and the forecast is that of a compliant position,
- Referral to treatment waiting times remain below target as expected due to the significant backlog accumulated during the surge. Performance in month stands at 79.21% for English commissioned activity and 82.32% for welsh commissioners, a slightly improved position compared to the previous month. This performance is in line with the Trust recovery trajectories.

- There were 54 patients waiting longer than 52 weeks at the end of October, an improved position compared to previous months. There are several challenges forecast for November in relation to critical care staffing that may impact on performance against the trajectory next month.
- Sickness increased slightly to 5.5% in month, 0.6% higher compared to the same period last year. The teams are focused on clear and early intervention to avoid long term sickness where appropriate.

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

Other performance exceptions to note are summarised as follows:

- Cancelled operations 28-day breaches – there were two breaches of the standard in month that were directly related to the reduced capacity in critical care towards the end of the month. Both patients have been dated for their operation in November.
- 28-day faster diagnosis standard – performance in month stood at 56%, the main challenges relate to EBUS and CT Guided Biopsy capacity with clear action plans in place to address both aiming for compliance in January 2022.
- HSMR – both indicators showing as non-compliant for the Trust, reasons and mitigations will be discussed under the Mortality Improvement Strategy on the Board of Directors November 2021 meeting.
- 62-day consultant upgrade – performance was non-compliant in month due to one patient that breached the target due to them having Covid, and not being able to receive treatment until after the isolation period.

2. Financial Position

The Trust reported a deficit of (£679k) in the period ending 31st October. At the time the financial position was finalised the planning process was still underway for the second half of the year (H2). Importantly, the income from the Integrated Care System (ICS) had not been agreed. However, it is now expected that the income will be confirmed at a level that will support the Trust to achieve a breakeven position for the year.

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

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

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

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

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

The Trust retains a strong cash position.

3. Conclusion

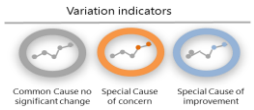
The Trust is performing well against the suite of statutory and Trust level KPIs as well as the recovery trajectories that were developed earlier in the year. The Trust is experiencing challenges with staffing across Cath Labs, Theatres and Radiology but these are being mitigated as far as possible.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

4. Recommendation

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

Item 4.1a

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%	●	79.21%	
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%	●	97.55%	
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%	●	6.9%	
Patients not booked in within 28 days (non clinical cancellations)	0	●	2	
Delayed Transfers of care	5.0%	●	4.23%	
Bed Occupancy	80.0%	●	79.08%	
Referral to treatment - Incomplete Pathways 52+ weeks	0	●	54	

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%	●	80.0%	
Welsh Patients: 26 weeks Referral To Treatment waiting times - Incomplete	95.0%	●	82.32%	
In-Hospital mortality	17	●	11	
Quantity of complaints	6	●	0	
Occurrence of any Never Events	0	●	0	
Mixed sex accommodation breaches	0	●	0	
Inpatient scores from Friends & Family Test - % positive	95.0%	●	100.0%	

Quality of Care

measure	target		in month	variation
Venous thromboembolism (VTE) risk assessment	95.0%	●	96.06%	
Clostridium Difficile	0	●	0	
MRSA Bacteraemias	0	●	0	
MSSA Bacteraemias	0	●	0	
Gram Negative Bacteraemias	0	●	0	
Hospital Standardised Mortality Ratio (HSMR) - basket diagnoses	101	●	175	
Hospital Standardised Mortality Ratio (HSMR) - all diagnoses	101	●	157	
Incidents - Serious incidents, Never Events, Adverse Events (Red)	1	●	1	
Clostridium difficile – infection rate	0	●	0	
Patient Safety Alerts not completed by deadline	0	●	0	
NHS Staff Survey - Staff recommendation of the organisation as a place to work	76.0%	●	76.0%	
NHS Staff Survey - Staff recommendation of the organisation as a place of treatment	96.0%	●	92.0%	

Organisational Health

measure	target		in month	variation
Staff Sickness (All Staff)	3.4%	●	5.5%	
Staff Turnover	10.0%	●	11.15%	
Executive Team Turnover	25.0%	●	22.7%	
Mandatory Training Compliance	95.0%	●	94.41%	
Appraisals Compliance	90.0%	●	89.18%	
Recurrent CIP identified	100.0%	●	76.43%	
Liquidity (days)	0	●	24	
I & E distance from target (cumulative) - £,000	0	●	-14	
Better Payment Practice Code	95.0%	●	99.0%	

Oct-21


Near misses
Current Financial Year
6
Previous Financial Year
0
Near misses
Current Month
1
Previous Month
1
Near misses
Current Month
Reported > 48 hrs
1
Previous Month
0
All incidents
Current Financial Year
1,140
Previous Financial Year
1,117
All Incidents
Current Month
188
Previous Month
155
All Incidents
Current Month
Reported > 48 hrs
30
Previous Month
22

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

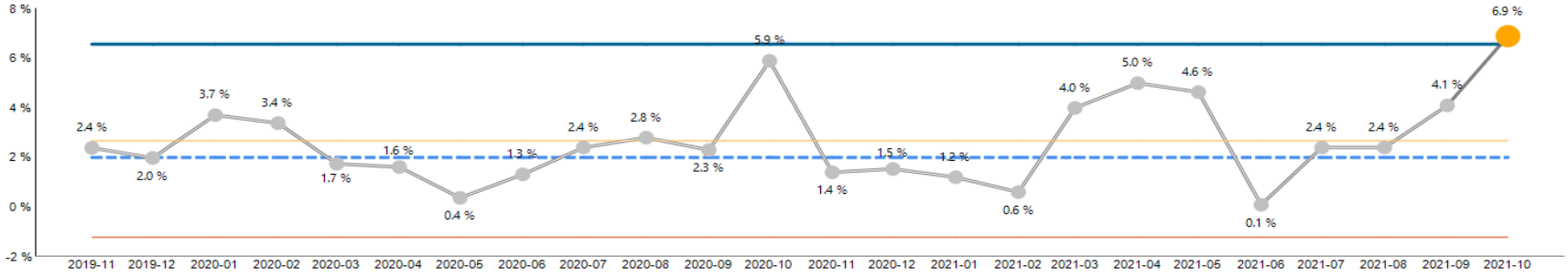
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Cancelled Operations for non-clinical reasons

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

Target	2019-11	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	2021-09	2021-10
<=2%	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%	4.1%	6.9%

Concern



ucl	6.57%
mean	2.67%
target	2.0%
lcl	-1.22%

Commentary:

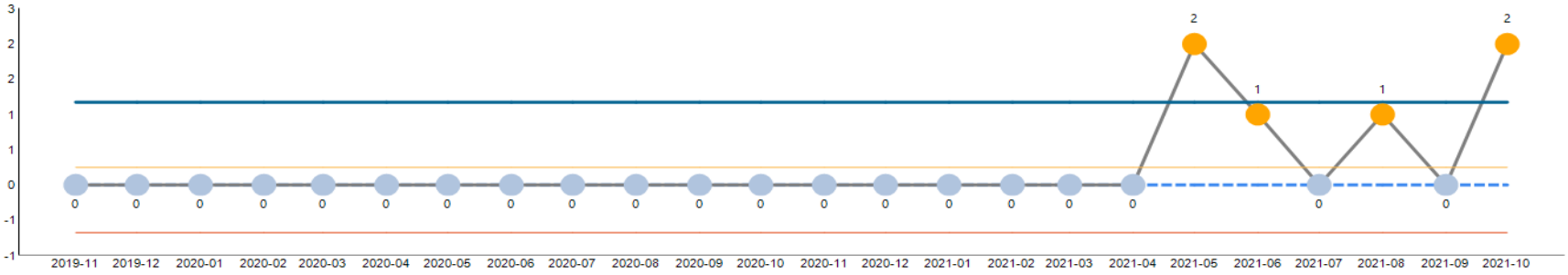
There were significant challenges at the end of October in relaiton to cancelled operations that were driven by critical care staffing and reduced capacity. Plans are in place to improve performance and these have been implemented during November with improved performance.

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	2019-11	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	2021-09	2021-10
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	1	0	2

Concern



ucl	1
mean	0
target	0
lcl	-1

Commentary:

Significant cancellations due to critical care staffing pressures leading to 2 patients not being treated within 28 days.

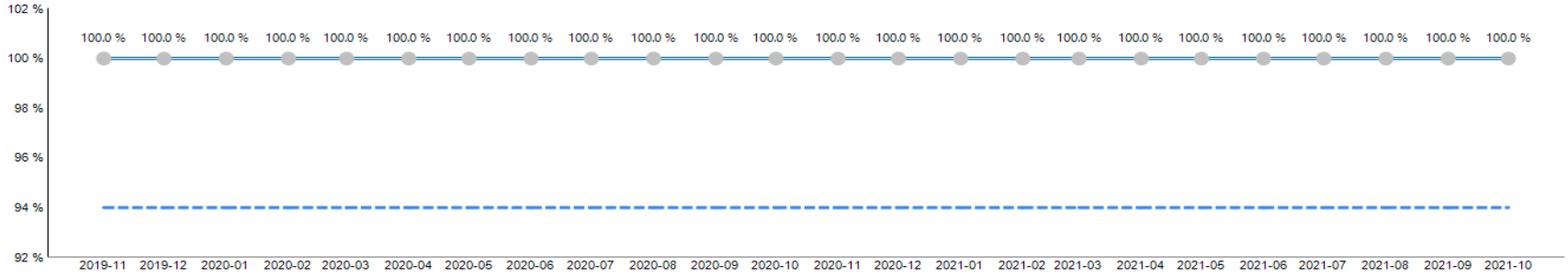
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

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

Patients waiting a maximum of 31 days for all subsequent treatments

Target	2019-11	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	2021-09	2021-10
>=94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Common Cause

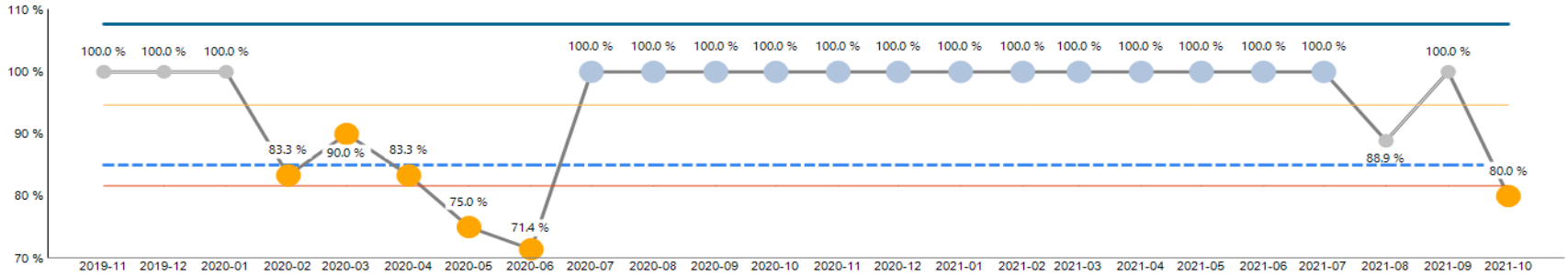
ucl	100.0%
mean	100.0%
target	94.0%
lcl	100.0%

commentary:

Cancer: 62 day Consultant Upgrade

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

Target	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	2021-09	2021-10
>=85%	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%	88.9%	100.0%	80.0%



Concern

ucl	107.7%
mean	94.67%
target	85.0%
lcl	81.64%

Commentary:

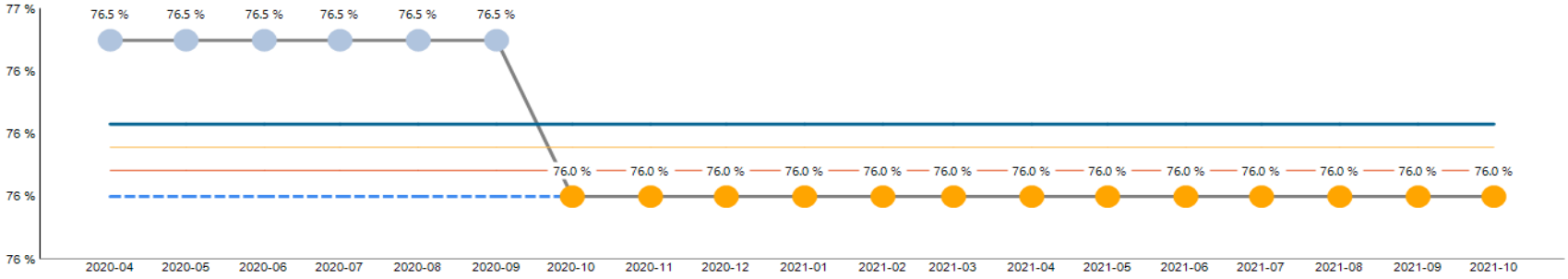
One patient breached the target as they were Covid positive and no adjustments can be made to the pathway.

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

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

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



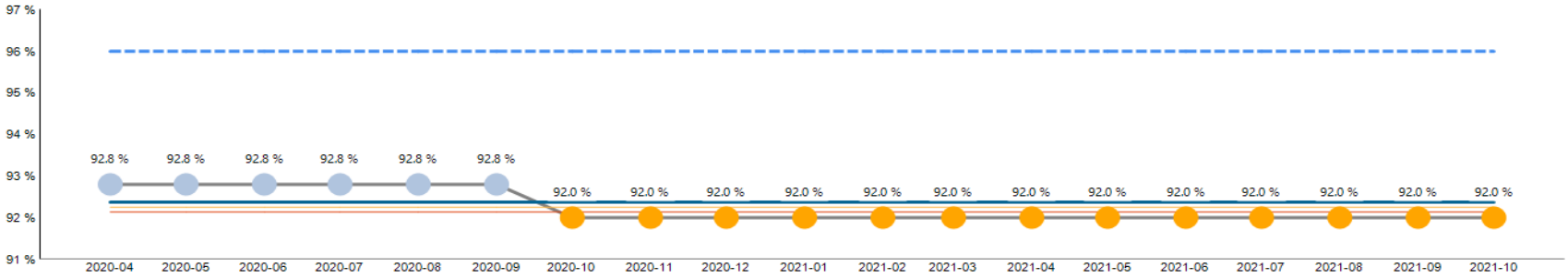
Concern

ucl	76.23%
mean	76.16%
target	76.0%
lcl	76.08%

commentary:

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

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



Concern

ucl	92.37%
mean	92.25%
target	96.0%
lcl	92.13%

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

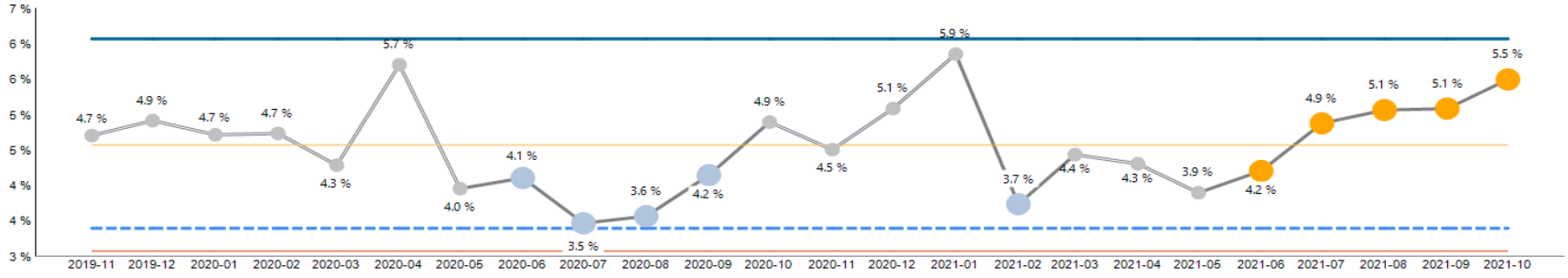
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Staff Sickness (All Staff)

Rate of sickness across all staff

Target	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	2021-09	2021-10
<=3.4%	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%	5.1%	5.5%

Concern



ucl	6.08%
mean	4.58%
target	3.4%
lcl	3.08%

Commentary:

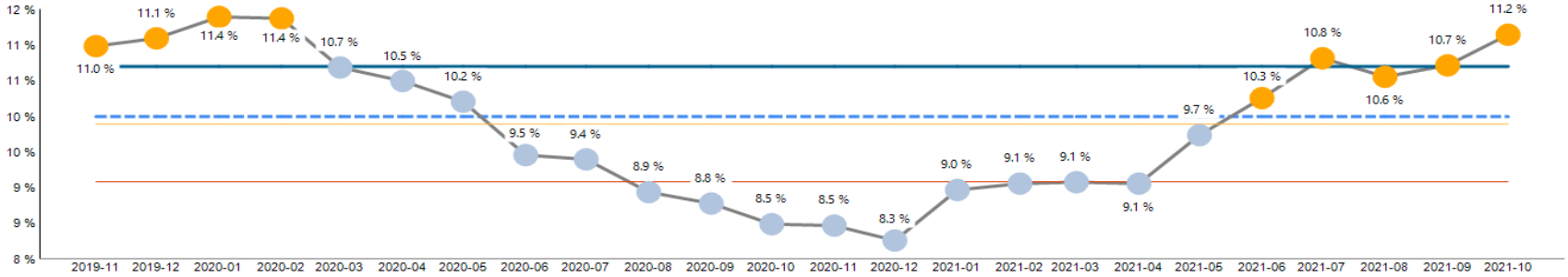
Slight rise in absence in October and it is 0.6% higher than this time last year. There is a continued focus on attendance and early intervention whilst anxiety, stress and depression remains the highest non-covid absence reason

Staff Turnover

Rate of turnover among voluntary leavers

Target	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	2021-09	2021-10
<=10%	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%	10.7%	11.2%

Concern



ucl	10.7%
mean	9.9%
target	10.0%
lcl	9.09%

Commentary:

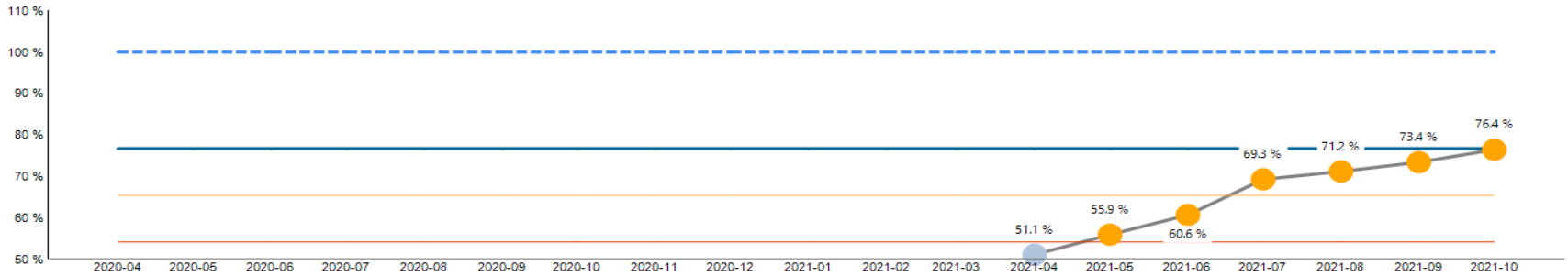
Voluntary turnover has increased to 11.2% which is a return to November 2019 levels. A retention group has been set up and a retention summit will be held in November; the latter will concentrate on RN and HCA retention

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Recurrent CIP identified

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



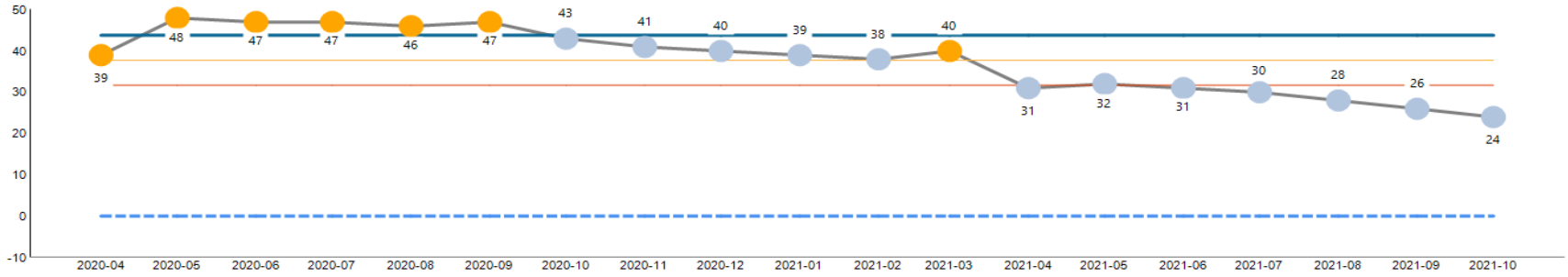
Concern

ucl	76.66%
mean	65.41%
target	100.0%
lcl	54.16%

commentary:

Liquidity (days)

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



Improvement

ucl	44
mean	38
target	0
lcl	32

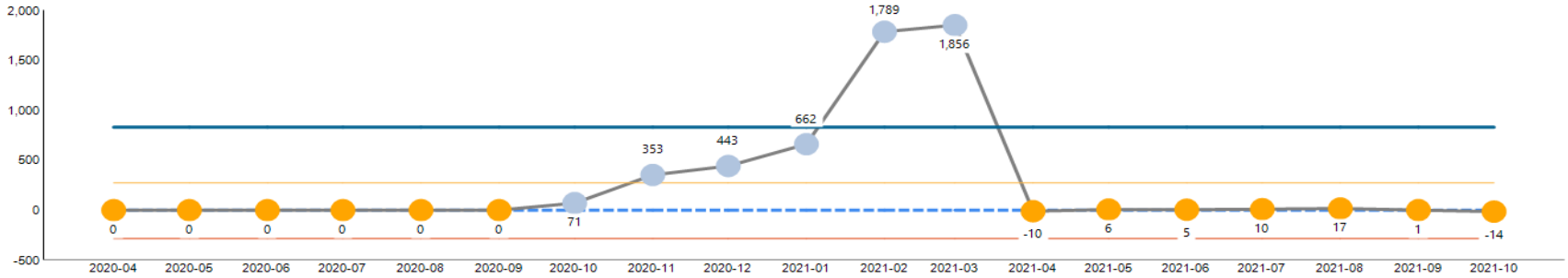
commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

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

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



Concern

ucl	832
mean	273
target	0
lcl	-286

commentary:

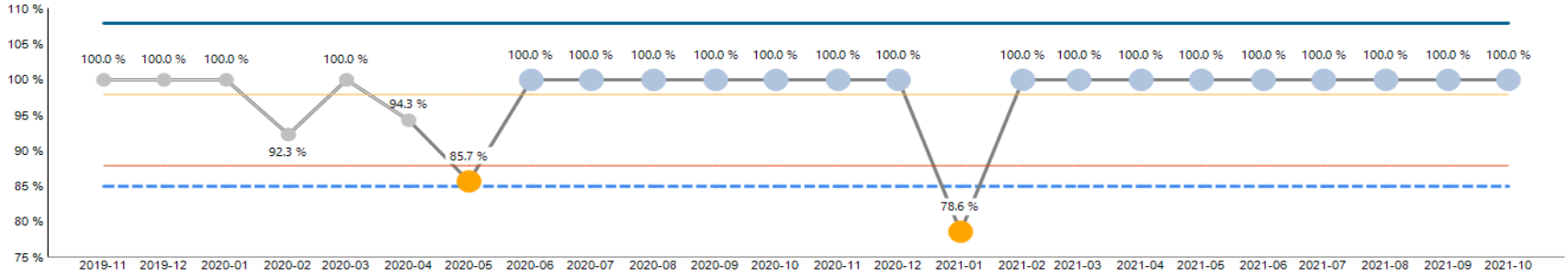
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

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

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

Target	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	2021-09	2021-10
>=85%	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%	100.0%	100.0%



Improvement

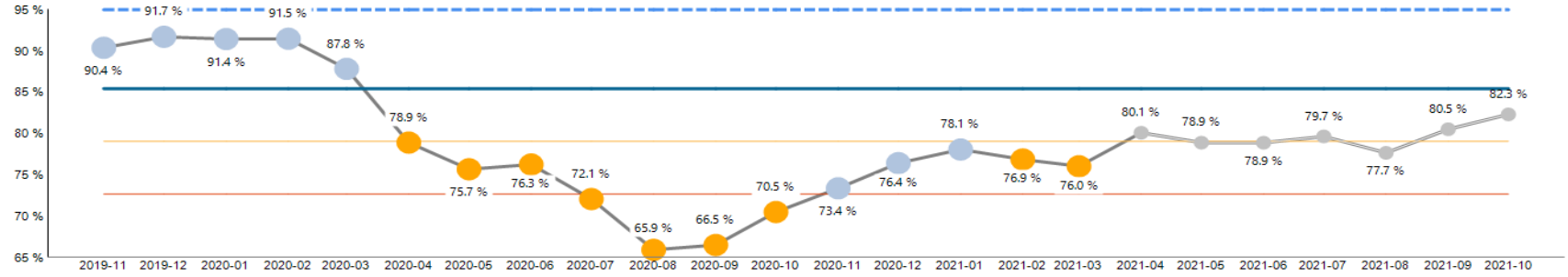
ucl	107.99%
mean	97.95%
target	85.0%
lcl	87.92%

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	2019-11	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	2021-09	2021-10
>=95%	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%	80.5%	82.3%



Common Cause

ucl	85.45%
mean	79.06%
target	95.0%
lcl	72.67%

Commentary:

The backlog of patients remains consistent and performance is in line with the recovery trajectory set as part of the phase one elective recovery plans and is monitored weekly through the Executive Committee.

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

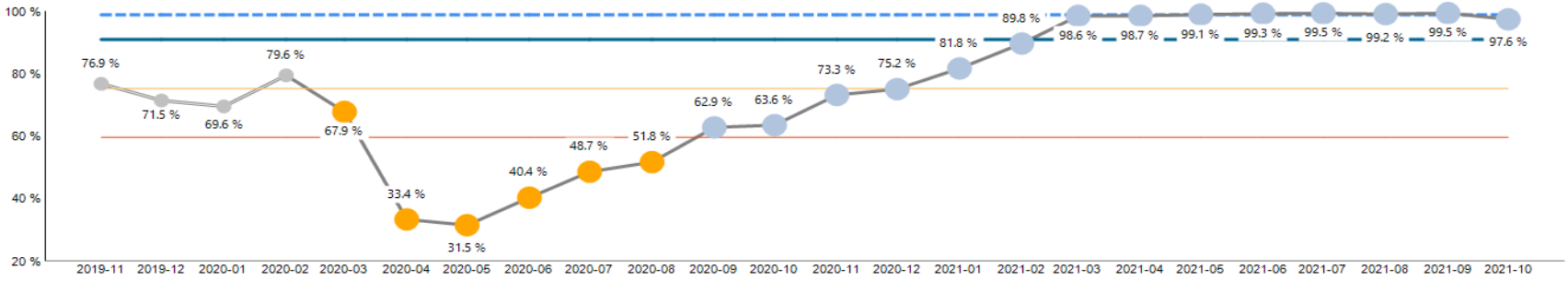
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Maximum 6-week wait for diagnostic procedures

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

Target	2019-11	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	2021-09	2021-10
>=99%	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%	99.5%	97.6%

Improvement



ucl	91.08%
mean	75.39%
target	99.0%
lcl	59.7%

Commentary:

After strong performance the Trust failed the target by less than 10 patients in October due to workforce challenges and not being able to staff an additional session. Staff have been recruited but are currently in the pipeline. Performance is expected to return to complaint in November.

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

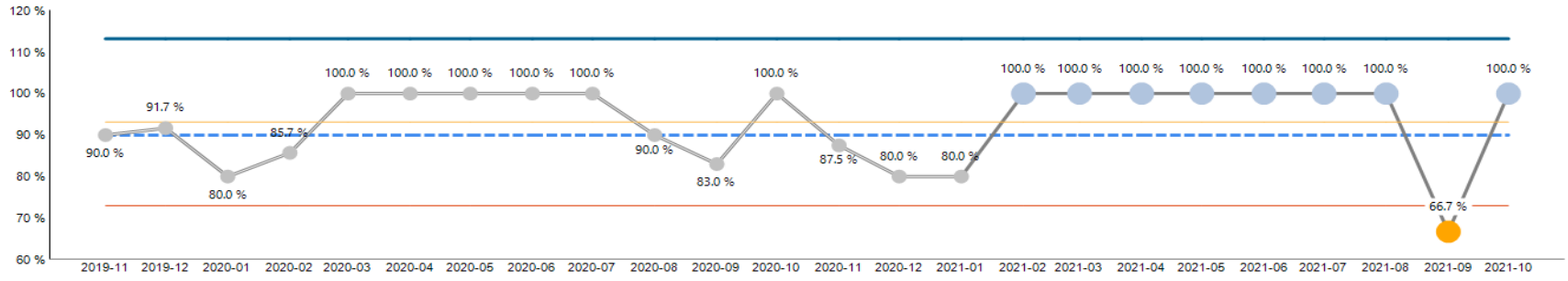
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Dementia - Find

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

Target	2019-11	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	2021-09	2021-10
>=90%	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%	66.7%	100.0%

Improvement



ucl	113.23%
mean	93.11%
target	90.0%
lcl	72.99%

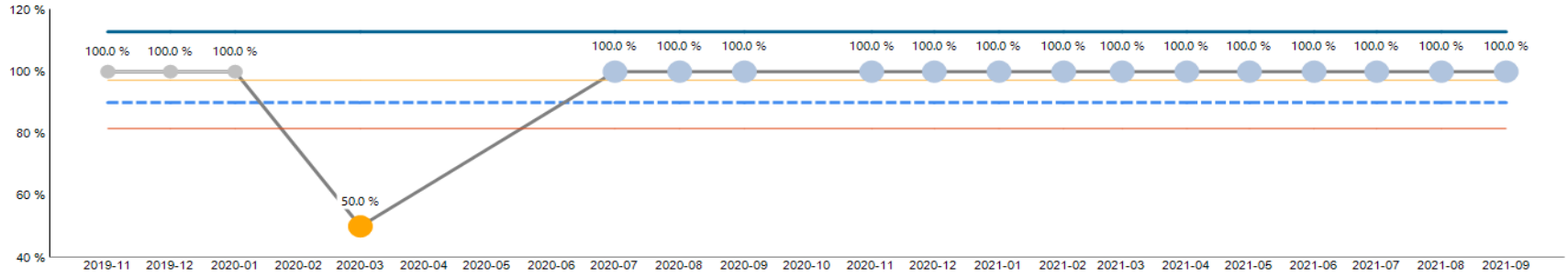
commentary:

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	2021-08	2021-09
>=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%	100.0%	100.0%

Improvement



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

commentary:

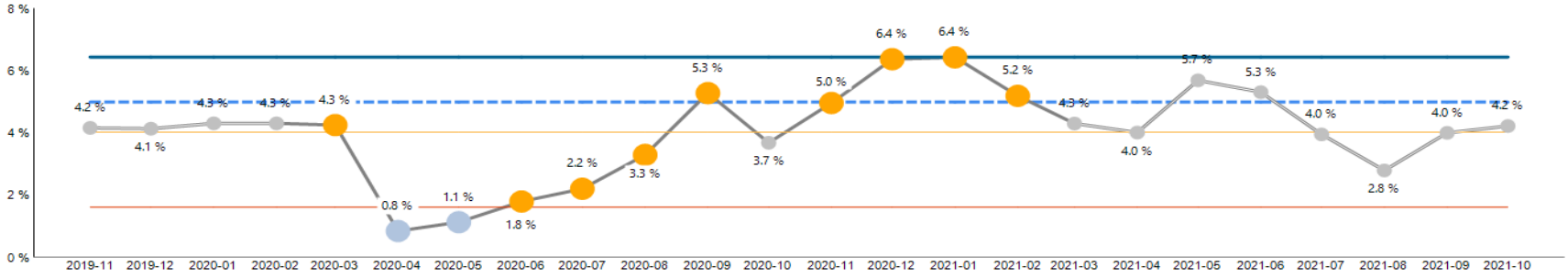
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

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	2019-11	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	2021-09	2021-10
<=5%	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%	4.0%	4.2%



Common Cause

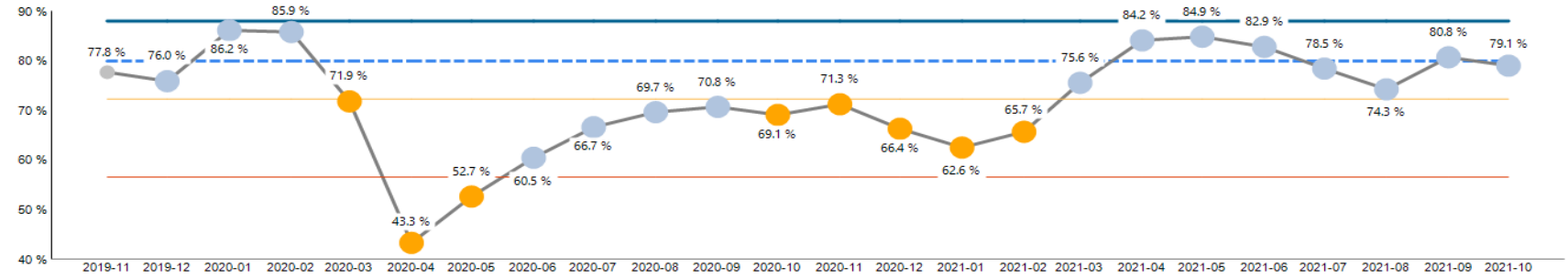
ucl	6.45%
mean	4.03%
target	5.0%
lcl	1.62%

commentary:

Bed Occupancy

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

Target	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	2021-09	2021-10
>=80%	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%	80.8%	79.1%



Improvement

ucl	88.1%
mean	72.36%
target	80.0%
lcl	56.63%

Commentary:

Bed occupancy was high towards the end of the month but then challenges within critical care staffing reduced surgical throughput and thus overall occupancy was lower than expected. During November the Trust has seen occupancy into the 90% as elective activity increases.

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

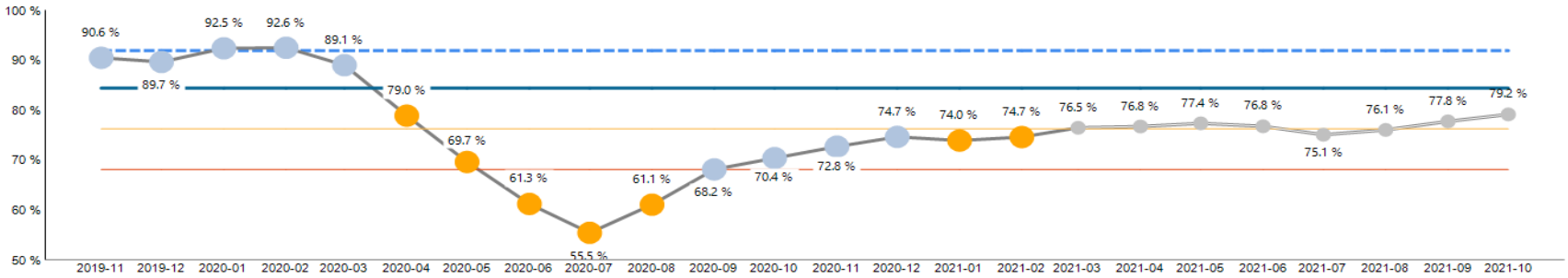
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

RTT 18 weeks in aggregate - Incomplete Pathways

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

Target	2019-11	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	2021-09	2021-10
>=92%	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%	77.8%	79.2%

Common Cause



ucl	84.47%
mean	76.31%
target	92.0%
lcl	68.14%

Commentary:

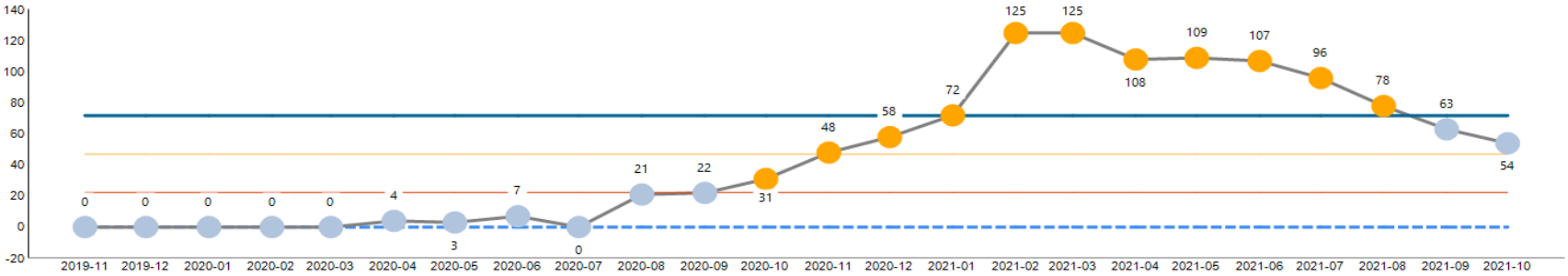
Slight improvement in performance in month but backlogs still remain high as an output of the pandemic. Performance is in line with the recovery trajectories set and are monitored weekly through the Executive Committee.

Referral to treatment - Incomplete Pathways 52+ weeks

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

Target	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	2021-09	2021-10
<0	0	0	0	0	0	4	3	7	0	21	22	31	48	58	72	125	125	108	109	107	96	78	63	54

Improvement



ucl	72
mean	47
target	0
lcl	22

Commentary:

Although the Trust aims for zero 52+ week waits this was a direct impact of the pandemic. The Trust has ambitous plans to reduce the 52 week waiters to an absolute minimum by the end of the financial year and performance in month is in line with the Trust trajectory.

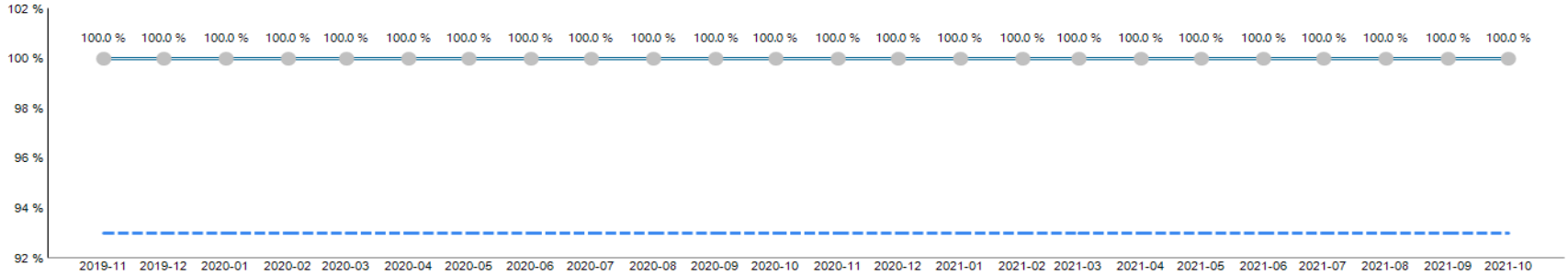
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

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	2019-11	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	2021-09	2021-10
>=93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Common Cause

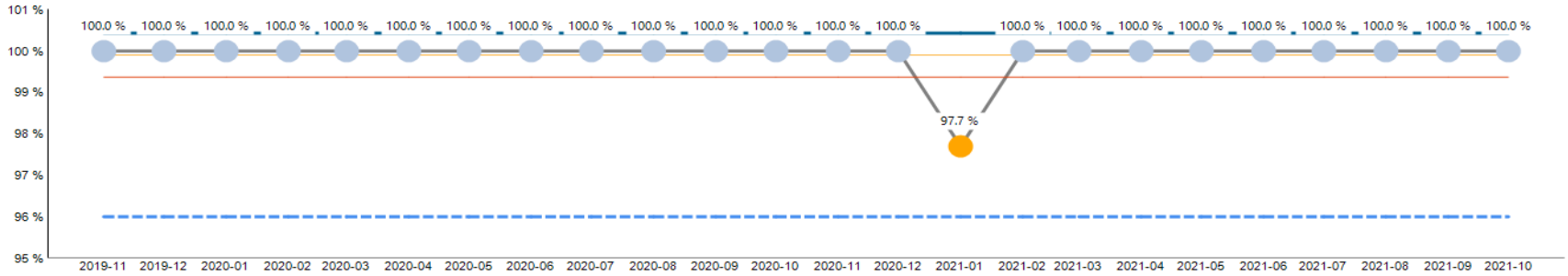
ucl	100.0%
mean	100.0%
target	93.0%
lcl	100.0%

commentary:

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

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

Target	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	2021-09	2021-10
>=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%	97.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Improvement

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

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

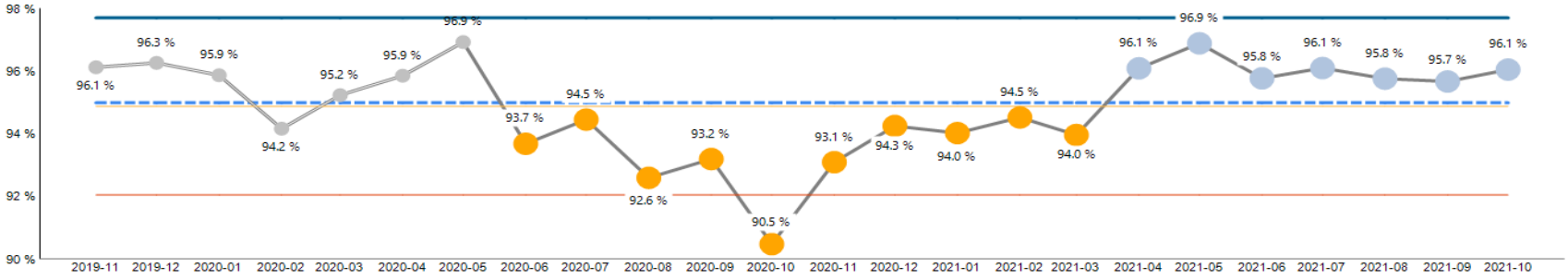
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Venous thromboembolism (VTE) risk assessment

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

Target	2019-11	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	2021-09	2021-10
>=95%	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%	95.7%	96.1%

Improvement



ucl	97.72%
mean	94.88%
target	95.0%
lcl	92.05%

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

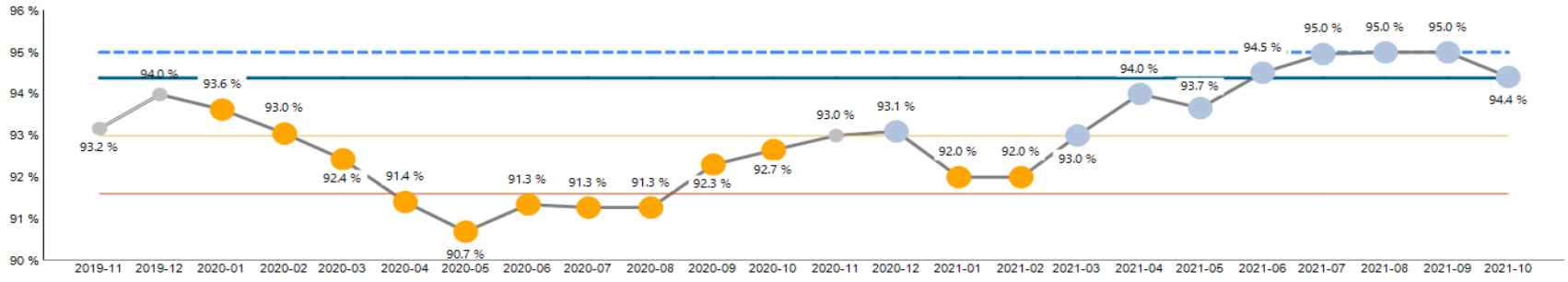
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Mandatory Training Compliance

Percentage of completed mandatory training

Target	2019-11	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	2021-09	2021-10
>=95%	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%	95.0%	94.4%

Improvement



ucl	94.39%
mean	92.99%
target	95.0%
lcl	91.6%

Commentary:

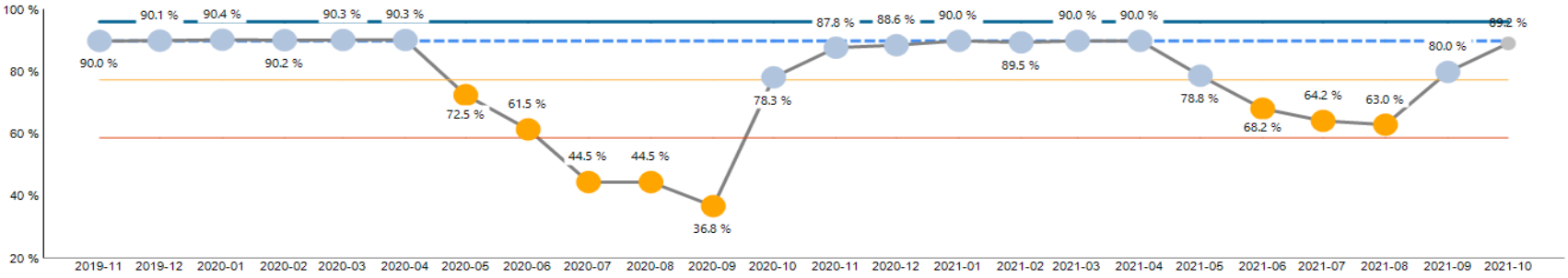
Mandatory training is 94.4% and efforts are being made to increase this to the 95% target

Appraisals Compliance

Percentage of annual appraisals completed

Target	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	2021-09	2021-10
>=90%	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%	80.0%	89.2%

Common Cause



ucl	96.11%
mean	77.44%
target	90.0%
lcl	58.76%

Commentary:

Target almost achieved in month with a final focus on the staff who haven't been appraised.

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

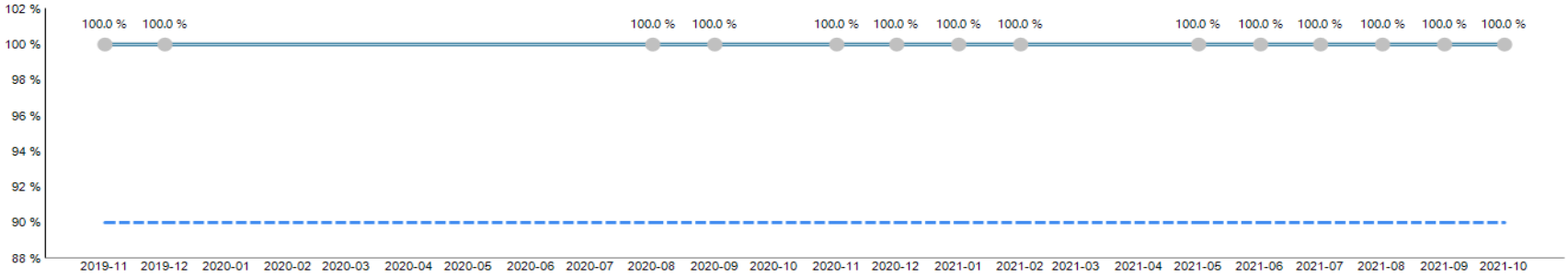
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

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	2021-09	2021-10
>=90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Common Cause



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

commentary:

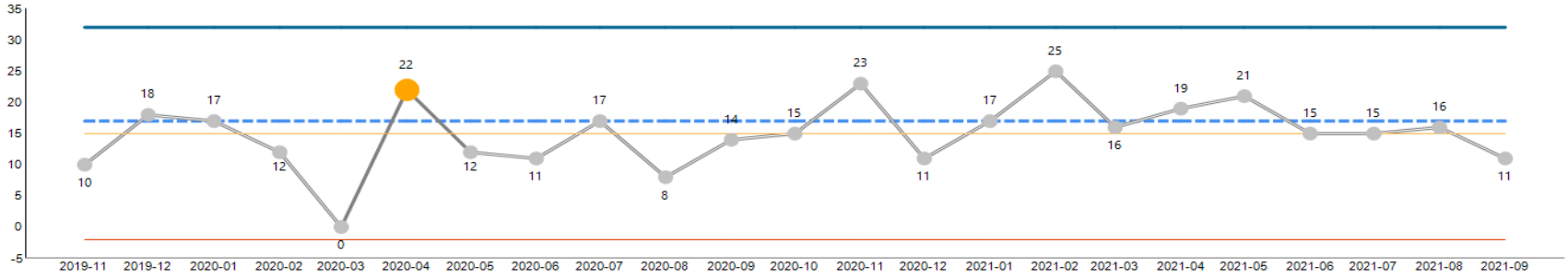
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

In-Hospital mortality

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

Target	2019-11	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	2021-09
<=17	10	18	17	12	0	22	12	11	17	8	14	15	23	11	17	25	16	19	21	15	15	16	11



Common Cause

ucl	32
mean	15
target	17
lcl	-2

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

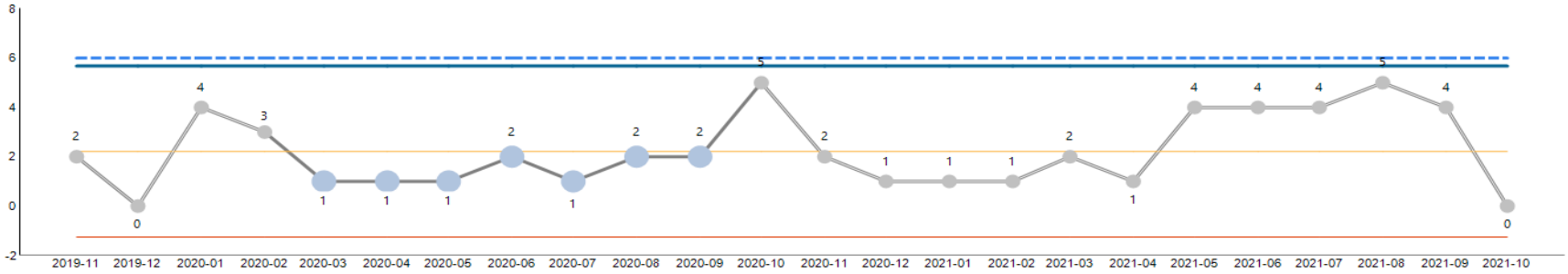
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Quantity of complaints

Quantity of complaints

Target	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	2021-09	2021-10
<=6	2	0	4	3	1	1	1	2	1	2	2	5	2	1	1	1	2	1	4	4	4	5	4	0

Common Cause



ucl	6
mean	2
target	6
lcl	-1

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

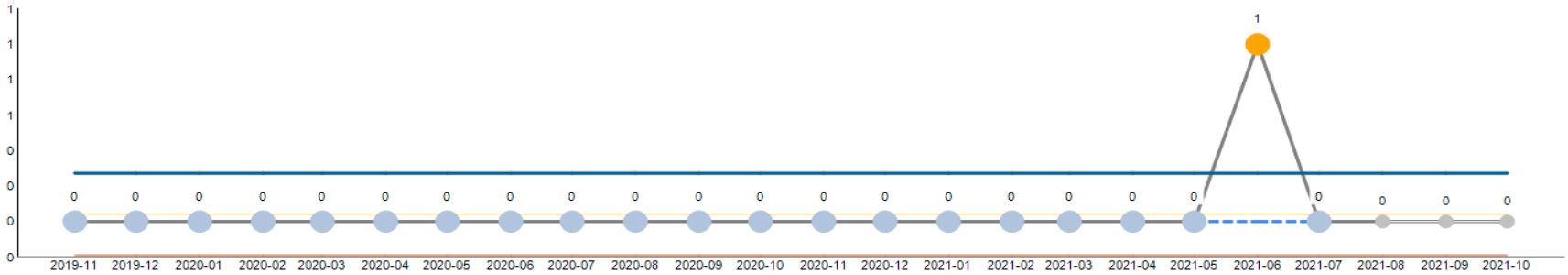
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Occurrence of any Never Events

Count of Never Events

Target	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	2021-09	2021-10
	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0

Common Cause



ucl	0
mean	0
target	0
lcl	-0

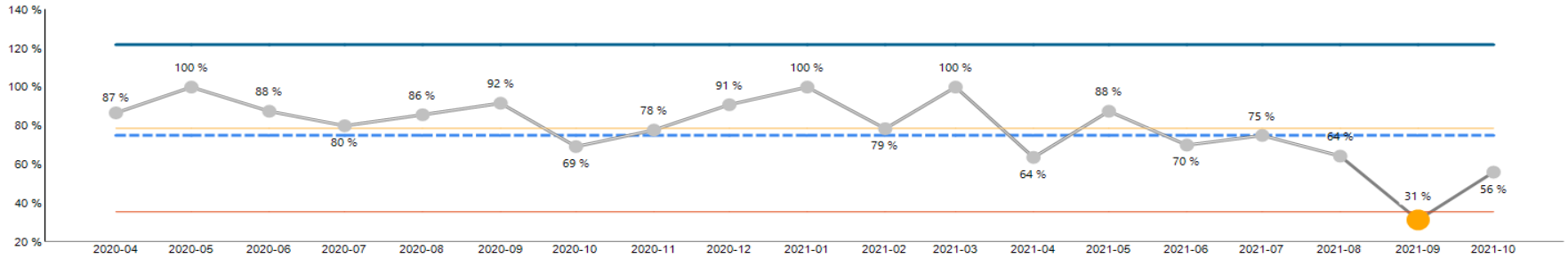
commentary:

Cancer - 28 day wait for Faster Diagnosis Standard

Maximum 28 days from:

Receipt of two week wait referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of two week wait referral of any patient with breast symptoms

	2020/21												2021/22						
Target	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10
>=75%	86.7%	100.0%	87.5%	80.0%	85.7%	91.7%	69.2%	77.8%	90.9%	100.0%	78.5%	100.0%	63.6%	87.5%	70.0%	75.0%	64.3%	31.3%	56.0%



Common Cause

ucl	122%
mean	79%
target	75%
lcl	36%

Commentary:

The Trust has an action plan to ensure performance is achieved in January 22, particular challenges relate to CT Guided Biopsy and EBUS. There are also challenges with PET capcaity that is provided externally to the Trust.

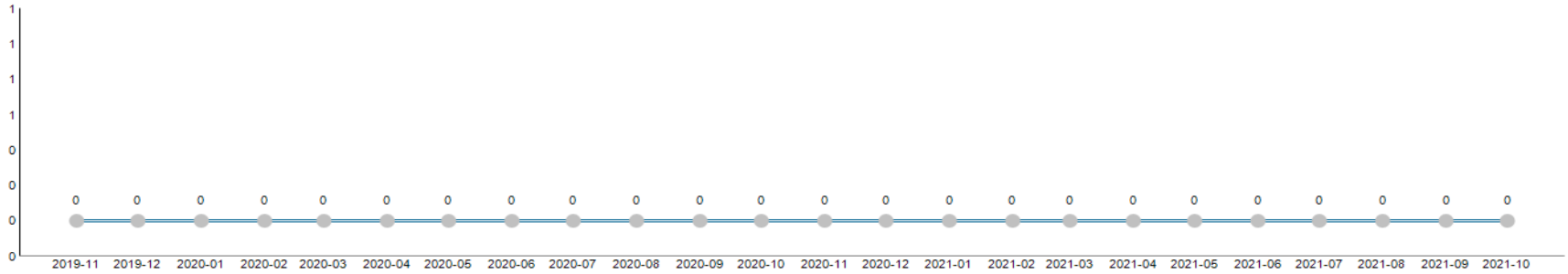
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Mixed sex accommodation breaches

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

Target	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	2021-09	2021-10
	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



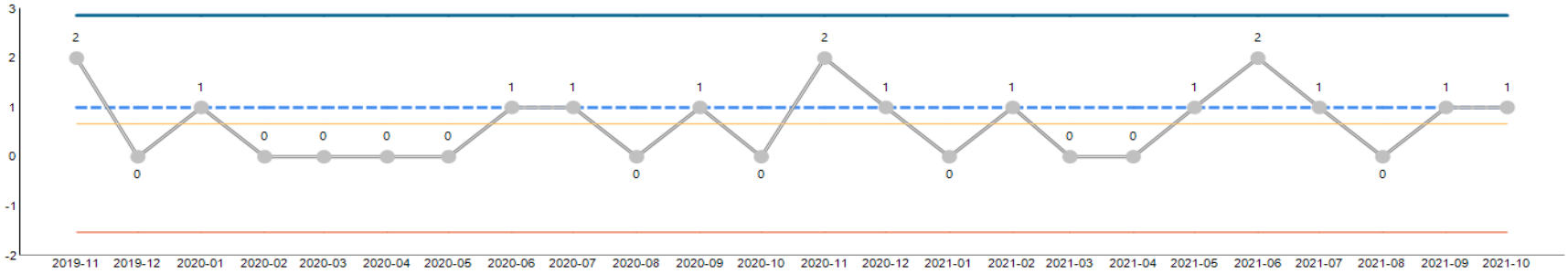
Common Cause

ucl	0
mean	0
target	0
lcl	0

commentary:

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

Target	2019-11	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	2021-09	2021-10
1	2	0	1	0	0	0	0	1	1	0	1	0	2	1	0	1	0	0	1	2	1	0	1	1



Common Cause

ucl	3
mean	1
target	1
lcl	-2

commentary:

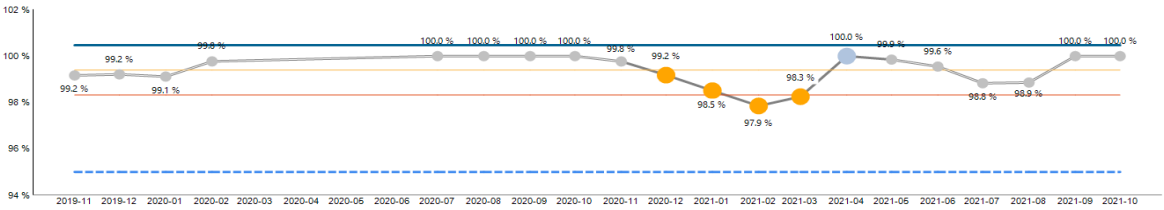
LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

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	2019-11	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	2021-09	2021-10
>=95%	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%	100.0%	100.0%



Common Cause

ucl	100.47%
mean	99.4%
target	95.0%
lcl	98.32%

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

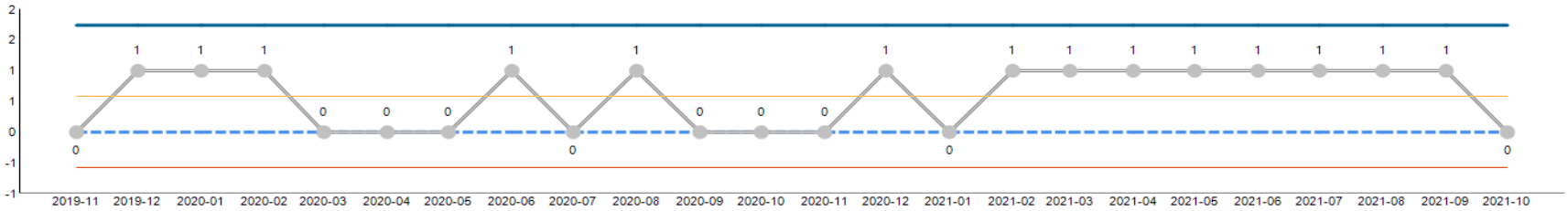
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Clostridium Difficile

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

	2019/20					2020/21												2021/22						
	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	2021-09	2021-10
6	0	1	1	1	0	0	0	1	0	1	0	0	0	1	0	1	1	1	1	1	1	1	1	0
						0	0	1	1	2	2	2	2	3	3	4	5	1	2	3	4	5	6	6

Common Cause



ucl	2
mean	1
target	0
lcl	-1

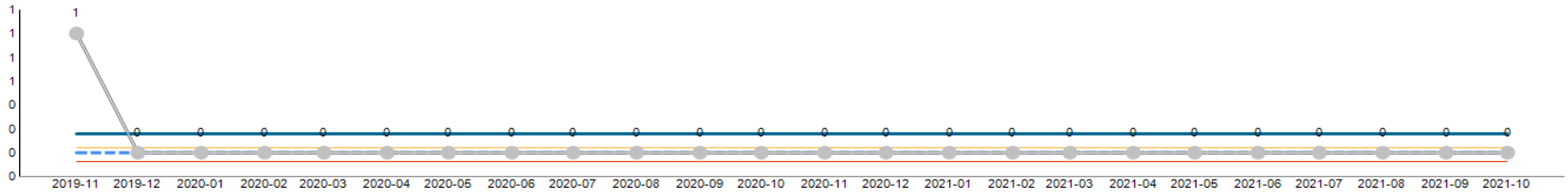
commentary:

MRSA Bacteraemias

Count of trust assigned MRSA infections

	2019/20					2020/21												2021/22						
	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	2021-09	2021-10
0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
						0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Common Cause



ucl	0
mean	0
target	0
lcl	-0

commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

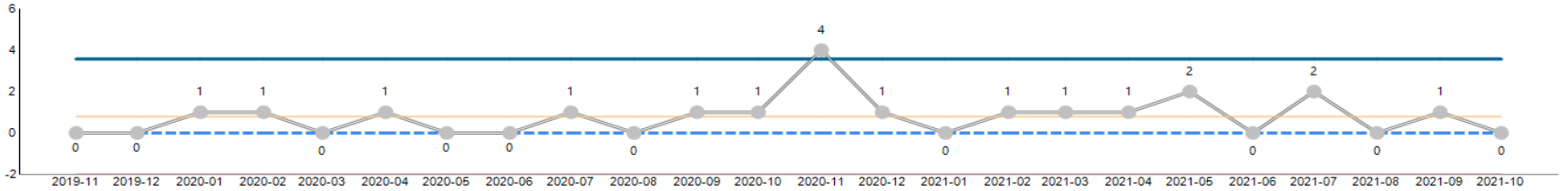
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

MSSA Bacteraemias

Count of trust assigned MSSA infections

	2019/20					2020/21											2021/22						
	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	2021-09	2021-10
9	0	0	1	1	0	1	0	0	1	0	1	1	4	1	0	1	1	1	2	0	2	0	1	0
						1	1	1	2	2	3	4	8	9	9	10	11	1	3	3	5	5	6	6

Common Cause



ucl	4
mean	1
target	0
lcl	-2

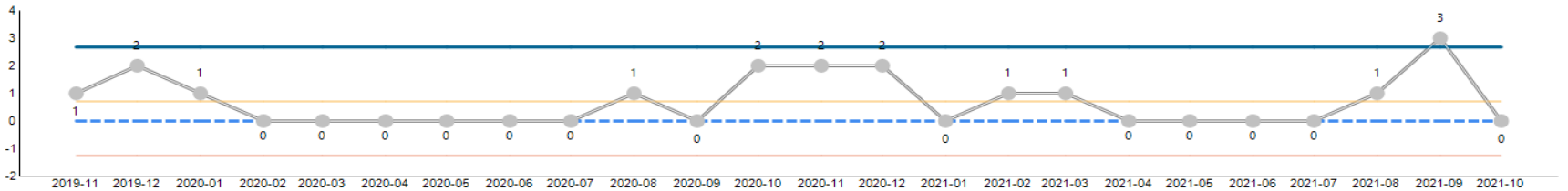
commentary:

Gram Negative Bacteraemias

Count of trust assigned Gram Negative Bacteraemias infections

	2019/20					2020/21											2021/22						
	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	2021-09	2021-10
13	1	2	1	0	0	0	0	0	0	1	0	2	2	2	0	1	1	0	0	0	0	1	3	0
						0	0	0	0	1	1	3	5	7	7	8	9	0	0	0	0	1	4	4

Common Cause



ucl	3
mean	1
target	0
lcl	-1

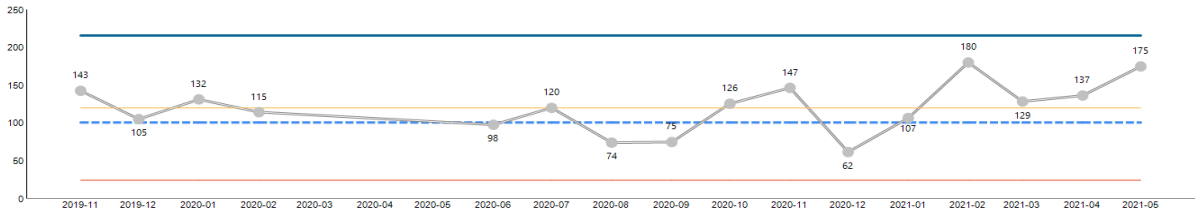
commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Hospital Standardised Mortality Ratio (HSMR) - basket diagnoses

patient characteristics for those treated there.

Target	2019-11	2019-12	2020-01	2020-02	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05
<=100	143	105	132	115	98	120	74	75	126	147	62	107	180	129	137	175



Common Cause

ucl	216
mean	120
target	101
lcl	25

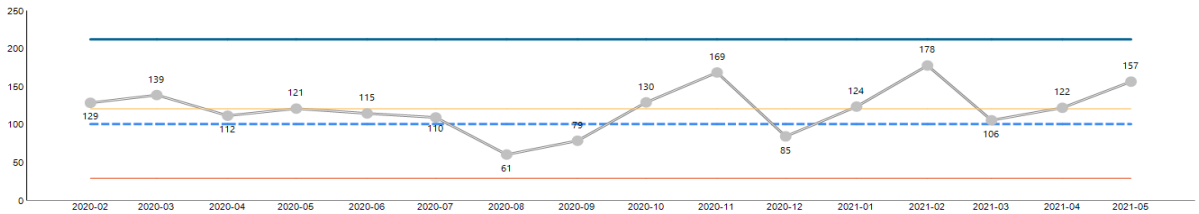
Commentary:

Mortality review group formed and paper to board november 2021

Hospital Standardised Mortality Ratio (HSMR) - all diagnoses

set of patient characteristics for those treated there.

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



Common Cause

ucl	213
mean	121
target	101
lcl	29

Commentary:

Mortality review group formed and paper to board november 2021

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

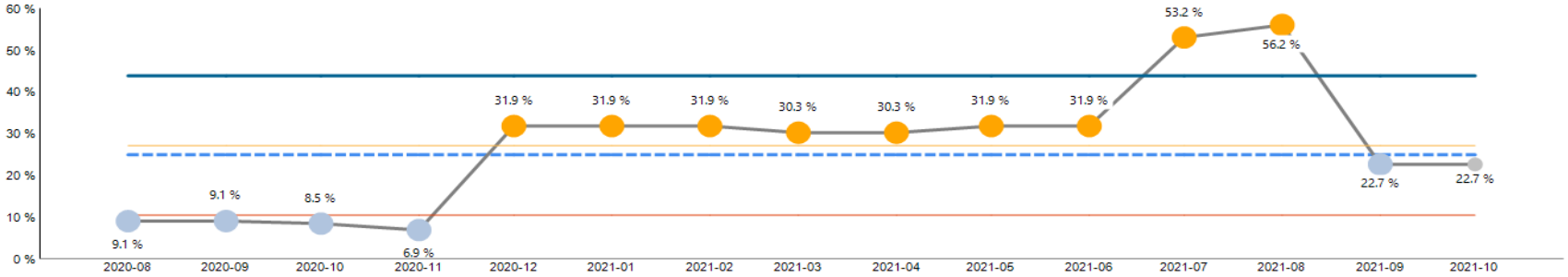
Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Executive Team Turnover

Rate of turnover among the executive team

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

Common Cause



ucl	43.95%
mean	27.23%
target	25.0%
lcl	10.5%

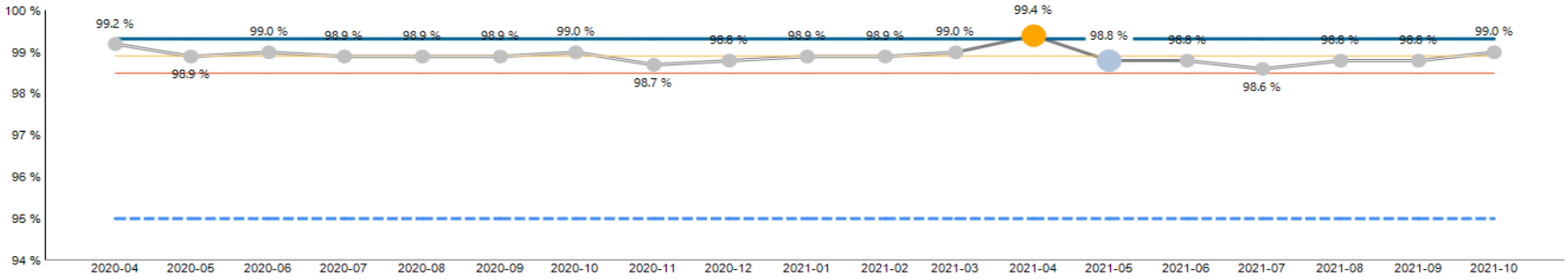
commentary:

LIVERPOOL HEART AND CHEST PERFORMANCE REPORT

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Better Payment Practice Code

Target	2020-04	2020-05	2020-06	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10
100%	99.2%	98.9%	99.0%	98.9%	98.9%	98.9%	99.0%	98.7%	98.8%	98.9%	98.9%	99.0%	99.4%	98.8%	98.8%	98.6%	98.8%	98.8%	99.0%



Common Cause

ucl	99.32%
mean	98.91%
target	95.0%
lcl	98.5%

commentary:

Item 4.2

2021/22 Operational Recovery

Board of Directors – November 2021

Hayley Kendall, Chief Operating Officer

Activity for 21/22

- Elective recovery is focussing on delivering 19/20 (pre covid) levels of activity .

Elective Recovery	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
19/20	655	678	662	756	641	711	779	742	634	746	736	637	8377
21/22 Actual	641	651	678	672	649	634	675						
Variance	-14	-27	+16	-84	+8	-77	-104						
% Delivery	98%	96%	102%	89%	101%	89%	87%						

**figures subject to slight variance with flex/freeze position*

Key pressure points:

- Staffing pressures within the ODP workforce (reduced activity within Theatres and Cath Lab)

52 Week Planning

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	85	72	54					
Variance	-17	-28	-15	-12	-3	-2	-1					

Key pressure points:

- Surgery Trajectory 9 patients off track in October, sub-specialty challenges/critical care staffing impacting
- LAAO, EP and Aortic Surgery main sub specialty pressures (based on clinical prioritisation)
- All 52 week breaches have a completed harm review and are prioritised where possible

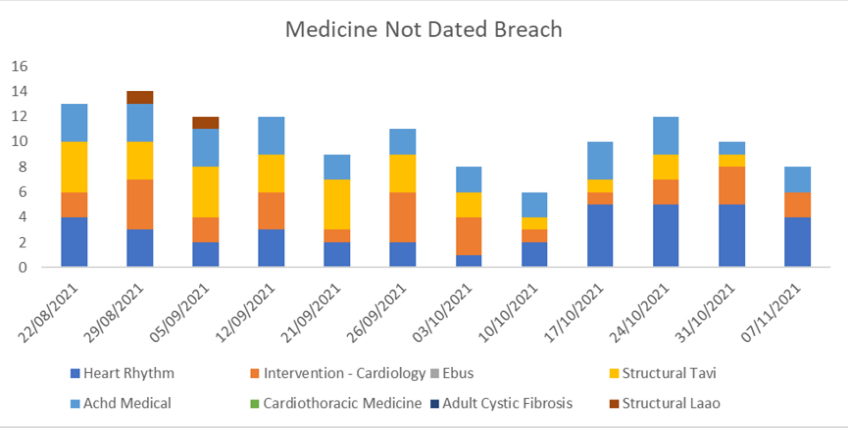
18 Week Trajectory

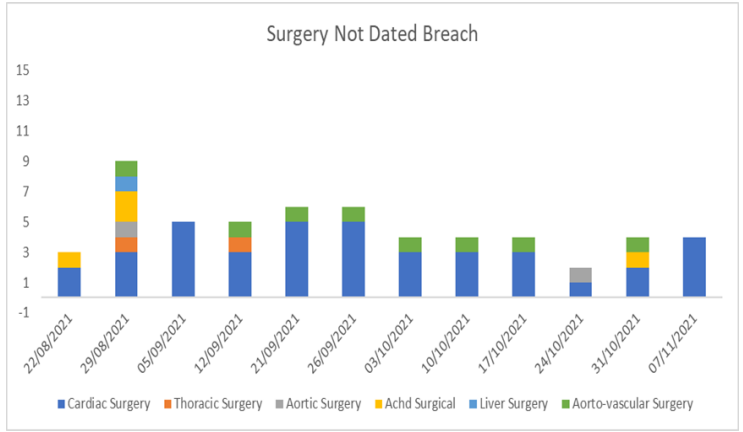
18 Weeks	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	952	863	879	844	804	772	740	700	668	628	596	564
Actual	869	839	829	877	799	777	791					
Variance	-83	-24	-50	+33	-5	+5	+51					

Key pressure points:

- Medicine position has significantly shifted with the transition of EMIS patients (October +69 variance)
- Good progress considering the impact of Covid, mutual aid and workforce availability

P2 Position





- P2 clinical target to have their procedure within 1 month
- Process being reviewed internally, regional submissions being manually validated

	05-Sep-21	12-Sep-21	19-Sep-21	26-Sep-21	03-Oct-21	10-Oct-21	17-Oct-21	24-Oct-21	31-Oct-21	07-Nov-21
Medicine										
Total P2 Waiting	48	47	41	42	40	44	43	44	48	34
Total P2 Not Dated Breach	12	12	9	11	8	6	10	12	10	8
Surgery										
Total P2 Waiting	43	33	36	32	45	48	51	41	56	55
Total P2 Not Dated Breach	5	5	6	6	4	4	4	2	4	4
Trust Total										
Total P2 Waiting	91	80	77	74	85	92	94	85	104	89
Total P2 Not Dated Breach	17	17	15	17	12	10	14	14	14	12

Clock Stops - Admitted

- First month of ERF performance
- Positive recovery position of 121% of admitted clock stops compared to 2019/20

Admitted Actual	Oct	Nov	Dec	Jan	Feb	Mar	Total
CARDIOTHORACIC SURG	106						106
CARDIOLOGY	298						298
CARDIOTHORACIC MEDICINE/SLEEP STUDIES	28						28
TOTAL	432						432

Admitted H2	Oct	Nov	Dec	Jan	Feb	Mar	Total
19/20 Actual	357						357
21/22 % of 19/20	121%						121%

Clock Stops – Non-Admitted

October Non-admitted performance 99% compared to 2019/20

Non-Admitted Actual	Oct	Nov	Dec	Jan	Feb	Mar	Total
CARDIOTHORACIC SURG	56						56
CARDIOLOGY	430						430
CARDIOTHORACIC MEDICINE/SLEEP STUDIES	302						302
TOTAL	788						788

Non-Admitted H2	Oct	Nov	Dec	Jan	Feb	Mar	Total
19/20 Actual	797						797
21/22 % of 19/20	99%						99%

Board of Directors (in Public)
Item 5.1

Subject: **Ratification of Consultant Appointments**
Date of Meeting: **Tuesday 30th November 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 Anaesthetist	Dr Emma Houston	In Post
Consultant Anaesthetist	Dr Melissa Evans	Starting in February 2022

2. Recommendation

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

Board of Directors (in Public)
Item 5.2

Subject: **Ratification of Use of the Trust Seal**
Date of meeting: **Tuesday 30th November 2021**
Prepared by: **Karan Wheatcroft, Chief Governance Officer**
Presented by: **Karan Wheatcroft, Chief Governance Officer**
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. Executive Summary

The purpose of the paper is to ask the Board of Directors to ratify application of the Trust's seal to documentation relating to the following:

- Replacement of Lifts 8 and 9 – Birch Ward, Liverpool Heart and Chest Hospital **JCT DB 2021 Contract Documents**

2. Background

The constitution of the Trust states, at Paragraph 40, that the Trust shall have a seal and that the seal shall not be affixed except under the authority of the Board of Directors.

Operational responsibility for the holding of and the use of the Trust seal is assigned to the Director of Corporate Affairs under the Board's Scheme of Reservation and Delegation.

Wherever possible, authority to apply the use of the Trust seal is sought in advance from the Board of Directors. When time does not permit this, then

ratification is sought at the next Board meeting.

All applications of the seal are recorded in a register and signed by two directors / senior officers ('sealing officers').

3. Use of the Trust Seal 23.09.21

The Trust seal was affixed on 23.09.21 to enable the Contract Documents as documented below:

Date	Document	Particulars	Sealing Officers	
23/09/21	Contract Documents	Replacement of Lifts 8 and 9 – Birch Ward, Liverpool Heart and Chest Hospital	HK	SP

4. Recommendation

The Board of Directors is asked to ratify the application Trust seal in respect of the above transaction.

Board of Directors (in Public)
Item 5.3

Subject: **Change to Delegated Authority Levels within the Scheme of Reservation and Delegation for Liverpool Health Partners (LHP)**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by: **Margaret Thomas, Head of Financial Management**
Presented by: **Karen Edge, Chief Finance Officer**
Purpose of Report: For Approval

BAF Reference	Impact on BAF
BAF 7	Revision to the expenditure approval limits for Liverpool Health Partners.

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

1. Executive Summary

Liverpool Health Partners (LHP) have requested a change to the expenditure approval limits in the Scheme of Reservation and Delegation (SoRD). This has been approved by the LHP Business Performance Sub-Group, chaired by Mike Burns, Chief Finance Officer at the Walton Centre and attended by Karen Edge, Chief Finance Officer at LHCH.

The Audit Committee has considered the proposed update and recommends that the Board of Directors approve the updated limits within the SoRD.

2. Key Updates

The LHP approval limits form part of the Trust's SoRD. The existing LHP approval limits contain some ambiguity and are not consistent with the desired working practices in place at LHP. The proposed revisions clarify what can be approved and will allow each LHP Executive Director the ability to approve expenditure up to £25,000. Approvals are made within the overall funding available and the expenditure plan agreed at the beginning of each financial year. The proposed expenditure limits are shown in appendix 1. An extract from the existing SoRD is detailed in appendix 2.

3. Recommendations

The Audit Committee has reviewed the requested change to the Delegation Levels for LHP Directors within the SoRD and recommends the change to the Board of Directors for approval and adoption.

Appendix 1 – Proposed Approval Limits for LHP

Category	Conditions	Authorised Signatory
A		Chief Executive Officer (CEO)
A, B, C, D, F, G	£1 - £2,000	Head of Delivery & Performance Head of LHP SPARK
A, B, C, D, F, G, H	£1 - £25,000	CEO Deputy Chief Executive LHP Executive Director
A, B, C, D, F, G, H	£25,000 - £100,000	CEO *and* Deputy Chief Executive
A, B, C, D, F, G, H	> £100,000	CEO *and* Deputy Chief Executive only after approval by FP& R Committee and LHP Board.
E		CEO, LHP Executive Team
H	£1 - £2,000	Office Manager/Senior Executive Assistant Head of Delivery & Performance Head of LHP SPARK LHP Programme Managers Communications Manager

Category	Description
A	Letters of support for applications to funding organisations, including but not limited to, Research Councils UK, ERDF, charities etc. including agreement to terms and conditions of any grant award
B	Applications to NHSE/NIHR where LHP is lead applicant (e.g. for joint strategic bids where a non-NHS organisation can be named applicant), including agreement to terms and conditions of any grant award
C	Agreements, including sub-contracts, with external organisations for R&D and educational programmes.
D	Procurement agreements for services, consultancy, equipment etc.
E	Non-Disclosure Agreements with third parties including collaborators, funders, sponsors and suppliers
F	Intellectual Property-related agreements, e.g. licence agreements and assignment agreements
G	Applications to other organisations, including but not limited to government departments and agencies, and industrial / commercial organisations.
H	Procurement of equipment and training for individual LHP programmes, including LHP SPARK

Appendix 2 – Extract from SoRD. Existing LHP Approval Limits

Category	Conditions	Authorised Signatory
A		Chief Executive Officer (CEO)
A, B, C, D, F, G	£1 - £2,000	Head of Delivery & Performance
A, B, C, D, F, G	£1,000 - £20,000	Head of LHP SPARK
A, B, C, D, F, G	£20,000 - £100,000	CEO, Deputy Chief Executive and LHP Executive Directors
A, B, C, D, F, G	> £100,000	CEO and Deputy Chief Executive
E		CEO and Deputy Chief Executive only after approval by FP& R Committee and LHP Board.
H	£1 - £2,000	CEO, LHP Executive Team

Category	Conditions
A	Letters of support for applications to funding organisations, including but not limited to, Research Councils UK, ERDF, charities etc including agreement to terms and conditions of any grant award.
B	Applications to NHSE/NIHR where LHP is lead applicant (e.g. for joint strategic bids where a non-NHS organisation can be named applicant), including agreement to terms and conditions of any grant award.
C	Agreements, including sub-contracts, with external organisations for R&D and educational programmes.
D	Procurement agreements for services, consultancy, equipment etc.
E	Non-Disclosure Agreements with third parties including collaborators, funders, sponsors and suppliers.
F	Intellectual Property-related agreements, e.g. licence agreements and assignment agreements.
G	Applications to other organisations, including but not limited to government departments and agencies, and industrial I commercial organisations.

Board of Directors (in Public)
Item 5.4

Subject: **Freedom to Speak Up (FTSU) Q1 2021/22 Report**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by: **Peris Widdows, Freedom to Speak Up Guardian**
Presented by: **Peris Widdows, FTSU Guardian**
Purpose of Report: **To Note**

BAF Ref	Impact on BAF
BAF 1-5	The report provides assurance on the arrangements in place to support staff to speak up and to ensure learning from staff concerns is identified and embedded.

Level of assurance (*please tick one*)

To be used when the content of the report provides evidence of assurance

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

1. Executive Summary

The purpose of this paper is to provide the Trust Board with an update of the work of the Freedom To Speak Up (FTSU) Guardian and Champions in supporting the safety culture within the Trust, provide an overview of issues and concerns raised in this quarter and updates from the National Guardians Office of Freedom To Speak Up, with the aim of giving assurance that the local arrangements in place continue to meet best practice and support staff to raise concerns.

The paper provides a reflection on the progress made by the FTSU Network in empowering staff to speak up freely and encourage ongoing positive cultural change.

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

2. Background

The National Guardian Office of Freedom to Speak Up (FTSU) emphasizes the need to empower workers to speak up without limitation "about anything which gets in the way of patient care and worker well-being" https://nationalguardian.org.uk/speaking-up/what-is-speaking-up/ and continues the mission to make speaking-up business as usual nationally. NHS Trusts and Foundation Trusts are mandated to employ a Freedom to Speak Up Guardian, whose role is to provide of an alternative channel for workers to raise concerns, to enhance patient safety. The FTSUG ensures that, issues raised are escalated and followed up, thanks and provides feedback and support for those who speak up. There are currently over 700 FTSU Guardians nationally, who are led, trained and supported by the National Guardian's Office. The NGO challenges and provides learning to the healthcare system on matters relating to speaking-up. Over 50,000 speak-up cases were raised through the FTSU Guardians since the role introduction in 2016, all creating learning and improvement opportunities.

The National Guardian's Office published a Strategic Framework in July 2021 whose themes fall into four core pillars of support as follows:

For workers:

- Championing speaking up
- Reflecting the voice of workers in speaking up reviews
- Engaging with partners to promote protection for those who speak up
- Providing training tools for workers to promote a speak up, listen up, follow up culture

For Freedom to Speak Up Guardians:

- To regularly review and update training, guidance and support provided to FTSU Guardians.
- To develop a register of FTSU Guardians that have completed NGO training.
- To develop standards and quality assurance mechanisms for FTSU Guardians.

For the leadership:

- To enable improvements of speaking up culture within organisations and across the system, by supporting the delivery of universal guidance and supportive tools for leaders.
- Provision of learning to support leaders to recognize and utilize the potential for speaking up to accelerate improvement.
- Provision of training for workers, including leaders, to promote a speak up, listen up, follow up culture.
- Promotion of the use of data and intelligence to inform good practice, describing trends and challenges, and encouraging improvement.

For the healthcare system:

- Promotion of universal principles for speaking up and their application across the system
- To produce information and guidance on good practice.
- Seek to establish a consistent set of metrics that allows speaking up culture to be understood at the organizational, system, and national level

- To develop a consistent and supportive response when workers speak up by bringing national bodies together.

Further details of the NGO strategy can be found at: https://nationalguardian.org.uk/wp-content/uploads/2021/07/NGO-Strategic-Framework-2021.pdf

Following the exit of Dr. Henrietta Hughes in September 2021, the new National Guardian, Dr Jayne Chidgey-Clark has been appointed and is expected to commence the role on the 1st of December. 2021. With over 30 years' experience in the NHS, higher education, private and voluntary sectors, Dr Chidgey-Clark, who has been Non-Executive Director and also FTSU Guardian at NHS Somerset Clinical Commissioning Group, acknowledged the role of FTSU in the delivery of high quality healthcare, and expressed her commitment to build on the progress made by the National Guardians Office over the past 5 years. (National Guardian Freedom to Speak Up: Press release: 11 Nov 2021: https://nationalguardian.org.uk/wp-content/uploads/2021/11/New-National-Guardian-appointed.pdf)

At the local level, the Liverpool Heart and Chest Hospital FTSU network comprises of the FTSU Executive Director, Non-Executive Director, the Freedom to Speak Up Guardian, Deputy Guardian and a network of multi-disciplinary FTSU Champions. November 2021 marks one year since the current FTSU Guardian took up post, during which time, over 40 concerns were raised through the FTSU channel. The efforts and support of the FTSU champions have been acknowledged. FTSU policy continues to be integrated at Liverpool Heart and Chest Hospital alongside the Trusts other forms of Speak-Up Safely channels. The Trust's Chief Executive emphasizes her personal pledge encouraging all staff to speak up, reassuring that, any concerns raised will be investigated, and the staff will be protected from any detriment after speaking up.

The FTSU Guardian works closely with the FTSU Executive Director and senior leaders to enable effective escalation, review and triangulation of safety and welfare concerns; a standard operating procedure within the governance process ensures that all concerns, especially any patient safety or serious issues are escalated immediately to the Chief Executive, investigated and followed up.

The FTSU Guardian maintains regular engagement and communication with the National Guardian's Office and the Northwest Regional Network of FTSU Guardians for updates, peer support and continued learning.

The FTSU Guardian also reports anonymized speak-up data as requested by the NGO, where themes and trends are analyzed, to inform guidance and improvements at a national level. Regional and national information is cascaded to the trust by the guardian, through regular meetings with the Executive FTSU Lead, to the wider organisation by presentations at the trust's monthly Team Briefs and to the Board of Directors through quarterly reports.

3.1 Assessment of issues: Quarter 2 2021/22:

New guidance on reporting cases by the National Guardian's office which came into effect in April 2021 has been applied in this report. Some of the changes to the data reporting guidance include addition of the "Worker Safety" category and added clarification of 'detriment', which in accordance to the NGO, means any "disadvantageous and/or demeaning treatment" based on the speaking-up person's perceptions.

- A total of 8 concerns were raised through the Freedom to Speak Up Policy in Quarter-2, 2021/22.

- These concerns relate only to those raised directly with the FTSUG / Champions network. Concerns raised through other safety channels e.g. through DATIX, HALT, Safety Huddles or with line managers are not logged unless referred to the FTSU Guardian.
- Concerns recorded as anonymous fall under those that were completely unidentifiable plus those that asked for their identity to be withheld but may be known to the champion they spoke to.
- One concern raised this quarter suggested potential risk to patient and staff safety through impact of human factors of exhaustion / workload. This was escalated to Divisional Head of Clinical Services and listening events have been initiated to facilitate a review of emergency and on-call policies in the department.
- The 5 concerns in the "Other Category" include issues relating to staff health and wellbeing, working practices and policies and upholding of organizational values and behaviours. One of the recurrent themes has been work-related stress from impacts and changes from the COVID-19 pandemic.
- All Concerns were escalated in line with FTSU standard operating procedure and actioned appropriately.
- 6 of the 8 concerns raised this quarter have been fully actioned and closed while 2 are still in progress, one of which concerns a review of relevant policies.
- The themes of the concern as per categorization by the National Guardians Office (NGO) can be viewed in table 3.1 below:

Table 3.1: Themes of cases raised in Q2-2021/22 as per the NGO's categorization

Total Number of cases raised to the Guardian / Champions	**8**
Number raised anonymously / identity withheld	**3**
Number of cases with an element of:	
Potential risk to patient and worker safety (Human Factors *from impact of staff exhaustion)*	1
Bullying or Harassment:	1
Detriment / demeaning treatment from speaking up (also with element of bullying and harassment)	1
Other Category: Includes staff health and wellbeing, trust values and behaviors, working practices and policies, staff wellbeing, work-related stress - impacts of COVID-19	5

Note: Some of the cases fall under two categories (for example: worker exhaustion with perceived potential impact on patient and staff safety, while another case fell was raised as B&H and detriment from speaking up).

3.2 A comparative summary of themes and trends over the past 4 quarters as categorized by the NGO is provided in table 3.2 below. The trend in concerns raised per themes has remained inconsistent. The varying nature of concerns raised in the 'Other category' can be an indicator that workers are comfortable to speak about anything that concerns them, which is one of the FTSU questions rated in the NGO's FTSU index.

Table 3.2: Comparative themes of trends of the current and previous three quarter's

Themes of concerns as categorised by the NGO	**Q2 2021/22**	Q1 2021/22	Q4 2020/21	Q3 2020/21
Element of Patient Safety or Quality / Staff Safety	**1**	0	4	2
Bullying and Harassment	**1**	5	2	4
Detriment / demeaning treatment from speaking up (with an element of bullying / harassment)	**1**	0	0	0
Other**:** Includes staff health and wellbeing, trust values and behaviors, working practices policies, impact of changes from COVID-19 pandemic	**5**	7	7	3
Total	**8**	12	13	9
Concerns raised anonymously	**3**	3	1	0

3.3 The table below reflects the professional level of individuals who spoke for the current and previous three quarters, as per the reporting guidance issued by the National Guardian Office. As with the previous quarters, the worker category raised the highest number of speak-ups.

Concerns raised by staff bands	**Worker**	**Senior Manager**	**Senior Leader**	**Unknown/ Undisclosed**	**Total**
Q2 2021/22	**7**	**0**	**0**	**1**	**8**
Q1 2021/22	9	0	0	3	12
Q4 2020/21	12	0	0	1	13
Q3 2020/21	8	0	0	1	9

3.4 The table below reflects the professional groups of the 'speak ups' for the current and previous 3 quarters as per the National Guardian Office guidelines.

Concerns raised by professional groups per quarter	**Q2 2021/22**	Q1 2021/22	Q4 2020/21	Q3 2020/21
Medics	**0**	2	1	2
RGN/ Midwives/ ANPs	**1**	3	4	2
Nursing Assistants & HCA	**0**	0	1	1
Allied Health Practitioners	**1**	0	4	1
Admin, Clerical	**3**	0	2	2
Maintenance/Ancillary/ Cleaning/ Catering	**0**	1	0	0

Corporate Service Staff	**0**	1	0	0
Undisclosed	**3**	5	1	1
Total number of speak-ups	**8**	1 2	1 3	9

3.5 Governance

Quarterly meeting between the FTSU Guardian, Executive Director, NED Lead for FTSU and the Chair have continued to brief on the issues raised, actions taken and learning. Feedback and learning from the issues raised is shared at safety huddles and team briefs.

Ongoing quarterly Safety Surveillance meetings to facilitate triangulation of FTSU with other patient-safety metrics.

The Quarterly 'Improving People Practices' meeting between the FTSU Guardian and HR Business Partner continue, which enables FTSU concerns to be triangulated with ongoing employee relations cases to facilitate a review of welfare support for any staff member undergoing an HR process.

Ongoing regular 1:1-meetings between the FTSU Guardian and Director of Executive Director of FTSU, who also holds an open-door policy for urgent advice and is contactable by emails.

Engagement with the FTSU champions has been enhanced by quarterly face to face workshops, additional to the fortnightly FTSU Guardian & champions drop-in sessions, which have been set up to facilitate learning and development, updates /guidance and to share experiences.

The first FTSU Workshop in this financial year, attended by the FTSU Executive Director, the new Non-Executive Director, FTSUG and champions, was held on 13th September and was a great success. The next quarterly workshop is due on the 2nd of December 2021.

NGO released a guidance document for the FTSU champion's role description in April 2021 (please see appendix 2). Following consultation with the champions at the workshop and after further clarifications with the NGO via the North West FTSU Guardians Network, conclusions were made that our Trust's champion's role description is aligned with the NGO's guidance, so no changes were made.

The FTSU escalation process is shared with the FTSU champions and upheld, to ensure adherence to the FTSU policy and the standard concern escalation process.

3.6 Raising FTSU profile and October Speak-up Month

The emphasis for the October Speak-Up month has been on raising awareness of the "Speak-up, Listen-up and upcoming Follow-up" training. Information notices were posted via by digital screen savers encouraging staff to access the training modules. Various middle and line managers were emailed links to enhance training uptake, as collaborative efforts continue between the FTSU Guardian and Education Centre to enable easy access on the trust's electronic staff record system. The FTSU Guardian is also engaging with the Education and Human Resources team to incorporate FTSU awareness links in the new civility awareness training in the trust.

To maintain a high profile within the organisation, visibility and awareness-raising walkabouts are continually conducted at by the guardian, deputy guardian and FTSU champions, with ad hoc one-to-one conversations with colleagues on how to access the FTSU policy and contacts details. These compliment other profile-raising activity such as such as monthly presentations at trust team briefs,

attendance of Trust Safety Huddles by the FTSU guardian, participation in Equality and Inclusion Steering Group as well the Health and Wellbeing Group to name a few.

Apart from raising awareness of the FTSU policy, these actions provide assurance to workers of the trust's commitment to maintain a safety speak-up culture. Efforts are underway to expand the FTSU champions network to enhance all round worker representation, with special attention being paid to under-represented staff groups such as student nurses, which has guided the appointment of the trust's Student Placement Education Facilitator as a new FTSU champion, currently awaiting induction. Further efforts are in place to seek recruitment amongst colleagues in catering, domestic, porter services and those who work permanent night shifts to address barriers to speaking up.

3.7 Learning Opportunities for LHCH

The NGO has published a case review of Blackpool Teaching Hospital speaking up culture, in October 2021, which looked at the speak-up culture, the Freedom to Speak Up Guardian and the leadership in the organisation. This publication can be viewed at: https://nationalguardian.org.uk/wp-content/uploads/2021/10/Blackpool_Teaching_Hospitals_FT_case_review.pdf
Most of the NGO recommendations are already embedded at LHCH such as thanking, supporting following up and feeding back staff who have spoken-up through the FTSU channel. A detailed analysis of the key recommendations will be undertaken at LHCH, to conduct at the trust's Team Briefs and the SOLE bulletin.

Another case report produced by the NGO from the100 Voices campaign, "Speaking up about burnout - improving worker experience", Liz Houchin, Freedom to Speak Up Guardian at Northern Lincolnshire and Goole NHS Foundation Trust" https://nationalguardian.org.uk/case-study/speaking-up-about-burnout-improving-worker-experience/, echoes some of the worker concerns raised at LHCH in this quarter. Learning from this case study will be extracted and shared to facilitate the listening processes.

3.8 Internal Evaluation and Assessment

Staff who have raised concerns to the FTSU guardian and champions are asked to feedback on their experience of speaking, after the cases have closed. Feedback received this quarter offers assurance that speak-up colleagues would be happy to raise concerns through the FTSU policy again. Below is one example of the FTSU feedback responses received:

Given your experience on speaking-up through the FTSU channel, would you speak up again? (Yes/No/ Maybe)	Please explain your response.
Yes	It was helpful speaking about the experience, and I would again consider speaking up if situation arose. Feedback was given and I was happy with the process.

4. Conclusion

The Freedom to Speak-Up channel compliments the well-established safety culture in the trust where staff are encouraged to raise concerns. FTSU network provides an alternative channel for staff to speak confidentially or anonymously, assurance that concerns will be escalated, and workers are supported while concerns are investigated.

The FTSU Guardian will continue to maintain an active role in engaging with the staff to raise the

FTSU profile, provide updates, quarterly and annual reports, on the number of concerns raised through the FTSU Network and any common themes to the Board of Directors. The FTSU guardian will also continue to engage with the National Office and regional network to ensure LHCH continues to lead the way in relation to best practice.

Next steps: To complete analysis, extract, cascade learning from the NGO case reviews.
The National self-assessment toolkit for FTSU and FTSU Strategy will be also be reviewed to align with the new NGO strategy as well as the Quality and Safety Strategy; these action points had been paused from impact of some sickness absence but will be revisited in the upcoming quarter.

5. Recommendations

The Board of Directors is asked to:

i) note the quarter 2 2021/22 report;
ii) note the NGO guidance for the FTSU Champion's role description and NGO recommendations from the Blackpool case review (raised in appendices 1 and 2);
iii) accept assurance that local FTSU arrangements are in place and meet best practice guidance.

Appendix 1

National Guardian's Office

Developing Freedom to Speak Up Champion and Ambassador Networks Guidance for Freedom to Speak Up Guardians April 2021

Summary of Recommendations

➢ Do not use the term 'Advocate'

➢ Distinguish between the role of guardian and champion so that only Freedom to Speak Up Guardians handle speaking up cases

➢ Champions are given ring fenced time to do the role

➢ Champions are appointed in a fair and open way and barriers to appointment are identified and addressed

➢ Encourage applications from groups who face barriers to speaking up

➢ Champions undertake NGO/Health Education England Speak Up, Listen Up training

➢ Champions are provided with regular and suitable support

➢ The use and effectiveness of local Freedom to Speak Up networks are regularly reviewed.

Appendix 2

NGO Recommendations: Blackpool Teaching Hospitals Case Review Oct 2021

Within three months, the trust should:

1.1 Continue to demonstrate that it values the views of its workers, including consulting staff about changes to their services as appropriate, in line with its policies and procedures and good practice.

1.2 Continue to take appropriate steps to promote a culture of visible and accessible leadership.

1.3 Take appropriate steps so that issues about which workers speak up are responded to in accordance with trust policies and procedures and good practice.

1.4 Take appropriate steps to ensure workers who speak up are meaningfully thanked for doing so, in accordance with trust policies and procedures and good practice.

1.5 Take appropriate steps to ensure its policies and procedures are fair and supportive of all workers in the speaking up process, including those who are the subject of matters that are raised.

1.6 Take appropriate steps to promote effective communication with those speaking up in order to effectively manage expectations.

1.7 Take appropriate steps to assure themselves that speaking up practices ensure that the confidentiality of workers who speak up is appropriately supported – including looking into cases where a breach of confidentiality is reported.

1.8 Take appropriate steps to ensure that workers who speak up can have input into the terms of reference for any subsequent investigations, in accordance with trust policies and procedures and good practice.

1.9 Take appropriate steps to ensure its response to workers speaking up, including the investigations of those issues and the implementation of learning resulting from them, is undertaken by suitably independent and trained investigators.

1.10 Take appropriate steps to ensure matters arising from cases of speaking up are investigated within reasonable timescales and without undue delay.

1.11 Take appropriate steps to ensure that workers who speak up receive meaningful and timely feedback in accordance with trust policies and procedures and good practice.

1.12 Communicate that detriment for speaking up will not be tolerated, act to prevent detriment occurring, and put in place procedures that would enable cases of detriment to be investigated effectively when they are reported.

1.13 Take appropriate steps so that those who speak up have access to appropriate support and are made aware of and appropriately supported to access this support in a timely way.

1.14 Work with their Freedom to Speak Up Guardian to identify potential groups that face barriers to speaking up, and work towards addressing those barriers.

1.15 Provide assurance that all three Freedom to Speak Up Guardians that support workers at the trust, are able to meet the requirements of the universal job description.

1.16 Revert to using the term 'Freedom to Speak Up Guardian' for all three guardians. It may, locally, consider how it communicates the primary functions of the individuals in each of the roles though, at all times, the individuals should be able to fulfil the requirements of the universal job description.

1.17 Ensure that that changes to the Freedom to Speak Up arrangements are communicated to workers in a timely way.

1.18 Take appropriate steps to assure themselves that their Freedom to Speak Up Guardian arrangements have the confidence of the workforce.

1.19 Provide the Freedom to Speak Up Guardian(s) with ring-fenced time for the role, taking account of the time needed to carry out the role and meet the needs of workers in their organisation. Leaders should be able to demonstrate the rationale for their decisions about how much time is allocated to the role.

1.20 Take appropriate action to ensure the Freedom to Speak Up Guardian(s) are appropriately supported to carry out their role, in line with guidance from the National Guardian's Office and NHS England and Improvement.
1.21 Take appropriate steps to ensure cases brought to the Freedom to Speak Up Guardian are recorded and reported in accordance with guidelines from the National Guardian's Office.

***Within six months, the trust should**:*
2.1 Continue with and review the effectiveness of its programme of work to challenge unwanted and/or unprofessional behaviors.
2.2 Continue to promote and facilitate the use of mediation where appropriate.
2.3 Continue to improve effectiveness of its governance arrangements, including the communication of information from and to 'board to ward'.
2.4 Continue to take appropriate steps to ensure human resources policies and processes have the confidence of its workforce, including effective training for workers in human resources.
2.5 Update and implement the trust's equality, diversity and inclusion strategy considering the findings of this review.
2.6 Provide and monitor the uptake of effective speaking up training for all workers, ensuring this meets the expectations set out in guidelines from the National Guardian's Office.
2.7 Complete the Freedom to Speak Up review toolkit and share this with NHS England and Improvement, in line with NHS England and Improvement guidelines.
2.8 Continue to improve the board reports presented by the Freedom to Speak Up Guardian, ensuring this is in line with guidelines from NHS England and Improvement.
2.9 Develop and begin the implementation of a strategy to improve the speaking up culture across its workforce, in line with guidelines from NHS England and Improvement. The plan should contain measures to identify the main issues the trust should address, clear actions to address those issues and steps to measure the effectiveness of those actions.
2.10 Develop and evaluate its Freedom to Speak Up communication plan in line with guidelines from NHS England and Improvement, ensuring this takes account of workers in the trust's community sites and other groups that may face barriers to speaking up.
2.11 Develop a plan to ensure that workers can speak up effectively about the impact of integration as its local integrated care system continues to develop and mature.

Within nine months, the trust should:
3.1 Review the use of the Freedom to Speak Up Champion role, ensuring this is in line with guidelines from the National Guardian's Office.

Within 12 months, the trust should:
4.1 Discuss and agree a continuity plan to support incoming Freedom to Speak Up Guardians and minimize any disruptions to the Freedom to Speak Up arrangements, ensuring this is in line with guidelines from the National Guardian's Office.
4.2 Take appropriate steps to identify and review measures to assure themselves that those with senior responsibility for Freedom to Speak Up have the confidence of the workforce, making improvements as needed.
4.3 Revise the trust's speaking up policy to take account of the observations made in this report.
4.4 Take steps to ensure all existing and new workers are aware of the contents and meaning of its revised speaking up policy.

Board of Directors (in Public)
Item 5.5*

Subject: **Communications Report Q2**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by: **Matthew Back, Head of Comms**
Presented by: **Karen Nightingall, Chief People Officer**
Purpose of Report: **To Note**

BAF Reference	Impact on BAF
N/A	None

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

1. Executive Summary

The purpose of this report is to keep the Board of Directors informed and provide a high level update on Trust communications activities during quarter 2 (July-Sept 2021).

2. Background

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

3. Highlights During Quarter 2 (July-Sept):

- We successfully delivered two staff events: LHCH Virtual Awards (attended by approx. 200 staff) and the LHCH Staff BBQ
- We organised the Annual Members' Meeting, including a brief highlights of the year video
- We completed the statutory Annual Report & Accounts and ensured this was laid before Parliament, and produced the Summary Annual Report/Year in Review.
- We received positive media coverage.

- We supported comms for multiple vacancies.
- We supported the launch of the Targeted Lung Health Check Programme in July
- We provided comms support for a performance from Maghull Wind Orchestra.
- We supported a number of awareness days/events including World Heart Day (incl. virtual online session with Natalie Hudson, Resus Lead) and World Sepsis Day and made extensive plans for October's Green Awareness Month.
- We provided brand support for the new Recruitment Strategy and Education Strategy.
- We launched a new podcast channel and recorded the first in a new series featuring Dr Vishal Luther, Consultant Cardiologist.
- Extensive planning and support for covid booster and flu campaigns
- Members Matters newsletter and survey produced, posted and shared.
- Ongoing planning for Highfield House formal opening.
- Ongoing planning for new LHCH Charity Christmas campaign – 12 Days of Christmas
- Production of Medical Student Training Guide and new Health & Wellbeing Newsletter
- Concluded governor elections: 3 seats Cheshire; 1 in Merseyside; 1 in North Wales; and 1 for Rest of England.

Q2 was a busy quarter for the communications team

- Positive engagement and reach was seen on all three main social media channels. Facebook performs best with patient experience/staff story content; and Twitter engagement with clinical content was positive.
- Overall, total social media impressions for Q2 was just over 321,000 with audience growth, year to date, across all three platforms between 6-10%.

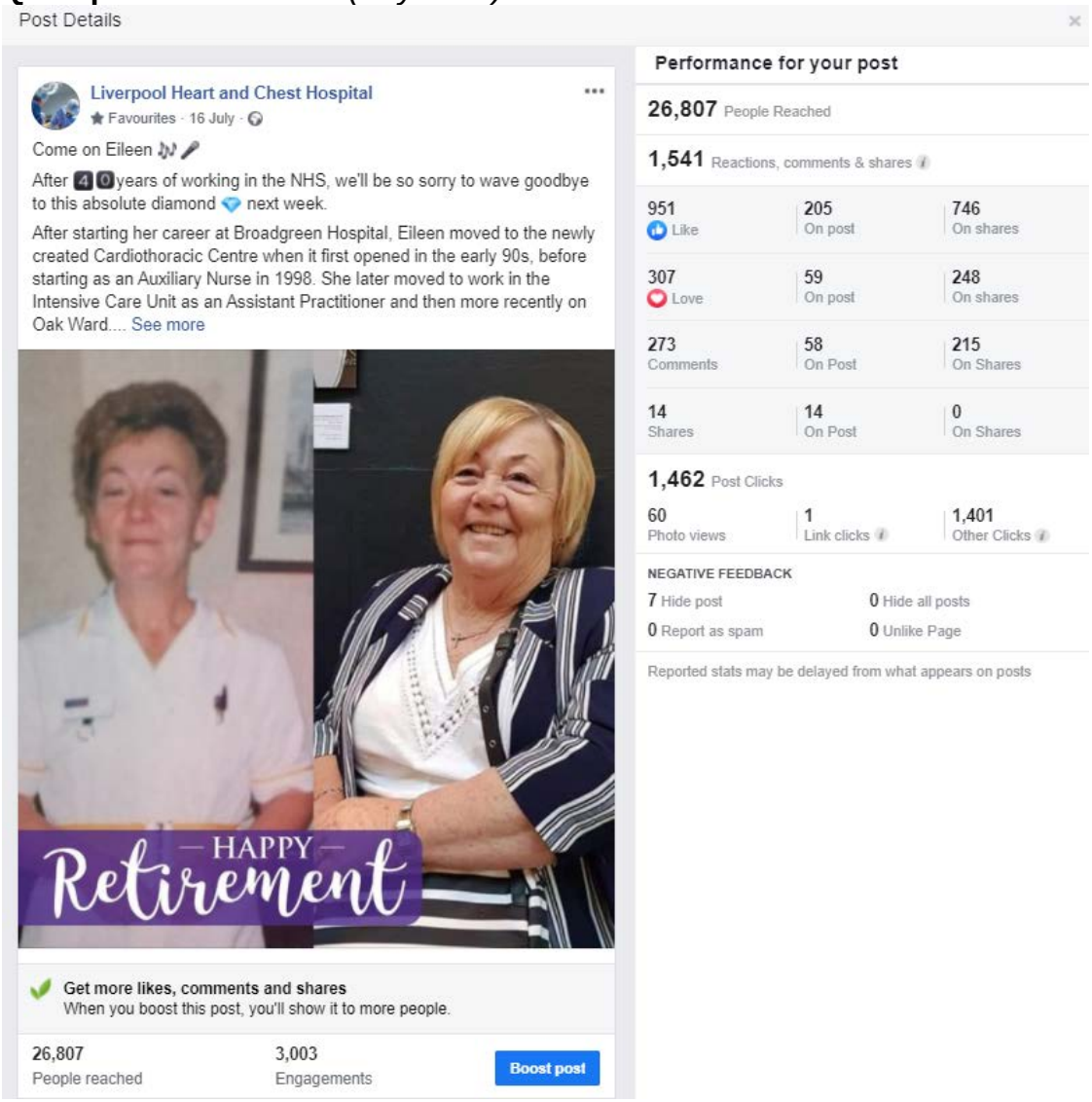
SOCIAL MEDIA MONITORING

Q2 2021/22	Twitter	Facebook	Instagram
Audience	6,687	7,120	1,325
Audience Growth YTD	5.95%	6.08%	10.4%
Reach	N/A	806,844	20,535
Impressions	153,800	167,798	66,750
Number of Posts	96	40	25

SOCIAL MEDIA ACTIVITY HIGHLIGHTS

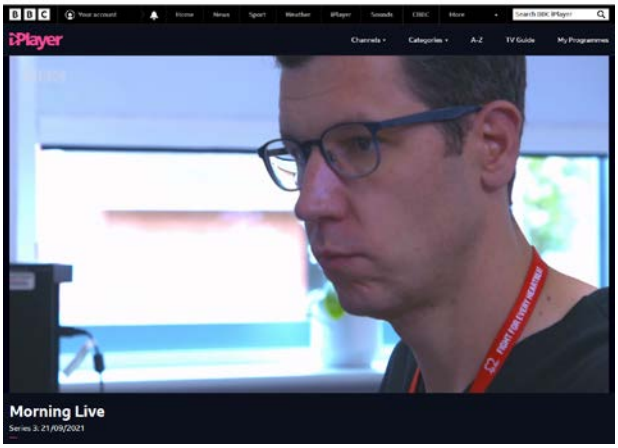
Q1 Top Tweet *(Aug 2021)*	**Q1 Top Mention** (*July 2021)*
	

Q1 Top Facebook Post *(July 2021)*



MEDIA COVERAGE

- Positive media coverage of the launch of the Targeted Lung Health Check Programme
- Dr Rob Cooper participated in a Liverpool Echo feature for World Heart Day and Prof Lip was interviewed by BBC Radio Merseyside for World Heart Day
- A total of 23 pieces of media coverage were picked up in quarter 2 including:
    - 1 radio interview *(Prof Greg Lip)*
    - 1 TV *(Dr Fairbairn on BBC One – Good Morning Live)*
- One negative piece was featured in Liverpool Echo re. coroner's verdict.



PLANS FOR Q3

- Exploration of new comms framework
- Develop new process for collating national award submissions
- Comms support for covid and flu campaigns
- Comms support for NHS staff survey
- Comms support for the launch of Be Civil Be Kind
- Comms support for October's Green Month and other awareness days/events (Pain Awareness, Pressure Ulcer Awareness, Allied Health Professionals Day, Remembrance Day, Radiography Day etc)
- New podcast guests interviewed and shared via social media.
- Planning for launch of LHCH photography competition in 2022.
- Live filming Cath Lab case with Prof Dhiraj Gupta
- Online membership events: cardio-oncology event with Ainsdale Medical Centre; CPR training at Marine FC

4. Conclusion

- Overall positive media coverage.
- Positive engagement across social media channels. Ongoing work to identify strong patient / staff stories, which deliver greatest reach.
- Extensive planning and support for the start of covid booster and flu campaigns
- Positive internal communications events with excellent engagement

5. Recommendations

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

Board of Directors (in Public)

Item: **6.1.1**
Subject: **Audit Committee BAF Key Issues Report**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by: **Jennifer O'Brien, Senior Executive Assistant**
Presented by: **Julian Farmer, Chair Audit Committee**
Meeting Held: **Tuesday 19th October 2021**

Agenda Item	Lead Exec	Assurance Received	New/Emerging Risks	Actions/Comments
3.1	KWh	Mid-Year Review of Assurance Committees	None	The Audit Committee noted the reports and received assurance that the Quality Committee, People Committee and Integrated Performance Committee was performing well against the objectives set out in their terms of reference.
3.2	KWh	Risk Management KPIs	None	The Audit Committee noted that work was progressing to improve the reporting functionality in order to automate the reports, allowing divisional leads to fully utilise the reports and identify any gaps with individual risks. The assurance KPI remained static at 91% against a 95% target and 68% of incidents had been closed within 28 days. It was recognised that further measures were needed to boost performance in the divisions, however it was

				confirmed the new reporting style allowed for live updates to the risks and it was anticipated that a much improved performance would be reported at the next Audit Committee.
3.3	KE	Losses & Special Payments	None	Reviewed and Noted
3.4	KE	Single Supplier Tender Waivers	None	Reviewed and Noted
3.5	KE	Review of SORD: LHP Updates	None	The Audit Committee reviewed and approved the requested amendment to the SORD for recommendation to Trust Board.
3.6	KWh	Compliance with Licence: Review of Quarterly Checklist	None	The Audit Committee reviewed the checklist and confirmed its satisfaction that there were effective systems and processes in place to identify and manage risks in relation to compliance with the licence. Assurance was provided on the Trusts 18 week wait times in comparison to other providers. ERF changes for H2 focussed on RTT clock stops and it was reported that LHCH were one of the highest performers in the region.
3.7	KE	Regulatory Action Plans	None	The Committee noted that there were no outstanding actions with either the CQC or NHSE/I.
3.8	KW	Cyber Security Update	None	The Audit Committee received an update relating to cyber security assurance, highlighting key controls, developments and performance against standards. The Audit Committee noted that the Trust were aiming to secure the Cyber Essentials accreditation by the end of March 2022, although it was hoped that this could be achieved sooner.
3.9	KW	Data Quality Assurance Report	None	The Audit Committee received the report which detailed the significant amount of work that had been carried out over the last six to nine months relating to the Data Quality policy, Data Quality Strategy, and a significant piece of work relating to waiting list

				management. The Patient Pathway Assurance Group (PPAG), weekly performance meeting and weekly report to the Executive Team provided assurance that this work was being monitored regularly.
3.10	KE	Third Party Assurances	None	The Audit Committee noted that the external reviews at both St Helens and Knowsley NHS Trust and SBS did not identify any material issues relating to the controls in place.
4.1	KE	Internal Audit Progress Report on Delivery of Plan	None	The report was noted and work was scheduled to be completed on time.
4.2	KE	Anti-Bribery Report	None	The full report was noted by the Audit Committee
4.3	KE	Research Finances Audit Report Action Plan	None	The Audit Committee noted the comprehensive overview of the action plan, although requested that it was developed to include implementation dates and timescales in order to provide greater assurance.
4.4	KE	Summary of Stakeholder Feedback: Internal Auditors	None	The results of the survey were very positive and indicated that MIAA highlighted and investigated the key areas of risk, had clear reports and their staff were responsive and professional. No areas for improvement were highlighted.
5.1	KE	Finalised Auditors Annual Report	None	The external auditors final annual report detailed the conclusion of the audit for 2020/21 and reflected on the work on the enhanced Value for Money (VFM) arrangements. The report confirmed that a qualified audit opinion had been issued on the Trusts financial statements, no Public Interest Report was issued and no referrals to the NHS Regulator were required.

				The Trust had responded to all necessary findings or recommendations and there were no areas of concern to highlight. The Audit Committee were assured with the very positive report and noted the full contents and appendices.

minutes

Item 6.1.1a*

E- Meeting of the Audit Committee

Minutes of the Audit Committee Meeting held on Tuesday 6th July 2021

Committee Members:	**Julian Farmer**	**Non-Executive Director-Chair**
	Bob Burgoyne	**Non-Executive Director**
	Karen O'Hagan	**Non-Executive Director**
Committee Attendees:	**James Bradley**	**Deputy Chief Finance Officer**
	Karen Edge	**Chief Finance Officer**
	Laura Hunter-Cross	**Head of Financial Services**
	Michelle Moss	**Anti-Fraud Specialist-MIAA**
	Marga Perez-Casal	**Director of Research & Innovation (item 3.3 only)**
	Karan Wheatcroft	**Corporate Governance Officer**
	Chris Whittingham	**Senior Manager-Grant Thornton**
	Nigel Woodcock	**Senior Internal Audit Manager-MIAA**
	Jennifer O'Brien	**Senior Executive Assistant (Minutes)**
Apologies:		
	Nick Brooks	**Non-Executive Director**
	Georgia Jones	**Key Audit Partner-Grant Thornton**
	Mark Jones	**Non-Executive Director**
	Lucy Lavan	**Director of Corporate Affairs**

	Action
In accordance with the Trust's response to COVID-19, the meeting was conducted remotely via video conferencing to maintain social distancing.	
1. Apologies for Absence	
As noted above.	
The Chair explained that the Director of Corporate Affairs would be taking a period of sickness absence during which time Karan Wheatcroft, who was welcomed to the Audit Committee meeting, would be supporting the Trust with their corporate governance arrangements.	
2. Declarations of Interest	
Karan Wheatcroft declared herself as a senior member of MIAA, the Trust's internal auditors, and confirmed that she would not take part in	

any discussion relating to any compromised agenda items. All other participants declared that they had no interests.

3. Governance and Risk
3.1 Annual Review of Corporate Governance Manual

The annual review of the corporate governance manual supported by the Trust's internal auditors was presented.

A table of contents was included as an appendix as were the proposed key updates. There were no major changes to highlight.

A query was raised due to Non-Executive colleagues being unable to access the staff intranet whilst working remotely and whether there should be concern that they could not access any of the Trust policies and terms of reference with their current devices and that laptops had been offered. The CFO confirmed that there was a rollout of new laptops throughout the Trust and she would liaise with the Chief Digital & Information Officer in order to ensure NED colleagues received new devices as soon as possible. **KE**

The Audit Committee reviewed the changes made to the corporate governance manual and recommended these to the Board of Directors for approval and adoption.

3.2 Risk Management KPIs

The paper showed the Risk Management KPIs that provided the Audit Committee with assurances around the effective implementation of the Risk Management policy.

There were no red indicators to note. The following points were highlighted:

- Risks reviewed by managers was showing a compliance rating of 96% against a target of 95%. The assurance KPI remained static at 91% against a 95% target, thus continuing to show as amber. This issue had been raised with senior managers and would continue to be monitored
- Incidents open over 28 days had improved significantly from 68% to 74% with the Executive team continuing to monitor and provide scrutiny. It was also noted that the Director of Nursing, Quality & Safety had introduced the requirement to review open incidents a week earlier than previously required, which allowed for a more proactive way of identifying and managing issues.

Historical risk management KPI improvements had been sustained and work was ongoing to ensure further improvements were made. It was noted that a review and refresh of the risk management KPIs was underway and a new reporting format was expected for the October Audit Committee.

Audit Committee members requested that the indicator relating to incidents open over 28 days be divided to show those that remained open due to external factors and those due to internal, as this would

provide a more accurate picture. The CFO confirmed that this would be considered as part of the refresh work discussed above.

Following a request to benchmark against other Trust's on this indicator, the CFO confirmed that data on this KPI would not be widely published, however enquiries would be made through the Specialist Trust Alliance to obtain benchmarking information. Colleagues were asked to note that this was an indicator that caused issues throughout other Trusts and was not unique to LHCH. **KW**

The Audit Committee noted the full contents of the report.

3.3 Review Clinical Audit Plan & 6 Monthly Progress Report including NICE Guidance Review

The comprehensive report provided assurance on delivering the Clinical Quality Audit Plan, including NICE, and provided in depth details regarding the work undertaken to support that aim. Comprehensive appendices were also included.

There was nothing of concern to note and the department had continued to work effectively during the pandemic and assurances continued to be provided.

Audit Committee members were informed that for the first year the national inpatient survey had introduced a new online system. Despite some initial issues, the return rate remained strong at 72%.

Work on the thoracic dataset development within EPR for reporting internally and externally had been delayed due to delays in the EPR system upgrade, however this was now scheduled for 10th July 2021, with documents expected to go live from 17th July 2021.

The Audit Committee noted the comprehensive report acknowledging the significant assurance it provided.

The Chair thanked the Director or Research & Innovation for her input into the Audit Committee over her tenure and wished her well as she moved on from LHCH.

3.4 Review Losses and Special Payments

For the period 1st March to 31st May 2021 there had been no fruitless payments, no losses and no special payments in excess of £10,000. Details of amounts less than £10,000 relating to losses and special payments were provided in Appendix 1 of the report.

The CFO informed the Audit Committee that the aged debt position for non-NHS debt had reduced by £1m following work with Isle of Man colleagues over the payment flow.

Hosted services aged debt was up by £1.1m, however, this was as a result of annual invoices raised, and therefore as expected and no cause for concern.

The Audit Committee noted the full contents of the report.

3.5 Review Single Supplier Tender Waivers

The Audit Committee noted that there had been 10 tender waivers raised between 12th of March and 25th of June 2021 for a total value of £941k. Four of the individual tender waivers raised were for over £100k and full details of the waivers were provided within Appendix 1 of the report.

Based on a recommendation from the internal auditors, one of the individual tender waivers was included under a universal waiver arrangement, as it related to a maintenance contract with the Original Equipment Manufacturer (OEM).

The Audit Committee acknowledged the extensive improvement seen in this area over recent years and were assured that there were now strong controls in place.

3.6 Compliance with Licence: Review of Quarterly Checklist

The quarterly checklist had been updated at Q1 2021/22. The primary risks related to;

- Diagnostic performance – prior to the national emergency arising from the Coronavirus pandemic the Trust was on trajectory to return to a compliant position by the end of Quarter 1, having invested in additional diagnostic capacity. However, the Trust continued to face pressures in diagnostic performance compliance due to the impact of COVID. Routine activity was ceased during the first wave of the pandemic and has since increased. The Trust had an improvement trajectory but achieving compliance was challenging due to the ongoing non elective demand by the Trust and region.
- RTT – the underperformance of the surgical activity plan had been corrected prior to the suspension of all elective activity in March 2020. The Trust faced pressure with achieving compliance against the 18 week target due to the significant backlog of patients that had treatment delayed during the pandemic and it would not be possible to be compliant with the statutory waiting time targets.
- Rollover of contracts due to the COVID-19 pandemic; the contractual process for 2021/22 had been suspended.

Audit Committee members acknowledged that the report aligned with the risks that colleagues were already sighted on and the document was useful to see on a quarterly basis.

The Audit Committee reviewed the checklist and confirmed its satisfaction that there were effective systems and processes in place to identify and manage risks in relation to compliance with the licence.

3.7 Review of Register of External Visits

The Audit Committee reviewed the Register of External Visits and confirmed their satisfaction with the governance arrangements in place to deal with the findings and recommendations following external visits and inspections.

The Audit Committee would continue to review the register on a bi-annual basis, with the next review scheduled for the 11th January 2022.

A query was raised in relation to the University of Liverpool Undergraduate Medical Education Quality Audit and the significant contribution one of the consultants makes in this area, and whether this was a potential single point of failure. The CFO confirmed that whilst this colleague was particularly instrumental in driving the project forward, there was a wider team supporting medical education and in addition the HR team were in the process of introducing succession planning in all areas of the Trust. However, assurance would be sought from the Chief People Officer in relation to this particular staff member. **KE**

3.8 Register of Interests Final Report 2020/21

The Audit Committee noted the improved final declarations of interest compliance rating for 2020/21 of 83% and were assured that there were no breaches of the Trust's Managing Conflicts of Interest Policy during 2020/21.

3.9 Regulatory Action Plans

The CFO confirmed that there were no outstanding actions with either the CQC or NHSE/I. The Director of Nursing, Quality & Safety would be presenting the new regime to the Board of Directors in September 2021.

4. Internal Audit

4.1 Progress Report on Delivery of Plan

The Senior Internal Audit Manager confirmed that since the March 2021 Audit Committee the following reviews had been finalised:

- Research Finances-limited assurance
- Medical Devices-moderate assurance
- Sepsis-moderate assurance
- Patient Administration System (PAS) Server-ungraded advisory report

Audit Committee members were informed that a detailed action plan had been created in response to the limited assurance research finances report and the full report and response would be presented at the Audit Committee in October 2021. Audit Committee members were asked to note that a significant part of the management response relied on the need for additional resources in the finance team whose first task would be to assess the £500k deferred research income on the balance sheet which needed to be allocated to specific projects.

The high-risk area noted on the medical devices audit related to the vulnerabilities identified with respect to the technical security and resilience of the medical device network for both in hospital devices and those used in the community.

The Senior Internal Audit Manager confirmed that the work carried out relating to the PAS server was ungraded as it was an advisory piece relating to challenges with the current server and the follow up actions had already commenced. IT colleagues were already managing this area and the advisory piece was to aid what was already planned. The CFO confirmed that there was an IT Operational Group responsible for monitoring and progressing the IT related audit reports.

The data protection toolkit had now been published as final and this would be presented at the October 2021 Audit Committee. A substantial grading relating to self-assessment had been given, whilst a moderate one was provided regarding new standards.

The following audit plan changes were requested:

- Trust management had decided not to proceed with the Corporate Governance Statement Review. A replacement audit would be proposed by the Trust later in the year and approval sought from the Audit Committee
- The Trust had requested that the Patient Consent audit was moved from Q1 to Q3 and the Financial Systems audit from Q2 to Q3

Whilst concern was raised by Audit Committee members relating to the research finances limited assurance report, the Senior Internal Audit Manager commended the Trust for requesting the audit. This was an area that had never been audited before, and therefore recommendations would be expected and the nine made were not unusual. The internal auditors were assured by the comprehensive action plan and expressed no cause for concern.

Audit Committee colleagues stated that the report showed no evidence of progress on the mitigating actions taken relating to the medical devices audit. The internal auditors stated that the wider risk management position of the Trust was taken into consideration and the risks were actively managed and flagged through exceptions reports. In addition, the fact that the medical device, sepsis and PAS server audits were highlighted as potential risk areas by Trust management showed that the risk management process was working.

The CFO stated that the Chief Digital & Information Officer had confirmed that significant progress had been made since the report was published in November 2020. Actions were being monitored under a service improvement plan which formed part of the digital governance arrangements. It was noted that all recommendations would be responded to within the specified timeframe. It was accepted that timeframes could be included as part of the report moving forward. **NW**

Appendix C of the report provided comprehensive details of the key

areas of work and actions to be delivered. It was noted that a comment included to state that actions had been agreed would be useful. **NW**

It was confirmed that colleagues would ensure the Quality Committee were aware of the recommendations made within the Sepsis audit and monitor the progress accordingly. **JO'B**

The Audit Committee noted the full report and approved the requests made regarding the changes to the Audit Plan for 2021/22.

4.2 Follow Up Report

This paper set out the completion of the most recent phase of follow-up reviews based on the target date for recommendation implementation and showed that the internal auditors had conducted independent follow up of those actions to evidence closure.

Audit Committee colleagues questioned whether the internal auditors were satisfied with the overall progress and that the nine outstanding recommendations were not indicative of the Trust's performance. The Senior Internal Audit Manager confirmed that it was the first time that a report was able to show no high risk recommendations and that this was as a result of the increased emphasis encouraged by the CFO, although continued focus was imperative to keep the number of open recommendations low.

The CFO confirmed that the recommendations were under regular review by the Executive team who were constantly striving to improve the position.

It was agreed that the wording relating to the actions would be updated as it was recognised that some recommendations would be under continual review despite there being a process in place to mitigate risks. It was confirmed that the action plan would close the research finances recommendation as there were no on-going actions expected. **NW**

The CFO informed Committee members that once in post, the new finance resource and the Head of Research & Innovation would determine whether Microsoft Edge was the most appropriate system for managing research finances.

The Audit Committee noted the full contents of the report.

4.3 Baseline Assessment: Government Functional Standard GovS 013: Counter Fraud

The Audit Committee noted the comprehensive report which provided an understanding of the recent changes resulting from the new government functional standard.

23 standards had now become 12 components and all the amber rated requirements would be delivered as part of the usual anti-fraud work.

4.4 Anti-Fraud Update Report

The report provided and update on the progress of works for the first quarter of 2021/22.

The executive summary on pages three and four of the report provided details on the high-level pieces of work undertaken.

Audit Committee members were informed that the online mandatory training requirement had now gone live with the Trust and a three yearly completion cycle would be required by staff members.

Appendix C of the report provided details on two claims that had been made during 2020/21; one in January 2021 and the other in March 2021. One related to anonymous allegations relating to six individuals whilst the other named a specific individual.

Since the submission of this report, the thorough investigations into both claims had been concluded and it was confirmed that there was no case to answer in either case. The update report presented at the October 2021 Audit Committee would show that both cases were closed.

The Anti-Fraud Specialist confirmed that advice had been given to HR colleagues regarding a working whilst off sick allegation. It was confirmed that there was no fraud to review and HR were dealing with the matter through the appropriate disciplinary procedure.

The Audit Committee noted the full report and were assured that thorough investigations into the two claims had been carried out and there was no case to answer.

4.5 Annual Review of Internal Audit Provision

The CFO confirmed that the Trust were very satisfied with the internal audit provision and confirmed that the feedback sought from stakeholders who had involvement with the internal auditors was very positive.

The flexibility shown by the internal auditors throughout the pandemic and the progress made with the audit plan was recognised by the Audit Committee.

KE

The CFO confirmed that a summary of the feedback received would be shared with Committee members.

5. External Audit

5.1 Final Audit Findings Report

The Senior Manager for the external auditors provided the comprehensive report stating that there was nothing further to add since the findings provided at the 11th June 2021 Audit Committee meeting.

Page three of the report confirmed that there were no significant issues to report; no adjustments to the financial statements that had resulted in adjustment to the Trusts retained surplus position were identified.
The audit report opinion would be qualified to reflect a limitation of scope over the Trust's opening inventory balance as discussed at the 11th June 2021 Audit Committee meeting. It was confirmed that this was commonplace due to the impact of COVID and the Trust would be free of this limitation of scope in next year's audit subject to no new restrictions.

There were no significant risks to report and the financial estimates were confirmed on pages 12 and 13 of the report, with the external auditors confirming that the approach and assumptions were appropriate.

Page 17 of the report confirmed that the external auditors did not rely on testing effectiveness of third party controls and as a result did not consider the qualifications significant enough to have an impact on the audit opinion. It was noted that those qualifications were relevant controls at the third party and not the Trust, with the external auditors commenting that they were satisfied with the appropriate compensating controls in place to mitigate against any increased area of risk.

Page 18 and 19 provided detail on the other areas of responsibilities under the code. It was noted that the Value for Money work was yet to be completed, however, it was noted at the 11th June 2021 Audit Committee that a revised submission deadline of 20th September 2021 had been agreed for this work.

The Senior External Audit Manager thanked finance staff for their support during the audit period.

5.2 Annual Review of Performance of External Auditor

The CFO confirmed that as the external audit had only just concluded a follow up meeting was still to be arranged with external audit colleagues. Discussions would take place relating to any improvements that could be made going forward and a stakeholder engagement piece would also be undertaken.

It was confirmed that feedback would be reported to the Council of Governors once the follow up session had been carried out and stakeholder feedback obtained.

6. Review of Audit Committee Work Plan

Committee members were satisfied that work was being carried out per the work plan schedule.

7. Minutes of e-Meeting held on Friday 11th June 2021

It was noted that the minutes of the Audit Committee meeting held on 11th June 2021 had been reviewed for accuracy by all meeting participants and were approved.

8. Action Log

Item 1-It was confirmed that the Executive team received a more comprehensive report in relation to incidents open more than 28 days by division. This item would be marked as complete and removed from the action log.

9. AGS Issues

It was noted that the limited assurance report on the research finances was included within the AGS. No further AGS issues were identified.

10. Evaluation of Meeting

The Audit Committee was content with the mechanism in place for the e-meeting, given the on-going social distancing measures.

11. Date and Time of Next Meeting:
Tuesday 19th October 2021, 8.30-10.30am

Board of Directors (in Public)
Item 6.1.2

Subject: **BAF Key Issues Quality Committee**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by: **Sue Pemberton, Director of Nursing, Quality & Safety**
Presented by: **Dr Nick Brooks, Non-Executive Director**
Meeting Held: **Tuesday 19th October 2021**
Purpose of Report: **To Note**

Agenda Item	Lead Exec	Assurance Received	New/Emerging Risks	Actions/Comments
6.2	SP	**Quality Strategy** It is to be determined how the Quality Committee will monitor the Quality Strategy. Progress update will come in April and July 2022, culminating in a report to the Board of Directors in October 2022. The DoNQS has met with the leads who have objectives within the strategy – in January, April and October updates will be provided on the progress being made and how the targets were to be achieved. Within the document there were several objectives that the DoNQS was to lead on: development of the role of a Safety Ambassador and developing patients as safety partners. Update to be provided in 12 months' time.	None	

6.3	RP	**Clinical Quality Report** . **CDIFF** National Infection Prevention Guidance was recently published, the Trust had reached the target for 2021/22, new guidance had come out in July on treatment and management of CDIFF which will be implemented by the Infection Prevention team. **Gram Negative Bacteraemias** The figures have changed, there were a total of 13-gram negative bacteraemias, this should be resolved for next month. It was suggested that an element of narrative might be good moving forward with the report to focus on the main points particularly those rated in red. **Radiological Alerts** A marked fall off in the numbers that were responded to, there were a very large number of alerts. The figures were lower than that on the weekly safety report, this would be looked at. The draft MIAA report on the SHM process had been received, a management plan has been developed and moderate assurance was received on the process. The MD would bring the report to various committees in due course. **Nutrition** A meeting was to be held with the Informatics team to determine if the information was being pulled from the correct place in EPR.	None	

6.4		**Quality Impact Assessments (CIPs) & Update Report** FISG had been replaced by Finance and Performance Group (FPG). The final Terms of Reference were yet to be completed but would be shared when readily available. The oversight of the QIA, EIA and CIP planning has remained in the same manner as FISG. The Improvement Team have made the process smooth for those who need to sign off documents or contribute to the document, the process was currently via Microsoft Teams, this was progressing well and was still a work in progress. The report was to be discussed within the Audit Committee.	None	
6.5		**QSEC Key Assurances / Risks Report 10th September 2021** **Delirium Risk Assessments** Originally this was done in ITU, this has since been rolled out to all the wards, this was important as the wards needed to assess the patients. The Trust were at the beginning of the journey and compliance will be improved.		
6.7		**Sepsis Improvement Plan & Sepsis Data Review** A version of the report was taken to the Commissioners, there were two areas: principle KPIs and one-hour antibiotics, all three have improved. The main problem was with ward screening for those patients who trigger three on MEWS on		

		two occasions and a MEWS of five on one occasion. Critical Care use a different screening method which is based on organ failure assessment. Score starts high but improves post-operatively.		
6.6	RP	Dr Foster presentation The Trust had become slicker with the process. Meetings had been set up which were helpful. No peaks had breached the cusum curves. There had been no specific alert to respond to. Discussions to be held on comorbidity scoring or coding as they seemed to be the underlying trends that could be affecting the figures. The Trust were always above 100 on the surface, regular reassurance on the reasons for those major spikes, with out of hospital cardiac arrests being the most important. Vitally important that this was monitored. Anna Rogers, Senior Consultant with Dr Foster (now Telstra Health UK) presented a review on measuring mortality. After an outline of the processes involved in delivering the HSMI (and SMI), there followed an analysis of the Trust's results. The presentation highlighted the following issues: The vital importance of accurate coding and completeness of input data The direct and indirect impact of Covid-19, which the model is unable to calculate The Committee discussed the factors underlying the overall higher-than-expected risk adjusted mortality rate in LHCH.	None	The meetings between LHCH and Dr Foster (Telstra health) have been formalised into the Mortality Improvement Group; meeting monthly. TORs have been agreed, there is an agreed agenda and admin support from Exec PA. The first formal meeting was on 3rd November and included most of the expanded membership with representation from coding, informatics and audit and the divisions. Representation from the MRG and digital systems has been agreed. The standard agenda includes a deep dive into outliers and follow up of previous deep dives. Initial scrutiny of factors driving outlier status have shown difficulties presented to coding by note keeping and also the difficulties in assessing Charleson and Carstairs scores. Actions are in place to improve this. The head of coding has joined the MRG and will facilitate accuracy of coding in discussion at the committee.

		Previous analyses presented to the Committee by the Medical Director have highlighted the impact of the management of unselected patients with out of hospital cardiac arrest as the main driver of the high mortality among patients with acute myocardial infarction. Moreover, the difficulty in identifying and recording risk-modifiers such as the Charlson and Carstairs indices, in patients admitted to hospital in extremis could probably have resulted in underestimation of their expected risk. Anomalous coding is the most likely explanation for the high RRs among patients with syncope and nonspecific chest pain; it was noted that the 2470.5 RR for syncope was derived from the deaths of two patients out of 112, whereas the expected mortality in this group was one in a thousand. It was pointed out that if a review of the coding issues confirmed the existence of anomalies and missing data, the analyses and published results could be amended. The Committee acknowledged the difficulty in addressing these issues in the short-term, pending the appointment of a successor to the Director of Research and Innovation but the MD undertook to ensure further exploration of the data, to the possibility of introducing measures to ensure its completeness, and to report back to the Committee in due course.		

6.7	RP	A version of the report was taken to the Commissioners, there were two areas: principle KPIs and one-hour antibiotics, all three have improved. The main problem was with ward screening for those patients who trigger three on MEWS on two occasions and a MEWS of five on one occasion. Critical Care use a different screening method which is based on organ failure assessment. Score starts high but improves post-operatively. This has been changed so that the lowest SOFA score is taken, this was being finalised and will come back when data quality is approved. Stems from the struggle and the gradual improvement. Taken to the commissioners, principle KPIs – 1 hr antibiotic the most important with all 3 gradually improving, some months may look bad, but some figures are better than interpreted. The education is outlined that the Infection Prevention Specialist Nurse has worked on, feedback was being delivered – positive and negative around screening. The improvement plans were outlined within the paper. Dr Omar AlRawi has been the Sepsis Lead for a number of years and has driven this, has recently become Clinical Lead for Anaesthesia, this baton will be handed over to Dr Ben Murray, Dr AlRawi will see this through and handover efficiently to Dr Murray, with the hope of the Infection Prevention Specialist Nurses	None	

		post to continue as this was only a secondment. The format of the weekly report is to be changed to express the data that is helpful with work on this to be continued.		

minutes

Item 6.1.2a*

Quality Committee

Minutes of the Quality Committee Meeting held on Tuesday 20th July 2021

Present:	
Nicholas Brooks (Chair)	Non-Executive Director
Sue Pemberton	Director of Nursing, Quality & Safety
Karen O'Hagan	Non-Executive Director
Manoj Kuduvalli	Associate Medical Director, Surgery
In Attendance:	
Megan Underwood	Personal Assistant (Minutes)
Jane O'Neill	Senior Improvement Lead (item 6.2 only)
Justin Ratnasingham	Associate Medical Director, Clinical Services (item 6.7 only)

1. Apologies for Absence
Raph Perry, Mark Jones.

2. Declarations of Interest

There were no declarations of interest to record.

3. Minutes of e-meeting held on: 13th April 2021

The minutes were recorded as a true and accurate record.

4. Patient Story

The Director of Nursing and Quality read the patient story.

5. Action Log

Item 1 – Quality and Patient Family Experience Assurances / Risk Report 12th July 2021 (late outcome of stroke patients) – Addressed as item 6.4 of the main agenda. The item was closed and removed from the action log.

Item 2 – QPFEC Key Assurances / Risks Report Quality Performance – Addressed as item 6.8 of the main agenda. The item was closed and removed from the action log.

Item 3 – Update Serious Incidents – Missed renal cancer diagnosis – Closed by STEIS and included with items 6.3 and 7.1. Removed from action log

Item 4 – Update Serious Incidents – ACHD interventions – The final report, when completed, will come to the committee as a main agenda item. Removed from the action log.

Item 5 – Update Serious Incidents – Patient who took their own life – A narrative verdict has been recorded by the coroner. The final report will be submitted when complete (see item 6.3 – timetable established). Removed from the action log.

Item 6 – Update Serious Incidents – Injury to subclavian artery – Closed on STEIS and removed from the action log.

Item 7 – QPFEC Key Assurances / Risk Reports (consent) – Addressed with item 6.3 of of the main agenda. Removed from the action log.

Item 8 – GIRFT report – actions and progress update (Surgery/stroke) – Addressed as part of main agenda items 6.3 and 6.4. Closed and removed from the action log.

6. Quality

6.1 Quality Report

The Director of Nursing, Quality and Safety (DONQS) and Associate Medical Director for Surgery (AMD) presented the report. Members of the Committee approved of the new format and agreed that it captures the essential performance indicators.

The Committee noted the recent improvement in sepsis KPIs:

- **Delivery of at least one sepsis antibiotic within one hour of prescription.**
  For the month of June, the Trust reported 77.8% against the target of 70%.

- **Delivery of a sepsis antibiotic within three hours of prescription (National Standard)**
  For the month of June, the Trust achieved 94.4% against the national 96% target.

- **Blood culture taken within 24 hours preceding first antibiotic given**
  For the month of June, the Trust achieved 88.9% against the target of 95%.

C.DIFFICILLE
One case reported for the month of June (against the zero target).

Observed mortality
Observed (unadjusted) mortality is slightly above the Trust target of 1.3% (at 1.8% in June), but since the risk-adjusted ratio (Dr Foster) has remained within the expected range, and with the rigorous mortality review process, the committee was assured that no further scrutiny is required at this stage.

Incidents
The Committee was informed of two new serious incidents, including a never event that occurred in June. (Open incidents were discussed under item 7.1).

Falls
An upward trend in the number of falls over recent months was noted with five in-month judged to have been avoidable. Further work, led by Christina Kenny, Matron for Patient Experience, was being undertaken to implement additional prevention measures. The Committee was informed that numbers remain low compared with other hospitals.

Percentage of radiological alerts with a response document
A decline in performance of this indicator over the last seven months was noted with concern, as the failure had, on two occasions in recent years, resulted in serious incidents. The target was set at 95%; in month it was 74%.

Changes to the reporting and follow-up of incidental findings are already in place (and reported previously to the Committee), and further work, with an MIAA audit, is being undertaken. In the meantime, the AMD for surgery assured the Committee that the existing system, with a dashboard supervised by the AMDs, had ensured that appropriate actions were being taken despite the absence of formal documentation.

The Committee accepted this assurance.

6.2 Quality Impact Assessments (CIPs) & Update

The Senior Improvement Lead joined the meeting to present the status of Quality Impact Assessments on the 2020/21 CIP programme.

The divisions have identified 52% of their CIP target of £4.2 million reflecting an increase of 29% from the previous update.

Of 19 schemes that met the criteria for QIA, 15 have been completed, none of which required a full EIA. Documentation for the remaining four was incomplete but in progress. Currently, only two of the 19 schemes had completed the final phase (4) for implementation but sign-off was anticipated in the near future.

The Committee noted that the trajectory for identification and final sign-off of CIPs was behind plan but were assured that the QIA/EIA process was being completed appropriately. Work on additional schemes was being supported by the team, supervised by the Operational Board and

monitored by the new Finance and Performance Steering Group with oversight by the Integrated Performance Committee

The Senior Improvement Lead left the meeting.

6.3 QSEC Key Assurances / Risks Report
7th May 2021
2nd July 2021

The QSEC assurance reports for May and July were reviewed and the following issues, excluding those considered under the main agenda, were discussed.

7th May
Regulation 28 Radiology – missed aortic leak
The coroner has issued a regulation 28 report following the inquest on this case, which had already been discussed in detail by the Committee. The response will be reported at the next QSEC meeting and then to the Quality Committee.

Diabetes
The DNQS outlined the workforce challenges and increasing demand affecting the diabetes team, despite which service provision has been maintained. An audit is being planned to ensure the Trust is compliant with the NICE guidance and the on-going work to reduce insulin incidents was noted.

Mortality Annual Report
No concerns were identified, but the full report will be included with the agenda for October 2021.

Fasting: Medicine and Surgery
This remains an area requiring improvement that will continue to be monitored by the QSEC.

Surgical Site Infections (DIPC annual report)
In response to the failure to meet the reduced target for MSSA infections, an increase in surgical site infections and issues with decolonisation exposed in a recent audit, the surgical site infection committee, led by the Head of Nursing for Surgery, has been re-established.

No benchmark exists for the incidence of surgical site infections, but the Committee was assured by the AMD that, as in the original response to the GIRFT report, it is low, and deep sternal infection is exceptionally uncommon.

2nd July
Falls
There have 35 falls year to date, nine of which were deemed to have been unavoidable. No themes have been identified, and the DON assured the Committee of the unrelenting focus on the problem, which is being driven in part by the ever-increasing age and frailty of the patients in the Trust.

Consent action plan
The action plan has been partially completed and leads for consent for medicine and surgery have been appointed. The aim is to develop an electronic consent process.

Resuscitation
Leadership of the cardiac arrest team and the shortfall in mandatory training have been identified as areas requiring further action.

6.4 Stroke Key Performance Indicators

The report, previously presented to QSEC, showed 100% compliance with the internally set KPIs. Concern was expressed by members of the Committee over the slow progress towards completion of actions to bring the service in to line with national standards for a stroke service. (see further detail under item 6.4.1).

6.4.1 Stroke Update

The AMD for Surgery shared a presentation, updated since the original response to the GIRFT report (which demonstrated that LHCH is not an 'outlier'), on perioperative stroke. The Committee congratulated the AMD for surgery on the rigorous documentation, and accepted assurance from the pre-, per- and postoperative measures being implemented to reduce the risk, which is particularly high in aortic patients.

Further discussion focussed on the progress towards improving the management of patients with strokes. It was explained that the existence of limited resources for the service reflects its stand-alone status in a small specialist trust. Agreement with LUHFT has re-established the weekly ward round by a stroke consultant. Outstanding objectives are to develop a seven-day service, ensure a therapy presence in follow-up clinics to secure data on outcomes, and all stroke patients to be cared for on Cedar ward together with up-skilling of the ward nurses and therapies team, and the provision of psychological support.

It was agreed that a progress report would be provided for the October 2021 meeting of the Committee. **MK/HR**

6.5 Sepsis Annual Report

The Committee received the sepsis annual report which was discussed together with the sepsis update (Dr Omar Al-Rawi 28/05/21 presented to the QSEC in response to the slow progress in consistently achieving the KPIs) and the MIAA audit that identified several medium risks, including inactivity of the sepsis group for over 18 months.

The sepsis group has been reinstated and formal TOR and reporting processes are to be developed. A critical care microbiology and sepsis specialist nurse has been appointed; education has been intensified with a video as part of mandatory training, and the successful pilot scheme on providing feedback is to be implemented. The Medical Director has been asked to develop the improvement plan with target dates for completion of each step. **RAP**

The Committee was informed that informal contacts have revealed similar problems in other acute trusts, and accepted assurance from the clear focus on the issues. It was explained that, even with the extra measures, improvement is likely to be gradual and incremental.

6.6 Dr Foster Dashboard – outlier reports

These cases had been discussed previously (QC April 2021; item 7.2) and assurance accepted.

6.7 GIRFT update Critical Care

The AMD for Clinical Services joined the meeting and presented the GIRFT update for Critical Care. An MDT working group has been established to identify and implement the priorities. Of 19 major recommendations (within nine themes), six have been assessed as complete. Seven require discussion with the network. The development of an adult critical care transfer service has already been discounted as being unnecessary for the Liverpool network.

Progress on the outstanding recommendations includes:

ANP cover
The business case has been approved for two additional ANP posts, which will reduce the commitment of surgical trainees to critical care and allow more time for surgical training. The eventual plan is for 24/7 ANP cover and complete withdrawal of the registrars from the rota; full implementation should be complete within 2.5 years.

Psychology support
The Trust now has an on-site psychologist available five days per week in accordance with GIRFT best practice. They will also take part in the ITU follow up clinics.

Enhanced Critical Care rehabilitation
A business case has been drafted to support a 7/7 rehabilitation and chest physiotherapy service.

Outreach service
Interim arrangements have been implemented to increase outreach staffing to cover 24/7, further enhancing the service and reducing the non-training commitment of the surgical registrars.

Enhanced recovery
Potential enhanced recovery beds have been identified but implementation awaits finalisation of the plan and staffing model. Availability of these beds would improve patient throughput and, potentially, reduce the number of readmissions to critical care.

The report was noted and approved. Further updates will be brought back to the committee in due course. **JR**

The AMD for Clinical Services left the meeting.

6.8 For Approval of Quality Metrics 2021/22

All the metrics were considered to be appropriate and comprehensive.

6.9 Sepsis Audit

Discussion of the audit took place under item 6.5.

7. Compliance and Regulation

7.1 SUIs

Video of patient shared on WhatsApp
This was reported as a serious incident; the investigation is ongoing, and the breach of confidentiality will be reported to the Information Commissioner's Office. Learning from the incident centres around the mobile phone policy.

Never Event – patient connected to medical air when oxygen was intended
No harm came to the patient. The investigation is ongoing.

Patient fall – deteriorated and died
Investigation by the Deputy Director of Nursing and Quality and Matron for Community is in progress. A coroner's inquest is to be held and the family is being supported by the Trust.

Insertion of chest drain
A chest drain inserted to relieve a pneumothorax perforated the pulmonary artery and the patient could not be saved. The incident has been reported to STEIS; immediate learning measures have been implemented to prevent a reoccurrence, and an RCA is being urgently conducted.

The Committee noted these serious incidents and awaits completion of the investigations.

7.2 Quality Risks

In response to questions from the Committee:

1. The shortage of anaesthetists and radiologists for CT guided biopsy:

Two of the radiologists have returned to work and a third is being trained. There is a national shortage of suitably trained anaesthetists. The immediate problem is being covered as far as possible by locum appointments. The situation will improve to some extent at the end of the holiday season.

2. Patients lost to follow up – this does not include the ACHD patients.

3. PACS failure – data would not have been irretrievably lost due to it being on an external server.

8. Date and Time of Next Meeting

Tuesday 5th October 2021, 11.00am-1.00pm, Research Meeting Room/Microsoft Teams	

Board of Directors (in Public)

Item: **6.1.3**
Subject: **Integrated Performance Committee BAF Key Issues Report**
Date of Meeting: **Tuesday 30th November 2021**
Prepared by: **Karen Edge, Chief Finance Officer**
Presented by: **Karen O'Hagan, Chair Integrated Performance Committee**
Meeting Held: **Monday 25th October 2021**

Agenda Item	Lead Exec	Assurance Received	New/Emerging Risks	Actions/Comments
5.1	KE	Financial Report including CIP	There are a number of uncertainties and risks regarding the financial arrangements and system allocations in H2 21/22 which may impact on our ability to deliver a financially sustainable plan in FY 21/22	The Committee were updated on the H1 position (Apr-Sept 2021) of a £1k surplus in line with the break-even plan. The system allocation for H2 has not as yet been confirmed and therefore uncertainty remains as to the income position and corresponding I&E impact. The Committee also received a presentation on the year to date position with regard to CIP, being £3.3m against a target of £4.2m, and the further actions that were in place to close the gap.
5.2	KE	Capital Report	Capital resource constraints at a system level will potentially impact upon the available resource for the 2022/23 programme. Prioritisation will be considered against risk	The Committee received an update on the 2021/22 Capital programme. The year to date position is £5.4m against a plan of £7.5m. Slippage has emerged as a result of rephasing of Estates schemes, however, the committee

			ratings should this be required.	were assured actions were in place to ensure the full deployment of the available resource for the 2021/22 financial year. The Committee were updated on the progress of the development of the Capital budget for 2022/23 being Year 2 of the agreed 5 Year programme agreed by the Board in October 2020. The final proposed Capital budget for 2022/23 will be presented to IPC and BoD for approval in January 2022. Programme updates on major schemes were provided and no risks were anticipated.
5.3	KE	Review of Costing and Reference Costs	None	The Committee received an update of the Trust SLR & PLICs strategy and noted the positive EY audit and progress made to date.
5.4	KE	National Cost Collection Submission 2020/21	None	The Committee noted the submission of the National Cost Collection (NCC) on 12th October 2021 and noted that the outstanding actions highlighted in the last paper to IPC in July 2021 were completed ahead of this national deadline.
5.6	JM	Q2 Performance	Statutory performance indicators are impacted by the backlog resulting from the COVID-19 pandemic	The Committee received the Q2 Performance Report, Strategy Report and Target Performance Report. It was noted that 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. The Trust has clear performance trajectories in place and a robust weekly performance review takes place.

				A number of exceptions to national performance standards were noted together with other performance exceptions.
5.7	JM	Covid Recovery & Performance against phase 3 recovery trajectories	Urgent demand and workforce gaps impacting on the pace of recovery.	The Committee received an update of the performance against the H1 trajectories for recovery of elective activity. Q1 targets were met but it has been more difficult in Q2 as a result of non-elective pressures and workforce gaps. The 52 week recovery trajectory remained on track.
5.8	JM	Outpatient transformation update	None	The Committee received an update on the outpatient transformation work and noted good progress against the national priorities.
6.2	KE	Finance & Improvement Steering Group Minutes (15.07.21 and 19.08.21)	None	Noted

Item 6.1.3a*

Integrated Performance Committee

minutes

Minutes of the Integrated Performance Committee Meeting Monday 26th July 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
	Carla Richardson	Head of Income and Costing
	Jennifer Ohlsson	Senior Executive Assistant (Minutes)
Apologies for Absence:		

Actions

1. Apologies for Absence
None to note.

2. Declarations of Interest
None declared.

3. Minutes of meeting held on 26th April 2021
Minutes from the meeting of 26th April 2021 were noted and approved.

4. Action Log
All actions on the log will be covered in today's meeting.

5. Financial / Performance Reporting
5.1 Finance Reporting including CIP
Chief Finance Officer presented an update on finance reporting including CIP.

The financial performance for the three months ending 30th June 2021 is a £490k surplus, against a plan of £485K surplus. This continues to be heavily reliant on receipt of the Elective Recovery Fund (ERF).

There was a year to date variance of £540K in income. £328K of the shortfall relates to hosted services, this is offset by lower spend. The

system funding was also lower than anticipated at £190K and the funding schedule from HEE indicated a reduction in training income of £99K. The cost per case income had improved in June and is now £40K higher than plan for the year to date. There was £3.6m of ERF income assumed in the position

Pay costs are consistent with budget, driven by vacancies in a range of areas, though some costs have risen in month such as nurse bank costs.

Non-pay costs are related to unidentified CIP and an underspend linked to hosted services. There is an overspend in Medicine related to a clinical supplies overspend. The Medtronic discount has been actioned in June and the remaining overspend relates to high cost devices for Welsh patients.

CFO also provided an update on ERF. The Trust has been performing as expected and better than the Trust's performance in terms of achieving 19/20 activity levels. Surgery elective activity is 107% of 19/20 levels and Medicine elective activity is 100% of 19/20 levels. Outpatients also performed well, and was 103% of 19/20 levels in June.

There has been a rich casemix, combined with high activity, suggesting ERF income of £4.2m for Q1, against a plan of £3.6m. This remains an estimate at this stage

Thresholds for ERF in Q2 have been raised from 85% to 95%, thus reducing the income available. The payment rate has also changed and only secure on 120% of tariff on activity above 100% of pre-covid levels. This introduces a risk to the Trust of a reduction between 1.3m and 2.8m.

Comments and questions were welcomed from colleagues and it was queried whether the ERF was being looked at from an ICS level, rather than a Trust level for H1 and it was also queried whether there is any retention of funds at ICS level. CFO confirmed that in terms of ICS the assumption is that the ICS has achieved the ERF threshold for Q1, so there should be no risk to the money flowing into the ICS for Q1. For Q2 there is a risk and this risk has not been fully quantified at present.

CFO noted that there is no retention of ICS monies. A set of principles was agreed at ICS level regarding how the ERF monies would flow to providers in Q1. For Q2 there is a group looking into how the risk will be shared across the ICS and CFO shared a table highlighting the income impact of ERF threshold change and ERF income comparison.

Clarity was sought on whether any actions or mitigations would be taken at Trust level to minimise the impact of the ICS risk. CFO confirmed that there is a review of the forecast position for Q2 and the second half of the year and a review of any possible mitigations that need to be put in place to avoid a deficit position.

There were no further comments or questions on ERF or the overarching finance position.

Deputy Chief Finance Officer presented an update on CIP to IPC colleagues. Though progress has been made, CIP identification remains behind schedule at £2.9m against a plan of £4.2m, creating a gap of £1.3m. Scheme maturity has improved in recent weeks, with most schemes now at level 2 or 3.

Medicine has made strong progress against the CIP target with £729K in development, against a target of £884K. Schemes are considered either low or medium risk suggesting high levels of confidence over deliverability. Further schemes are to be scoped out and costed up include increasing income from the Isle of Mann and exploring opportunities associated with expanding the community and public health services. Non-recurrent schemes will only be considered as a last resort to close any in-year gap.

Surgery has £388K in development against a target of £739K. The majority of schemes are rated as low or medium risk. There are regular meetings with departmental managers to identify further opportunities and the key lines of enquiry include working with procurement to review non-pay consumables, a workforce and skill-mix review, expanding private patient provision and seeking overseas patient income and the proceeds from the sale of equipment.

Clinical Services have the largest target of £953K with £352K in development. The full year impact is 50% of the target. All identified schemes are rated low or medium risk. The key lines of enquiry include review of SLAs, reduction of premium spend and outsourcing through capacity and demand modelling, private patient radiology provision, reviewing granular data on drugs and consumables, pharmacy savings through a number of waste reduction initiatives and a nursing review in critical care.

Corporate have a target on £1,637K. An in year impact of £1,051K and a full year impact £1,057K. There is ongoing scrutiny with each department to explore additional savings including a procurement workplan, workforce review and maintenance contracts. Other potential KLOEs include a review of portering, catering provision, green initiatives, travel expenses, training courses and printing and stationery.

There were no further comments and it was requested that IPC have oversight of this on a regular basis.

5.2 SLR 2020/21 position and Costing updates
IPC colleagues were asked to note the SLR and costing update paper, circulated prior to the meeting and CFO provided an overview.

The Covid pandemic completely changed the way NHS organisations provided care to patients. With such an exceptional year, there were significant changes to the type, number and cost of patients. Whilst overall patient activity decreased during 2020/21, the costs of providing care increased.

The 2020/21 SLR model has drawn attention to the impact of Covid, quantifying increased average patient costs across services impacted by

changing costs, service provision reconfigurations and activity fluctuations.

The Trust achieved an improvement in the 2019/20 NCCI moving from a non MFF adjusted score of 106 to 101, demonstrating comparative increased cost efficiency performance.

The collection window for the 2020/21 NCC submission has been confirmed, and a timetable for submission is underway to ensure achievement of the 12th October deadline and an update will be provided at October IPC on the submission. **KE**

CFO noted that an Audit report has now received with lots or areas of good practice noted. The report also includes improvement items and timelines to be built into the SLR development plan and future models.

It was queried whether a timeframe was known for the logic costing system upgrade linked to the Data warehouse and CFO confirmed that regular meetings are in place to understand the action plan and ensure that this is delivered in line with the timescales.

There were no further comments or questions.

5.3 Update on H2, 2022/23 planning

KE presented an update on H2 and 2022/2023 planning and noted that there is no agreed financial settlement between the Treasury and the Department of Health yet and this is expected in September 2021.

The assumption is that the H1 system funding envelopes will be the starting point for the H2 funding arrangements, albeit with greater waste reduction targets than H1. Block arrangements are to continue and a waste reduction estimated at 3% is to be applied to block payments. The Covid top-up funding is to continue, but will be lower than H1 as systems are expected to release costs and Covid demand decreases.

As financial constraints increase through Q2and into H2, it is important that commitments are reviewed and forecasts revisited.

The government is expected to run a multi year spending review, with the outcome announced in December 2021 and planning for next year will comment in January 2022. If a multi-year settlement is agreed, this will drive the need for systems and providers to produce long-term financial plans.

Comments and questions were welcomed from colleagues and it was queried what is being done for assumption planning at LHCH and CFO confirmed that the forecast will be looked at based on the run rate and assumptions made based on what we already know. A number scenarios will be considered and what the risks would be and mitigations available.

5.5 Q1 Performance Report

5.4.1. Strategy report

IPC colleagues were asked to note the strategy report circulated prior to the meeting ad item 5.4.1 and Chief Operating Officer provided an overview.

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 76.8% for English commissioned activity and 78.9% for welsh commissioners, a slightly improved position compared to the previous month.

There were 107 patients waiting longer than 52 weeks at the end of June, a marginal improvement compared to last month but 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 IPC and submitted to the regional recovery programme.

Sickness decreased slightly in month to 4.2% with a couple of challenging areas across the Trust.

There was one never event and two serious incidents in month that will be discussed at the Board of Directors.

One patient breached the 28 day cancellation target which related to the time at which the majority of elective activity was stood down due to the unprecedented levels of urgent demand within the surgical service.

COO also noted that there was 1 C Diff case in month, a full review was undertaken by the Infection Prevention Team and no lapses of care were identified.

Clarity was sought on what the impact of the current Covid-19 situation would be on the waiting list and COO confirmed that at present the Trust is protecting it's own waiting list pressures as no additional support will be required regionally.

A query was also made on how comfortable the Trust is with the current trajectories in light of the ever changing landscape and COO confirmed the trajectories are reviewed on the weekly basis as part of the C&M system and as a Trust.

Further detail was sought on the anaesthetic capacity issues and COO confirmed that there is a capacity issue due to absence resulting in lost activity in June, July and August. Currently there are 3 gaps on the anaesthetic rota. COO added that there will be a locum Anaesthetic Consultant starting in August. Two Consultant posts have also gone out to advert. It is expected that the position will improve in August and September.

5.4.2. Target performance report

IPC colleagues were asked to note the target performance report circulated prior to the meeting as item 5.4.2 and COO noted that the Medicine DNAs will be covered in the Outpatient transformation update.

Further information was requested regarding delayed transfers of care not hitting the target in May and June. COO noted that these patients are reviewed daily and taken to the bed huddle for review and added that there are issues engaging with the packages of care and pressures getting patients repatriated to other hospitals. COO also noted that this is not impacting the Trust's ability to achieve trajectories

5.5 Covid Recovery & Performance against phase 3 recovery trajectories

COO presented an update on Covid recovery and performance against phase 3 recovery trajectories and noted elective recovery is focussing on delivering 2019/20, pre covid levels of activity.

Key pressure points include G&A bed capacity, non-elective demand being higher than pre-covid levels and significant staffing challenges across nursing and inability to provide additional capacity.

The key pressure points for 52 week planning include LAAO, EP and PFO sub speciality pressures, based on clinical prioritisation. COO noted all 52 week breaches undergo a harm review and are prioritised where possible.

Key pressure points for the 18 week trajectory are that all capacity is being focussed on P2 and long waiting patients and it was noted that until this is addressed 18 week compliance will continue to be a significant challenge.

COO also provided an update on the P2 position and stated that the Trust position is 115 P2 patients waiting. 13 of which have breached. This is monitored on a C&M basis and the team have a daily review of the P2 patients.

An update was provided on the recovery business cases and the ongoing nursing recruitment was noted. Also noted was the Spirometry man in a van procurement has also commenced and charitable fund bid can now offset the in year cost.

The risks to delivery of recovery include the general anaesthetic capacity due to absence, organisation changes taking longer than planned, potential disruption of activity due to the Cath Lab refurb, high non-elective demand, staffing challenges and the potential impact of a further Covid surge and the requirement to provide mutual aid.

There were no further comments or questions

5.6 Outpatients transformation update

HK provided an overview of the outpatients transformation update. The key elements of the transformation of outpatient services include referral optimisation, digital outpatients and patient initiated follow up.

A query was raised on whether it would be possible to automate the data shared with the C&M Outpatient transformation network and COO noted that this will be looked into further with the Chief Digital and Information Officer. It was agreed that an update will be brought back each quarter.	**HK**
6. Governance **6.1 IPC Work Plan Review** IPC colleagues were asked to note the IPC workplan and no further comments or questions were raised.	
6.2 Finance and Improvement Steering Group Approved minutes & Issues for escalation for the IPC IPC colleagues were asked to note the Finance and Improvement Steering Group minutes from 20.04.2021 and 27.05.2021 and no further comments or questions were raised.	
6.3 Treasury management policy IPC colleagues are asked to note the treasury management policy and this was approved by IPC.	
6.4 Credit card policy IPC colleagues are asked to note the credit card policy and this was approved by IPC.	
7. Evaluation of Meeting All committee members confirmed that the meeting had been conducted effectively and useful documentation had been received and useful discussions had taken place. Chair thanked Mark Jones on behalf of the IPC for all his contributions.	
8. Date and Time of Next Meeting: Monday 25th October 2021, 09.30am – 11.30am, Microsoft Teams	

Board of Directors (in Public)

Item 7

minutes

Minutes of the Meeting of the Board of Directors held on 28th September 2021

Present:	**Neil Large**	**Chair**
	Jane Tomkinson	**Chief Executive**
	Nick Brooks	**Non-Executive Director**
	Bob Burgoyne	**Non-Executive Director**
	Margaret Carney	**Non-Executive Director**
	Karen Edge	**Chief Finance Officer**
	Julian Farmer	**Non-Executive Director / Deputy Chair**
	Mark Jones	**Non-Executive Director**
	Hayley Kendall	**Chief Operating Officer**
	Karen O'Hagan	**Non-Executive Director**
	Sue Pemberton	**Director of Nursing, Quality & Safety**
In Attendance:	**Jonathan Develing**	**Director of Strategic Partnerships**
	Karen Nightingall	**Chief People Officer**
	Nigel Scawn	**Deputy Medical Director**
	Kate Warriner	**Chief Digital & Information Officer**
	Karan Wheatcroft	**Interim Chief Governance Officer**
	Jay Wright	**Interim Director of Research & Innovation**
Observers- Governors/ Staff/ Members of the Public:	**Adam Beattie**	**Service Line Manager**
	Allan Pemberton	**Public Governor- Cheshire**
	Trevor Wooding	**Senior Governor (Public -Merseyside)**
Apologies for absence:	**Raph Perry**	**Medical Director/Deputy Chief Executive**
	Lucy Lavan	**Director of Corporate Affairs**

Chair's Initials

		Action
1	**Opening Matters**	
1.1	**Apologies for Absence** Apologies for absence were received from Raph Perry 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 welcomed the newest Non-Executive Director, Margaret Carney, to the Trust and her first Board of Directors meeting. The Chair acknowledged Non-Executive Director Mark Jones' final Board of Directors meeting and thanked him for his service over the past 7 years. The Chair commented that Mark's skills had been greatly valued and he had made a significant contribution to LHCH during his tenure. Mark thanked his colleagues for his positive experience as Non-Executive Director and Chair of People Committee at the Trust. The Board of Directors (BoD) were informed that the LHCH Chair recruitment process was on plan and final interviews were scheduled for November 2021. The ICS had recently completed the recruitment process for the Chair role, with an announcement of the appointment due in October 2021. It was noted that the recruitment process for a CEO was on-going. The Chair highlighted World Heart Day on Wednesday 29th September, noting that several LHCH colleagues were participating in various related events. Thanks was also given to Maghull Wind Orchestra who gave a recent performance for patients and staff, which was very well received. The Chief Digital Information Officer, who forms part of the group, informed colleagues that a Christmas performance would be scheduled for December.	
1.4	**Patient Story** The Director of Nursing, Quality and Safety shared a video of a patient who required emergency treatment at the Trust, who acknowledged the high level of care he had received during his stay and beyond.	
1.5		

Chair's Initials

Patient Story

1.6 The Chief People Officer provided a staff story about one of the Trusts Pharmacy Technician's, detailing her journey from student technician to fully qualified status.

Medical Devices

The Interim Director of Research & Innovation provided an in-depth overview of the devices service, including research, activity, performance and local, national and international profile. The Chair thanked the team for the clear work and developments over the last 10 years.

The backlog on atrial appendage closures devices was acknowledged, with colleagues stating that reducing the backlog was a priority for clinical leads, however it was dependant on Cath Lab availability and anaesthesia support.

The Board noted the excellent low complication rates seen at the Trust and recognised that Consultant led sessions was key to those results. It was stated that this was continually monitored by clinical colleagues and the positive results allowed for a strong relationship with commissioners as well as a greater experience for patients.

Moving forward, ensuring close collaboration within the ICS was essential to ensure the Trust continued to lead in as many areas as possible.

2 Patient Safety and Quality

2.1 Infection Prevention and Control:

2.1.1 IPC BAF

The Deputy Medical Director provided an update in terms of the IPC assurance report. Confirmation that the Trust were not relaxing COVID measures was given and also that microbiology cover was now in place with a microbiologist consultant and advanced nurse practitioner.

The Board acknowledged the high level of assurance that the report provided, noting the progress made within the Trust. It was confirmed that staff testing compliance had recently been mandated and staff data for compliance with LAMP or Lateral flow testing was registered and tracked weekly.

The recent COVID outbreak effecting six patients had been managed effectively with good outcomes for patients and there were now only two ward based COVID positive patients. The Trust would continually work to maintain the hospital as green site status.

The Director of Nursing, Quality & Safety confirmed that there were no plans to relax visiting rules at the Trust, other than those patients at end of life or with enhanced needs. New guidance had

Chair's Initials

recently been distributed for consultation which would give more autonomy to organisations regarding IPC measures. Although it was noted that mask wearing and staff testing was likely to remain in place as business as usual.

The Board **noted** the report.

2.2 ***LHCH Monthly Nurse Staffing Report for July and August 2021***

The question was raised about mandated vaccines and it was confirmed that anecdotal discussions had taken place which indicated those unvaccinated staff may be more likely to get vaccinated should the requirement become mandatory. Although the impact this would have on staff retention would have to be considered.

The national recruitment and retention challenges were acknowledged and it was confirmed that the Trust were continuing with their recruitment plans and activity, which included a recent recruitment day and on-going international recruitment. The importance of focussing on retention was also recognised and identified as a key priority for senior managers at LHCH. Whilst the use of agency staff wasn't at a significant level for the Trust there was some work taking place within Cheshire & Merseyside regarding the sharing of workforce solutions.

The Director of Nursing, Quality & Safety confirmed that the Trust were always planning ahead in relation to recruitment, understanding the need to look at recruitment now for the future, stating that 33 nurses had recently been recruited, however not all were fully qualified yet. The 50 remaining overseas nurses were expected by December 2021.

Whilst it was expected that there would be staffing challenges within critical care through the winter period, the Chief Operating Officer was currently identifying how staffing resources could be utilised across the region. Although the Trusts strong position was noted in terms of the Trusts use of bank staff rather than agency.

It was stated that nursing was always challenging due to the continual expansion of community and nurses moving into that area. However, the overseas nurses would help stabalise the situation.

The Board **noted** the report.

2.3 ***Winter Preparedness Plan***

The Board **noted** the report and supported the proposed actions.

3 **Strategy and Development**

3.1 **New Quality Strategy**

Chair's
Initials

The Board noted the comprehensive document and acknowledged the alignment to the Trust's other strategies.

The strategy, including the top five clinical care priorities, would be monitored and tied into the Quality dashboard overseen by the Quality Committee who would provide the assurance to the Board of Directors.

Whilst there was a the reduction in the response rate to the safety culture survey, the Director of Nursing, Quality & Safety explained that this was expected due to the impact of COVID and previously the response rate had been very strong. The strategy was very robust, and colleagues were confident that it would be well embedded.

The dependency on digital work was recognised with colleagues informed that NHSX had launched some national guidance on how digital could support the safety strategies of organisations, many of the recommendations were already embedded within LHCH or included in the Trusts digital plans.

The Board **approved** the strategy.

3.2 Research and Innovation Strategy Update

The Board received the Research & Innovation strategy update, noting that it was still in the development stages.

The strategy showed the aspirations of the Trust for the next 5 years, highlighting that achieving university accredited Trust status was a key priority, in order to support this, progress had been made on the Clinical Research Facility application. It was acknowledged that greater levels of funding and NIHR grants needed to be achieved, with an estimation of three a year required.

Other key priorities were noted as continued commercial funding, to remain leaders for cardiothoracic research, increase preventative research, increase patient access and involvement, and ensure that research was part of Trust core business. This also aligned to Trust objectives and would be underpinned by collaboration, infrastructure, added value and digital solutions.

In response to a question raised regarding academic appointments, the Interim Director of Research & Innovation confirmed that recruitment was ongoing, including for honorary positions, CRN sponsorships and fellowships. It was noted that there would be some financial implications to those appointments and understanding the finances would be key in order to build in those areas and there would be a need to encourage but control scholarship requests, taking into account elective pressures.

It was confirmed that the research strategy would be aligned externally with population health needs and ICS developments, in particular, identifying health & inequalities gaps when determining

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research needs. The model would also need to be self-financing and bring together the LCCS, ICECAP and core research requirements going forward.

It was noted that the Board of Directors would monitor the strategy and the progress of implementation on a regular basis.

The Board **noted** the strategy update.

People Plan Delivery Report

3.3* In response to a question raised about the national tracking of the people plan, the Chief People Officer confirmed that specific areas including wellbeing, retention and absence had more focus regionally. However, the Trust had been implementing their own people plan effectively and this would be tracked until March 2022, with broader discussions expected at future Board meetings.

The Board **noted** the report.

4 Targets and Financial Performance

4.1 **Board Dashboard period Ended 31st August 2021**

The Chief Operating Officer (COO) presented the high level messages within the Board dashboard.

The strong performance across all cancer indicators and the 6-week diagnostic target achievement was noted. A few challenges around capacity and CT guided biopsies were highlighted, although plans were already in place to mitigate the issues.

The plan was to have occupancy between 85-90% heading into winter, although the fluctuating elective pressures during that time were recognised, with it noted that the teams were well sighted on the challenges and demands from winter pressures.

It was confirmed that mutual aid would be offered by the Trust to organisations across the area during October 2021 to March 2022 and this would be similar to that provided during the COVID-19 response. The impact this would have on elective work would be continually monitored and assessed.

In response to a question raised regarding potential harm for long waiting patients, assurance was provided that there was an admin and clinical process to support the review of those patients and regular correspondence and communication with patients was in place, although colleagues were looking at ways to enhance this further. Wider AI developments in this area were also being considered.

The Board were asked to note that the HSMR data coloured in red for the RAG rating was an error and this should be green.

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

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4.2 **Phase 4 Recovery**
The Chief Operating officer set out the performance against the trajectories.

A strong performance against trajectories overall was noted although considerable worked continued in terms of clinically urgent and long waiters.

In relation to health inequalities the Trust's Director of Strategic Partnerships provided the context in terms of the need in the future to develop the focus on inequalities further and in particular prevention; highlighting the importance of using leadership and influence.

It was noted that the discussions regarding winter mutual aid and priorities across Cheshire & Merseyside would impact recovery plans and trajectories meaning they may need to be revisited as appropriate. It was vital that the Trust was seen as a responsive and supportive partner.

The daily workforce challenges were noted, although the Trust currently reported a good position in this area.

The Board **noted** the strong performance and risks highlighted within the paper.

5 Governance and Assurance

5.1 **Consultant Appointments**
The Board **ratified** the following consultant appointments:

- Mr Amir Khosravi-Consultant Surgeon
- Dr Linu Kuruvilla-Consultant Radiologist

5.2* ***Governor Election Report***

The Chair welcomed the newly elected governors and welcomed those that had been re-elected. The Chair thanked Allan Pemberton for his continued support.

The Board **noted** the report.

5.3* ***Emergency Preparedness Resilience Response (EPRR) Core Standards Self-Assessment***

The Board **noted** the report.

6 Board Assurance

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

6.1.1 **People Committee: BAF Key Issues and Approved Minutes for Meeting held on 8th June 2021**

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The People Committee Chair commented on the wellbeing of staff and the Trusts 7-point plan, informing the Board that the mental health advocates were now in place at the Trust.

The People Committee had reviewed the culture survey results and actions, and a more in-depth response was to be presented at the December Committee.

A considerable amount of work had taken place regarding the development of the Educational strategy and a full review was expected at the Committee in March 2022.

Value based recruitment and international recruitment was also a key topic of discussion for People Committee members.

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

The Board received and **noted** the approved minutes of the People Committee meeting held on the 8th June 2021.

6.1.2 Integrated Performance Committee: Approved Minutes for Meeting held on 26th April 2021

The Chair of the Integrated Performance Committee highlighted the strong work ethic seen within the finance and operational teams in the ever changing challenging landscape.

The Board received and **noted** the approved minutes of the Integrated Performance Committee meeting held on the 26th April 2021.

7 Minutes of the Board of Directors Meeting held (in public) on 27th July 2021

The minutes of the meeting of the Board of Directors held on 27th July 2021 (in public) were reviewed for accuracy and **approved** by the Board.

8 Action Log (Public) from Previous Meeting

The action log was reviewed and updated as follows:

Item 2- Hospital mortality target review, a full mortality review and improvement plan will be reported to Board in November 2021 and the hospital mortality target will form part of that report.
Item 6-Development of New IPC strategy deferred to November 2021.

All other actions remained on the action log.

9 Legality of Board Documentation and Decisions

Board members confirmed that the conduct of the meeting and decisions made by the Board, to the best of their knowledge, complied with the law. Board members confirmed they were satisfied with the format of the meeting.

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10 **Date and Time of Next Meeting:**
Tuesday 30th November 2021, 10.00 hours

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

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

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Board of Directors (in Public)
Item 8

Action log

Updated 28.09.21

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	Objectives refreshed Nov 21 and KPI update planned Jan 22	Nov 21	
2.	4.1 Board Dashboard period ended 30th June 2021	Hospital mortality target to be reviewed	RAP	Mortality improvement plan developed	Nov 21	
3.	4.2 Phase 4 Recovery	Present a further recovery paper looking ahead for 2022/23	HK/KE	Complete -on agenda	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	Complete -on agenda	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	Complete -on agenda	Nov 21	
7.	3.1 Strategic objective – quarterly update	Present new R&I strategy	JT/JW	An update was provided on the development of the strategy at the Sept BoD	TBD	
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	Complete – see Strategy day agenda	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	