NHS
Alder Hey Children's
NHS Foundation Trust

**BOARD OF DIRECTORS PUBLIC MEETING**

**Thursday 25th November 2021, commencing at 9:00am**

**via Microsoft Teams**

**AGENDA**

| VB no. | Agenda Item | Time | Items for Discussion | Owner | Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N) | | Preparation |
|---|---|---|---|---|---|---|---|
| **PATIENT STORY (9:00am-9:15am)** | | | | | | | |
| **1.** | **21/22/181** | **9:15 (1 min)** | **Apologies.** | Chair | To note apologies. | **N** | For noting |
| **2.** | **21/22/182** | **9:16 (1 min)** | **Declarations of Interest.** | All | Board members to declare an interest in particular agenda items, if appropriate. | **R** | For noting |
| **3.** | **21/22/183** | **9:17 (3 min)** | **Minutes of the Previous Meeting.** | Chair | To consider and approve the minutes of the meeting held on: **Thursday 28th October 2021.** | **D** | Read enclosure |
| **4.** | **21/22/184** | **9:20 (5 mins)** | **Matters Arising and Action Log.** | Chair | To discuss any matters arising from previous meetings and provide updates and review where appropriate. | **A** | Read enclosure |
| **5.** | **21/22/185** | **9:25 (10 mins)** | **Chair/CEO's Update.** | Chair/ J. Grinnell | To provide an update on key issues and discuss any queries from information items. | **N** | Verbal |
| **POST COVID-19 Recovery Plan 2021/22** | | | | | | | |
| **6.** | **21/22/186** | **9:35 (30 mins)** | **Delivering a Safe Winter; including:**<br>- **Update on restoration and recovery.**<br>- **Keeping the Trust safe.**<br>- **Update on People Issues.**<br>- **IPC; including an update on the Staff Influenza Vaccination Programme** | A Bateman<br><br>N. Askew<br>M Swindell<br>B Larru | To provide an update on the development of operational plans for the 2021 winter period. | **A** | Presentation |
| **Strategic Update** | | | | | | | |

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| **7.** | **21/22/187** | **10:05 (10 mins)** | **ICS Development Update.** | D. Jones | To receive an update on the development of ICSs. | **A** | Presentation |
| **8.** | **21/22/188** | **10:15 (10 mins)** | **Alder Hey in the Park Campus Development Update.** | D. Powell | To receive an update on key outstanding issues/risks and plans for mitigation. | **A** | Read report |
| **Sustainability through Partnerships** | | | | | | | |
| **9.** | **21/22/189** | **10:25 (45 mins)** | **Cheshire and Merseyside Children and Young People Transformation Programme Update.** | D. Jones/ L. Crabtree | To receive an update on the Cheshire and Merseyside Children and Young People Transformation Programme | **A** | Presentation |
| **Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led** | | | | | | | |
| **10.** | **21/22/190** | **11:10 (10 mins)** | **Serious Incident Report.** | N. Askew | To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour. | **A** | Read report |
| **11.** | **21/22/191** | **11:20 (10 mins)** | **Q2 PALS and Complaints Report.** | N. Askew | To receive the PALS and complaints report for Q1. | **A** | Read report |
| **12.** | **21/22/192** | **11:30 (10 mins)** | **UNCRC letter: A Child's Right to Clean Air.** | S. Mayell/ I. Sinha | To provide an overview of the freedom to breathe letter calling on the UN Convention on the Rights of the Child to acknowledge a child's right to clean air. | **N** | Presentation |
| **13.** | **21/22/193** | **11:40 (40 mins)** | **Corporate Report – Divisional updates:**<br>- **Medicine.**<br>- **Community & Mental Health.**<br>- **Surgery.**<br>**Cumulative Corporate Report Metrics – Top Line Indicators:**<br>• **Quality/Safety.**<br>• **Effective/Responsive.** | U. Das<br>L. Cooper<br>A Bass<br>N. Askew<br>A. Bateman | To receive a report on Trust performance for scrutiny and discussion**,** highlighting any critical issues. | **A** | Read report |

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|---|---|---|---|---|---|---|---|
| **LUNCH (12:20pm-12:50pm)** | | | | | | | |
| **The Best People Doing Their Best Work** | | | | | | | |
| **14.** | **21/22/194** | **12:50 (5 mins)** | **Cumulative Corporate Report Metrics – Top Line Indicators:**<br>• **People.** | M. Swindell | To receive a report on Trust performance for scrutiny and discussion**,** highlighting any critical issues. | **A** | *Refer to item 13* |
| **15.** | **21/22/195** | **12:55 (10 mins)** | **BAME Inclusion Taskforce update.** | C. Dove/<br>M. Swindell | to receive an update on the work conducted by the BAME Inclusion Taskforce. | **A** | Presentation |
| **16.** | **21/22/196** | **13:05 (10 mins)** | **North West Wellbeing Pledges.** | M. Swindell/<br>F. Marsden | For information and discussion. | **N** | Read report |
| **Strong Foundations (Board Assurance)** | | | | | | | |
| **17.** | **21/22/197** | **13:15 (10 mins)** | **2021/22 H2 Plan; including: Financial Update, M7 2021/22.** | R. Lea | To provide an overview of the H2 plan and the position for Month 7. | **A** | Read report/ Presentation |
| **18.** | **21/22/198** | **13:25 (5 mins)** | **Board Assurance Framework Report.** | E. Saunders | To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed. | **A** | Read report |
| **19.** | **21/22/199** | **13:30 (20 mins)** | **Board Assurance Committees; report by exception:**<br>• **Audit and Risk Committee:**<br>- **Chair's Highlight Report from the meeting that took place on the 18.11.21.**<br>- **Approved minutes from the meeting that took place on the 23.9.21.**<br>• **Resources and Business** | K. Byrne<br><br>I Quinlan | To escalate any key risks, receive updates and note approved minutes. | **A** | Verbal/ read approved minutes |

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| | | | **Development Committee:**<br>- **Chair's verbal update from the meeting held on the 22.11.21.**<br>- **Approved minutes from the meeting held on the 21.10.21**<br>• **Safety and Quality Assurance Committee:**<br>- **Chair's verbal update from the meeting held on the 24.11.21.**<br>- **Approved minutes from the meeting held on the 20.10.21.**<br>• **People and Wellbeing Committee:**<br>- **Chair's verbal update from the meeting held on the 23.11.21.**<br>- **Approved minutes from the meeting held on the 21.9.21** | F. Beveridge<br><br>F. Marston | | | |
| **Items for information** | | | | | | | |
| **20.** | **22/22/200** | **13:50 (4 mins)** | **Any Other Business.** | All | To discuss any further business before the close of the meeting. | **N** | Verbal |
| **21.** | **21/22/201** | **13:54 (1 min)** | **Review of meeting.** | All | To review the effectiveness of the meeting and agree items for communication to staff in team brief. | **N** | Verbal |
| **Date and Time of Next Meeting:** Thursday, 16th December 2021, 9:00am-1:00pm, via Microsoft Teams. | | | | | | | |

Alder Hey Children's NHS Foundation Trust

| REGISTER OF TRUST SEAL |
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| **The Trust Seal was used in October 2021**<br>- 374 to 377: Section 106 agreement, Liverpool City Council, Laidrah, Alder Hey and Seddon Investments |

| SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION | |
| --- | --- |
| CQC Action Plan | E. Saunders |
| Financial Metrics, M7, 2021/22 | R. Lea |
| DIPC Monthly Exception Report | B. Larru |

Alder Hey Children's NHS
NHS Foundation Trust

# PUBLIC MEETING OF THE BOARD OF DIRECTORS

**Confirmed** Minutes of the meeting held on **Thursday 28th October 2021 at 9:00am,** via Microsoft Teams

| | | | |
|---|---|---|---|
| **Present:** | Dame Jo Williams | Chair | (DJW) |
| | Mr. N. Askew | Chief Nurse | (NA) |
| | Mrs. S. Arora | Non-Executive Director | (SA) |
| | Mr. A. Bateman | Chief Operating Officer | (AB) |
| | Prof. F. Beveridge | Non-Executive Director | (FB) |
| | Mrs. K. Byrne | Non-Executive Director | (KB) |
| | Mrs. C. Dove | Non-Executive Director | (CD) |
| | Mr. J. Grinnell | Acting Chief Executive | (JG) |
| | Mrs. A. Marsland | Non-Executive Director | (AM) |
| | Dr. F. Marston | Non-Executive Director | (FM) |
| | Dr. N. Murdock | Medical Director | NM) |
| | Mr. I. Quinlan | Vice Chair/Non-Executive Director | (IQ) |
| | Mrs. M. Swindell | Director of HR & OD | (MS) |
| **In Attendance:** | Mr. A. Bass | Director of Surgery | (ABASS) |
| | Prof. M. Beresford | Assoc. Director of the Board | (PMB) |
| | Ms. L. Cooper | Director of Community Services | (LC) |
| | Dr. U. Das | Director of Medicine | (UD) |
| | Mr. M. Flannagan | Director of Communications | (MF) |
| | Dr. A. Hughes | Deputy Medical Director | (AH) |
| | Mrs. D. Jones | Director of Strategy and Partnerships | (DJ) |
| | Mrs. R. Lea | Acting Director of Operational Finance | (RL) |
| | Mrs. K. McKeown | Committee Administrator (minutes) | (KMC) |
| | Mr. D. Powell | Development Director | (DP) |
| | Ms. E. Saunders | Director of Corporate Affairs | (ES) |
| | Mrs. K. Warriner | Chief Digital and Information Officer | (KW) |
| **Observing** | Prof. J. Jankowski | Member of the public. | (JJ) |
| | Ms. L. Smith | Governor. | (LS) |
| | Ms. L. Smith | Director of Nursing at Southport & Ormskirk | (LS) |
| **Apologies:** | Mrs. C. Liddy | Director of Innovation | (CL) |
| | Mrs. L. Shepherd | Chief Executive | (LS) |
| **Staff Story** | Ms. A. McDonald | Matron | (AM) |
| **Item 21/22/154** | Ms. B. Larru | Director of Infection Prevention Control | (BL) |
| **Item 21/22/164** | Mr. B. Pizer | Consultant Paediatric Oncologist | (BP) |

**Staff Story**

The Chair welcomed Angela McDonald who had been invited to October's Trust Board to provide an overview of the recent award that she won (*RCN North West – Black History Month 2021)* for an outstanding contribution to Equality, Diversity and Inclusion in Health and Social Care.

Nathan Askew advised the Board that as part of the Black History Month celebrations, the North West (NW) set out to recognise influential nurses as part of the RCN's work within the region. Nathan pointed out that he has been working with Angela for the last twelve months and has never met anybody as humble with regards to the work that they do whilst being unaware of the influence that they have on those who surround them. Nathan has had the pleasure of talking to

Angela about her life story and her journey throughout her career and decided to nominate Angela for this award to recognise her contribution to Alder Hey and what it means to those who admire what she does, plus he knew it was something she wouldn't do herself.

Angela provided an overview of her family's history, advising that the name McDonald came from a place where her ancestors came from, Jamaica. McDonald would have been the name of the plantation owner who would have given that name to Angela's ancestors. It was pointed out that Jamaica was the last destination on the slave trade, and it is often said in history that the people in Jamaica are the strongest of the Caribbean race. As a result of this Angela advised that she is a very strong, proud, black woman who is really proud of her maiden name and therefore uses McDonald in her nursing career

Angela shared her husband's family history along with some photographs depicting family members over the years from both families and advised of the changes to her husband's family surname throughout the generations to fit in with society and the community. Angela informed the Board that that all of her family members depicted in the photographs had a sense of community and supported each generation to develop and move forward. As a result of this, Angela advised that she also has a strong sense of community. Angela referred to her love of travel and the sense of community that she feels when visiting other countries/cultures and tries to reflect this in the work that she conducts on a daily basis.

Angela reported that she was warmly welcomed by all colleagues in the Trust when she took up a nursing post four years ago but was taken aback when she didn't see other black independent females or males in the nursing establishment. There was also a lack of recognition of different cultures therefore Angela decided to see how these conversations could be progressed. Following discussions with senior colleagues the Trust held an International Nurses Day and the Trust celebrated all international nurses, AHPs and other specialities. In addition to this Angela spoke with senior leaders about encouraging nursing students to come to Alder Hey and offering support, particularly male students from Afro Caribbean and African countries. Throughout Angela's time at Alder Hey she has spoken with patients about her nursing career/journey and promoted the Trust as a place to work. Angela informed the Board that she is comfortable about asking challenging questions, recognises and celebrates all cultures, is motivated by other colleagues in the Trust and in turn motivates others. Angela felt that this all links in with the photographs that were presented earlier and the support that has cascaded throughout the generations of Angela's family.

The Chair thanked Angela for sharing an insight into her family history and the things that inspire her and pointed out that the Board is enormously grateful for all of her contributions to the Trust. Angela thanked Nathan Askew for nominating her for the award.

**21/22/150 Welcome and Apologies**

The Chair welcomed everyone to the meeting and noted the apologies received.

**21/22/151 Declarations of Interest**

The Board noted the declaration received from Fiona Marston in relation to her association with the Liverpool Tropical School of Medicine.

**21/22/152 Minutes of the previous meetings held on Thursday 30th September 2021**
**Resolved:**
The minutes from the meeting held on the 30.9.21 were agreed as an accurate record of the meeting.

**21/22/153 Matters Arising and Action Log**

*Matter Arising*

There were none to discuss.

*Action Log*

**Action 21/22/65.1**: *Approach to End of Life Care when there is a dispute (Look into agreeing a process to provide families with feedback following an end of life decision)* – An update will be provided on the 25.11.21.

**Action 21/22/105.1:** *Alder Hey in the Park Campus Development Update (Provide an update on the gap in accommodation for staff, during October's Trust Board)* – This item has been included on October's agenda. **ACTION CLOSED**

**21/22/154 Post Covid-19 Recovery Plan 2021/22**

It was reported that during the meeting a reflection on the Trust's challenges will take place and an overview will be provided in terms of the actions that have been taken to mitigate some of these issues. It was pointed out that the Trust is very conscious about the health and wellbeing of its workforce and maintaining access for children and young people (CYP).

A number of slides were submitted to the Board to provide an update on safe staff, safe care and delivering the autumn and winter plan. Attention was also given to the national financial and operating framework for H2. The following points were highlighted:

Current Status

- *Emergency Department (ED)*
  - The Trust cared for 5,910 patients in ED during September 2021; 13% higher in comparison to pre-Covid figures.
  - Performance during September was 73.4%. It was reported that Alder Hey is the second-best performing type 1 department at the present time.
  - The proportion of patients treated within 4 hours has reduced due to the level in demand. It has been identified that two thirds of presentations are lower acuity; 65% with a 33% increase in acuity in terms of patients being categorised as yellow, amber, red following triage and therefore it is imperative that these patients are treated in clinical priority.
  - The conversion rate to admission has remained stable throughout the period but due to the upsurge in volume this has meant an increase in over 400 admissions during the last 6 months in comparison to 2019.
  - Each week the Trust has had higher medical admissions in comparison to 2019 with the majority of illnesses relating to respiratory viruses.
- *Elective Recovery*
  - The Trust is trying to protect its elective programme to ensure that patients on the waiting list are treated as soon as possible. It was reported that performance in outpatients during September was 97% recovery. It was pointed out that each day the Trust is treating as many patients as it was prior to the pandemic.
  - There have been a number of challenges in terms of inpatients/day case over the last few months that link to staff availability. It was reported that performance during September was 92%.

- Diagnostics have started to see as many patients as they were pre-Covid, with performance during September achieving 100%.
- It is the Trust's goal to attain a figure of 0 in terms of patients who are waiting 52 weeks for treatment. Following this there will be a focus on patients waiting over 18 weeks for treatment. As part of the Safe Waiting List Management work, the validation of 50,000 records has been completed to check that each patient is on the appropriate waiting list. This will have an effect in terms of a number of reportable long waits hence the rise in figures for September following the inclusion of a number of additional patients on the Trust's national 52 week wait pathway.

- *Staff Availability*
  - It was reported that as an organisation the Trust has over recruited against budget for its nursing staff to accommodate the expected number of maternity leave, etc.
  - Work has taken place recently to looked at establishments against acuity and the independence of patients and it has been found that the Trust needs to increase its baseline slightly. It was reported that there is a total of 17.6% of the frontline nursing workforce unavailable for work due to maternity leave, long-term sick, secondment, leavers and vacancies.
  - Overall sickness absence is 7.53% which covers a range of sickness factors. Attention was drawn to the challenges being experienced in PICU. The service is in the process of recruiting staff, but it was pointed out that when you take this into account along with staff absence it equates to a deficit of 21 nurses who are unavailable to work in that area.

Safe Staff, Safe Care, Delivering the Autumn and Winter Plan

- Attention was drawn to the areas that are central facets to the Trust's plan over the next six months;
  - Focus on keeping staff safe and available to work throughout the period.
  - Protect elective recovery where possible.
  - Focus on patient flow in order to improve the timeliness of care in the Emergency Department.
  - Increase PICU capacity.
- It was reported that over the past month support for staff and a number of interventions have taken place;
  - Staff breaks are really being encouraged. To facilitate this during the evening period the Trust has arranged for complimentary refreshments to be made available for staff.
  - The Trust also undertook a super Saturday session to enable 25 patients to receive the operations that they were in need of.
  - A large cohort of new nurses (52) commenced in post during September and 11 Healthcare Assistants started with the Trust in October.
- The Board was advised of the detailed actions that are underpinning the priorities of the autumn and winter plan. In terms of keeping patient care safe throughout the period, in addition to the ongoing work around safety priorities, there is to be a focus on ensuring;
  - >90% compliance in all on line mandatory training courses.
  - >90% of policies, guidelines and patient information leaflets to be in date.
  - 90% of issues flagged via the PALS route to be responded to in 5 working days.
  - 100% of complaints to be responded to within 25 working days.
  - 100% of risks to be reviewed and in date. Monitor/manage risks actively via regular review and complete all investigations and any subsequent actions that come from these.

- 0 overdue Serious Incident actions.
- 0 overdue Serious Incident investigations.

- *Critical Care Escalation* – Intensive Care is a regional service that the Trust provides and is integral to Alder Hey's elective recovery programme. This area is really challenged at the present time due to an increase in children and young people suffering from respiratory related conditions and lack of staff availability therefore the Trust has implemented a number of actions to help support this area of work;
  - Increased the rate of pay for bank shifts for nurses in line with other PICUs around the country/region.
  - The Trust has introduced training for non-PICU nurses in critical care skills. A group of non-critical care nurses have participated in a week's training programme and have since been deployed to work on ICU It was reported that the national surge model allows 2 non-PICU nurses to work under the supervision of a PICU nurse thus enabling the Trust to open up an additional PICU bed which will provide additional capacity in ICU. There are further plans in place to develop this work based on regional demand. One of the drivers for this is that the Trust has had 4 out of region transfers in August and September showing the pressure on the system internally. It was also reported that the North West is seeing more patients than some areas of the country.
- *Emergency Department* – There are three large interventions that the Trust is trying to prioritise in order to provide additional capacity and more timely care from an ED perspective;
  - Alder Hey has submitted two bids for further investment to help address volume and presentation at the front door. One bid relates to a new out of hours services which will be delivered by Health Visitors/GP stream. If the bid is successful, this service will provide the Trust with 40 additional appointments per day in which to see lower acuity patients.
  - In conjunction with Primary Care 24 a bid has been submitted for two respiratory hubs which would be based in community hubs. If the bid is successful, this will provide 30 additional appointments per day.
  - ED is continuing to look at other actions that can be taken internally. It was pointed out that an external review of ED's workforce data has taken place which signalled a need for the prioritisation of overnight medical cover therefore work is taking place to look at potentially compiling a new roster to have more senior cover overnight. Discussions are also taking place with the team around doing something differently with regards to follow up care and having more senior cover within the department.
- *Patient Flow* – The Board was advised of the challenge across the organisation due to additional patients being admitted which leads to medical outliers on the surgical wards and a delay in the timeliness of discharge for these patients. It was reported that there is to be whole hospital endeavour to address this area of work with the following actions to take place:
  - Standardise the process around discharge, embedding good practice and aim to more discharges to earlier in the day with a minimum of two discharges before 11:00am on each of the main inpatient wards.
  - Establish 2nd consultant of the week to reduce medical LoS and therefore outliers.
  - Theatre lists to commence on time.
  - Virtual Ward and the Home Care service will used to support with discharges and prevention.
  - A super-rota for enhanced out-of-hours clinical cover is to be established.
- *Elective Recovery* – There has been a lot of work conducted in day surgery in terms of the pathway into theatre and making the process as efficient as possible. The last audit identified that 90% of day-case patients arrived in

theatre by 9:00am which is a significant improvement. It is the Trust's intention to maximise the amount of patients that are offered a day case operation throughout winter and there is an improvement programme in place to support this. An Outpatients Performance Framework is also in the process of being implemented to support the Trust in achieving a high level of recovery in outpatients.

- *Elective Recovery (workforce)*
  - Work has been taking place with the Recruitment team in terms of KPIs and timeframes for recruitment. It was reported that the new recruitment system 'Track' is due to go live on the 2.11.21 which will reduce some of the administration around recruitment.
  - The Trust's aim is to achieve 90% of return to work meetings being completed on time following absence. The Board was advised that the most up to date data for non-Covid related sickness absence is around 6%.
  - It was reported that there is to be a focus on recruitment hotspots at Alder Hey; ED, ODAs and PICU. A plan is to be established to look at different ways in which to recruit; alternative places to advertise posts, media campaign to attract prospective staff.
- *Workforce: Focus on nurse staffing*
  - Baseline establishments have been reviewed and will be increased by 26 WTE RN and 22 WTE HCA staff.
  - Bank Rates have been increased across all areas.
  - International recruitment continues with 25 RNs arriving in December, and a further round being explored.
  - Targeted recruitment for specific areas such as ED, PICU and Theatres.
  - Supportive consistent sickness management.
  - Senior nursing team recruitment and retention group formed.
- The Board received an update on the Trust's vaccine programmes. As of the 27.10.21 it was reported that a total of 2,340 Covid-19 booster vaccines had been administered along with 1,901 flu vaccines. Nathan Askew thanked the staff who led the clinics and the vaccinators who supported the programme.
- *Inform (Communications)* – Work has been taking place to improve internal communications and establish a visibility programme for staff. The Trust is in the implementation stage in terms of providing weekly Exec level blogs, connect boards and providing information for staff about the help and support that is available. The Trust is also looking at revising the Alder Hey weekly broadcast and replacing it with a news channel.
- *Connect* – A piece of work is being conducted to understand the challenges that staff are experiencing in terms of taking a break or time away during the working day. Data is being collected from staff members at ward and department level and following this, solution focussed activities will take place to support teams/departments to make the most of their downtime during the day. In addition to this, the Chief Nurse is leading a piece of work to develop an Exec Engagement Plan. The Execs will link in and visit departments on a monthly basis in order to build a relationship with respective staff members, understand the challenges they are experiencing and celebrate their successes.
- *Support* – It was reported that the SALS team has got a comprehensive staff support programme in place which includes everything from the Alder Centre to the work that the team are doing. There is also a Wellbeing Steering Group in place with a good range of staff who are helping to form the programme. The Trust has also been looking at providing catering for staff outside of usual hours, refreshments and team funds to support individual departments with small but important things.

The Chair thanked the team for the comprehensive update on the actions that are being taken ahead of the coming autumn and winter. The Chair felt that the presentation reflects a whole Trust approach and shows how responsive the Trust is in terms of improving a number of areas.

Fiona Beveridge pointed out that Was Not Brought rates have been climbing and queried as to whether the organisation has been able to respond to this in order to minimise the impact. It was reported that the Trust has a significant improvement planned around the predictor of families who are at risk of not attending follow-ups and that programme is underway. The Radical option is to help families who are at risk of not attending via the use of the new Alder Hey Artificial Intelligence tool. It was agreed to include WNB rates on the RABD action log and provide an update to RABD on this area of work.

**21/22/154.1 Action: AB**

Fiona Marston raised a question in relation to the quality of experience in terms of patients/carers who wait for long periods of time in ED and asked as to whether this is an area that the Trust needs to focus on. Fiona Marston queried as to whether there is anything that can be done to improve the experience of patients waiting in ED, whilst acknowledging that that the organisation is doing everything it can to reduce the waiting time, especially as the Trust is starting to see patients leave without being seen by a clinician due to the long wait. It was recognised that patient experience needs to improve in a number of areas, ED in particular. It was reported that there have been a number of enhancements made to the environment in ED and staff carry out a welfare check on patients who are waiting a long time. This is a new step which involves apologising and explaining the situation to families whilst monitoring the patient to make sure they don't deteriorate during their time with the organisation. There is a real commitment in ED to improve the experience of patients, but it was pointed out that it has been really difficult for the team in terms of the department being understaffed and the increase in patients. The Board was advised that patients who leave the department prior to being seen by a clinician are either monitored or receive a call and are checked back in by one of the Trust's consultants. The Chair pointed out that the Trust has also done a lot of work with the security team in terms of how they respond to patients at the front door in a positive and compassionate way.

John Grinnell thanked the team for the presentation and the amount of work and effort that went into producing it. It's necessary to hone in on the levers that are in Alder Hey's control as there will be a number of areas that the Trust won't be able to influence at pace over the winter, from a system wide perspective. It was pointed out that this has had some bearing on the reshaping of Gold Command and the Trust's approach. At the heart of this is the responsibility and accountability which is part of the Brilliant Basics approach being used to inform how the Trust is going to deliver its autumn and winter plan. It was reported that a score card is going to be developed which will wrap around the plan.

The Chair pointed out that the plan is very much about patient safety, responsiveness to patients as well as looking after the Trust's workforce, and colleagues welcome this. The Chair drew attention to the detail of the work that is taking place by the Executives and the Divisions to ensure the Trust is doing everything it can to respond to the issues and restore services. The Chair felt that the detail will help Non-Executive Directors to support the work that is taking place, via the Assurance Committees and their roles. In addition to this there may be an opportunity over the coming months to increase NED visibility by connecting with the Divisions in order to listen and learn from staff. The Chair highlighted the importance

of circulating communications about the Trust's plan to ensure that staff members are aware of the support that is being implemented for them.

- *Governance Lite Approach* – Work is taking place from an operational aspect to manage a governance lite approach as well as looking at how metrics feed into the Assurance Committees. Alignment of the metrics with the Committees will be done ahead of November's round of meetings. This will be in line with the principles agreed at the start of the pandemic, with a reflection on where the current pressures are. It was reported that the Trust is working alongside KPMG to look at the streamlining of meetings with a focus on agendas. A request was made for members to provide any feedback on this area of work that they might have, especially Committee Chairs.

**21/22/154.2** **Action: All**

National Financial Operating Framework for half 2.

- *2021/22 Operational Priorities* – It was reported that the six priority areas that were set out in March 2021 have remained the same for half 2 and will be the main focus for 2021/22. The priorities are focussed on supporting the health and wellbeing of staff, delivering the Covid-19 vaccination programme, building on lessons learnt from the pandemic in terms of recovery and restoration, primary care expansion, urgent and emergency care, collaboration and working across the systems.
- *Key Operational Metrics* – A number of operational metrics have been included in the new guidance for providers and ICSs which need to be achieved by March 2022; patient initiated follow-ups, remote and digital outpatients, advice and guidance, elective recovery fund incentive and mental health investment standard (MHIS). Lisa Cooper advised that the Community Division has secured funding to help with the MHIS and are out to recruitment at the present time.
- *Draft Activity Submission* – The 1st draft activity submission was made on the 12.10.21 with the next due on the 2.11.21. The Board was provided with an overview of the key headlines from the submission which related to; waiting time projections, bed modelling and activity recovery.
- *H2 2021/22 Financial Headlines* – The key aspects of the H2 planning guidance are;
  - Rollover of H1 blocks.
  - 1.16% net inflation has been applied to the blocks which covers the pay award less the 0.82% CIP.
  - Covid funding has been reduced by 6% in H2.
  - 25% reduction in lost income funding.
  - A targeted efficiency has been applied to systems in deficit.
  - The overall impact for C&M is an overall £26.6m less than H1 across all providers and CCGs. Work is ongoing to fully understand this figure and see how it has been calculated/proportioned.
  - All systems have to break even by March 2022.
  - Elective Recovery Fund (ERF) is now linked to the RTT and therefore it is very unlikely that C&M will receive funding in H2.
  - Funding opportunities; ERF, targeted investment fund, digital and innovation and capacity funding.
- *Draft Financial Plan* – Since the guidance has been published the Trust has been working with C&M and providers across the system to understand the implications for Alder Hey. A draft indicative income allocation has been fed into the Trust's submission, as follows:
  - Assumptions

  - System funding £7.4m – This is a reduction of £1.8m.
  - Pay award funding of £1.1m – There a shortfall of £1.4m.
  - No contribution from ERF – Loss of £4.4m from H1.
  - Costs H2 activity & winter pressures with no confirmed income - £1.2m
- Opportunities:
  - System allocations refined/increased.
  - £1bn national funding ERF.
  - New funding for capital/tech/critical care.
  - Non recurrent release of technical budgets.
- Risks/Downsides:
  - Further stretch/CIP allocated by C&M to close gap.
  - Unidentified CIP plans.
  - C&M unable to reach breakeven = cash reduction.
  - Impact on SOF rating.

- *H2 Financial Approach* – Attention was drawn to the challenges and complexity of the current financial situation and the importance of looking at what can be done to improve Alder Hey's position. It was reported that the Trust will be focussing on the following approach; Accelerator Programme, benefit realisation, managing cash, commissioner/ICS, investments and technology.
- *Next Steps and Submissions* – The fundamental principle of the 2021/22 planning process is ICS/STP led therefore all submissions are to be submitted to the C&M system. It was confirmed that the Trust Board will sign off the final financial and activity plans on the 8.11.21, the final plans will be submitted to C&M on the 11.11.21 and the system plans will be submitted to NHSE/I on the 16.11.21.

A discussion took place around the financial risks/challenges for the Trust, the possible avenues for funding and the importance of ensuring the Trust receives a proportionate amount of the allocated system funding in H2, whilst acknowledging the £140m deficit that has been declared by the ICS. It was reported that work is taking place on a stakeholder lobbying map which will map out the organisation's partners and financial opportunities. This it to be submitted to the Executive Team in the next two to three weeks.

Fiona Beveridge asked as to how the Trust is going to manage key headlines for staff in terms of the funding challenges. It was reported that as the Trust develops its ICS plan communications will wrap around it.

*IPC Update*

The Board received an update on Infection, Prevention and Control. The following points were highlighted:

- It was reported that there have been two cases of C difficile in oncology patients. One has been deemed as a lapse of care *(as reported in September)* and the other case is to be reviewed in the next week. With regards to the second case the preliminary advice from Oncology is that there is no lapse in care.
- Fit-Testing – 90% of the Trust's staff have been fit-tested.
- Supporting Vaccination in CYP:
  - The Trust is going to ensure that long-term patients are vaccinated.
  - Facilitate access to Covid-19 vaccine to clinically vulnerable children.
  - Offer the flu vaccine for outpatients.

- A patient was identified with Pseudomonas BSI following an inpatient stay on Ward 3B. A scheduled water sample was taken on the 13.9.21 by an external company who identified Pseudomonas in several outlets sampled in Oncology. This incident is being managed by the Water Safety Group and remedial actions have been undertaken and additional sampling of all outlets on 3B have been undertaken.
- The Board was provided with an overview of the strategy to manage health care workers exposed to Covid-19

**Resolved:**
The Board noted the updates provided under the post Covid-19 Recovery Plan 2021/22.

**21/22/155 ICS Development Update**

The Chair opened this agenda item by providing some context in terms of the Governments priority/focus on restoring the NHS and building public trust over the next two years. Attention was drawn to the pressures that are flowing down from the Centre to ICSs to address four main priorities; better outcomes, reduction in health and inequalities, value for money and supporting the wider economic social systems within communities. The Chair pointed out that the Trust will have to continue to work collaboratively and build partnerships in a variety of different ways in order to move forward, and when putting the Trust's case forward it will be necessary to provide data to evidence/describe the work that is being done as this will be critical to the way in which Alder Hey will work within the ICS. It's about transformation, innovation, delivering services, keeping patients safe, but doing it in alternative ways. The lessons learnt since the beginning of the pandemic has enabled the Trust to address a variety of issues in a creative way and it was felt that this information should be shared across the wider ICSs to help demonstrate the impact on the four key areas, and likewise in terms of the work that has been done to date to address health inequalities. It was reported that on the 1.4.22 the ICS will be fully established with an Integrated Board and an Integrated partnership. The Chair pointed out that this is the context of how the Trust will be working in the future as an organisation.

Dani Jones advised the Board that in practical terms there are a number of areas that are progressing slowly but there is a lot of nuance, signals, and relationships changing on the patch.

A number of slides were presented to the Board to provide an update on the development of the ICSs. The following information was shared:

- What's happened in the last month:
  - Regional Director is becoming embedded.
  - NHS System Oversight Framework (SOF) published
- System oversight framework (SOF) scope and matrix:
  - Alder Hey has been categorised as a 2 in terms of the scale and nature of support needs, therefore work is taking place to gain clarity on this matter and look at how the Trust becomes a 1.
- Alder Hey's successes:
  - Bids won; Obesity Tier 3 (£400k), Long Covid (£200k), Autism Friendly Ward ((£150k) and C&M CYP Transformation CAMHS Integration (£200k). It was pointed out that work will continue to ensure that the Trust maintains access to any available opportunities.
  - Pipeline; Gender Identity Service (*bid in preparation*), diabetes and epilepsy to be confirmed.
- What's happened in the last month:
  - ICS Chair yet to be appointed. A second round of interviews will take

place in January 2022 and David Flory has agreed to continue as the interim Chair until April 2022.
- The appointment of the ICS CEO is expected to be announced soon.
- The Acute and Specialist Provider Collaboration is formalising.

- What's happened in the last month; Place:
  - New discussions in Liverpool; Sir David Dalton is the new CEO of Liverpool University Foundation Trust, there is a focus on system collaboration and discussions are taking place from a CEO Specialist Trust Alliance perspective.
  - The Trust has commissioned a BAF review with MIAA due to the lack of clarity around ICS risks.
- What's planned for the next month; top level system engagement.
- The Trust's big messages; CYP advocacy, commitment to collaboration, transformation, innovation and data, health inequalities, ICS/ICB, clinical and system networks and relationships.
- Next Steps:
  - One hour strategy session post November Board to discuss the emerging questions, ICS development and multiple pitches.

The Chair thanked all those involved for the work that has taken place to put the Trust in a good position. The Chair felt optimistic that Alder Hey's advocacy and leadership will make a difference as the ICS progresses, and it was agreed that an informal discussion should take place following November's Trust Board to think about the organisation's position.

**21/22/155.1 Action: DJ**

**Resolved:**
The Board noted the ICS development update.

**21/22/156 Alder Hey in the Park Campus Development Update**

The Board received an update on the progress, risks and actions on key capital projects. The following points were highlighted:

- *Relocations* - The fit out works at Liverpool Innovation Park is progressing well and occupation will commence at the beginning of November. It was reported that recent negotiations with senior officers of the Police has potentially released the ground floor of the building for Trust occupation by the end of November. A draft agreement for lease has been issued to the Police for comments. Work is also been taking place to look at the use of the Institute in terms of the space that is to be preserved for growth and how much can be used for relocations.
- *Schemes* – The construction of the Catkin Centre and Sunflower House is progressing well and on track to open in February 2022. Once the scheme is complete clinical services will move into the buildings. It was reported that any outstanding Community staff based on the site of Alder Hey will be housed in the Histology building on a short term basis. In order to complete the final piece of the development in terms of rehousing staff it was reported that the Trust is looking at three different options; 1. Agree the plans for the nursing home. 2. Potential facilities for use by the Trust on the North East Plot development. 3. Construction of a science/office building on the land that sits next to the Alder Centre which the Trust has the option to buy back. Work will take place during November/December to understand all options and make a final decision.

- *North East Plot Development* – The Trust has asked Step Places to incorporate guidelines into the procurement process for the appointment of a new nursery provider.
- *Park Reinstatement* – It was reported that a meeting is due to take place with Councillor Murray to discuss opportunities for the park development and the Lord Mayor and CEO of Liverpool City Council are visiting the park during November. The Trust is also looking at how the work that is being conducted on the site of Alder Hey and the park can support the Green agenda in the City.

The Chair summarised the update and advised that the Trust is on target with capital projects. Further work is to take place to understand the options available in terms of the use of further space, and the vision for the park is to improve health with the possibility for the Trust's clinicians to use the park's amenities alongside the community.

Lisa Cooper felt that it would be beneficial to have a regular update in the report on the cohort of staff who are moving into the Histology building to ensure that the Board is sighted on the final destination in terms of rehousing these staff members. A request was also made for a response to be included in October's report following a formal query form NHSE asking as to why there is a police evidence suite based in the children's Tier 4 inpatient unit.

**21/22/156.1 Action: DP**

Mark Flannagan advised the Board that the Trust has received two queries from the Liverpool Echo based on responses to Freedom of Information (FoI) requests. The organisation has also received a FoI about the funding of Capacity Lab. It was confirmed that Alder Hey is responding to all requests.

Shalni Arora queried the Trust's obligation under the current contract for the restoration of the park and asked as to whether Alder Hey is carrying out any additional work that doesn't form part of the contract. It was reported that the Trust is honouring its contract to restore the park, the facilitating of enhancements would have to be funded from another source and owned by LCC. It was felt that there are a number of enhancements that would be beneficial for the park, but this isn't part of the Trust's delivery. It was pointed out that the facilitation work that is taking place in terms of community building is funded elsewhere.

**Resolved:**
The Board received and noted the Campus Development update.

**21/22/157 Serious Incident Report**

The Serious Incident report was submitted to the Trust Board to provide a performance position for open and closed incident investigations that met the serious incident criteria and were reported externally to the Strategic Executive Information System (StEIS). The following points were highlighted:

- It was reported that there were no serious incident reported in September 2021, and zero 'Never Events' reported.
- StEIS reference; 2021/1899 and 2021/12203 due to closed in October were closed on time.

**Resolved:**
The Board received and noted the contents of the Serious Incident report for 2021.

**21/22/158 Digital Information Technology Update**

The Board was provided with a digital update including national digital direction of travel and local progress with Digital Futures. Key headlines included:

- 'What Good Looks Like' Framework has been published. Following the launch of the framework it was reported that Alder Hey was the only provider cited in the national CIO's blog in terms of a provider exemplar of 'What Good Looks Like'.
- *Who Pays for What and Unified Tech Fund* - The Trust has submitted a range of bids via the Unified Tech Fund Progress against a number of key areas to further develop the Trust's frontline digitisation in line with the published criteria.
- The Trust won an award for the work that took place around 'CYP Mental Health As One' NHS X project and was 'Highly Commended' for Excellence in Cyber Security at the recent Health Tech Network awards.
- The Board was advised that the Alderc@re programme is progressing, and the Trust is looking to launch it in 2022. A significant amount of the system has been built with recent developments in terms of the prototype 4 of the new build. Challenges continue in relation to prescribing with external support therefore the Trust has brought in additional senior resources to supplement the organisation's in-house capability with regards to supplier management, particularly as the Trust moves into the next phase of the programme. Feedback from speciality teams has been positive following the commencement of the system being built. It was reported that this will be the first implementation of its kind in the UK.
- The Board was advised that the Trust is being assessed by two national teams on the 16th and 17th of November for HIMMS level 7 accreditation.
- *Digital Partnerships* – The iDigital Service is continuing to develop. A significant piece of work has been conducted around information governance in collaboration across Alder Hey and LHCH. The Trust is also progressing a number of other opportunities within both trusts and thinking more broadly to those wider system opportunities.

In summary, progress with digital developments and delivery at Alder Hey remain positive. Performance of operational key performance indicators are good and customer service satisfaction feedback is high. The Chair thanked Kate Warriner and her team for the work that has taken place to achieve this position.

**Resolved:**
The Board received and noted the digital information technology update.

**21/22/159 Cumulative Corporate Report – Top Line Indicators**

The Division of Medicine, Community/Mental Health and Surgery provided an update on the following domains; Safe, Caring and Responsive as detailed in the Corporate Report.

Alfie Bass drew attention to a piece of work that took place around theatres that was completed in September. It was reported that 15 listening events have taken place with theatre staff and a survey was conducted in order to receive feedback from surgeons/anaesthetists about how they find working in theatres. This information has been integrated into an improvement plan which is due to be launched in October 2021. There are four themes to the plan; leadership, FPP standards using the Brilliant Basics approach, wellbeing of staff and roles and responsibilities. The Board was

advised that an update will be provided once the programme has been finalised and rolled out.

**21/22/159.1 Action: ABASS**

John Chester advised of the visit to the Trust by the interim Chair of the ICS, David Flory. The Trust put a particular emphasis on partnerships during the visit with regards to R&I working in partnership internally/externally with various partners. Examples of partnership working was provided; Liverpool Women's Hospital and colleagues in Mental Health/Public Health. Attention was also drawn to the significant workforce issues in the department as a result of short-term sick leave.

**Resolved:**
The Board received and noted the Divisional updates that are highlighted in the Corporate Report and the weekly cumulative Corporate Report top line metrics.

**21/22/160 Cumulative Corporate Report – Top Line Indicators**
*People*

**Resolved:**
The Board noted the people update that is highlighted in the Corporate Report and the weekly cumulative Corporate Report top line metrics.

**21/22/161 Workforce Disability Equality Standard (WDES) Report, 2021**

The Board received the Workforce Disability Equality Standard (WDES) annual report for 2021. The following points were highlighted:

- The data for this report comes from a number of sources; staff survey, recruitment data and workforce representation.
- The Trust has improved its reporting as a result of encouraging its workforce to identify their disability status, and it was confirmed that reporting is at 70% to date.
- Work will continue to take place to look at what else needs to be done to ensure the organisation becomes a really inclusive employer.
- *Likelihood of appointing* – The data highlights that people are less likely to be appointed if they are disabled, however the Trust has low numbers of applications and not everybody declares a disability. There is no evidence that there is an issue with people who have a disability entering the disciplinary process as the numbers are so small that the Trust is unable to generate a likelihood score.
- *Staff Survey* - In general staff are advising that their experiences are getting better year on year in terms of experiencing harassment, bullying or abuse and are reporting better scores in terms of feeling valued/employer taking reasonable adjustments seriously. The Trust's scores look better than the NHS average but there is still further work to do.
- *Board representation* – There is good representation on the Board but not everyone on the Board is reporting their position and there are no Board members reporting a disability. The Trust has taken steps in recruiting at Board level in terms of diversity from a race perspective. The next step will be to look at diversity in its broader sense.
- There is a clear action plan in place for this area of work, and the Trust has appointed a temporary EDI lead who has helped compile the reports and is looking at the actions that the Trust needs to take around disability.

The Chair advised Melissa Swindell that she would like to discuss job carving for people with special needs outside of the meeting.

**21/22/161.1 Action: MS**

Fiona Marston queried as to whether the Trust has statistics on disability for the population of Liverpool so that it can benchmark itself compared to the population that the organisation will primarily recruit from. Melissa Swindell advised that the interim EDI lead is focussing on this agenda and looking at how the Trust can progress the disability network, whilst understanding what is taking place outside of Alder Hey. Fiona Marston asked as to whether the Trust Bullying Policy falls into zero tolerance. It was confirmed that it does.

John Grinnell asked as to whether a piece of work could take place to enable the Trust to benchmark itself against other NHS providers, especially in terms of zero tolerance. The Chair pointed out that the Trust is above the national average, but the bar is quite low, and felt that it would be beneficial for the organisation to set a target going forward so that it can plot a trajectory to monitor performance.

**21/22/61.2 Action: MS**

Melissa Swindell informed the Board that the Trust's results are getting better year on year. Zero tolerance work is being addressed by the BAME Taskforce and covers all elements of discrimination.

Fiona Beveridge supported the comments that were made in terms of benchmarking and highlighted the importance of setting targets and monitoring trajectories. In terms of setting a target it was suggested that the Trust look at other organisations to see what is good to help with setting a realistic target.

**Workforce Race Equality Standard (WRES) Report, 2021**

The Board was advised that the Trust has improved its reporting as highlighted in the figures in the report, but it was pointed out that there is still work to do. It was reported that the new EDI Lead will be commencing in post in January and will work across three trusts; Alder Hey, The Walton Centre and Clatterbridge. It was felt that that this role will bring challenge and a real lens to this area of work.

**Gender Pay Gap Annual Report 2020**

The Board received the Gender Pay Gap Annual Report for 2020. The following points were highlighted:

- The report itself is looking at the Trust's gender pay gap *(the difference in pay between men and women)* and not equal pay. The data looks similar to the previous year with the mean gender pay gap at 29% and the median at 19%. This is due to the disparity in pay with medics, by removing this group of staff out of the equation the Trust has a slightly negative agenda pay gap toward males. This is as a result of having a predominantly female workforce.
- The Board was advised that the Trust has a really good gender split in terms of doctors, but a lot of the male workforce have a longer length of service thus giving them incrementally a higher salary and the opportunity of gaining a Clinical Excellence Award. Attention was drawn to the changes made by the Government in terms of the allocation of Clinical Excellence awards with funding being shared across trusts.
- It was pointed out that the Trust is able to provide an explanation for its gender pay gap. It is imperative that the organisation provides opportunities

for staff and has a lens on the differences in the higher pay bands. It was also felt that the Trust's data will change as a result of staff retiring.
- It was reported that Claire Dove is keen for the Trust to undertake an ethnicity pay gap review.

Fiona Beveridge asked that the Trust look at the staff survey data provided by male nurses/small numbers of male staff in order to provide more support for them.

**BAME Inclusion Taskforce**

The Board received an update on the progress of the BAME Inclusion Taskforce. The following points were highlighted:

- The Trust has received positive feedback from its volunteers, who have been invited to the next taskforce meeting to enable them to share their feedback with the group.
- It was reported that the comms for 'Black History Month' were excellent.
- There is to be a focus on the launch of the BAME staff network during the next couple of weeks.
- It was confirmed that Charlee Martin and Rushownara Miah have agreed to fill the network Chair roles on a temporary basis.
- The LGBT network has progressed with the support of Nathan Askew.
- It was confirmed that Claire Dove will be available to attend Board in November in order to provide an update.

The Chair thanked all those involved in driving the work of the taskforce forward.

**Resolved:**
The Board received and noted all three reports; WDES, WRES and the Gender Pay Gap which will be uploaded onto the Trust's website. The Board also noted the BAME Inclusion Taskforce update.

**21/22/162 GMC Annual Audit and Statement of Compliance for Medical Appraisals**

The Board received the General Medical Council Annual Audit and Statement of Compliance for Medical Appraisals.

It was reported that the Trust acquired a new appraisal system, L2P in order to manage appraisals and job planning. This was launched in December 2020. The introduction of L2P coincided with the implementation of a new way of scheduling appraisals across the Trust, whereby consultants now have their annual appraisal scheduled in their birth month. This model was introduced to alleviate the blockages caused by the previous model which ran from September to January and caused significant pressures. The new approach will be reviewed throughout the year and early feedback suggests the new approach is embedding well.

In addition, the Trust has increased the number of appraisers by 28 to 76 and has held two appraiser training courses. All new appraisers will be allocated two appraisees for the next appraisal year, this will increase to a minimum of five in accordance with GMC requirements.

Kerry Byrne advised the Board that the Audit and Risk Committee has been tracking the progress of the job planning portal for consultants following a critical report from MIAA which included 5/6 high recommendations. It was reported that this area of work has progressed immensely since Urmi Das has commenced to lead on it.

It was confirmed that the Trust is compliant with GMC requirements. The implementation of the L2P system has been well received and the new framework is being rolled out in-year.

**Resolved:**
The Board received and noted the General Medical Council Annual Audit and Statement of Compliance for Medical Appraisals.

**21/22/163 Award Nominations Summary**
**Resolved:**
The Board noted the award nominations summary.

**21/22/164 Department of International Child Health Update**

A number of slides were submitted to the Board to provide an update on work of the Department of International Child Health (ICH). The following information was shared:

- The history of engagement with ICH.
- The visions for ICH at Alder Hey.
- Themes; health partnerships, humanitarian work, commercial activities, Research and Innovation and education.
- Framework for NHS Involvement in International Development.
- Benefits.
- Business Case and benefits for ICH engagement.
- How ICH fits in with the Trust's values.
- Moving from strategy to successful delivery.
- The official launch of the ICH department on the 9th of November 2018 and the successes between 2018 and 2020.
- Benefits for the organisation and patients.
- Challenges.
- £300k grant to develop children's cancer services in Nepal.

The Board was asked to;

- Give full support to the reconfiguration/re-energising of the department of ICH.
- Agree that international work should be embedded within the Trust's strategy.
- Agree that international work becomes a feature of the Trust's Communication Strategy.

The Chair thanked Barry Pizer for providing an update on ICH and felt that in terms of the overall direction of travel the Board will want to support this work. It was pointed out that the Trust has a number of priorities that it needs to address before it can contemplate progressing ICH but raising awareness of this work at Board level is the first step to moving it forward.

Kerry Byrne asked as to how the Trust is going to balance this work in terms of investment and carving out the time to have discussions.

Fiona Marston pointed out that there isn't a clear enough road map in place at the present time that the Board can endorse, but felt that it is a good time to take stock in light of the changes that are taking place presently, for example, digital is fuelling innovation from an international perspective and taking stock will lead to prioritisation. It will be necessary to horizon scan for other opportunities and look at

how much Alder Hey wants to be part of the Liverpool international brand. Fiona Marston offered to contribute in terms of the work required to take stock.

Shalni Arora reported that elements of ICH will be addressed via the R&I Strategy and felt that it would be beneficial to have a conversation to see if the strategy meets some of the requirements highlighted in the presentation.

John Grinnell advised that the Executive Team will be addressing the Trust's 2030 vision in the new year. It was felt that Alder Hey will need to challenge itself in terms of wanting to be a world leading organisation and it might be that ICH sits in the centre of this vision. It was agreed that the ICH agenda needs to be revisited in order to gain further clarity.

The Chair concluded this item by suggesting the establishment of a working group, with NED involvement, to see if this work can be progressed.

**21/22/164.1 Action: BP**

**Resolved:**
The Board received and noted the update on ICH.

**21/22/165 Neonatal Partnership – Next Steps**

The Board received the proposal for the evolution for the Liverpool Neonatal Partnership and was provided with an overview of the work that has been taking place along with the next steps that are required in terms of the vision for the Liverpool Neonatal Partnership (LNP). Attention was drawn to the proposed streamlined governance and line reporting structure as a principle on page seven of the report which requires endorsement. It was reported that both trusts will work closely together to create a stronger governance structure for those that sit under the LNP Partnership Board.

Fiona Beveridge highlighted the importance of having a governance process in place, establishing KPIs, agreeing the risks and the management of them. It was reported that work is taking place on a template for working in partnership, of which, LWH has agreed to participate in the pilot for the development of the framework.

John Grinnell pointed out that the proposed governance and line reporting arrangements are key to the partnership and the opening of the unit. Attention was also drawn to the importance of agreeing the LNP vision as it was felt that this will put the partnership in a much stronger position with regards to having a single service across C&M. Nicki Murdock felt that working as a partnership bears more opportunities.

**Resolved:**
Following discussion, it was agreed that the Board would support the following recommendations:

- The vision for the LNP described in the report.
- The extension of the scope of the LNP to include all neonates (medical and surgical) across the two sites.
- The proposal to have the LNP Leadership Team 'hosted' by LWH creating a single operational line reporting structure.
- The current LNP Partnership Board developing detailed proposals for a more streamlined governance structure.
- The new Partnership Board creating a longer term vision and strategy for the development of the Partnership across Cheshire and Merseyside.

**21/22/166 Board Assurance Framework**

The Board receive a summary of the monthly updates to the BAF for review and discussion. Th purpose of the report is to provide assurance on how strategic risks that threaten the achievement of the Trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey currently consists of a set of 12 principal risks aligned to the Trust's strategic objectives. The Following points were highlighted:

- It was reported that the principal risks have been scrutinised by the respective Assurance Committees.
- Attention was drawn to the importance of embedding the metrics in report ahead of next month's reporting round.

**Resolved:**
The Board received and noted the contents of the Board Assurance Framework report as at the end of August 2021.

**21/22/167 Board Assurance Committees**

*RABD* – The approved minutes from the meeting that took place on the 27.9.21 were submitted to the Board for information and assurance purposes. During the meeting on the 21.10.21 there was a focus on the overspend in the neonatal budget and a discussion took place on the challenges of planning for H2 going forward.

*SQAC* – The approved minutes from the meeting that took place on the 22.9.21 were submitted to the Board for information and assurance purposes. During the meeting on the 20.10.21 the Committee focussed on quality priorities, the progress that has been made in all three quality priorities, transition and compliance with NICE guidelines and pressures in ED.

**Resolved:**
The Board noted the updates and approved minutes of the respective Assurance Committees.

**21/22/168 Any Other Business**

The Chair offered congratulations to Adrian Hughes on his appointment as deputy Medical Director.

Erica Saunders advised that following the collaboration with LHCH it has been agreed that the responsibility of the SIRO will be handed over to the Chief Digital and Information Officer, Kate Warriner.

**21/22/169 Review of the Meeting**

The Chair felt that the time spent on the operational issues was beneficial and thanked all those concerned for the work that has taken place. The Chair drew attention to the importance of looking at a way in which to progress the work of ICH.

**Date and Time of Next Meeting:** Thursday the 25th November 2021 at 9:00am via Teams.

**Alder Hey Children's NHS Foundation Trust**
**Trust Board - Part 1**
**Action Log (April 2021-March 2022)**

Alder Hey Children's NHS Foundation Trust

| Meeting date | Ref | Item | Action | By whom? | By when? | Status | Update |
|---|---|---|---|---|---|---|---|
| **Actions for the 25th November 2021** | | | | | | | |
| 25.2.21 | 20/21/252.1 | Mortality Report, Q2 | *National Changes to the Child Death Mortality Process* - Acquire written confirmation from David Levy's office acknowledging that the Trust's system is fully compliant and in line with the new national guidance. | Nicki Murdock | 28.10.21 | On Track | **19.3.21** - A verbal update will be provided on the 25.3.21. **25.3.21** - It was reported that the Trust is awaiting a reply from David Levy's office. **29.4.21** - It was reported that the Trust is awaiting a reply from David Levy's office. **20.5.21** - The Medical Examiner regional lead, Dr Huw Twamley, has discussed the Trust's Medical Examiner proposal with Julie Grice. He awaits national guidance with reference to the stand alone tertiary paediatric centres. The national Medical Examiner, Alan Fletcher, has also looked at this. There is no further guidance available yet, but Alder Hey's system is more rigorous than the national process. **ACTION TO REMAIN OPEN** |
| 24.6.21 | 21/22/65.1 | Approach to End of Life Care when there is a dispute | Look into agreeing a process to provide families with feedback following an end of life decision. | Adrian Hughes | 25.11.21 | On Track | **30.9.21** - It was agreed to provide an update on the 28.10.21. **28.10.21** An update will be provided on the 25.11.21. **ACTION TO REMAIN OPEN** |
| 28.10.21 | 21/22/154.2 | Post Covid-19 Recovery Plan 2021/22 | *Governance Lite Approach* - Provide feedback/comments on any areas of the governance lite approach that the Trust is taking. | All | 28.10.21 | On Track | |
| 28.10.21 | 21/22/156.1 | Alder Hey in the Park Campus Development Update | Include an a regular update in the Campus report on the cohort of staff who are moving into the Histology building to ensure that the Board is sighted on the final destination in terms of rehousing these staff members. Provide an update in November's report to explain why there is a Police evidence suite based in the children's Tier 4 inpatient unit. | D. Powell | 28.10.21/ ongoing | On Track | |
| 28.10.21 | 21/22/161.1 | Workforce Disability Equality Standard (WDES) Report, 2021 | Melissa Swindell and Dame Jo Williams to discuss job carving for people with special needs. | Melissa Swindell | 28.10.21 | On Track | |
| **Actions for December 2021** | | | | | | | |
| 24.6.21 | 21/22/68.1 | BAME Inclusion Taskforce | Meeting to take place to discuss the broadening of the EDI agenda for all staff in order to give this area of work some traction. | Nathan Askew/ Nicki Murdock/ Melissa Swindell | 28.10.21 | On Track | **23.7.21** - A meeting took place on the 23.7.21. It was agreed to submit an action plan to the Board in the autumn. |
| 28.10.21 | 21/22/154.1 | Post Covid-19 Recovery Plan 2021/22 | *WNB Rates* - Include WNB rates on the RABD action log and provide an update to RABD on this area of work. | Adam Bateman | 16.12.21 | On Track | |
| 28.10.21 | 21/22/155.1 | ICS Development Update | Arrange for an informal Board Strategy Session to take place after November's Board to discuss emerging questions, ICS development and multiple pitches. | Dani Jones | 16.12.21 | On Track | **23.11.21** - This item has been deferred to a later date. **ACTION TO REMAIN OPEN** |
| 28.10.21 | 21/22/161.2 | Workforce Disability Equality Standard (WDES) Report, 2021 | Conduct a piece of work to enable the Trust to benchmark itself against other NHS providers, especially in terms of zero tolerance. As part of this work, set a target going forward so that the Trust can plot a trajectory to monitor performance. | Melissa Swindell | 16.12.21 | On Track | |
| 28.10.21 | 21/22/164.1 | Department of International Child Health Update | Establish a working group, with NED involvement, to revisit the ICH agenda, gain clarity and look at whether the Trust can progress this area of work. | Barry Pizer | 16.12.21 | On Track | |
| **Actions for June 2022** | | | | | | | |

**Alder Hey Children's NHS Foundation Trust**
**Trust Board - Part 1**
**Action Log (April 2021-March 2022)**

Alder Hey Children's NHS Foundation Trust

| Meeting date | Ref | Item | Action | By whom? | By when? | Status | Update |
|---|---|---|---|---|---|---|---|
| 24.6.21 | 21/22/65.2 | Approach to End of Life Care when there is a dispute | Provide a progress update on the Trust's process that supports end of life discussions and agreements. | Nicki Murdock/ Adrian Hughes | Jun-22 | | |
| | | | | | | | |
| | | | | | | | |
| **Status** | | | | | | | |
| Overdue | | | | | | | |
| On Track | | | | | | | |
| Closed | | | | | | | |
| | | | | | | | |

Alder Hey Children's NHS
NHS Foundation Trust

# Board of Directors

**Thursday, 25th November 2021**

| | |
|---|---|
| **Report of** | Development Director |
| **Paper prepared by** | Associate Development Director- (16/11/2021)<br>Russell Gates |
| **Subject/Title** | Development Directorate<br><br>Campus Development report on the Programme for Delivery |
| **Background papers** | Nil |
| **Purpose of Paper** | The purpose of this report is to update the Trust Board on the Campus delivery. |
| **Action/Decision required** | The Board is asked to acknowledge the content of the report, the current status, risks and actions. |
| **Link to:**<br><br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | ➢ Delivery of outstanding care<br>➢ Sustainability through external partnerships |
| **Resource Impact** | Capital projects budget. |

Alder Hey Children's NHS
NHS Foundation Trust

# Campus Development report on the Programme for Delivery

## November 2021

### 1. Introduction

The purpose of this report is to keep the Board informed of progress, risks and actions on the key capital projects as they arise.

As of Month 2 in Quarter 3 of 2021/22 the programme Delivery Timetable RAG rates projects against planned commencement date.

### 2. Programme Delivery Timetable

Table1. Sets out the planned programme for the years 2019-2023 (financial years).

| Table 1. | 19/20 | 20/21 | | | | 21/22 | | | | 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Scheme** | **Qtr. 4** | **Qtr.1** | **Qtr.2** | **Qtr.3** | **Qtr.4** | **Qtr.1** | **Qtr.2** | **Qtr.3** | **Qtr.4** | **Year** |
| Initial Park Reinstatement (Phase 1) **COMPLETE** | | | | | | | | | | |
| Alder Centre occupation **COMPLETE** | | | | | | | | | | |
| Acquired buildings occupation Future use under review | | | | | | | | | | |
| Police station (Lower Floor) occupation | | | | | | | | | | |
| Commence relocations from retained estate. | | | | | | | * | | Final phase | |
| Decommission & Demolition Phase 3 (Oncology, boiler house, old blocks) **COMPLETE** | | | | | | | | | | Final phase |
| Main Park Reinstatement (Phase 2/90%) | | | | | | | | | | |
| Mini Master plan (Eaton Rd Frontage) 2 phases to plan | | | | | | | | | | |
| Infrastructure works & commissioning | | | | | | | | | | |
| Catkin Centre Construction | | | | | | | | | | |
| Catkin Centre Occupation | | | | | | | | | | |
| Sunflower House Construction | | | | | | | | | | |
| Sunflower House Occupation | | | | | | | | | | |
| Demolition Phase 4 (Final) | | | | | | | | | | |
| Final Park Reinstatement (Phase 3) | | | | | | | | | | |
| Neonatal Development Tendering and Design | | | | | | | | | | |
| Neonatal Construction | | | | | | | | | | |
| Neonatal Occupation | | | | | | | | | | |
| Orthotics move | | | | | | | | | | |

## 3. Project updates

### Park Reinstatement Phase 1

| Current status | Risks & Issues | Actions/next steps |
|---|---|---|
| Phase 1 of the park is now operational, however, the legal agreement has not yet been completed.<br><br>A planning application for the Multi-Use Games Area (MUGA) has now been submitted.<br><br>Work continues by Capacity Lab and the local community to organise events during the school holidays. | Location of Multi-Use Games Area (MUGA). (Risk 2348, risk rating 9) | Await feedback from LCC on the desired location. |

### Acquired Buildings Occupation (neighbouring sites)

| Current Status- on hold | Risks/issues | Action/next steps |
|---|---|---|
| **Knotty Ash Nursing Home**<br>**Under review following fire on 10th May.** | Delays to insurance pay out delays rebuild | Extent of fire damage being assessed by Loss Adjusters. Awaiting direction on full re-build or partial reinstatement/rebuild |

## Police Station (lower floor) occupation

| Current status | Risks/issues | Actions/next steps |
|---|---|---|
| Negotiations on the Agreement for `lease and leases progressing well. Police are content for us to move in to the ground floor of the Eaton road premises in November | Police do not release the space while decisions are made in regard to additional police funding and its use. (Risk 2088, risk rating 12) | Complete legal agreements. |

## Relocations

| Current status | Risks/issues | Actions |
|---|---|---|
| Occupation will of Innovation Park offices is underway.<br><br>The additional space to allow the CAMHs team along with some therapy space to relocate and expand is now out to tender. | Timely relocation and redirection of services are delayed (2104 risk rating 9 and 2105 risk rating 12) | Work with the landlord and furniture suppliers to implement design and procure furniture in accordance with e programme.<br>Await tender response. |

## Demolition Phase 3 (Oncology, boiler house, old blocks)

| Current status - COMPLETE | Risks/issues | Actions |
|---|---|---|
| Phase 3 demolitions complete. | None | |

### Park reinstatement Phase 2/3

| Current status | Risks/issues | Actions |
|---|---|---|
| Landscaping has commenced. Bulk materials are being delivered to site whilst the Trust has access to the back of the site from Alder Road to avoid using the Blue Light road. | Delays to demolition of old Catkin delays completion of phase 2 | Vacation of old Catkin into various locations is planned to complete in spring ready for decommissioning and demolition |
| Capacity Lab have two major parties interested is supporting enhancement to the park through provision of a café/changing area. | Funding required is not delivered through the partnership approach. (relates to risk 1241 , score 16) | Capacity lab continues to hold regular discussion with LCC and also keep the local community up to date with progress. |

### NEW Mini Master Plan for Eaton Rd frontage

| Current status- | Risks/issues | Actions |
|---|---|---|
| *No further progress required at the moment*<br>Design is now complete, taking in the Blue Light Road, the landscape surrounding the new Builds (Institute, Alder Centre and Cluster). Part of the scope will be funded by the 2 development sites as and when these are brought forward. | If not planned appropriately is could cause traffic congestion in the future. (Risk 2354, risk rating 8)<br>Insufficient budget to complete the work | Plan the appropriate start date for the works to coincide with other works on site. |

## Infrastructure works & commissioning

| Current status | Risks/issues | Actions |
|---|---|---|
| The programme for the new infrastructure is progressing in line with the overall delivery programme for the campus developments. Civils works concrete plinths, retaining walls and trenches) are well underway. | Early indication is that to complete all of the work will exceed budget.<br><br>Must maintain programme to avoid delays to the cluster and neonates projects | The works remain on programme but close monitoring is being continued to watch for slippage. |

## Catkin Centre and Sunflower House Construction

| Current status | Risks/issues | Actions |
|---|---|---|
| Contract with Galliford Try remains on programme with good visible progress. However, discussions are taking place regarding the impact of the infrastructure works.<br><br>Planning of the occupational commissioning continues with representation of the users, clinical staff, FM and estates.<br><br>Furniture and interiors are in discussion so that furniture can be ordered at the end of November. | Ongoing design development potentially could raise issues of quality leading to increases on cost. Late change leads to delays and additional costs.<br><br>Budget for furniture is inadequate | Continue with weekly meetings with Galliford Try and challenge design where necessary.<br><br>Costed schedules to be produced to ensure affordability. |

## Demolition Phase 4 (Final)

| Current status | Risks/issues | Actions |
|---|---|---|
| N/A at current time, planned for Qtr. 4. 21/22 | Cost may exceed current allocated budget. | Monitor demolition budget management on a monthly basis and work up contingency plan. |

## Neonatal Development

| Current status | Risks/issues | Actions |
|---|---|---|
| Trust Board agreed to increase the budget and a VE exercise is underway. Current progress on VE is positive and will complete by the end of the year ready to enter in to a contract in January 2022. | Project Co engagement extending the programme and increasing costs.<br><br>Concerns about construction cost inflation being very volatile in the market with shortages of metals and timbers. This is particularly affecting any plant and materials with metal (plumbing, ventilation, reinforcement etc). | Continue working with Project Co to mitigate impact.<br><br>Continue to work with a contractor to bring the scheme in to the increased budget. |

## North East Plot Development

| Current status | Risks/ Issues | Actions/next steps |
|---|---|---|
| **StepPlaces,** the Developer who has purchased the north east plot of land, is currently in discussion with the trust on how the development could support.<br><br>StepPlaces has received a planning consent.<br><br>Ronald MacDonald Charity not favouring a move to a new building. However, discussions still taking place. | Change process with Staff will present some challenges | Maximise our offering/ support /negotiation on development content and opportunities.<br>Work through each work stream and provide a business case for each to demonstrate requirements, sustainability and affordability.<br><br>Produce robust business cases to highlight any issues/risks. |

## Communications

| Current status- | Risks / issues | Actions/next steps |
|---|---|---|
| Regular dialogue between development team and Communications department are now in place to cover the park development.<br>Fortnightly meetings established to discuss wider campus development progress. | Loss of reputation, locally and regionally.<br>Lack of engagement internally and externally | Maintain links with community and support their development work. |

## Car Parking

| Current status | Risks/Issues | Actions/next steps |
|---|---|---|
| *Status unchanged*<br>The Trust has now opened the Thomas Lane car park which is being leased from Liverpool City Council. The car park provides 134 spaces and will be open from 6am-6pm Monday to Friday. | Staff resistance to change and work to coordinate with external public transport providers/council/highways needs a dedicated Green Travel Plan co-ordinator | Review car parking requirements in view of the home working and off-site office building.<br><br>Recruit a travel plan co-ordinator. |
| A new member of staff is being sought commence work on the implementation of a green travel plan. | Travel plan from Mott MacDonald does not provide realistic and evidenced solution. | Car parking group to continue to work with Mott MacDonald and internal group members to produce an overall green travel plan. |

**Orthotics move to Outpatients**

| Current status | Risks/Issues | Actions/next steps |
|---|---|---|
| Moving Orthotics service into space in the lower ground floor of outpatients is moving forward. The service will share reconfigured space with medical illustration. A temporary home for Medical photography has now been agreed to clear te space for the works. | Temporary home of medical photography studio | Agree date for moving the service |

## 4. Trust Board of Directors

The Trust Board of Directors is requested to receive and acknowledge the update provided as of 20th October 2021.

Alder Hey Children's NHS
NHS Foundation Trust

# BOARD OF DIRECTORS

## Thursday, 25th November 2021

| | |
|---|---|
| **Paper Title:** | Serious Incident Board Report<br>1st October 2021 – 31st October 2021 |
| **Report of:** | Nathan Askew, Chief Nursing Officer |
| **Paper Prepared by:** | Cathy Umbers, Associate Director of Nursing and Governance |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ☑<br>Information ☐<br>Regulation ☑ |
| **Background Papers and/or supporting information:** | Seven Steps to Patient Safety. National Patient Safety Agency 2004.<br>Health and Social Care Act 2008 (Regulated Activities). Regulation 20 'Duty of Candour'.<br>Serious Incident Framework. Supporting learning to prevent recurrence. NHS England 2015.<br>Serious Incident Framework. Frequently asked questions NHS England 2016.<br>NHS Patient Safety Strategy. NHS Improvement. July 2019.<br>Never Events List ( revised February 2021) |
| **Action/Decision Required:** | The action required is both to note and approve the report.<br><br>To note ☑<br>To approve ☑ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ☑<br>**The best people** doing their best work ☑<br>Sustainability through **external partnerships** ☐<br>Game-changing **research and innovation** ☐<br>**Strong Foundations** ☑ |
| **Resource Impact:** | None identified |
| **Associated risk(s):** | Managed via risk register |

## 1. Purpose.

The purpose of this report is to provide the Trust Board with an overview and performance position for open and closed incident investigations, that met the serious Incident criteria, reported externally to the Strategic Executive Information System (StEIS),

## 2. Summary

**Table 1** (appendix 1) provides the performance position for StEIS reported incidents including serious Incidents and Never Events for this financial year. There was one serious incident reported in October (ref: 2021/20934) and zero 'Never Events' reported.

**Table 2** (appendix 1) provides an overview of the current open StEIS investigations There are four StEIS open investigations progressing during this reporting period. Duty of candour has been completed for all incidents, in line with regulation 20.

**Table 3** (appendix 1) provides overview of the one closed investigation during this reporting period.

**Appendix 1**
**Table 1 StEIS reported Incidents and Never Events performance data 2021/22**

| Serious Incidents | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |
| **Month** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| **New** | **0** | **1** | **2** | **0** | **1** | **0** | **1** | | | | | |
| **Open (Total)** | **5** | **5** | **5** | **5** | **4** | **4** | **4** | | | | | |
| **Closed** | **0** | **1** | **2** | **0** | **2** | **0** | **1** | | | | | |
| **Never Events** | | | | | | | | | | | | |
| **Month** | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| **New** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | | | | | |
| **Open (Total)** | **1** | **1** | **0** | **0** | **0** | **0** | **0** | | | | | |
| **Closed** | **0** | **0** | **1** | **0** | **0** | **0** | **0** | | | | | |

**Note:** 5 open investigations carried forward 2020/21

**Table 2 Open ongoing StEIS reported investigations**

| StEIS Reference | Date reported | Incident | Agreed date of completion |
|---|---|---|---|
| 2021/20934 | 06/10/2021 | Delay in treatment | 07/01/2022 |
| 2021/17974 | 16/07/2021 | Severe Haemophilia A: Treatment outside usual clinical pathway. | 07/12/2021 |
| 2021/12203 | 27/06/2021 | Delay in treatment. Delay in transfer to HDU. Suboptimal care of deteriorating patient? | 30/11/2021 |
| 2021/12387 | 12/06/2021 | Patient ingested large overdoes of tablets at home, including Omeprazole and Colchicine. Patient died due to impact of Colchicine toxicity. | 22/12/2021 |

**Table 3 Closed StEIS reported investigation**

| StEIS Reference | Date reported | Incident | Date completed |
|---|---|---|---|
| 2021/1899 | 24/01/2021 | Unexpected death of a patient (HDU). Joint Perinatal review ( PMRT) with Warrington and Halton Hospitals. | 07/10/2021 (submitted within agreed timeframe) |

**END**

Alder Hey Children's NHS Foundation Trust

**BOARD OF DIRECTORS**

**Thursday, 25th November 2021**

| | |
|---|---|
| **Paper Title:** | **Quarter 2 2021/22 Complaints, PALS and Compliments report** |
| **Paper of:** | Nathan Askew Chief Nurse |
| **Paper Prepared by:** | Val Shannon Patient Experience/Quality Lead<br>Pauline Brown Director of Nursing |
| **Paper Presented by:** | Nathan Askew Chief Nurse |

| | |
|---|---|
| **Purpose of Paper:** | The purpose of this paper is to provide Trust Board with an update and assurance on the performance against complaints and PALS in Q2 2021/22, a thematic analysis of the top reasons for complaints and PALS, action taken as a result of concerns raised, and proposed developments planned in 2021/2022. |
| **Summary and/or supporting information:** | There has been a slight increase in formal complaints received during Q2 (39) compared to Q1 2021/22 (34). The top reason for formal complaints received in Q2 was consent, communication and confidentiality. Compliance within the 3 working day acknowledgement for formal complaints is 95% in Q2. Compliance with the internal Trust target of 25 working days to respond was 46% (19 out of 39). This is a decrease compared to Q1 which was 50% compliance. There are currently 11 ongoing cases with 2 cases being reopened within Q2. There are 27 cases ongoing from April 2021 plus 4 that have been reopened.<br><br>Two complaints from Q2 were responded to as second stage complaints. The Trust has 0 new referrals to the PHSO in Q2. There are two current ongoing cases.<br><br>There has been a consistent number of informal concerns (PALS) received during Q2 (384) compared to Q1 2021/22 (378).<br><br>The main reason for informal PALS concerns is regarding communication failure as the main concern. Compliance with the 5-day target to resolve informal concerns is 63%.<br><br>76 compliments are recorded centrally in the Ulysses system for Q2. |

Alder Hey Children's NHS Foundation Trust

| | |
|---|---|
| **Financial Implications** | None |
| **Key Risks Associated** | Reputational risk associated with not meeting the quality priorities and the Trust targets. |
| **Quality Implications** | Poor patient experience due to not meeting the required time frame for response and resolution |
| **Link To:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | **Delivery of outstanding care**<br>**The best people doing their best work**<br>Sustainability through external partnerships<br>Game-changing research and innovation<br>Strong Foundations |
| **Resource Impact:** | Yes |
| **Action/Decision Required:** | Trust Board are asked to note the content of this report and support the ongoing Complaints Improvement Plan. |

Alder Hey Children's NHS Foundation Trust

## 1. Introduction

The Trust is committed to ensuring all our children, young people and their families receive the highest quality of care. However, where care and treatment does not meet the standard of care our service users expect, the Trust has a duty to listen to their concerns, investigate them fully, and provide a full, appropriate and compassionate response. Compliments, concerns and complaints are an important measure of the quality of care we deliver and are used to learn and further improve our services.

This report aims to provide assurance that the Trust is responding to patient complaints in line with its procedures, Department of Health legislation and standards expected by the Parliamentary and Health Service Ombudsman (PHSO).

This report provides an overview of formal complaints and informal PALS concerns received and completed between July to September 2021 (Q2). This report aims to provide assurance that the Trust is responding to the concerns raised by children, young people and their families in line with Trust procedures, Department of Health legislation and standards expected by the PHSO; identifying and analysing themes more widely that the Trust needs to address to make service improvements; and to highlight action taken.

## 2. Formal Complaints

### 2.1 Number of formal complaints received in Q2 2021/22

The Trust experienced a slight increase in the number of formal complaints in Q2 2021/22 compared to Q1, with 39 submitted in Q2 compared to 34 in Q1. There is a slight increase compared to the same period last year (Q2 2020/21) when 35 cases were reported. A comparison of Q2 2021/22 with the same period last year (Q2 2020/21) is shown in Figure 1; Figure 2 shows the breakdown of complaints received by service in Q2.

**Figure 1: Number of formal complaints in Q2 2021/22 compared to same period in Q2 2020/21**

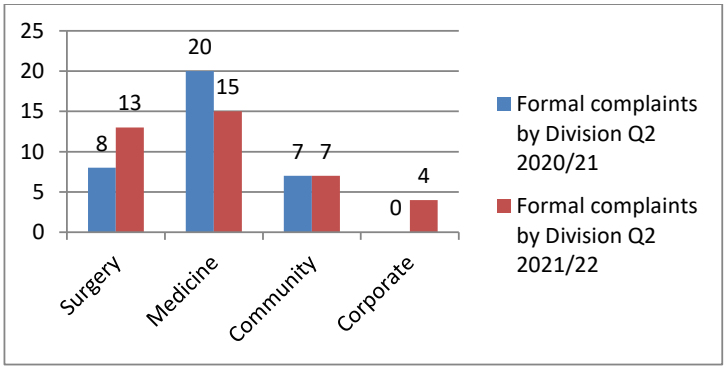
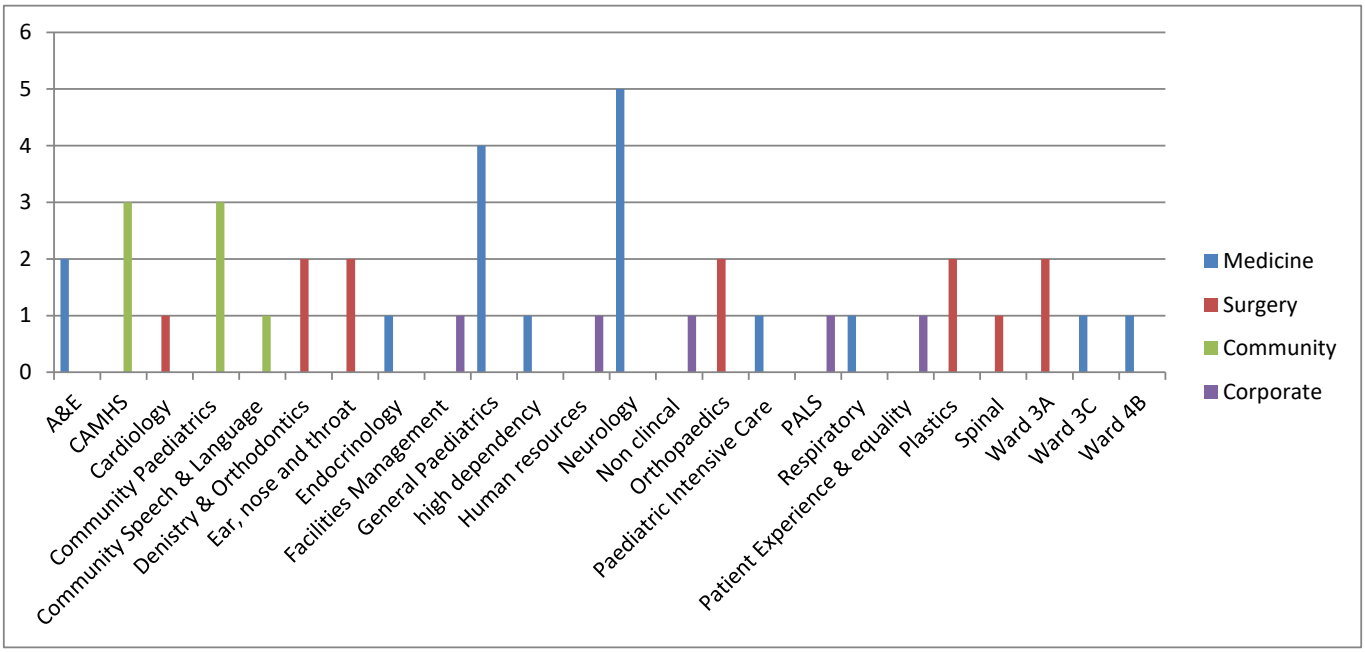


**Figure 2: Number of formal complaints by service in Q2 2021/22**




### 2.1.2 Number of formal complaints received in year 2021/22

There have been 73 formal complaints received so far in 2021/22 as shown in Figure 3. Figure 4 shows the number of complaints by Division for Q2.

**Figure 3: Number of formal complaints 2021/22**

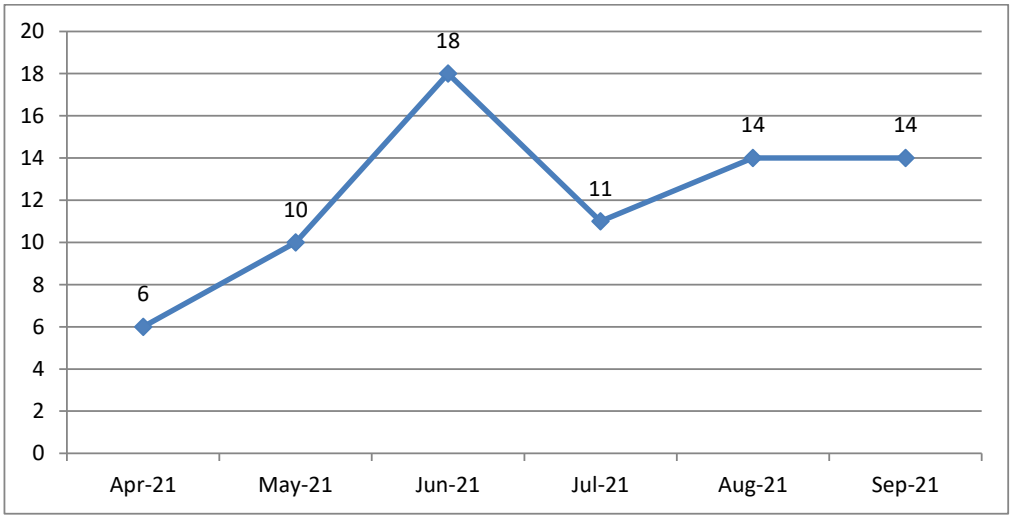
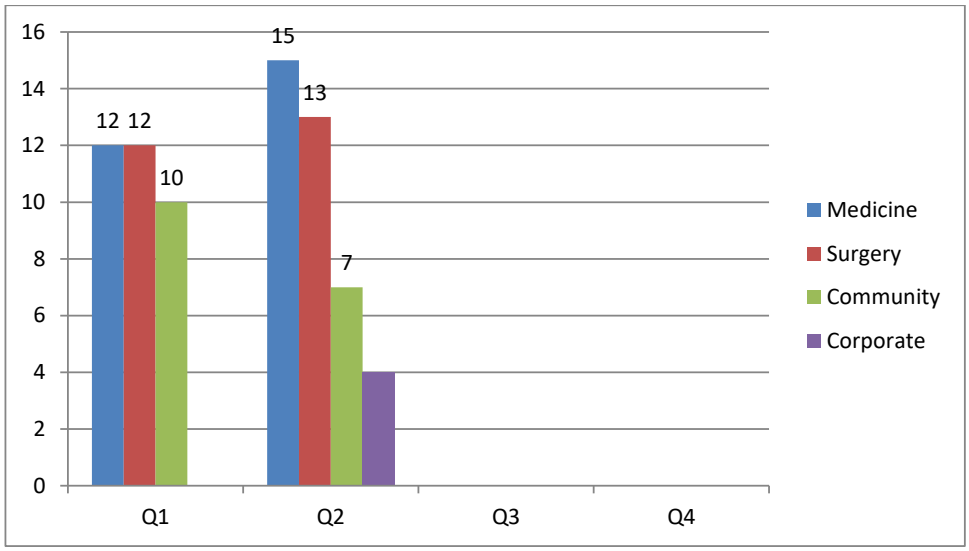


**Figure 4: Number of formal complaints by Division in Q1 and Q2 2021/22**

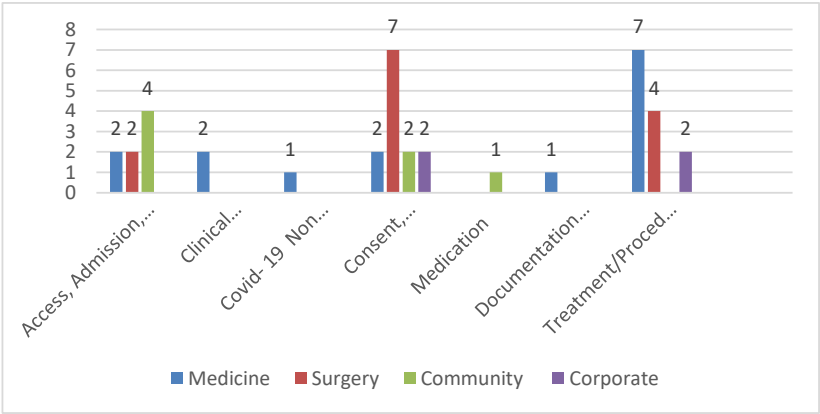



## 2.2 Complaints received by category Q2 2021/22

Complaints are categorised by subject as set in the Trust Ulysses complaints system. A complainant may raise several issues that the Trust must respond to, and all concerns expressed by families are categorised within the record, however the primary issue is used within this report to monitor key trends.

Figure 5 below demonstrates that the main theme in this quarter continues to be in relation to consent, communication and confidentiality with a total of 13 complaints (33%) in Q2.

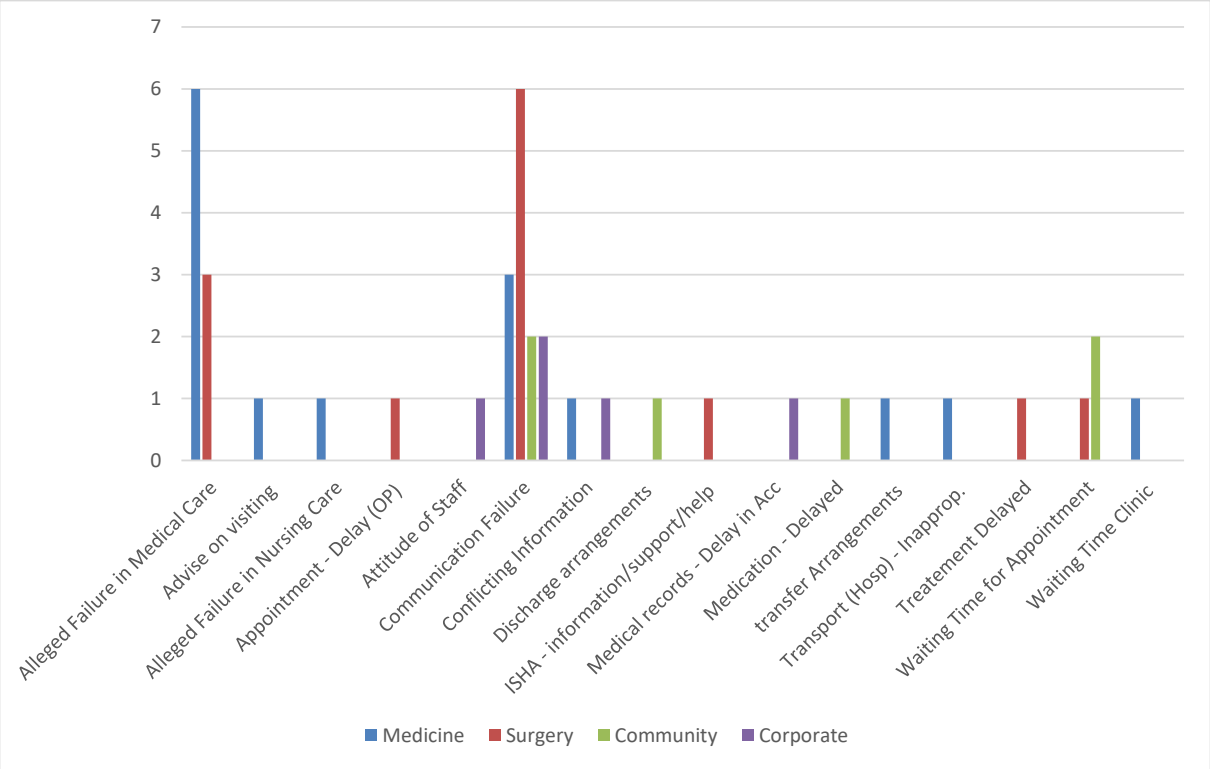
**Figure 5: Primary categories of complaints Q2 2021/22**



Alder Hey Children's NHS Foundation Trust

Sub-category identification provides further detail regarding the primary issues raised by families. Figures 6 demonstrate that the main theme within the consent, communication, and confidentiality category is in relation to alleged failure in communication with 13 complaints (31%) in Q2.

**Figure 6: Subcategories of complaints Q2 2021/22**




A review of the Ulysses complaints module has been undertaken to ensure the categories are in in line with the NHS Digital complaints categorisation.

## 2.3 Trust performance against Key Performance Indicators (KPI)

### 2.3.1 National context

Current national guidance has set out that Trusts must continue to comply with NHS Complaints Regulations, however acknowledges that in some settings it may take longer to respond to a complaint and consider it currently permissible for this to go beyond the usual six month maximum time period. However, organisations should opt to operate as usual regarding the management of complaints if they are able to do so. The Trust continues to aspire to responding to complaints in line with RM6 Complaints and Concerns policy.

### 2.3.2 Compliance with 3-day acknowledgement 2021/22

The NHS Complaints Guidance (updated January 2021), sets out that complaints should be formally acknowledged within 3 working days; reflected in the Trust policy (RM6 Complaints and Concerns policy). The Trust has a generic formal complaint acknowledgement email that is sent out to the complainant; this includes a named contact for the complainant to contact should they require to do so (including the direct phone number) and the date the response is expected to be with them. The email also includes information relating to the services offered by Healthwatch Advocacy. The Complaints Officer may also telephone the complainant to discuss their concern further.

In Q2, 95% of formal complaints received were acknowledged within 3 working days, with 33 (85%) being acknowledged on the same day. This is a sustained improvement in performance over the last 12 months towards the Trust target of 100%. The two complaints that were not responded to within 3 days were responded to on Day 4 and Day 6; this was overlooked due to staff resource within the PALS and complaints team. The Director of Nursing is in the process of reviewing the PALS and complaints staffing resource.

Figure 7 below shows a breakdown of acknowledgment times providing the Trust assurance with continued high compliance with the standard.

**Figure 7: Compliance with 3-day acknowledgement Q2 2021/22**

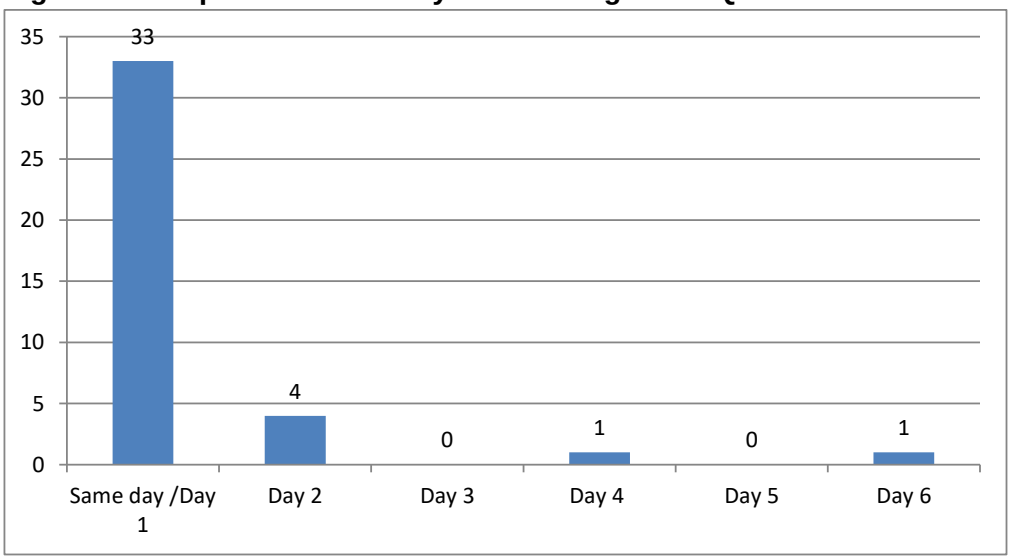


**Table 1** shows the compliance by number demonstrating increased compliance with this standard.

| Table 1: Compliance with 3 day acknowledgement | Total number of complaints received in Quarter | Total number acknowledged within 3 working days | % number acknowledged within 3 working days |
|---|---|---|---|
| Q1 (2020/21) | 23 | 19 | 82% |
| Q2 (2020/21) | 35 | 29 | 83% |
| Q3 (2020/21) | 45 | 44 | 98% |
| Q4 (2020/21) | 53 | 53 | 100% |
| Q1 (2021/22) | 33 | 33 | 100% |
| Q2 (2021/22) | 39 | 33 | 95% |

### 2.3.3 Complaints responded to and closed in Q2 2021/22

A total of 33 complaints were responded to and closed in Q2 of which 19 were received during Q2; 14 were received in Q1 2021/22, one case has now been reopened. There is an ongoing complaint received in Q1 (74 days) received by the Surgical Division in relation to diagnosis not made/failure. Due to the complexity of the case in both legality and being a joint complaint with another Trust, this case has been escalated to the Director of Nursing for review and support.

### 2.3.4 Compliance with 25-day response

Whilst the NHS Complaints Guidance states that there is no set timeframe to respond to a formal complaint, as this is dependent on the nature of the complaint, the Trust has set an internal timeframe in the Complaints and Concerns policy to respond to formal complaints within 25 working days. Where a complaint is complex and / or multi organisational, this is discussed with the complainant to negotiate an extended timeframe with them and agree a new date for response. A meeting with appropriate Trust representatives is also offered as this can lead to a successful resolution of the concerns raised.

19 of 39 (46%) complaints received in Q2 were responded to during the same quarter. The response times are illustrated in Table 2 below.

**Table 2 – Response days for complaints received in Q2**

| | Total complaints received in Quarter | Complaints received and responded to in same Quarter | 0-25 days | 26-35 days | 36-45 days | 46-55 days | 56-65 days | 66-75 days | More than 75 days |
|---|---|---|---|---|---|---|---|---|---|
| Q2 2021 /22 | 39 | 19 | 9 (47%) | 6 (32%) | 3 (16%) | 1 5% | | | |

**Figure 8: Comparison of complaint number with 25-day response between 2020/21 and 2021/22**

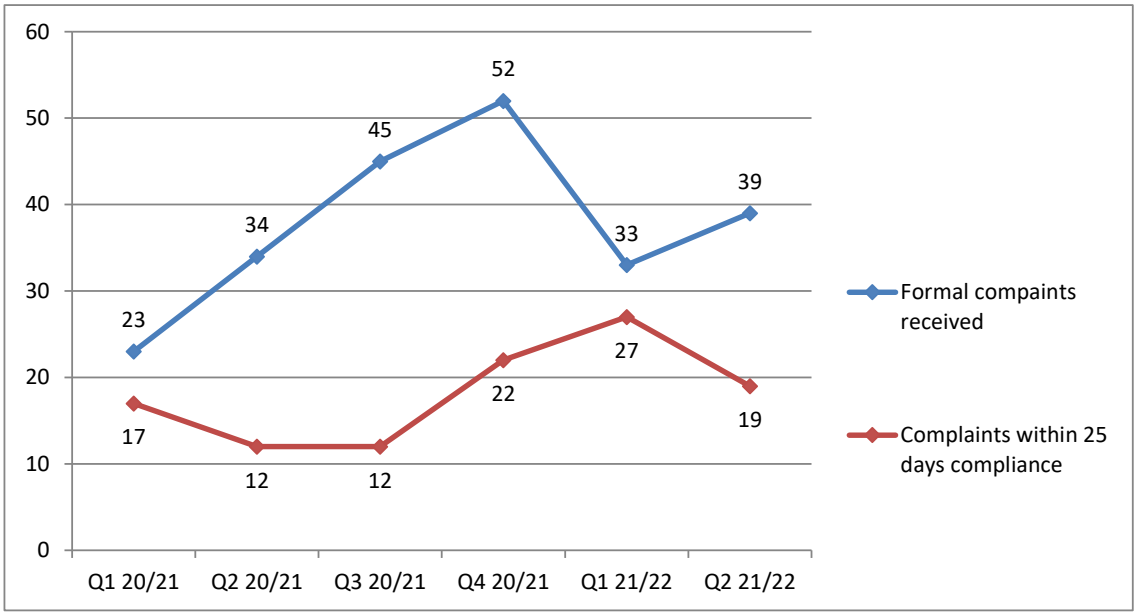
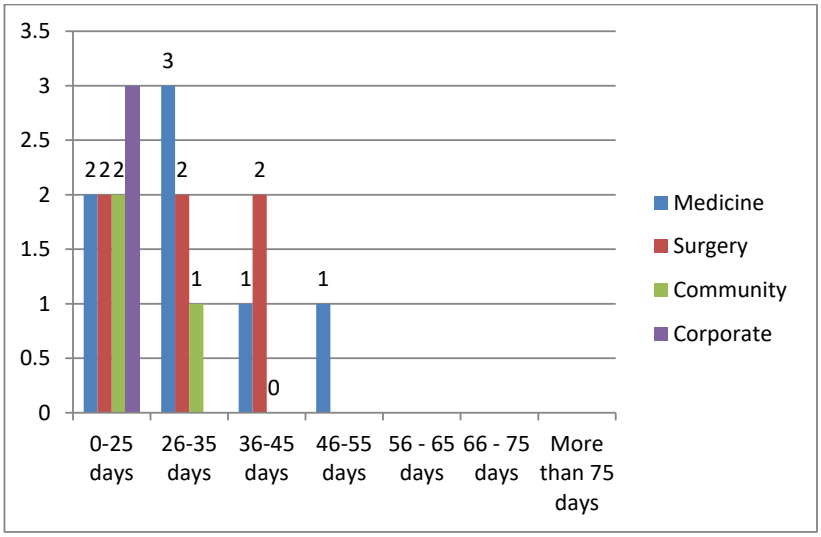


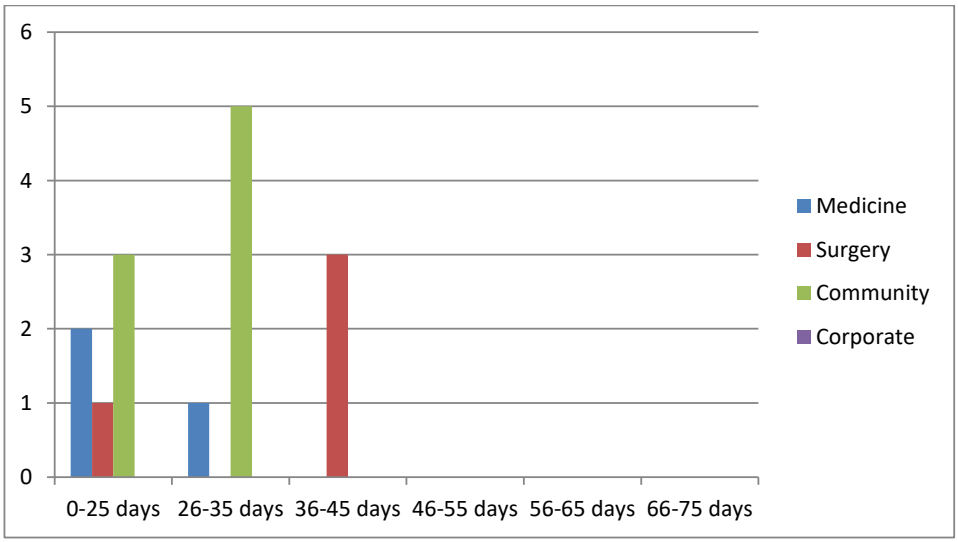

Figure 9 below demonstrates the monthly compliance with the 25-day response by Division related to complaints received and responded to within Q2.

**Figure 9: Compliance with 25-day response – complaints received and responded to in Q2**




Of the remaining 20 formal complaints opened in Q2, 4 have subsequently been responded to and closed within 25 days (which will be reported in Q3 report), and 4 have subsequently been responded to and closed between 30-36 days (which will be reported in Q3 report). 12 formal complaints have ongoing investigations, however 8 of these have exceeded the 25 working day response time (3 in Medicine, 3 in Surgery, 1 in Community, 1 in Corporate) and 21 cases (Medicine) have been reopened.

**Figure 10: Compliance with 25-day response by Division – complaints received in Q1 (2021/22) and responded to in Q2**



### 2.3.5 Number of open and closed formal complaints by month

Table 3 shows there were 73 formal complaints opened in 2021/22 and 47 closed. The number of open complaints is inclusive of second stage complaints.

Complaints that are received in a month may not be responded to until the next month in line with the 25-day response timeframe.

| **Table 3 - Formal Complaints received 2021/22** | | | | | | | | | | | | | **Cumulative to date** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Month** | **April** | **May** | **June** | **July** | **Aug** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** | |
| **New** | 6 | 10 | 18 | 11 | 14 | 14 | | | | | | | **73** |
| **Open** | 18 | 17 | 24 | 21 | 29 | 33 | | | | | | | |
| **Closed** | 25 | 11 | 8 | 14 | 9 | 10 | | | | | | | **77** |

Note* 25 complaints carried over from the previous financial year 2020/21

Delays in completion of responses have on occasion been a result of complex complaints. Delays have also been caused where corporate quality check of the complaint has identified that further work is required by the associated Division to ensure that the complaint response fully answers the concerns raised, demonstrates compassion, apologises, and identifies what action will be taken as a result of the learning from the complaint; some responses have required multiple corporate quality checks to ensure they attain the expected standard. The Divisions recognise the importance of responding to families within 25 days and continue to strive to reach this key performance metric. Where a complaint is expected to breach the 25 day timeframe, a process has been put in place to review and agree an extension, as appropriate, with the Chief Nurse and the parent.

### 2.3.5 National complaint reporting: KO41a return

The Trust is mandated to submit data nationally regarding the status, categories and outcome of complaints on a quarterly basis to NHS Digital using the Hospital and Community Health Services Complaints Collection (KO41a) tool.

The information obtained from the KO41a collection monitors written complaints received by the NHS. It also supports the commitment given in equity and excellence to improve the patient experience by listening to the public voice.
For assurance, Q2 data has been submitted in October 2021.

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## 2.4 Outcome of the complaint

### 2.4.1 Complaints upheld

The outcome of each complaint response is reviewed and assigned by the Chief Nurse or deputy. In Q2 and of the 19 closed complaints, 1 complaint was withdrawn and 1 was resolved; 6 were not upheld/resolved, 7 were partially upheld, and 13 were fully upheld. A complaint will be partially upheld if any one concern raised is upheld irrespective of whether most concerns in a complaint are not upheld. This is a significant marker of an open, transparent and learning organisation. Figures 11, 12 and 13 show the outcome of complaints by Division.

**Figure 11: Outcome of 19 complaints closed in Q2 received in Q2**

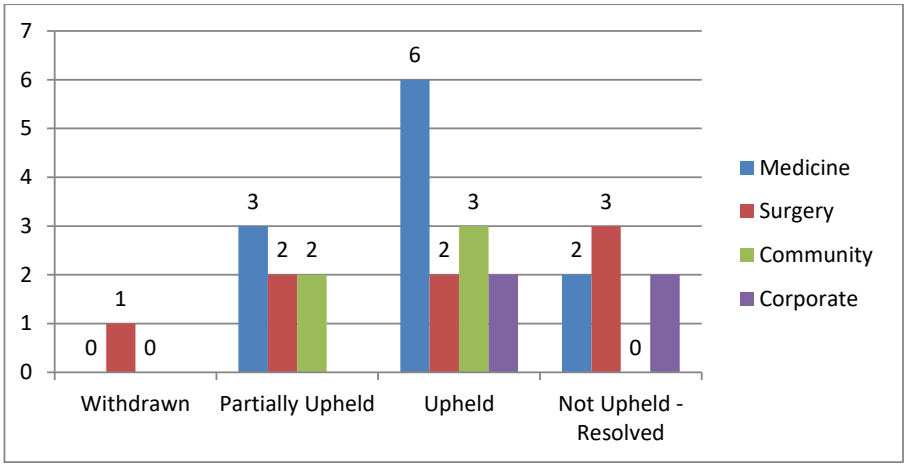
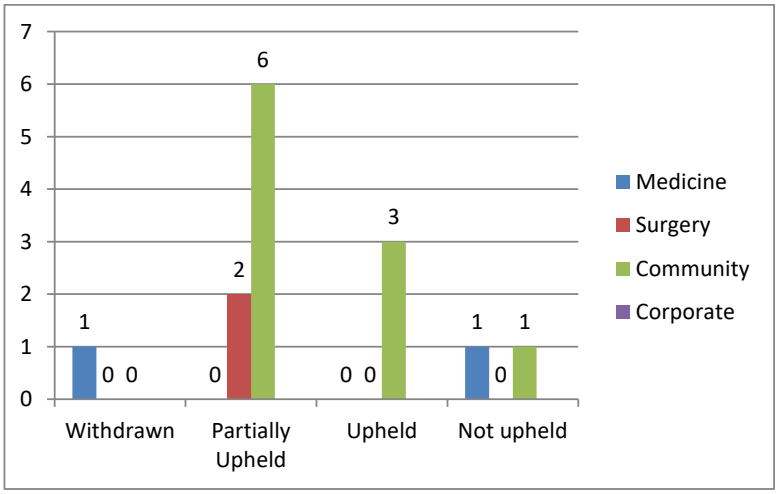



**Figure 12: Outcome of 14 complaints closed in Q2 received in Q1 2020/21**



### 2.4.2 Second stage complaints

Second stage complaints are a rich source of valuable data and a key indicator of our performance. They can be triangulated to inform the Trust of how satisfied our families are with the quality of our response, and as an early indicator of families who may seek further resolution through the Parliamentary & Health Service Ombudsman. Second stage complaints are monitored on a monthly basis as a key performance indicator.

The initial response letter advises the complainant that, should they be dissatisfied with any part of the initial complaint response, or requires further assistance, they should contact the Trust within 25 working days in order that the Trust can try to resolve any outstanding concerns.

In Q2, 2 families informed us that they were not satisfied with the outcome of their initial complaint response. Families have been dissatisfied either because they felt the response did not answer their questions fully or because they disagreed with our response. The 2 cases received in Q2 remain open and under continued investigation.

Two second stage complaints have been received in 2021/22 so far. Therefore, at the time of reporting 5 % (4 out of 77) complaints responded to in 2021/22 have resulted in a second stage complaint. Whilst this indicates an overall high level of satisfaction with the quality and content of the initial complaint response, there is a need to monitor and review the reasons why families remain dissatisfied in order to ensure our investigations, responses and actions are appropriate and of the highest standard for our families.

Table 5 below shows the number of second stage complaints received and acknowledged within 25 working days in 2021/22; all complaints (100%) were received within 25 days working days after the initial response.

**Table 5: second stage complaints received**

| Q | Total complaints received in Quarter | Total second stage received in Quarter | Number of days between initial response sent and second stage received (advised 25 days) | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | within 25 days | 26-40 days | 41-60 days | 61-80 days | 81-100 days | More than 100 days |
| Q1 | 33 | 2 | 2 | | | | | |
| Q2 | 39 | 2 | 2 | | | | | |
| Q3 | | | | | | | | |
| Q4 | | | | | | | | |

As second stage complaints may not necessarily fall within the same Quarter, they cannot be displayed in accurate percentage terms by quarter.

### 2.5 Referrals to Parliamentary & Health Service Ombudsman (PHSO)

There were no new referrals to the Parliamentary & Health Service Ombudsman during this period. However, there are two ongoing investigations, one in the Surgical division (received April 2019) and one in Medicine (received February 2021).

### 2.6 Actions and learning from complaints

Complaint Officers log actions and learning within Ulysses. Formal complaints are reviewed at the monthly Divisional Integrated Governance meetings to ensure senior divisional oversight of the current trends, to enable learning, to enable identification of specific areas of concern and any strategic actions, and ensure actions are fully disseminated, implemented and reviewed. Updates are shared by the Divisions at the Clinical Quality steering Group (CQSG) each month to ensure Trust wide learning.

Examples of improvements made to services as a result of concerns raised can be seen in Appendix 2.

### 3.1 Number of informal PALS concerns received Q2 2021/22

There were 384 informal concerns received during Q2 2021/22, compared to 280 in Q2 2020/21. There were fewer formal concerns raised in the same period last year as the Trust experienced reduced service and number of appointments during the beginning of COVID-19. In Q1 2021/22, 378 informal concerns were received, therefore the number has remained consistent with the previous quarter. A number of informal concerns have been managed informally to the satisfaction of the family member avoiding escalation to a formal complaint.

Figure 13 below shows the number of informal PALS concerns in 2021/22, highlighting the figures for each month.

**Figure 13: Monthly figure of PALS recorded**

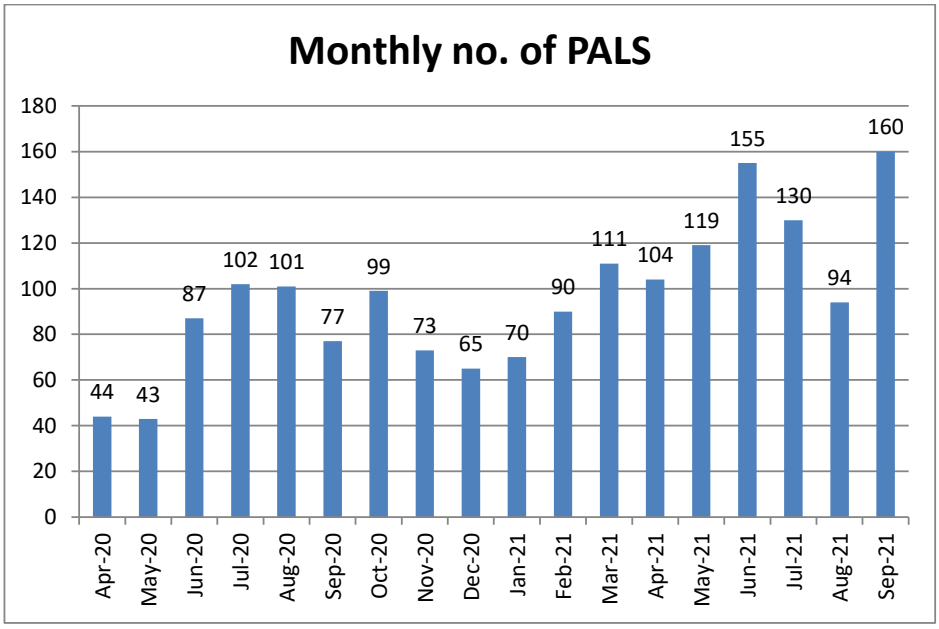



Figure 14 below shows the number of informal PALS concerns in Q2 2021/22 compared with the same period in 2020/21; demonstrating an increase in the Trust as a whole.

**Figure 14: Number of PALS in Q2 2020/21 and Q2 2021/22**

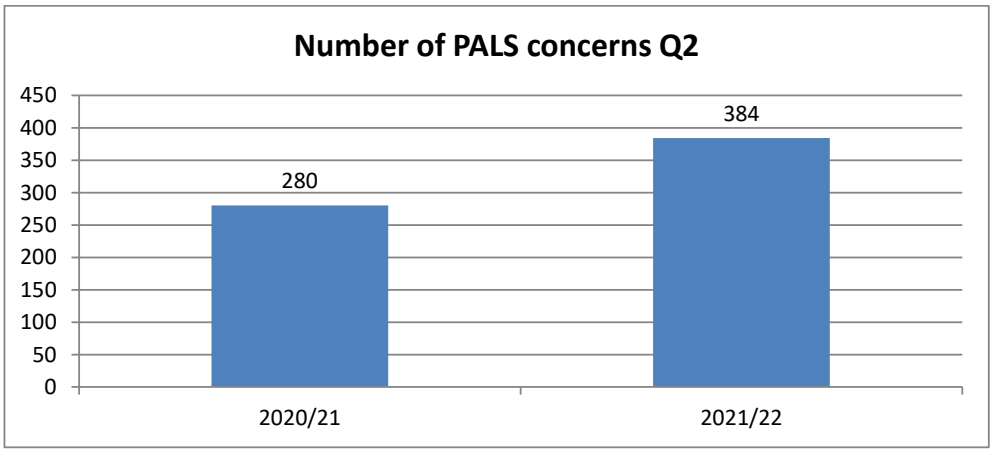



Figure 15 below shows the number of informal PALS concerns by Division in Q2 2021/22 compared with the same period in 2020/21; demonstrating an increase in all Divisions.

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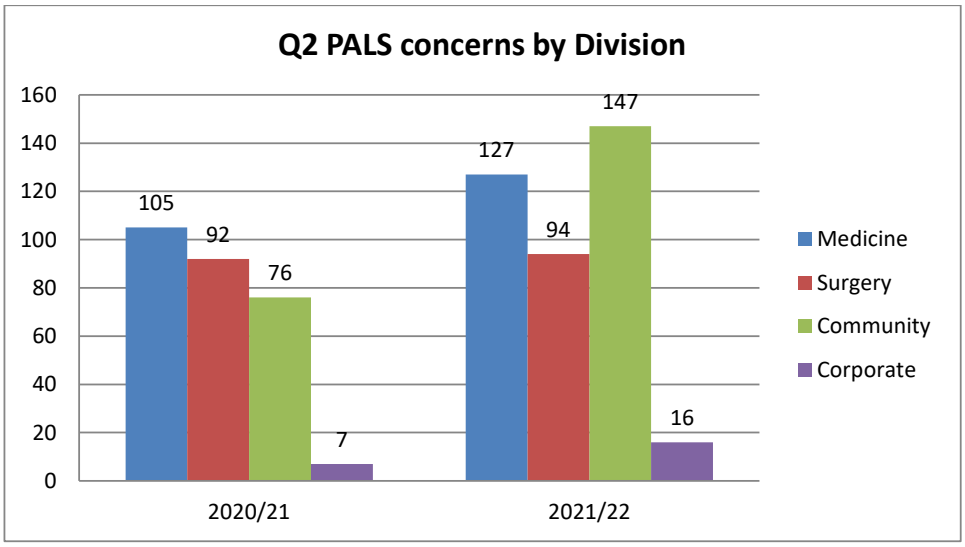
**Figure 15: Q2 PALS concerns by Division**




## 3.2 Informal PALS concerns received by category Q2 2021/22

All informal PALS concerns are categorised by subject using the same system as formal complaints, which assists with data analysis and monitoring. The main issues raised within Q2 relate to communication, appointment waiting times, and attitude of staff as shown in Figure 16 and 17. **Figure 16: Categories of informal PALS concerns Q2**

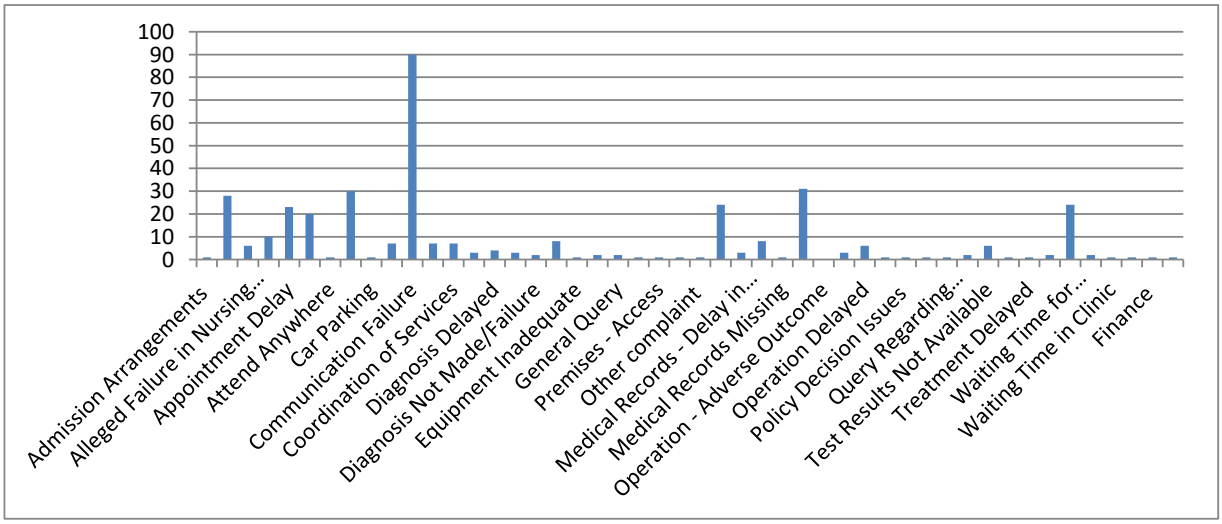


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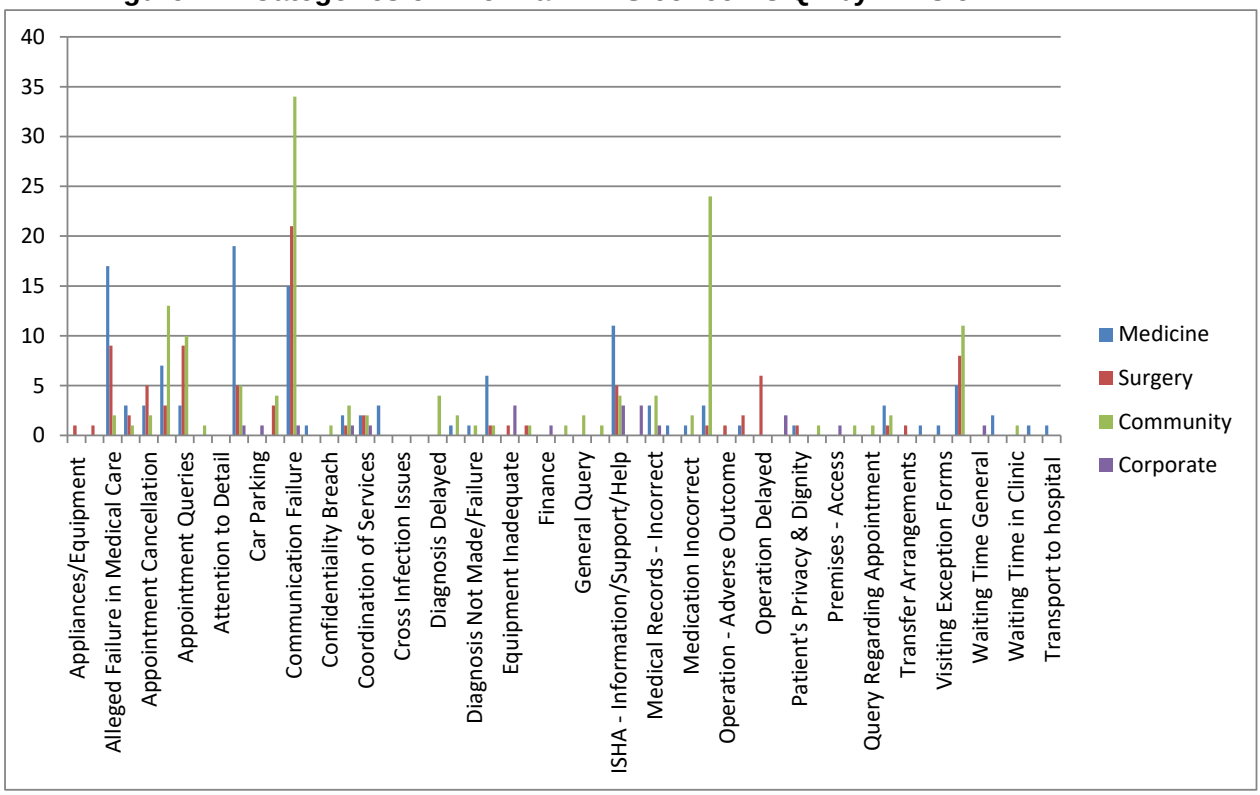
**Figure 17 - Categories of informal PALS concerns Q2 by Division**




A significant improvement for families wishing to raise an enquiry or needing support has been through the establishment of the Family Support Helpline initially set up as a pandemic helpline. In Q2 there were 1,391 calls received this is a decrease of 283 compared to Q1 (1674); this figure is inclusive of any informal PALS concern raised by telephone. The call line is currently staffed by members of the Patient Experience team. The call line currently operates from 0900-1800 Monday to Friday and 0900-1500 at the weekend, providing increased accessibility for our families needing help, and has responded to an average of 140 calls per week. It is acknowledged that a proportion of these calls will have been made to different services within the Trust (appointments line and Attend Anywhere) prior to establishing the helpline however families have fed back that the central point of contact has been useful in ensuring their call is directed appropriately as required. Work has begun to redirect these calls back to outpatients.

**Figure 18: Number of calls to the helpline Q1 and Q2 2021/22**

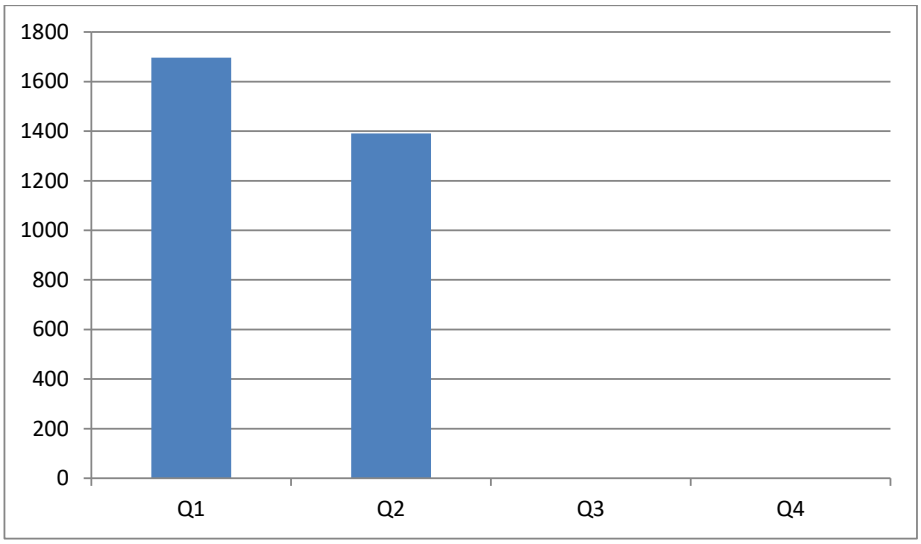
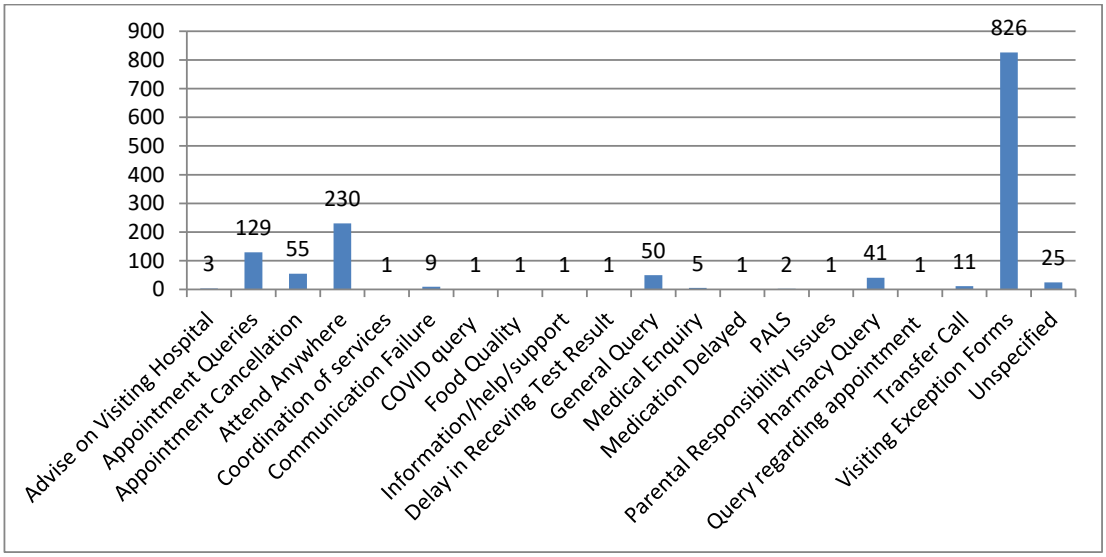



Figure 19 shows that the highest numbers of activity are due to patient experience staff processing visiting exception forms (826), which have been introduced to assist with visiting arrangements which has been restricted due to COVID regulations. The second highest reason for calls to the helpline were made regarding help, support and advice in relation to appointments (230 regarding Attend Anywhere, 129 appointment queries, and 55 related to cancelled appointments).

**Figure 19: Categories of calls/activity to the Family Support Helpline**



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### 3.3 Trust performance against Key Performance Indicators (KPI): compliance with 5-day response

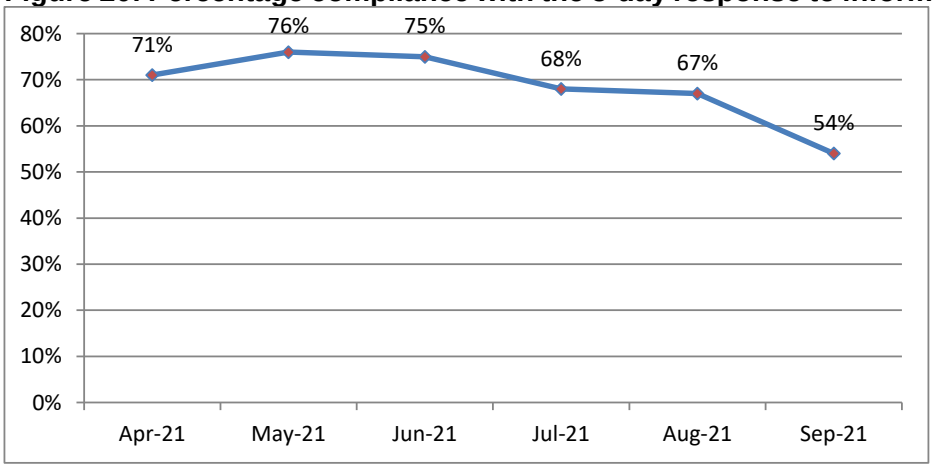
The PALS and Complaints teams endeavour to respond to concerns within the 5-day timeframe in order to try and obtain quicker resolution for children and young people. For Q2, the KPI of 100% of concerns responded to within 5 days was not met, with 63% of PALS reported to be concluded within this time period as recorded within the Ulysses system and shown in Table 6 below. This is a decrease compared to Q1 2021/22 which had 74% of PALS concerns responded to within 5 days.

**Table 6: Compliance within 5-day response to PALS concerns**

| PALS | Received Q2 | Q2 5-day response | Q2 overdue |
|---|---|---|---|
| Surgery | 94 | 59 (63%) | 35 (37%) |
| Medicine | 127 | 79 (62%) | 48 (38%) |
| Community | 147 | 87 (59%) | 60 (41%) |
| Corporate | 16 | 11 (69%) | 5 (31%) |
| **Total** | **384** | **236 (61%)** | **148 (39%)** |

Figure 20 below shows the compliance by month in 2021/22 demonstrating that the Trust has not met this standard.

**Figure 20: Percentage compliance with the 5-day response to informal concerns**




A workshop has been held to review and improve the process for managing PALS concerns

## 4. Compliments in Q2

Compliments are an equally important measure of the quality of care, treatment and service the Trust delivers, providing powerful and valuable feedback and demonstrating that a family feels compelled to share this with us by taking precious time to share what has been good about their experience. This feedback also provides important balance with concerns raised.

| Table 7: Compliments recorded on Ulysses | |
|---|---|
| **Division** | **No. of compliments** |
| Community | 65 |
| Medicine | 2 |
| Surgery | 8 |
| Other | 2 |

Appendix I provides examples of compliments received during Q2.

## 5. Proposed developments in the management of complaints and PALS

Progress continues in line with the improvement plan. A complaints workshop has taken place with Divisional leads to review ways of working and resources, with the Patient Experience continuing to support the PALS office. The Trust works in partnership with Healthwatch, and a significant development being explored to further support parents and families is that Healthwatch will be based in the PALS office once a week from January 2022. In Quarter 3, an external review of complaints management processes will commence, undertaken by MIAA. Terms of reference have been agreed by the Chief Nurse.

Alder Hey Children's NHS Foundation Trust

## Appendix I: Examples of compliments received during Q2

### Surgery Division

#### a. 1C & Cardiology & 4C

*Dad was complimentary of the hospital, the nurses and Drs who have been looking after (the patient) . "He stated he could not fault the care that Noah has received and that all the staff have been friendly and professional and have done their very best for Noah. He said he feared the worst when Noah was admitted, and he cannot thank the teams enough for everything that they have done"*

#### b. General surgery

*Traumatic nasty appendicitis however parent complimented all staff involved from 3A to medical team, radiology and especially Natasha Demelweek the ANP*

#### c. Ophthalmology

*I just wanted to say how amazed I am by the service we received yesterday at Ophthalmology. I referred my son on Monday with the health visitor and we were seen 2 days later. They did a full health check on his eyes and I am now so relieved and have peace of mind. The hospital was so accommodating in letting my partner come with me due to my anxiety. The receptionists at the main entrance were fantastic. I would also like to say that our experience in the A&E department in August – October was fantastic bar one rude male nurse but other staff more than made up for that. The infant feeding clinic is fantastic, thanks to Helen McIlroy.*

### Community Division

#### a. CAMHS

*A Thank You card saying "To Sue Thank you so much and I can't thank you enough. You are an angel on earth. It's sad to see you going but it's life. Thank you sue is what I can say to show my appreciation for everything you have done for me. You will never be forgotten. Thank you, Sue. Khaled. All the best"*

#### b. ASD/ADHD

*"Thank you so much for your help I really appreciate it, this journey of diagnosis and EHCP has been far from straightforward but I'm so grateful to have met a few wonderful caring professionals along the way. Your approach really gives me hope that everything will work out ok in the end! Thank you again for being so polite and kind and listening to me, I really appreciate it"*

**c. Complex Discharge Team**

*"The complex discharge team has been very supportive and from my experience is a vital part of the hospital process. I felt listened to and respected and never felt that my views or requests were being ignored".*

***d. Rainbow Department***

*A judge involved with Community and Mental Health Division regarding the placement of a child due to be discharged from the hospital, thanked the team for how they worked with the authorities in providing the information needed with ease. Good successful communicating and timely responses.*

## Medicine Division

**a. Ophthalmology**

*A letter received from 16-year-old patient and family thanking Mr Jose Gonzalez-Martin, Consultant Ophthalmologist for the wonderful care provided. The patient reported his care and compassion helped her overcome her fear and anxieties and his clinical care was excellent.*

**b. ED**

*Mum has been in touch with Pals regarding a visit to AE. Dad brought his daughter along with suspected Tonsillitis however, Evelyn was getting distressed and dad felt she was upsetting all the other children in there. Dad arrived at the decision to leave it was also a 5hr wait. Mum and dad said that it is very hard in getting medical help at the moment but would like to say a thank you to the department for providing the care throughout what has been a difficult time.*

**c. Psychology**

*An out of area young person has been subject to a delayed discharge from the ward because she had no placement to go to. Her case has been heard in front of the same judge over multiple weeks and she has on more than 1 team. At the point of discharge the solicitor representing Alder Hey reported the following "The Judge again passed on her thanks to Alder Hey saying she simply doesn't know what everyone would have done without you all, and commended the staff for their excellent care and support of X and wanted that to be relayed to all." In concluding her email the solicitor also commented "Thank you all for your excellent care and timely responses to my queries when needed. Let's hope this is a successful placement for X."*

Further compliments will be reported from research and the corporate divisions in the next quarter

Alder Hey Children's NHS Foundation Trust

## Appendix 2: Action taken/proposed developments planned

### Surgery Division

| | Recommendations/key Learning | Actions | Target date for implementation | Status (Monitoring & Evaluation arrangements) Embed Evidence | Additional resources required (Time, money etc.) | Sign off completed date |
|---|---|---|---|---|---|---|
| | If the drug checking process is interrupted, it must be restarted | Nurses to complete a reflective learning tool and discuss with senior nursing staff. | 19/10/21 | | | 14/09/21 |
| | | Drug administration competencies and periods of supervised practice with staff involved. | 19/10/21 | | | 14/09/21 |
| | | Psychological support to be offered to staff involved. | 19/10/21 | | | 14/09/21 |
| | | Observation of practice of drug | | | | 14/09/21 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | administration process. Discussed at handover and safety huddles | 19/10/21<br><br>19/10/21 | | | 14/09/21 |
| 2. | Inadequate staffing levels for the patient acuity within the Unit. | Ensure inadequate staffing levels for patient acuity are escalated appropriately.<br><br>Work with Band 7 team to ensure consistent reporting of patient acuity levels.<br><br>Discuss at handover and safety huddles. | 19/10/21<br><br>19/10/21<br><br>19/10/21 | | | 14/09/21<br><br>14/09/21<br><br>14/09/21 |

## Medicine Division

| | Recommendations/key Learning | Actions | Target date for implementation | Status (Monitoring & Evaluation arrangements) Embed Evidence | Additional resources required (Time, money etc.) | Sign off completed date |
|---|---|---|---|---|---|---|
| **1** | Raise staff awareness re infant reflux | Training session held for ED staff on infant reflux. | 26/10/2021 | | | July 2021 |
| **2.** | Improve communication skills | Parent's concerns fed back to the administrative team. Admin team always reminded of the importance of professionalism and clear communication. | 26/10/21 | | | 26/10/21 |

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## Community Division

| | Recommendations/key Learning | Actions | Target date for implementation | Status (Monitoring & Evaluation arrangements) Embed Evidence | Additional resources required (Time, money etc.) | Sign off completed date |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | To communicate Medication Initiation Clinic appointments are to be attended. Also, to offer further support from outside agencies who may be of help. A medical review to be offered to. | Information to be provided to mum regarding medication in order to make an informed decision as to whether this is a choice for her son<br><br>Mrs L B to provide with consent parents name and contact details to two support agencies who will contact mum and offer appropriate services<br><br>Medical review appointment to be arranged for the child | None given | | | 03/09/2021<br><br>07/09/2021<br><br>28/10/2021 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 2 | Lack of communication and her expectation of follow up appointments | Clear clinical dialogue with mum to discuss next steps for child<br><br>Medication Initiation Clinic appointment to be arranged | | | | 26/08/2021<br><br>26/08/2021 |

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# TRUST BOARD Report October 2021

How Did We Do?

**Executive Summary** **Month: October** **Year: 2021**

Alder Hey Children's NHS NHS Foundation Trust

Delivery of Outstanding Care

## Safe

- October was a relatively low reporting month for clinical incident reporting with only 278 incidents reported resulting in no harm the lowest reported number this year.
- We continue to provide both internal and external assurance with regard to safety and quality through servicing CQSG, SQAC and also CQRM, our commissioners quality and safety meeting.

### Highlight

- Continued excellent performance re pressure ulcers with no category 3 or above reported in the last 7 months.
- No Hospital acquired infections reported in October.
- No Never events for 7 months in a row.
- Improved performance regarding suspected sepsis patients being treated with 60 minutes in AED albeit still below 90%.

### Challenges

- 1 moderate harm in the month of October relating to a patient treated for sepsis. Delay in antibiotic and fluid therapy treatment relating to lack of IV access and delay also with contacting ID team. RCA 2 is being undertaken which will be shared for lessons learn.
- 3 medication incidents involved minor harm in **October**. Fluids were given to a patient at a rate above that intended & additional blood tests were returned normal. 2 patients received overdoses of medicine due to prescriptions written by their GP. 1 was a tenfold overdose of an antibiotic, investigations completed at Alder Hey were normal and the GP has been made aware. 1 was due to incorrect directions on an Alder Hey discharge letter, this has been investigated and actions to prevent recurrence are underway.

The Best People Doing their Best Work

## Caring

The overall Friends and Family score for those recommending the Trust was only 84.9%, the lowest this year. Probably a reflection of the continued high volume of patients we are seeing in AED as although the overall score is low, all other areas scored above 90%, with AED at 61%. The AED team and management colleagues are continuing to assess this information and address the key areas highlighted in the feedback.

### Highlight

- Family and Friends score for all areas outside of AED is consistently above 90%
- Complaint numbers are static at 13 against a backdrop of very high PALS reports. This reflects the effective work teams are doing to address PALS issues before they escalate to formal complaints.

### Challenges

- PALS numbers remain high in comparison to last year again reflecting activity levels at this time.

Delivery of Outstanding Care

## Effective

In October the trend of high emergency care demand (16.5% higher than 2019, and the second busiest month on record) and longer waiting times (72.5% treated within 4 hours) continued. In November we are testing improvements to streaming and ensuring rapid assessment and treatment is practiced more often. In the medium-term, we will launch a symptom checker to support self-care (December) and a new overnight medical rota (January). Externally, we are working with the ICS to invest in additional capacity for urgent and emergency care this Winter, to deliver a health visitor service (in December) and a multi-professional urgent care service (in January).

Bed occupancy remains high which is affecting cancelled operations, although the number has reduced from September as we introduced a new standing operating procedure for starting all theatre lists unless the hospital status is on red. Cancelled operations has, in turn, an adverse effect in theatre utilisation.

**Highlight**

- Cancelled operations reduced (month on month)

**Challenges**

- Timeliness of care in the Emergency Department
- Cancelled operations

Delivery of Outstanding Care

## Responsive

Our waiting list size and number of reportable long wait patients has increased following the conclusion of the outpatient pathway data assurance review, as part of the Safe Waiting List Management Programme. We expect that, through strong recovery and specialty-based improvement plans, we will reduce by a third the number of C&YP waiting over 52 weeks in quarter 4.

**Highlight**

- Access to cancer care

**Challenges**

- Waiting times for planned care (RTT and greater than 52 ww)

The Best People Doing their Best Work

## Well Led

**Finance**

For the Month of October (Month 7), H2 control totals are yet to be finalised at Cheshire & Mersey System level. As such rather than compare performance against control total, we have reported against actual income and expenditure incurred in month.

The month 7 position is showing a deficit of £0.9m which is largely driven by 2 key areas:

- Loss ERF contribution H1 – which equates to £0.7m per month
- Reduction in system funding for H2 as per current allocations - £0.2m per month

Cash in the bank at the end of October was £94m.

The overall capital expenditure in month for October was ££11.1m year to date which demonstrates that spend is in line with plan year to date.

**Sickness update**

Attendance management remains a key priority for the trust. Supporting people to remain in work through well-being and other forms of support, as well as maintaining contact with colleagues who are away from the workplace; to avoid feelings of isolation and enable a smooth transition back to work when they are fit to return. A range of mechanisms are utilised to facilitate this.

A key focus is return to work interviews, with a drive to enable all areas to be green, linked to our KPI.

**Mandatory Training**

Mandatory Training this month has remained at 87%, with focus on the same 3 areas; Resus Training, Practical Moving & Handling and the Estates and Facilities Staff Group.

**Highlight**

- Long term sickness rates falling
- Capital programme back in line with plan
- Mandatory training within Estates & ancillary staff group

**Challenges**

- H2 Financial plans and the requirement to reach a break even position with increased efficiencies against a reduced funding envelope.
- Delivery of CIP through remainder of 2021/22 with increasing operational pressures.
- Managing sickness rates and staff returning to work.
- PDR compliance.

Resus launched their online Basic Life Support Training at the Start of November and have brought in additional external trainer capacity until the end of the year to improve PLS/APLS compliance rates. This has seen their compliance go from 75% to 77% overall in the last month.

Moving & Handling have a new lead trainer who started at the beginning of November on a secondment basis and also have some additional resource from staff working bank whilst they re-develop a Job Description for a permanent Moving & Handling Training Lead.

Estates and Facilities are working closely with the L&D function to come up with additional methods of training the staff within this area who are struggling to access ESR, this includes training Facilities management to deliver some of the courses, supervisors assessed workbooks, recorded sessions and face to face sessions, this has seen their compliance improve from 58% to 69% in the last month.

As well as the usual departmental and divisional reports, all staff who have any training outstanding received an email this month highlighting their areas of non-compliance and details on how to action this.

**PDR**

As at the end of September appraisals were at 71% across the Trust overall. Whilst staff who have not had an appraisal are still encouraged to do so, the appraisal window is now closed.

**Turnover**

Turnover is an area of focus for all divisions as most areas are either just below or just above the 10% KPI. A deep dive to gain greater understanding of the reasons for this as highlight any common trends is currently being undertaken. The finding of which will be utilised to facilitate a plan of action, linked to the winter plan.

Game Changing Research and Innovation

## Research and Development

Month 7 Research Activity:

- 182 research studies currently open
- 931 patients recruited to research studies (7476 in 21/22)

Divisional Participation:

- Division of Medicine – 149 open studies
- Division of Surgical Care – 29 open studies
- Division of Community & Mental Health – 4 open studies

Research Assurance:

- GCP training compliance – 97%
- Research SOP compliance – 98%

**Highlight**

- Gold Ward Accreditation for Clinical Research Facility

**Challenges**

- Staffing levels

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# Leading Metrics

**SAFE**

| Clinical Incidents resulting in catastrophic, death | Hospital Acquired Organisms - C.difficile | Hospital Acquired Organisms - MRSA (BSI) | Medication errors resulting in harm | Never Events | Sepsis: Patients treated for Sepsis within 60 mins - Inpatients |
|---|---|---|---|---|---|
| 0 | 0 | 0 | 3 | 0 | 86.96 % |
| Oct 2021 | Oct 2021 | Oct 2021 | Oct 2021 | Oct 2021 | Oct 2021 |

| Sepsis: Patients treated for Sepsis within 60 Minutes - A&E |
|---|
| 85.90 % |
| Oct 2021 |

**CARING**

| Friends & Family: Overall Percentage Recommended Trust |
|---|
| 84.87 % |
| Oct 2021 |

**EFFECTIVE**

| ED: 95% Treated within 4 Hours |
|---|
| 72.46 % |
| Oct 2021 |

**RESPONSIVE**

| 31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) | All Cancers: 31 day wait until subsequent treatments | Cancer: 2 week wait from referral to date 1st seen - all urgent referrals | Diagnostics: % Completed Within 6 Weeks |
|---|---|---|---|
| 100 % | 100 % | 100 % | 96.25 % |
| Oct 2021 | Oct 2021 | Oct 2021 | Oct 2021 |

| Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. | RTT: Open Pathway: % Waiting within 18 Weeks | Waiting Greater than 52 weeks - Incomplete Pathways | Waiting List Size |
|---|---|---|---|
| 100 % | 62.11 % | 318 | 18495 |
| Oct 2021 | Oct 2021 | Oct 2021 | Oct 2021 |

**WELL LED**

| Cash in Bank (£'000s) | Control Total In Month Variance (£'000s) | Mandatory Training | Safer Staffing (Shift Fill Rate) | Sickness |
|---|---|---|---|---|
| 94111 | -852.72 | 87.34 % | 91.61 % | 6.46 % |
| Oct 2021 | Oct 2021 | Oct 2021 | Oct 2021 | Oct 2021 |

Delivery of Outstanding Care

SAFE


Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of Near Miss, No Harm & Minor Harm | D | 100.0% | 100.0% | 99.8% | 99.8% | 99.8% | 99.8% | 99.8% | 99.1% | 99.6% | 99.6% | 99.8% | 100.0% | 99.6% | | >=99 % N/A <99 % | ✔ |
| Clinical Incidents resulting in Near Miss | D | 75 | 100 | 74 | 53 | 63 | 98 | 80 | 82 | 91 | 74 | 63 | 91 | 87 | | No Threshold | |
| Clinical Incidents resulting in No Harm | D | 327 | 410 | 314 | 288 | 333 | 401 | 394 | 362 | 321 | 329 | 297 | 310 | 278 | | No Threshold | |
| Clinical Incidents resulting in minor, non permanent harm | D | 67 | 83 | 75 | 81 | 76 | 95 | 91 | 80 | 71 | 96 | 88 | 78 | 87 | | No Threshold | |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 4 | 1 | 1 | 1 | 0 | 1 | | No Threshold | |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | | 0 N/A >0 | ✔ |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | 0 N/A >0 | ✔ |
| Medication errors resulting in harm | D | 1 | 11 | 0 | 6 | 3 | 4 | 4 | 2 | 2 | 2 | 6 | 5 | 3 | | <=3 N/A >3 | ✔ |
| Pressure Ulcers (Category 3) | W | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 | ✔ |
| Pressure Ulcers (Category 4) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 | ✔ |
| Never Events | W | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 | ✔ |
| Sepsis: Patients treated for Sepsis within 60 Minutes - A&E | D P | 74.1% | 79.2% | 73.7% | 89.5% | 80.6% | 100.0% | 85.0% | 94.4% | 87.9% | 88.9% | 90.2% | 76.6% | 85.9% | | >=90 % N/A <90 % | ✔ |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients | D P | 94.3% | 80.8% | 70.8% | 87.5% | 84.0% | 88.9% | 83.3% | 89.7% | 91.7% | 88.9% | 86.4% | 81.1% | 87.0% | | >=90 % N/A <90 % | ✔ |
| Number of children that have experienced avoidable factors causing death - Internal | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 | ✔ |
| Hospital Acquired Organisms - MRSA (BSI) | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 | ✔ |
| Hospital Acquired Organisms - C.difficile | D | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | | 0 N/A >0 | ✔ |
| Hospital Acquired Organisms - MSSA | D | 0 | 1 | 0 | 3 | 1 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 1 | | No Threshold | |

The Best People doing their best Work

## CARING


Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Friends & Family: Overall Percentage Recommended Trust | W | 94.7% | 93.7% | 91.5% | 95.3% | 94.9% | 92.9% | 94.0% | 90.2% | 91.0% | 87.6% | 92.3% | 88.4% | 84.9% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family A&E - % Recommend the Trust | D | 92.1% | 89.2% | 91.5% | 93.2% | 93.1% | 88.0% | 88.0% | 76.2% | 79.2% | 59.8% | 79.6% | 64.3% | 61.1% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Community - % Recommend the Trust | D | 94.7% | 98.8% | 100.0% | 92.7% | 96.7% | 93.0% | 95.9% | 92.4% | 95.9% | 97.1% | 96.2% | 92.7% | 93.4% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Inpatients - % Recommend the Trust | D | 94.5% | 95.5% | 93.4% | 94.2% | 90.4% | 89.8% | 96.4% | 95.1% | 87.0% | 88.8% | 91.4% | 92.9% | 94.2% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Mental Health - % Recommend the Trust | D | 89.7% | 91.3% | 100.0% | 96.3% | 90.3% | 87.9% | 90.6% | 85.7% | 95.0% | 94.7% | 95.8% | 96.3% | 90.6% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Outpatients - % Recommend the Trust | D P | 95.5% | 93.9% | 90.4% | 96.1% | 96.0% | 95.1% | 95.3% | 94.4% | 94.8% | 95.5% | 95.4% | 94.7% | 91.8% | | >=95 % >=90 % <90 % | ✔ |
| Complaints | W | 19 | 15 | 10 | 15 | 11 | 23 | 5 | 9 | 15 | 10 | 12 | 13 | 13 | | No Threshold | |
| PALS | W | 99 | 74 | 65 | 68 | 88 | 110 | 101 | 119 | 150 | 122 | 89 | 148 | 135 | | No Threshold | |

Delivery of Outstanding Care

## EFFECTIVE


Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG | | | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % Readmissions to PICU within 48 hrs | W | 1.6% | 4.2% | 1.4% | 0.0% | 0.0% | 1.6% | 0.0% | 2.6% | 0.0% | 1.4% | 2.7% | 0.0% | 0.0% | | No Threshold | | | |
| ED: 95% Treated within 4 Hours | D | 96.8% | 97.1% | 98.6% | 98.5% | 97.8% | 95.3% | 92.5% | 81.1% | 85.5% | 67.9% | 87.7% | 73.4% | 72.5% | | >=95 % | N/A | <95 % | ✔ |
| ED: Number of patients spending >12 hours from decision to admit to admission | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | N/A | >0 | ✔ |
| On the day Elective Cancelled Operations for Non Clinical Reasons | D | 19 | 16 | 10 | 5 | 7 | 12 | 13 | 7 | 13 | 13 | 12 | 32 | 23 | | <=20 | N/A | >20 | ✔ |
| 28 Day Breaches | W | 2 | 1 | 3 | 3 | 1 | 2 | 4 | 3 | 0 | 3 | 8 | 5 | 11 | | 0 | N/A | >0 | ✔ |

Delivery of Outstanding Care

RESPONSIVE


Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IP Survey: % Received information enabling choices about their care | W | 95.4% | 95.7% | 97.5% | 99.3% | 93.6% | 95.6% | 96.0% | 98.0% | 94.3% | 94.4% | 96.2% | 97.5% | 95.8% | | >=95 % >=90 % <90 % | ✔ |
| IP Survey: % Treated with respect | W | 98.3% | 98.6% | 97.5% | 100.0% | 98.1% | 94.7% | 98.5% | 99.0% | 94.3% | 94.4% | 97.8% | 96.8% | 97.6% | | >=95 % >=90 % <90 % | ✔ |
| IP Survey: % Know their planned date of discharge | D P | 96.7% | 97.8% | 95.0% | 98.5% | 98.1% | 94.2% | 98.5% | 92.2% | 96.4% | 93.9% | 93.0% | 95.5% | 93.3% | | >=90 % >=85 % <85 % | ✔ |
| IP Survey: % Know who is in charge of their care | W | 100.0% | 99.3% | 91.7% | 100.0% | 94.9% | 96.1% | 98.5% | 98.5% | 98.6% | 97.0% | 96.2% | 96.8% | 98.8% | | >=95 % >=90 % <90 % | ✔ |
| IP Survey: % Patients involved in Play | D | 83.3% | 84.9% | 76.7% | 80.3% | 85.9% | 78.2% | 81.1% | 80.0% | 79.3% | 82.7% | 77.4% | 75.2% | 78.8% | | >=90 % >=85 % <85 % | ✔ |
| IP Survey: % Patients involved in Learning | D | 88.3% | 71.9% | 81.6% | 94.9% | 92.9% | 90.9% | 91.0% | 91.7% | 89.3% | 91.9% | 87.6% | 89.2% | 92.7% | | >=90 % >=85 % <85 % | ✔ |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 53.8% | 58.7% | 60.9% | 61.1% | 63.2% | 68.1% | 68.6% | 71.9% | 74.8% | 72.7% | 71.1% | 66.5% | 62.1% | | >=92 % >=90 % <90 % | ✔ |
| Waiting List Size | W | 10,838 | 10,755 | 10,443 | 10,648 | 11,453 | 11,892 | 11,110 | 11,564 | 11,414 | 12,096 | 13,286 | 13,092 | 18,495 | | No Threshold | |
| Waiting Greater than 52 weeks - Incomplete Pathways | W | 145 | 148 | 184 | 222 | 307 | 361 | 283 | 235 | 204 | 187 | 195 | 263 | 318 | | 0 N/A >0 | ✔ |
| Cancer: 2 week wait from referral to date 1st seen - all urgent referrals | W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.7% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % N/A <100 % | ✔ |
| Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. | W | 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 % N/A <100 % | ✔ |
| All Cancers: 31 day wait until subsequent treatments | W | 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 % N/A <100 % | ✔ |
| 31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) | W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 0.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % N/A <100 % | ✔ |
| Diagnostics: % Completed Within 6 Weeks | W | 96.4% | 97.1% | 92.3% | 93.7% | 95.8% | 97.5% | 95.2% | 95.2% | 98.5% | 95.5% | 94.7% | 97.2% | 96.3% | | >=99 % N/A <99 % | |
| PFI: PPM% | | 100.0% | 98.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | | | >=98 % N/A <98 % | ✔ |

The Best People doing their best Work

# WELL LED


Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG | | | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | -358 | 332 | 687 | 243 | 591 | 3,825 | -954 | 593 | 392 | -588 | -50 | 836 | -853 | | >=-5% | >=-20% | <-20% | ✔ |
| Capital Expenditure In Month Variance (£'000s) | W | 187 | -1,733 | 1,610 | -1,979 | -3,207 | -5,794 | -910 | 974 | 13 | 162 | 234 | -339 | -221 | | >=-5% | >=-10% | <-10% | ✔ |
| Cash in Bank (£'000s) | W | 109,084 | 110,503 | 110,776 | 110,776 | 110,871 | 92,708 | 92,708 | 88,440 | 82,001 | 82,006 | 82,121 | 88,514 | 94,111 | | >=-5% | >=-20% | <-20% | ✔ |
| Income In Month Variance (£'000s) | W | -792 | 748 | 235 | 228 | 2,310 | 18,172 | -494 | 716 | 1,598 | 2,981 | -1,713 | 2,767 | -2,609 | | >=-5% | >=-20% | <-20% | ✔ |
| Pay In Month Variance (£'000s) | W | 20 | 492 | -192 | -373 | -387 | -13,171 | -308 | -370 | -545 | 553 | 71 | -2,466 | 2,477 | | >=-5% | >=-20% | <-20% | ✔ |
| Non Pay In Month Variance (£'000s) | W | 414 | -909 | 644 | 387 | -1,333 | -1,176 | -153 | 247 | -661 | -4,122 | 1,591 | 534 | -720 | | >=-5% | >=-20% | <-20% | ✔ |
| AvP: IP - Non-Elective | W | 961 | 950 | 929 | 747 | 731 | 1,066 | -98 | -102 | 1,289 | -187 | -141 | -69 | 1,371 | | >=0 | N/A | <0 | ✔ |
| AvP: IP Elective vs Plan | W | 400 | 411 | 390 | 340 | 353 | 455 | -89 | -62 | 448 | -22 | -113 | -82 | 399 | | >=0 | N/A | <0 | ✔ |
| AvP: Daycase Activity vs Plan | W | 1,660 | 1,772 | 1,713 | 1,507 | 1,599 | 2,075 | 184 | -7 | 2,104 | 267 | -125 | 180 | 1,935 | | >=0 | N/A | <0 | ✔ |
| AvP: Outpatient Activity vs Plan | W | 22,780 | 23,899 | 20,866 | 22,303 | 22,359 | 26,688 | 1,573 | 4,089 | 27,125 | 4,855 | 294 | 4,969 | 23,691 | | >=0 | N/A | <0 | ✔ |
| PDR | W | 62.6% | 72.4% | 74.6% | 74.4% | 74.4% | 74.4% | 0.9% | 6.3% | 19.7% | 56.3% | 65.0% | 67.3% | 71.2% | | No Threshold | | | ✔ |
| Medical Appraisal | W | 95.6% | 95.6% | 95.9% | 95.9% | 95.9% | 95.9% | 21.9% | 30.9% | 34.8% | 42.4% | 70.8% | 55.2% | 83.9% | | No Threshold | | | ✔ |
| Mandatory Training | W | 88.6% | 85.8% | 85.0% | 86.0% | 85.8% | 86.8% | 88.4% | 87.2% | 88.1% | 88.0% | 87.4% | 87.3% | 87.3% | | >=90 % | >=80 % | <80 % | ✔ |
| Sickness | D | 6.0% | 5.4% | 5.6% | 7.1% | 5.7% | 4.7% | 4.6% | 5.3% | 5.6% | 6.3% | 6.5% | 6.3% | 6.5% | | <=4 % | <=4.5 % | >4.5 % | ✔ |
| Short Term Sickness | D | 1.9% | 1.3% | 1.1% | 2.3% | 1.2% | 1.2% | 1.1% | 1.4% | 1.5% | 1.8% | 1.6% | 1.8% | 2.1% | | <=1 % | N/A | >1 % | |
| Long Term Sickness | D | 4.1% | 4.2% | 4.5% | 4.9% | 4.4% | 3.6% | 3.4% | 3.9% | 4.1% | 4.5% | 5.0% | 4.5% | 4.3% | | <=3 % | N/A | >3 % | |
| Temporary Spend ('000s) | D | 1,061 | 1,365 | 1,392 | 1,373 | 1,279 | 2,272 | 1,071 | 1,040 | 960 | 1,130 | 1,096 | 1,368 | 1,137 | | No Threshold | | | ✔ |
| Staff Turnover | D | 9.3% | 9.1% | 9.0% | 9.0% | 8.9% | 8.8% | 9.4% | 9.8% | 9.4% | 9.7% | 9.7% | 10.2% | 10.7% | | <=10 % | <=11 % | >11 % | ✔ |
| Safer Staffing (Shift Fill Rate) | W | 94.2% | 94.9% | 93.6% | 90.5% | 94.5% | 94.0% | 97.7% | 98.8% | 97.6% | 89.6% | 92.2% | 94.5% | 91.6% | | >=90 % | N/A | <90 % | ✔ |
| Domestic Cleaning Audit Compliance | W | 90.0% | 87.5% | 90.4% | 94.4% | 97.7% | 97.7% | 97.7% | 88.6% | 100.0% | 97.7% | 100.0% | 97.7% | 100.0% | | >=85 % | N/A | <85 % | ✔ |
| NHS Oversight Framework | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | <=1 | >1 | ✔ |

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG | | | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Open Studies - Academic | W | 66 | 71 | 76 | 80 | 80 | 90 | 100 | 103 | 108 | 117 | 125 | 132 | 139 | | >=130 | >=111 | <111 | ✔ |
| Number of Open Studies - Commercial | W | 34 | 37 | 36 | 36 | 36 | 36 | 34 | 36 | 38 | 37 | 38 | 40 | 43 | | >=30 | >=21 | <21 | ✔ |
| Number of New Studies Opened - Academic | W | 1 | 4 | 4 | 1 | 0 | 6 | 7 | 2 | 3 | 7 | 3 | 7 | 7 | | >=3 | >=2 | <2 | ✔ |
| Number of New Studies Opened - Commercial | W | 2 | 1 | 0 | 0 | 0 | 2 | 0 | 3 | 1 | 1 | 0 | 2 | 3 | | >=1 | N/A | <1 | ✔ |
| Number of patients recruited | W | 665 | 832 | 182 | 504 | 403 | 105 | 1,055 | 1,039 | 896 | 439 | 1,060 | 983 | 931 | | >=100 | >=86 | <86 | ✔ |

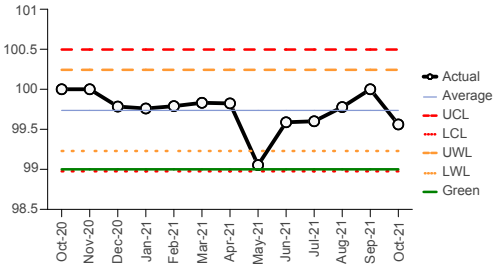
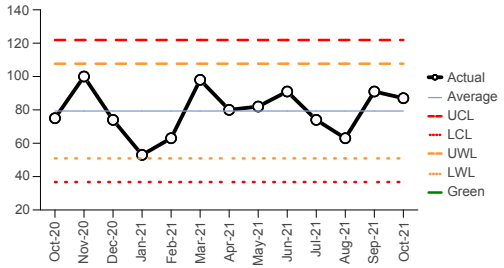
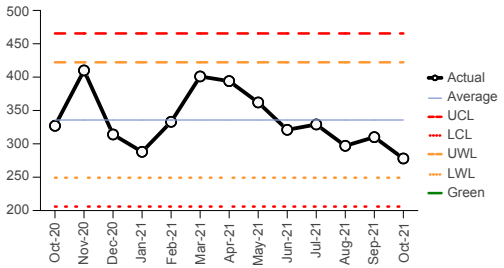
Delivery of Outstanding Care

## 7.1 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Proprtion of Incidents | **Proportion of Near Miss, No Harm & Minor Harm** D<br>Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 99.56 % | R <99 %<br>A N/A<br>G >=99 % |  | No Action Required |
| Incidents: Increasing Reporting | **Clinical Incidents resulting in Near Miss** D<br>Total number of Near Miss Incidents reported<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 87 | No Threshold |  | |
| Incidents: Increasing Reporting | **Clinical Incidents resulting in No Harm** D<br>Total number of No Harm Incidents reported.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 278 | No Threshold |  | |

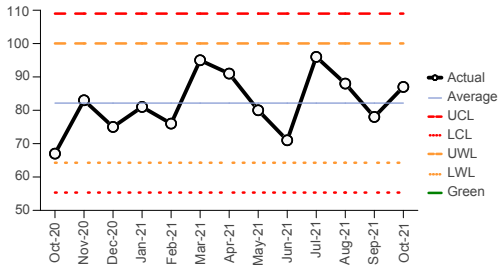
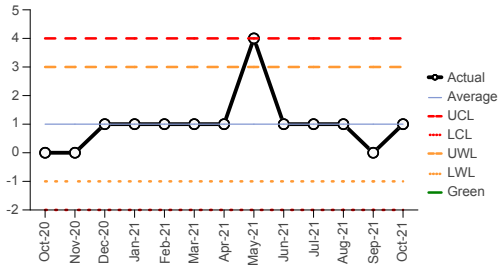
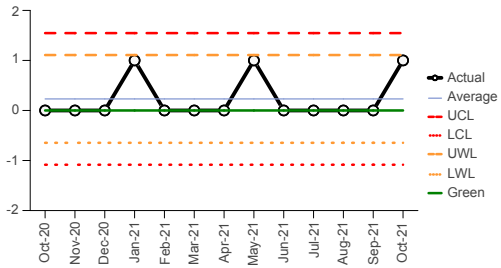
Delivery of Outstanding Care

## 7.2 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

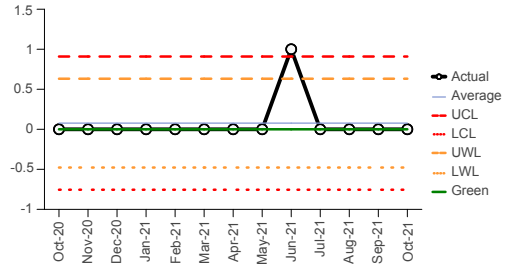
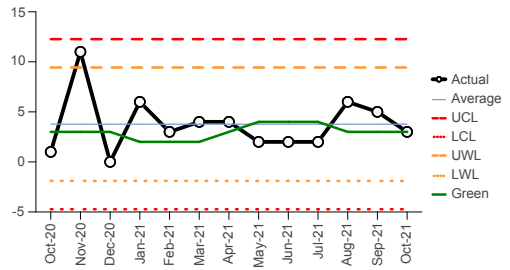
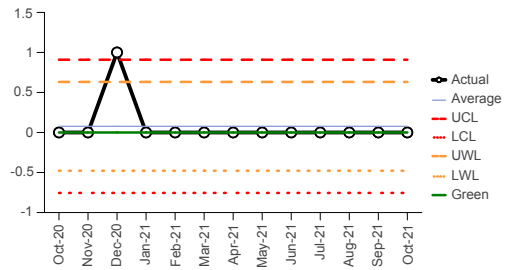
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Incidents: Reducing Harm | **Clinical Incidents resulting in minor, non permanent harm** D<br>Total number of Minor Harm Incidents reported.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 87 | No Threshold |  | |
| Incidents: Reducing Harm | **Clinical Incidents resulting in moderate, semi permanent harm** D<br>Incidents reported resulting in moderate harm.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 1 | No Threshold |  | |
| Incidents: Reducing Harm | **Clinical Incidents resulting in severe, permanent harm** D<br>Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 21/22 aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 1 | R >0<br>A N/A<br>G 0 |  | StEIS 2021/20934 – 72 hour review completed, immediate lessons learned identified and actions for improvement implemented to minimise risk. Duty of candour completed in line with regulation 20. RCA level 2 in progress in line with Trust policy. |

Delivery of Outstanding Care

## 7.3 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Incidents: Reducing Harm | **Clinical Incidents resulting in catastrophic, death** D<br>Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 21/22 aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Reducing Medication Errors | **Medication errors resulting in harm** D<br>Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 20% reduction on the period Apr 20 - Mar 21. 21/22 aim is less than 52 annually for the trust.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 3 | R >3<br>A N/A<br>G <=3 |  | No Action Required |
| Reducing Pressure Ulcers | **Pressure Ulcers (Category 3)** W<br>Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 21/22 Aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |

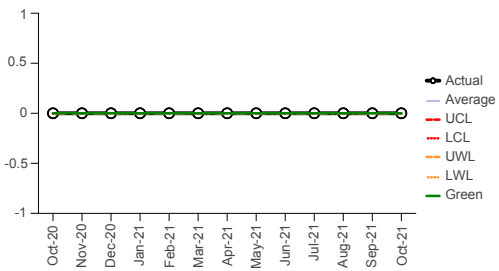
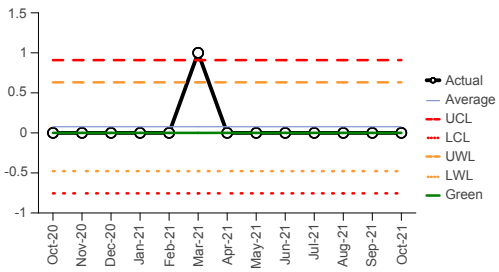
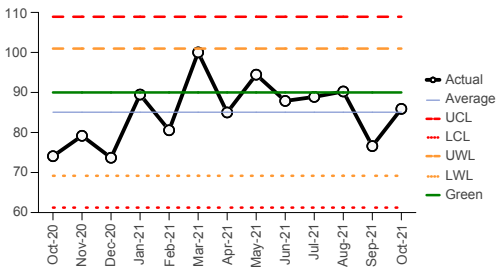
Delivery of Outstanding Care

## 7.4 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Reducing Pressure Ulcers | **Pressure Ulcers (Category 4)** W<br>Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 21/22 Aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Never Events | **Never Events** W<br>Never Events. The threshold is based on this event never occuring. 21/22 aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Sepsis | **Sepsis: Patients treated for Sepsis within 60 Minutes - A&E** D P<br>Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 21/22 aim is 90%.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 85.90 % | R <90 %<br>A N/A<br>G >=90 % |  | Eleven patients did not receive antibiotics within 60 minutes and 6 within 90 minutes; predominantly due to difficulty gaining intravenous access and difficulty carrying out lumbar puncture. Those with no clear cause for delay were incidented for further investigation. One delay was due to further discussions required regarding treatment and antibiotic choice, and two were slightly over by 3 and 4 minutes. |

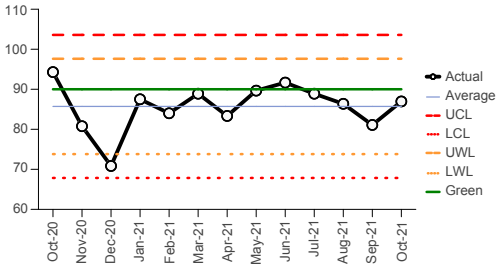
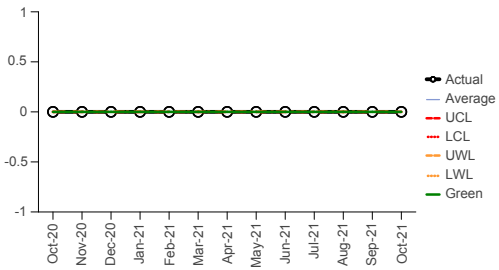
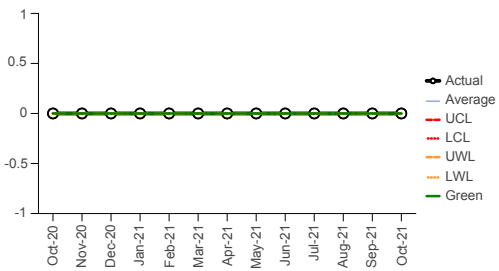
Delivery of Outstanding Care

## 7.5 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

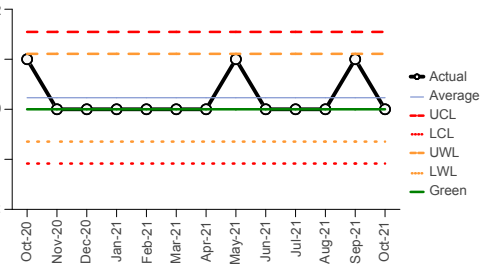
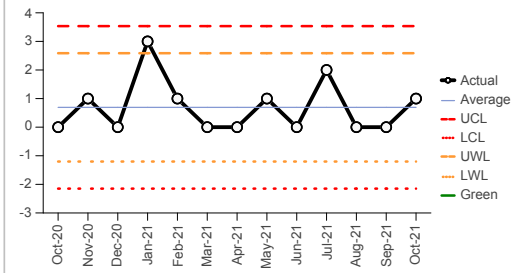
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Sepsis | **Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P<br>Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 21/22 aim is 90%.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 86.96 % | R <90 %<br>A N/A<br>G >=90 % |  | Increase in numbers and acuity throughout the trust. Slight increase in average IVAB times but strong number of sepsis concerns and awareness/escalation and sepsis bundle treatment. Need to continue with strong message of importance of sepsis awareness. 2 delays times over 90mins, patients were not clinically septic and treated as a precaution. |
| Mortality | **Number of children that have experienced avoidable factors causing death - Internal** W<br>Total number of children that have experienced avoidable factors with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 21/22 is zero.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Reducing Infections | **Hospital Acquired Organisms - MRSA (BSI)** D<br>The threshold is based on this event never occuring. 21/22 Aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |

Delivery of Outstanding Care

## 7.6 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Reducing Infections | **Hospital Acquired Organisms - C.difficile** D<br>The threshold is based on this event never occuring. 21/22 Aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Reducing Infections | **Hospital Acquired Organisms - MSSA** D<br>Hospital Acquired Organisms - MSSA . 20/21 aim is to reduce by 10% or more.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 1 | No Threshold |  | |

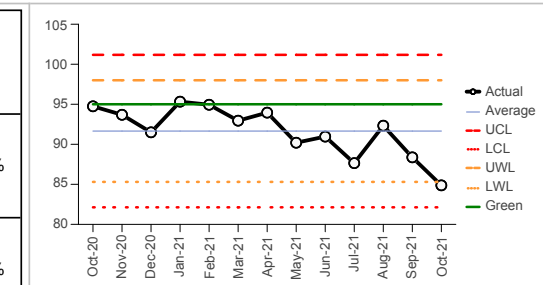
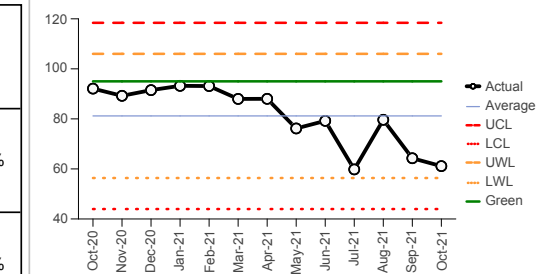
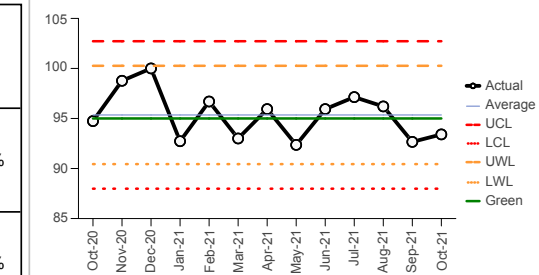
The Best People doing their best Work

## 8.1 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Friends & Family | **Friends & Family: Overall Percentage Recommended Trust** W<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 84.87 % | R <90 %<br>A >=90 %<br>G >=95 % |  | In October 2021, there were 1,437 responses to the Family & Friends Test out of a possible average of 32,000, which gave an overall Trust FFT percentage of 84.87% who found their experiences to be either good or very good. Medicine has decreased by 5.23% and community has decreased by 1.85% of their positive response compared to October and Surgery has stayed the same past few months 94%. |
| Friends & Family | **Friends & Family A&E - % Recommend the Trust** D<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 61.11 % | R <90 %<br>A >=90 %<br>G >=95 % |  | A&E data has dropped by 3% from the previous month, which significantly lower than the month of august (80%) . This relates to high number of attendances which impacted on patient experiences due to long waiting times and attendees leaving without being seen. When respondents were asked how we could improve 157 comments highlighted waiting times. However, they did state when receiving the care it was outstanding. |
| Friends & Family | **Friends & Family Community - % Recommend the Trust** D<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 93.41 % | R <90 %<br>A >=90 %<br>G >=95 % |  | Community overall has done well but has had some decline in the October across a few of the services. ADHD, ASD service and Blood test clinic has had a slight decline in October which is shown in the data. The Community Medicine Clinic and Sefton CAMHS has had a decline in October which has also had an impact to the Community division overall. Currently community has been struggling with patients trying to phone in to the services for appointments and medication related issues. Positive comments 'quick efficient, very polite and shown considerate'. |

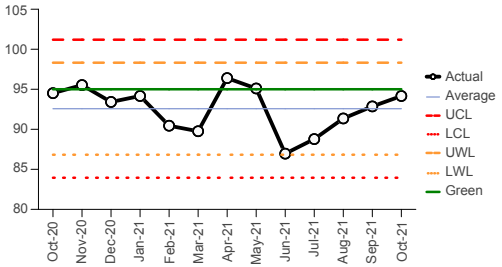
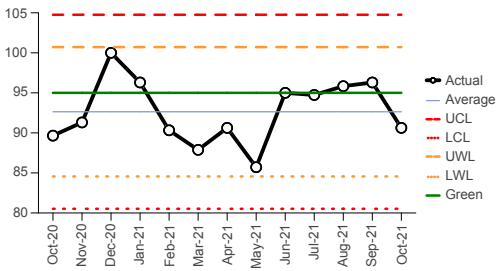
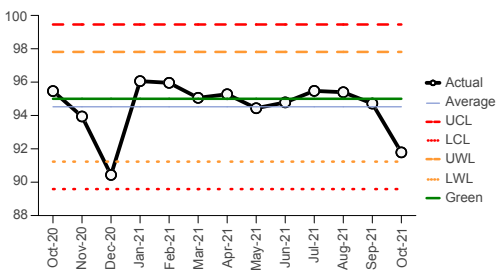
The Best People doing their best Work

## 8.2 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Friends & Family | **Friends & Family Inpatients - % Recommend the Trust** D<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 94.16 % | R <90 %<br>A >=90 %<br>G >=95 % |  | In October there were 154 responses same as last month. Surgical day care, ward 1B (Burns unit), 1B (High dependency unit), 1C (cardiac & neonatal) all had positive 100% feedback. Positive comments: 'Our visit was effortless, calm and relaxing. Cared for to high standard and everything ran smoothly'. Ward 3B had one very poor response, and comment highlighted how the parent did not get to speak to the doctor before the surgery to clarify how long their stay would be. |
| Friends & Family | **Friends & Family Mental Health - % Recommend the Trust** D<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 90.63 % | R <90 %<br>A >=90 %<br>G >=95 % |  | In October there were 32 responses, in Clinical Health Psychology, Eating Disorder Service and Sefton CAMHS all received 100% positive feedback. Positive comments: 'the information and help given is explained and well delivered'. In the areas of Crisis Care and Liverpool Fresh CAMHS there was a decline of 20%. Comments highlighting how they would like to observe the session with the Child and be more involved with the care. |
| Friends & Family | **Friends & Family Outpatients - % Recommend the Trust** D P<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 91.79 % | R <90 %<br>A >=90 %<br>G >=95 % |  | 776 responses in October 122 decrease on the previous month. Urology clinic with 34 positive feedback responses at 100%, followed by the cardiology clinic with 40 positive feedback responses at 97.5%. Positive comments: 'The care that my son has received has been amazing. Such lovely staff, kind and calm manner on the phone. So supportive and provides very clear and helpful guidance. As firstime mum, who was concerned about my sons reflux, put me at complete ease, I can't thank alder hey enough'. Negative:' sometimes the follow up appointment can be too far away & may need to be seen quicker. |

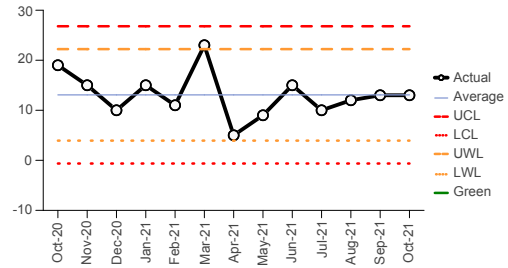
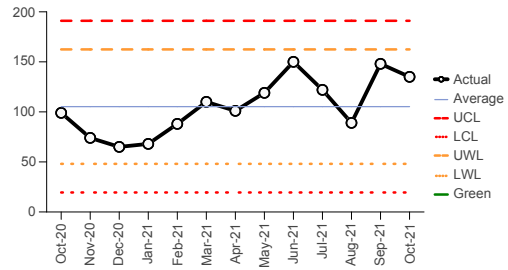
The Best People doing their best Work

## 8.3 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Complaints | **Complaints** W<br>Total complaints received.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 13 | No Threshold |  | |
| PALS | **PALS** W<br>Total number of PALS contacts.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 135 | No Threshold |  | |

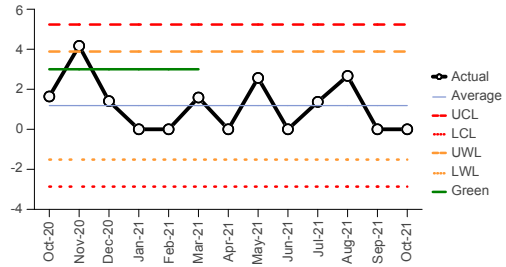
Delivery of Outstanding Care

## 9.1 - QUALITY - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

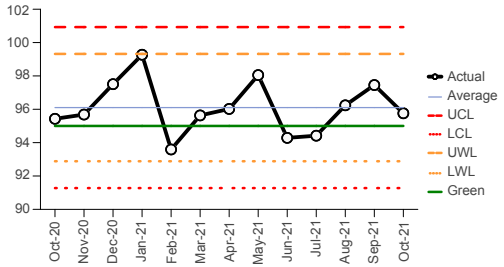
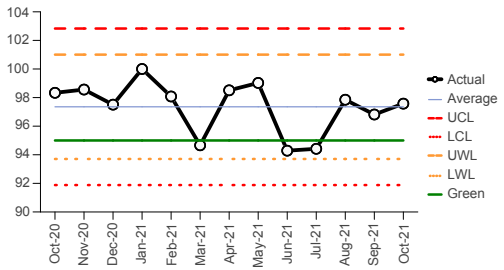
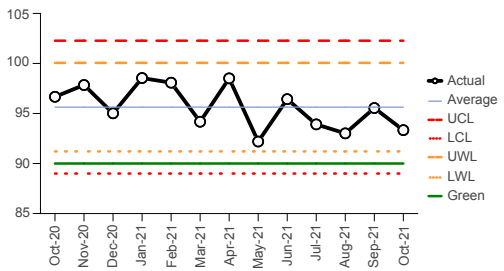
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| PICU Re-admissions | **% Readmissions to PICU within 48 hrs** W<br><br>% of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4%<br><br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 % | No Threshold |  | |

Delivery of Outstanding Care

## 10.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

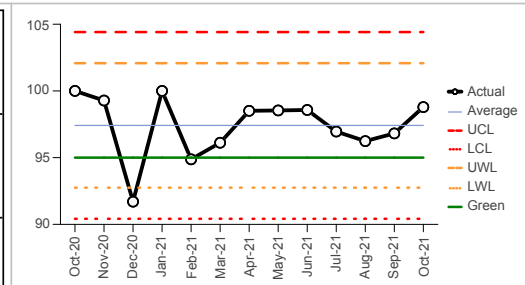
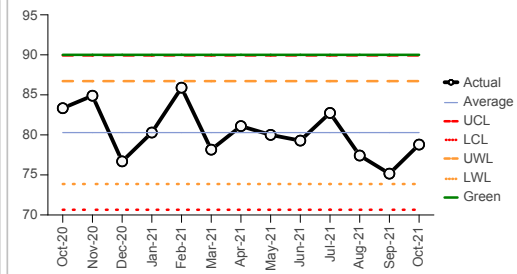
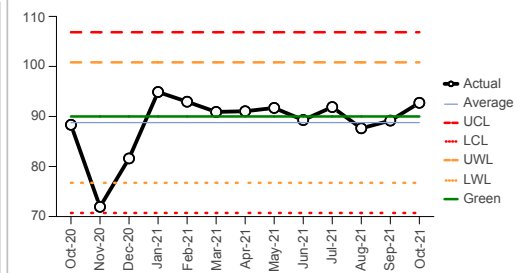
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Inpatient Survey: Choices | **IP Survey: % Received information enabling choices about their care** W<br>Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 21/22 aim is 95% or above.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 95.76 % | R <90 %<br>A >=90 %<br>G >=95 % |  | No Action Required |
| Inpatient Survey: Respect | **IP Survey: % Treated with respect** W<br>Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 21/22 is 100%.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 97.58 % | R <90 %<br>A >=90 %<br>G >=95 % |  | No Action Required |
| Inpatient Survey: Date of Discharge | **IP Survey: % Know their planned date of discharge** D P<br>Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 93.33 % | R <85 %<br>A >=85 %<br>G >=90 % |  | No Action Required |

Delivery of Outstanding Care

## 10.2 - QUALITY - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Inpatient Survey: In Charge of Care | **IP Survey: % Know who is in charge of their care** W<br>% of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 21/22 aim is 95% or above.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 98.79 % | R <90 %<br>A >=90 %<br>G >=95 % |  | No Action Required |
| Inpatient Survey: Play | **IP Survey: % Patients involved in Play** D<br>% of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 78.79 % | R <85 %<br>A >=85 %<br>G >=90 % |  | Play has increased slightly from the previous month by 3%. The review of the play services is still under way and is being carried out by the Director of Nursing and the Patient Experience/Quality Lead to identify were the improvements are required and what resources are needed including materials for the older/young person. The team is working closely with the innovation team to support the Alder App and LMarks to identify any business's that can support play. |
| Inpatient Survey: Learning | **IP Survey: % Patients involved in Learning** D<br>% of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 92.73 % | R <85 %<br>A >=85 %<br>G >=90 % |  | No Action Required |

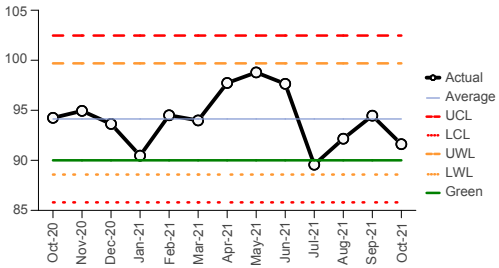
The Best People doing their best Work

## 11.1 - QUALITY - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Staffing | **Safer Staffing (Shift Fill Rate)** W<br>Safer Staffing. Threshold is based on National Target of 90% or above.<br><br>**Exec Lead:** Pauline Brown<br>**Committee:** SQAC | 91.61 % | R <90 %<br>A N/A<br>G >=90 % |  | No Action Required |

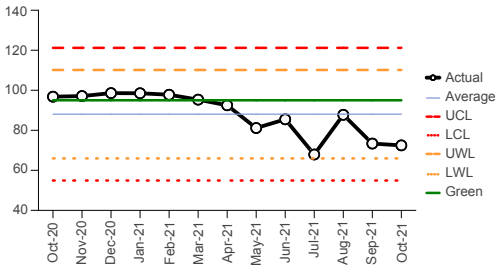
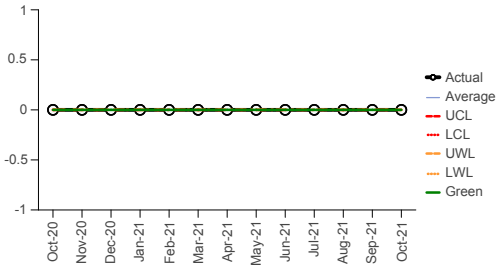
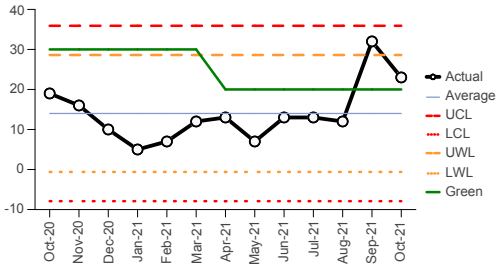
Delivery of Outstanding Care

## 12.1 - PERFORMANCE - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

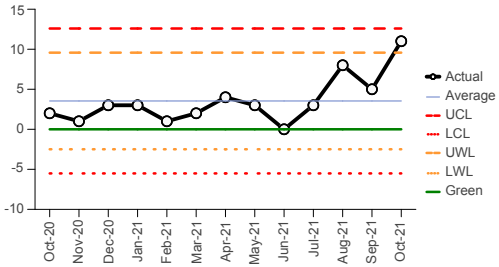
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| ED 4 Hour Standard | **ED: 95% Treated within 4 Hours** D<br>Threshold is based on National Guidance set by NHS England at 95%.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 72.46 % | R <95 %<br>A N/A<br>G >=95 % |  | Continued pressure on ED. Attributed to limited patient access to P/C, other H/C providers and a lack of F2F appts. High priority placed ensuring the dept is well staffed and safe ensuring acutely unwell patients are seen in the appropriate time and triage wait is no longer than 15 mins. Also maintain a strong focus on staff's well-being. High-med acuity patients continue to be priority, however we're looking at deflection of appropriate patients to access providers/treatments most suitable (walk in centres, 111 and Pharmacy). External comms being reviewed to try to support the dept also. |
| ED 12 Hr Waits | **ED: Number of patients spending >12 hours from decision to admit to admission** W<br>Number of patients spending >12 hours in A&E from decision to admit to admission. This is a national standard with a zero tolerance threshold.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Cancelled Operations | **On the day Elective Cancelled Operations for Non Clinical Reasons** D<br>Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 23 | R >20<br>A N/A<br>G <=20 |  | On the day cancellations are reducing as a result of the same but also proactively managing TCIs, looking ahead and cancelling earlier if we have concerns about bed pressures but also pushing for TCIs to go ahead on the day as much as possible. |

Delivery of Outstanding Care

## 12.2 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

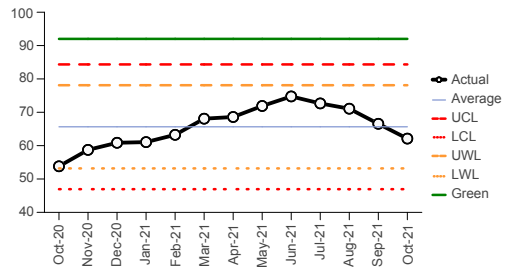
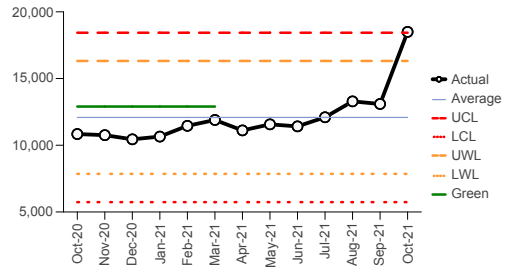
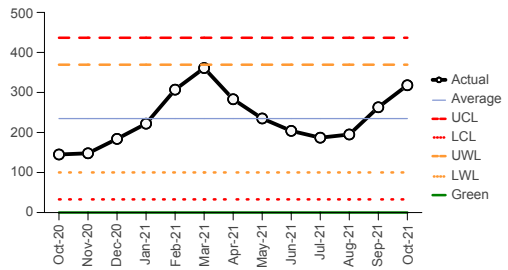
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Operation Breaches | **28 Day Breaches** W<br>Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance.<br><br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 11 | R >0<br>A N/A<br>G 0 |  | 28 day breaches continue to be a challenge due to on going NEL pressures but we are working on the theatre SOP to support reducing this. |

Delivery of Outstanding Care

## 13.1 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

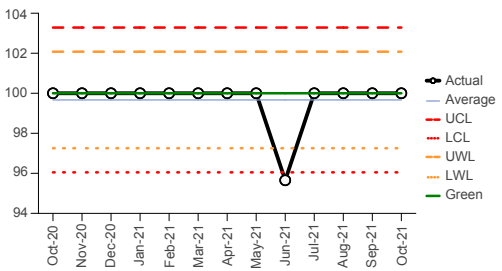
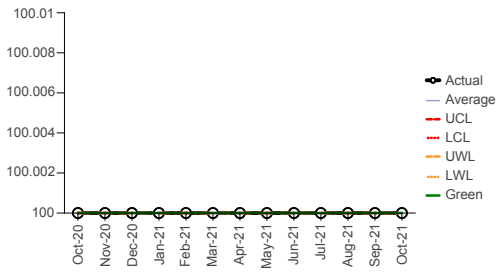
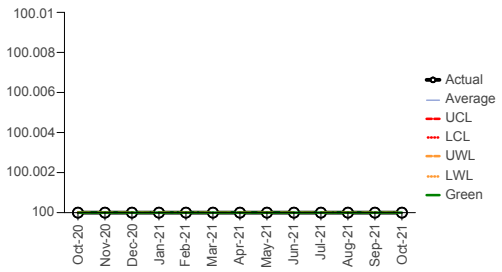
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| RTT | **RTT: Open Pathway: % Waiting within 18 Weeks** W<br>Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 62.11 % | R <90 %<br>A >=90 %<br>G >=92 % |  | Performance has steadied following months of continued improvement with notable progress against our restoration targets. Continued challenges remain primarily within surgical specialities. Each speciality below 95% RTT has an individual delivery plan to support their achievement of RTT pathways within coming weeks or months. |
| Waiting Times | **Waiting List Size** W<br>Total waiting list size of Inpatient and Outpatient RTT incomplete pathways<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 18495 | No Threshold |  | |
| Waiting Times | **Waiting Greater than 52 weeks - Incomplete Pathways** W<br>Total number of more than 52 weeks for first treatment on an incomplete pathway. The threshold is based on this event never occuring. 21/22 aim is zero annually.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 318 | R >0<br>A N/A<br>G 0 |  | Performance has steadied in recent months for the number of C&YP waiting over 52wks to receive treatment. Majority of patients are waiting surgical treatment. All have received a clinical review with plans to treat asap. Challenging specialities have made significant progress by creating more capacity to accommodate as many of these C&YP. Some of the C&YP have also been established via additional validation associated with the Safe WL Programme. |

Delivery of Outstanding Care

## 13.2 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

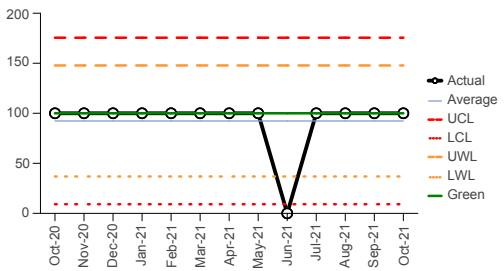
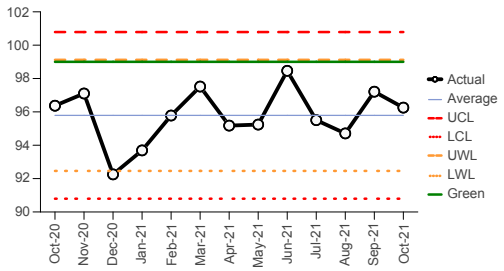
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Cancer RTT | **Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W<br>Threshold is set at 100% which a stretch target set higher than national performance.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 100 % | R <100 %<br>A N/A<br>G 100 % |  | No Action Required |
| Cancer RTT | **Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.** W<br>Threshold is set at 100% which a stretch target set higher than national performance.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 100 % | R <100 %<br>A N/A<br>G 100 % |  | No Action Required |
| Cancer RTT | **All Cancers: 31 day wait until subsequent treatments** W<br>Threshold is set at 100% which a stretch target set higher than national performance.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 100 % | R <100 %<br>A N/A<br>G 100 % |  | No Action Required |

Delivery of Outstanding Care

## 13.3 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Cancer RTT | **31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** W<br>Threshold is set at 100% which a stretch target set higher than national performance.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 100 % | R <100 %<br>A N/A<br>G 100 % |  | No Action Required |
| Diagnostics | **Diagnostics: % Completed Within 6 Weeks** W<br>Threshold is based on National Guidance set by NHS England at 99%.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 96.25 % | R <99 %<br>A N/A<br>G >=99 % |  | |

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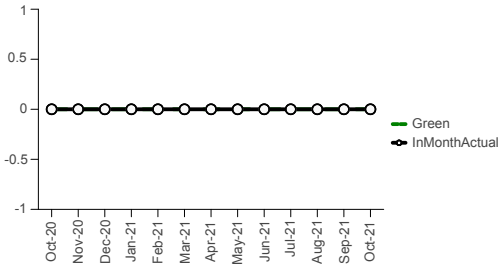
## 14.1 - PERFORMANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Governance | **NHS Oversight Framework** W<br>Five themes against which trusts' performance is assessed and the indicators that trigger consideration of a potential support need: Quality, Finance and UOR, Operational performance, strategic change and Leadership and improvement capability (well led).<br><br>**Exec Lead:** Erica Saunders<br>**Committee:** SQAC | 0 | R >1<br>A <=1<br>G 0 |  | No Action Required |

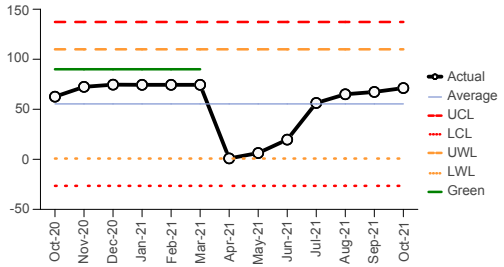
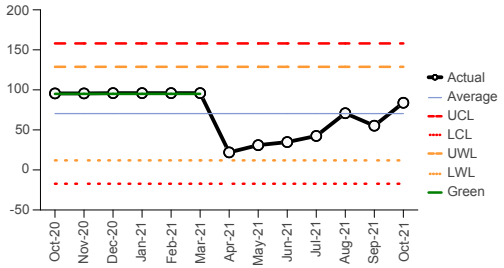
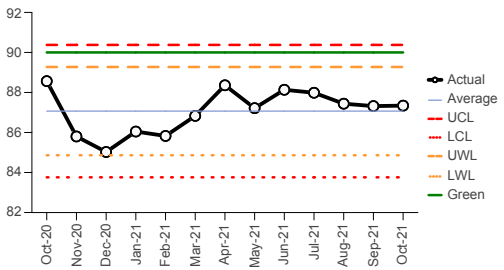
The Best People doing their best Work

## 15.1 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Personal Development | **PDR** W<br>Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July).<br>**Exec Lead:** Melissa Swindell **Committee:** PAWC | 71.19 % | No Threshold |  | As at the end of September appraisals were at 71% across the Trust overall. Whilst staff who have not had an appraisal are still encouraged to do so, the appraisal window is now closed. |
| Appraisal | **Medical Appraisal** W<br>Trust Target for compliance for medical staff, which is on a rolling 12mth period.<br>**Exec Lead:** Melissa Swindell **Committee:** PAWC | 83.86 % | No Threshold |  | |
| Training | **Mandatory Training** W<br>This is a Trust target that measures all required training including Resuscitation.<br>**Exec Lead:** Melissa Swindell **Committee:** PAWC | 87.34 % | R <80 %<br>A >=80 %<br>G >=90 % |  | Mandatory Training this month has remained at 87%, with focus on the same 3 areas; Resus Training, Practical Moving & Handling and the Estates and Facilities Staff Group. Resus launched their online Basic Life Support Training at the Start of November and have brought in additional external trainer capacity until the end of the year to improve PLS/APLS compliance rates. This has seen their compliance go from 75% to 77% overall in the last month. Moving & Handling have a new lead trainer who started at the beginning of November on a secondment basis. |

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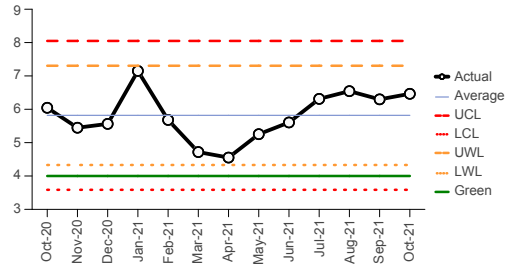
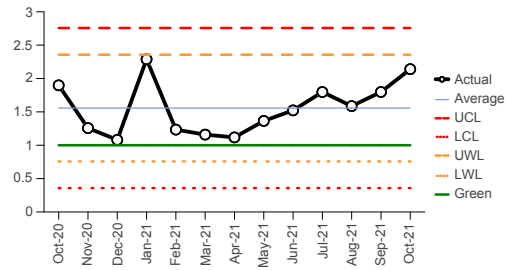
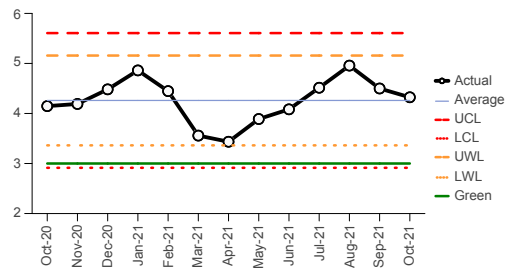
# 15.2 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Sickness | **Sickness** D<br>% of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics<br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 6.46 % | R >4.5 %<br>A <=4.5 %<br>G <=4 % |  | Attendance management remains a key priority for the trust. Supporting people to remain in work through well-being and other forms of support, as well as maintaining contact with colleagues who are away from the workplace; to avoid feelings of isolation and enable a smooth transition back to work when they are fit to return. A range of mechanisms are utilised to facilitate this. A key focus is return to work interviews, with a drive to enable all areas to be green, linked to our KPI. |
| Sickness | **Short Term Sickness** D<br>% of Trust staff who have been absent from work due to sickness lasting less than 28 days<br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 2.14 % | R >1 %<br>A N/A<br>G <=1 % |  | |
| Sickness | **Long Term Sickness** D<br>% of Trust staff who have been absent from work due to sickness lasting 28 days or more<br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 4.32 % | R >3 %<br>A N/A<br>G <=3 % |  | |

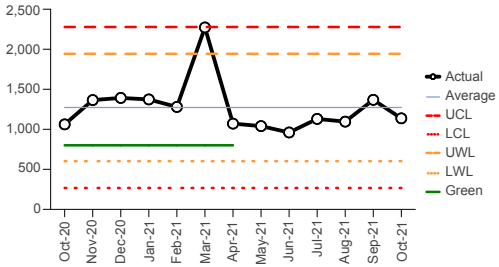
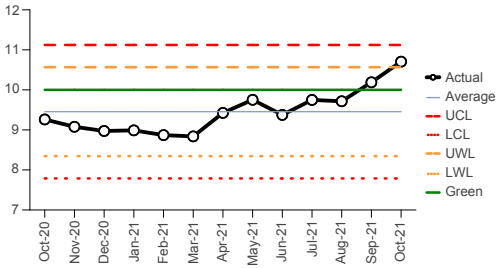
The Best People doing their best Work

## 15.3 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Temporary Spend | **Temporary Spend ('000s)** D<br>Indicates the expenditure on premium temporary pay spend and monitors the reduction.<br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 1136.82 | No Threshold |  | |
| Staff Turnover | **Staff Turnover** D<br>Trust Target which is based on a rolling 12mth period<br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 10.71 % | R >11 %<br>A <=11 %<br>G <=10 % |  | Turnover is an area of focus for all divisions as most areas are either just below or just above the 10% KPI. A deep dive to gain greater understanding of the reasons for this as highlight any common trends is currently being undertaken. The finding of which will be utilised to facilitate a plan of action, linked to the winter plan. |

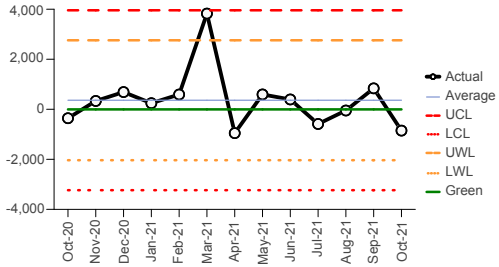
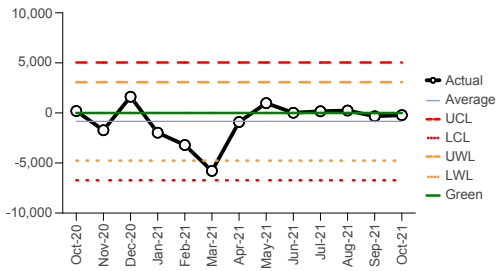
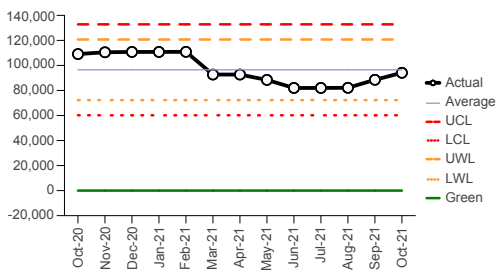
The Best People doing their best Work

## 16.1 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Finance | **Control Total In Month Variance (£'000s)** W<br>Variance from Control Total plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | -853 | R <-20%<br>A >=-20%<br>G >=-5% |  | The month 7 position is showing a deficit of £0.9m which is largely driven by two key areas: Loss ERF contribution H1 – which equates to £0.7m per month and Reduction in system funding for H2 as per current allocations - £0.2m per month. |
| Finance | **Capital Expenditure In Month Variance (£'000s)** W<br>Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | -221 | R <-10%<br>A >=-10%<br>G >=-5% |  | Month 7 saw an in-month overspend against the NHSi plan of £221k, meaning year to date the programme is ahead of plan by £83k. The Trust is reporting a year to date spend of £11.1m which is in line with expectations, much of which is driven by the profiling of the Campus re-development and IM&T programmes. Capital forecast to the end of 2021/22 remains to plan and will be carefully monitored. |
| Finance | **Cash in Bank (£'000s)** W<br>Variance from Cash plan. Variation between months is usual and the threshold of -5% to -20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | 94,111 | R <-20%<br>A >=-20%<br>G >=-5% |  | No Action Required |

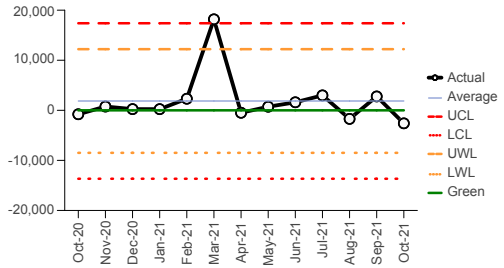
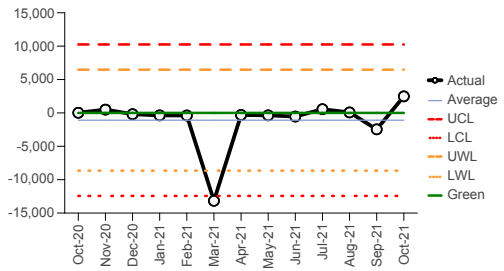
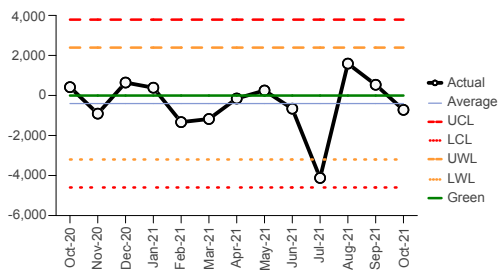
The Best People doing their best Work

## 16.2 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

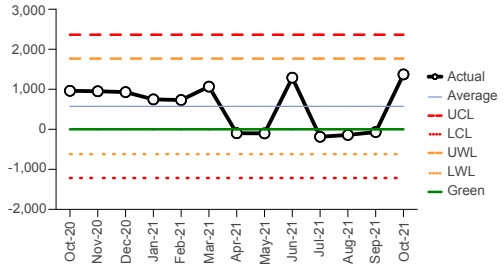
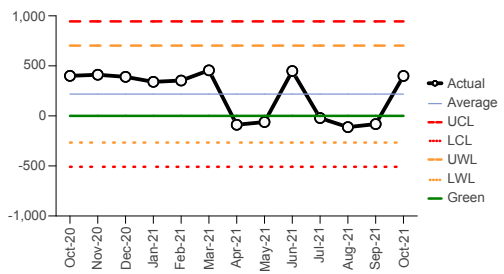
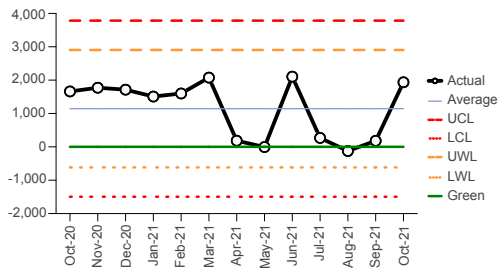
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Finance | **Income In Month Variance (£'000s)** W<br>Variance from income plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | -2,609 | R <-20%<br>A >=-20%<br>G >=-5% |  | £2.5m income received in month 7 in relation to the backdated pay award paid in month 6 as specified in the NHSEI guidance. Variance is correct year to date. |
| Finance | **Pay In Month Variance (£'000s)** W<br>Variance from pay plan. Variation between months is usual and the threshold of -5% to -20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | 2,477 | R <-20%<br>A >=-20%<br>G >=-5% |  | No Action Required |
| Finance | **Non Pay In Month Variance (£'000s)** W<br>Variance from non pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | -720 | R <-20%<br>A >=-20%<br>G >=-5% |  | Cost Pressure in month predominantly relates to Energy costs exceeding initial estimations, plus drugs costs and aseptic outsourcing charges. |

The Best People doing their best Work

# 16.3 - FINANCE - WELL LED

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Finance | **AvP: IP - Non-Elective** W<br>Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell **Committee:** RABD | 1371 | R <0<br>A N/A<br>G >=0 |  | No Action Required |
| Finance | **AvP: IP Elective vs Plan** W<br>Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell **Committee:** RABD | 399 | R <0<br>A N/A<br>G >=0 |  | No Action Required |
| Finance | **AvP: Daycase Activity vs Plan** W<br>Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell **Committee:** RABD | 1935 | R <0<br>A N/A<br>G >=0 |  | No Action Required |

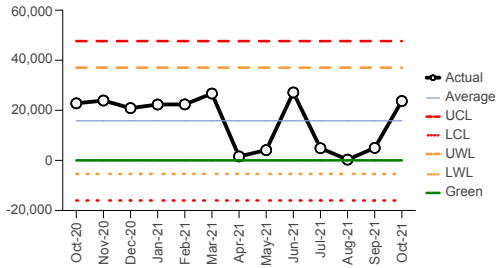
The Best People doing their best Work

# 16.4 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Finance | **AvP: Outpatient Activity vs Plan** W<br>Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher.<br><br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | 23691 | R <0<br>A N/A<br>G >=0 |  | No Action Required |

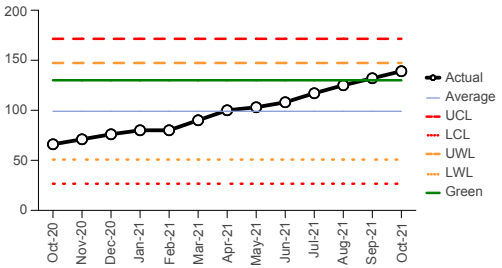
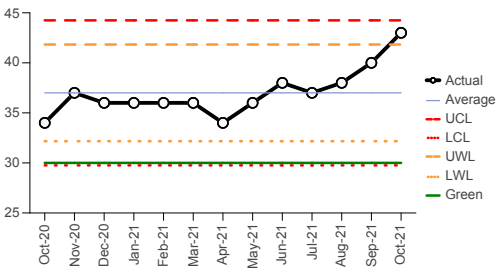
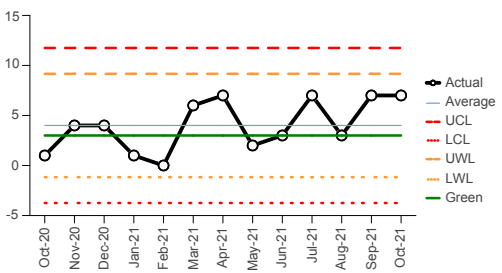
Game Changing Research & Innovation

## 17.1 - RESEARCH & DEVELOPMENT - WELL LED

GROW THE FUTURE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Clinical Research | **Number of Open Studies - Academic** W<br>Number of academic studies currently open.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 139 | R <111<br>A >=111<br>G >=130 |  | No Action Required |
| Clinical Research | **Number of Open Studies - Commercial** W<br>Number of commercial studies currently open.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 43 | R <21<br>A >=21<br>G >=30 |  | No Action Required |
| Clinical Research | **Number of New Studies Opened - Academic** W<br>Number of new academic studies opened in month.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 7 | R <2<br>A >=2<br>G >=3 |  | No Action Required |

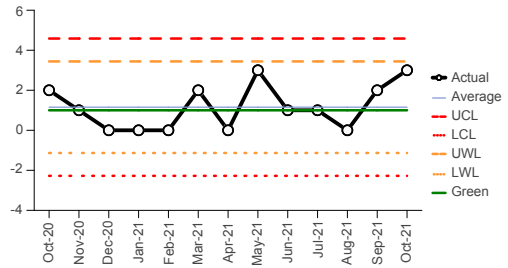
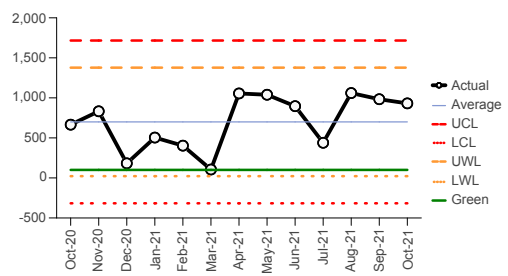
Game Changing Research & Innovation

## 17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

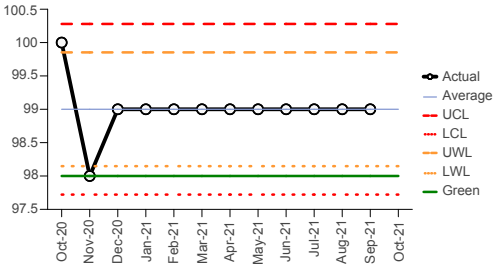
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Clinical Research | **Number of New Studies Opened - Commercial** W<br>Number of new commercial studies opened in month.<br>**Exec Lead:** Jo Blair **Committee:** RMB | 3 | R <1<br>A N/A<br>G >=1 |  | No Action Required |
| Clinical Research | **Number of patients recruited** W<br>Number of patients recruited to NIHR portfolio studies in month.<br>**Exec Lead:** Jo Blair **Committee:** RMB | 931 | R <86<br>A >=86<br>G >=100 |  | No Action Required |

Delivery of Outstanding Care

## 18.1 - FACILITIES - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Facilities | **PFI: PPM%**<br>PFI: Scheduled maintenance as part of Planned and Preventative Maintenance (PPM) schedule to ensure compliance with statutory obligations and provide a safe environment 98%<br><br>**Exec Lead:** David Powell<br>**Committee:** RABD | | R <98 %<br>A N/A<br>G >=98 % |  | No Action Required |

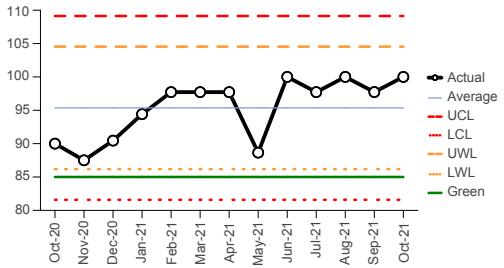
The Best People doing their best Work

## 19.1 - FACILITIES - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Facilities | **Domestic Cleaning Audit Compliance** W<br><br>Auditing for Domestic Services, aim is to ensure National Cleaning Standards.<br><br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 100 % | R <85 %<br>A N/A<br>G >=85 % |  | No Action Required |

# All Divisions

D Drive W Watch P Programme

## SAFE

| | | COMMUNITY | MEDICINE | SURGERY | RAG |
|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss | D | 5 | 37 | 32 | No Threshold |
| Clinical Incidents resulting in No Harm | D | 64 | 92 | 106 | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm | D | 7 | 30 | 42 | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 0 | 1 | No Threshold |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 1 | 0 / N/A / >0 |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 / N/A / >0 |
| Medication errors resulting in harm | D | 0 | 1 | 1 | No Threshold |
| Pressure Ulcers (Category 3) | W | 0 | 0 | 0 | 0 / N/A / >0 |
| Pressure Ulcers (Category 4) | W | 0 | 0 | 0 | 0 / N/A / >0 |
| Never Events | W | 0 | 0 | 0 | 0 / N/A / >0 |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients | D P | | 91.3% | 82.6% | >=90 % / N/A / <90 % |
| Hospital Acquired Organisms - MRSA (BSI) | D | 0 | 0 | 0 | 0 / N/A / >0 |
| Hospital Acquired Organisms - C.difficile | D | 0 | 0 | 0 | 0 / N/A / >0 |
| Hospital Acquired Organisms - MSSA | D | 0 | 1 | 0 | No Threshold |

## CARING

| | | COMMUNITY | MEDICINE | SURGERY | RAG |
|---|---|---|---|---|---|
| Complaints | W | 2 | 5 | 4 | No Threshold |
| PALS | W | 50 | 51 | 26 | No Threshold |

## EFFECTIVE

| | | COMMUNITY | MEDICINE | SURGERY | RAG |
|---|---|---|---|---|---|
| % Readmissions to PICU within 48 hrs | W | | | 0.0% | No Threshold |
| ED: 95% Treated within 4 Hours | D | | 72.5% | | >=95 % / N/A / <95 % |
| ED: Number of patients spending >12 hours from decision to admit to admission | W | | 0 | | 0 / N/A / >0 |

# All Divisions

D Drive W Watch P Programme

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| On the day Elective Cancelled Operations for Non Clinical Reasons | D | 0 | 3 | 20 | No Threshold | | |
| 28 Day Breaches | W | 0 | 1 | 10 | 0 | N/A | >0 |

## RESPONSIVE

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| IP Survey: % Received information enabling choices about their care | W | | 88.7% | 99.1% | >=95 % | >=90 % | <90 % |
| IP Survey: % Treated with respect | W | | 94.3% | 99.1% | >=95 % | >=90 % | <90 % |
| IP Survey: % Know their planned date of discharge | D P | | 86.8% | 96.4% | >=90 % | >=85 % | <85 % |
| IP Survey: % Know who is in charge of their care | W | | 100.0% | 98.2% | >=95 % | >=90 % | <90 % |
| IP Survey: % Patients involved in Play | D | | 73.6% | 81.2% | >=90 % | >=85 % | <85 % |
| IP Survey: % Patients involved in Learning | D | | 86.8% | 95.5% | >=90 % | >=85 % | <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 53.3% | 65.4% | 61.7% | >=92 % | >=90 % | <90 % |
| Waiting List Size | W | 1,530 | 5,605 | 11,360 | No Threshold | | |
| Waiting Greater than 52 weeks - Incomplete Pathways | W | 1 | 23 | 294 | 0 | N/A | >0 |
| Cancer: 2 week wait from referral to date 1st seen - all urgent referrals | W | | 100.0% | | 100 % | N/A | <100 % |
| Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. | W | | 100.0% | | 100 % | N/A | <100 % |
| All Cancers: 31 day wait until subsequent treatments | W | | 100.0% | | 100 % | N/A | <100 % |
| Diagnostics: % Completed Within 6 Weeks | W | | 96.4% | 88.9% | >=99 % | N/A | <99 % |
| 31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) | W | | 100.0% | | 100 % | N/A | <100 % |

## WELL LED

| | | COMMUNITY | MEDICINE | SURGERY | RAG |
|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | 16 | -127 | -349 | No Threshold |
| Income In Month Variance (£'000s) | W | -78 | -184 | -43 | No Threshold |
| Pay In Month Variance (£'000s) | W | 142 | -35 | -82 | No Threshold |
| Non Pay In Month Variance (£'000s) | W | -48 | 91 | -223 | No Threshold |

## All Divisions

D Drive W Watch P Programme

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| AvP: IP - Non-Elective | W | 0 | 1,002 | 369 | >=0 | N/A | <0 |
| AvP: IP Elective vs Plan | W | 0 | 119 | 278 | >=0 | N/A | <0 |
| AvP: Daycase Activity vs Plan | W | | 1,208 | 725 | >=0 | N/A | <0 |
| AvP: Outpatient Activity vs Plan | W | 3,847 | 6,354 | 11,455 | >=0 | N/A | <0 |
| PDR | W | 80.9% | 72.8% | 60.0% | No Threshold | | |
| Medical Appraisal | W | 80.0% | 81.8% | 87.0% | No Threshold | | |
| Mandatory Training | W | 91.6% | 86.1% | 88.4% | >=90 % | >=80 % | <80 % |
| Sickness | D | 6.0% | 6.6% | 0.0% | <=4 % | <=4.5 % | >4.5 % |
| Short Term Sickness | D | 2.1% | 2.3% | 0.0% | <=1 % | N/A | >1 % |
| Long Term Sickness | D | 4.0% | 4.3% | 0.0% | <=3 % | N/A | >3 % |
| Temporary Spend ('000s) | D | 192 | 311 | 363 | No Threshold | | |
| Staff Turnover | D | 11.0% | 9.5% | | <=10 % | <=11 % | >11 % |
| Safer Staffing (Shift Fill Rate) | W | 108.0% | 83.8% | 94.8% | >=90 % | >=80 % | <90 % |

| Medicine Division | | |
|---|---|---|
| **SAFE** | Gen Paeds to ensure all new patients are handed over to COW/PTWR Consultant for clinical review. Outliers to be identified for separate review.<br><br>Reminders will be communicated via review meetings to ask for push to close as soon as possible if no further investigation required. | **Highlight**<br>Multidisciplinary attendance at weekly divisional incident review meeting for rapid learning and sharing<br>Incident themes identified :<br>1) allocation of emergency admissions under incorrect Consultant/Specialty<br>2) Recognition of clinical deterioration/ use of 'parent/nurse' concern<br>**Challenges**<br>504 incidents open on Ulysses.<br><br>Sepsis performance improving but still below target |
| **CARING** | Reminders being sent by Complaints and PALs Officer with follow up from Risk ad Governance Lead.<br><br>Supporting Complaint and PALS officer to progress delayed responses. | **Highlight**<br>Complaint numbers remain on average 4 a month. The high number in March (12) did not indicate a shift.<br>**Challenges**<br>Achieving the 25-working day target for a response remains a challenge (14 currently open).<br>6 breaches currently (as of 08/11) - 3 breaches due to delays in compiling response; 2 due to resolution meeting ; 1 due to child passing away recently<br>8 awaiting response – currently on track |
| **EFFECTIVE** | Multiple workstreams ongoing to improve patient flow<br><br>Review of medical rostering in ED to better align current workforce to demand<br><br>Theatre Util for Gastro being closely monitored through expected number of procedures per list. Service manager attending theatre lists to observe processes to identify improvements | **Highlight**<br>NEL LOS continues to decrease month on month<br><br>ED reattendance rate reduced Aug-Oct<br>**Challenges**<br>ED performance remains outside of target at 72%<br><br>Theatre Util dipped in October due to late cancellations. |
| **RESPONSIVE** | In discussions with LUFT to jointly recruit to additional Derm posts<br><br>Regional contract with 2nd outsourcing company at reduced rates for radiology reporting. | **Highlight**<br>Improved performance against DM01 waits for MRI<br><br>Additional sleep and VT posts recruited to which will help reduce waiting times<br>**Challenges**<br>RTT performance reduced to 76%<br><br>Radiology reporting over 2 week standard<br><br>IP survey results dipped across the board |

| | | |
|---|---|---|
| **WELL LED** | Identification for hot spot areas and individual action / support plans<br>Moving & Handling engagement should increase linked to the appointment of a new trainer. Weekly senior mgmt meetings to review mandatory training are underway.<br><br>Review Junior Doctors<br>Review CIP plans and progress in order to meet recurrent target<br>Request funding with CCG to support increased activity in A&E<br>Identifying emerging pressures for 22/23 budget setting and external discussions | **Highlight**<br>Overall absence has reduced by 0.8%<br>Short term absence remains static<br>0.8% reduction in long term absence due to people returning to work and application of stage 3 of policy.<br>Mandatory training at 86.71 %<br>Although green, turnover has increased to 9.5%<br>83% of CIP target has been achieved as at M6<br>**Challenges**<br>Although the monthly trend is showing a reduction, there are weekly variations which can at time increase to 7% (including COVID related absence)<br>Main topics of concern are Basic Life Support, PLS/APLS & Moving & Handling L2<br><br>Ongoing COVID pressures<br>Spend on junior doctors |

Alder Hey Children's NHS
NHS Foundation Trust

# Medicine

D Drive W Watch P Programme

## SAFE

| | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss D | 28 | 34 | 22 | 18 | 23 | 33 | 43 | 33 | 37 | 30 | 28 | 32 | 37 | | No Threshold |
| Clinical Incidents resulting in No Harm D | 70 | 126 | 99 | 90 | 97 | 125 | 122 | 123 | 89 | 100 | 99 | 131 | 92 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm D | 11 | 18 | 19 | 21 | 17 | 19 | 23 | 24 | 16 | 18 | 17 | 17 | 30 | | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm D | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 2 | 1 | 1 | 0 | 0 | 0 | | No Threshold |
| Clinical Incidents resulting in severe, permanent harm D | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Clinical Incidents resulting in catastrophic, death D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Medication errors resulting in harm D | 0 | 0 | 0 | 4 | 1 | 2 | 0 | 0 | 1 | 0 | 2 | 3 | 1 | | No Threshold |
| Medication Errors (Incidents) | 24 | 32 | 36 | 34 | 28 | 39 | 29 | 41 | 25 | 14 | 20 | 35 | 23 | | No Threshold |
| Pressure Ulcers (Category 3) W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Pressure Ulcers (Category 4) W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Acute readmissions of patients with long term conditions within 28 days | 0 | 0 | 1 | 0 | 2 | 4 | 1 | 3 | 2 | 0 | 2 | 1 | 5 | | No Threshold |
| Never Events W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients D P | 100.0% | 75.0% | 90.9% | 83.3% | 84.6% | 87.5% | 90.9% | 88.2% | 93.3% | 96.2% | 75.0% | 85.7% | 91.3% | | >=90 % N/A <90 % |
| Pressure Ulcers (Category 3 and above) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - MRSA (BSI) D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - C.difficile D | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - CLABSI | 0 | 0 | 2 | 2 | 2 | 1 | 5 | 0 | 0 | 2 | 3 | 3 | 4 | | No Threshold |
| Hospital Acquired Organisms - MSSA D | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | No Threshold |
| Cleanliness Scores | 98.0% | 96.0% | 95.1% | 98.4% | 97.2% | 98.6% | 98.7% | 98.2% | 98.6% | 98.6% | 98.7% | 98.8% | 99.4% | | No Threshold |
| Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region. | 99.8% | 99.7% | | | | | | | | | | | | | >=95 % N/A <95 % |
| Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed. | 49.3% | 64.6% | 71.3% | 53.9% | 68.2% | | | | | | | | | | >=50 % N/A <50 % |
| Pharmacy - Dispensing for Out Patients - Routine within 30 minutes | 85.0% | 85.0% | 85.0% | 85.0% | 84.0% | | | | | | | | | | >=90 % N/A <90 % |
| Pharmacy - Dispensing for Out Patients - Complex within 60 minutes | 100.0% | 77.0% | | 100.0% | 100.0% | | | | | | | | | | >=90 % N/A <90 % |

## CARING

| | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints W | 8 | 7 | 6 | 8 | 3 | 12 | 4 | 5 | 2 | 4 | 4 | 3 | 5 | | No Threshold |
| PALS W | 24 | 28 | 27 | 25 | 20 | 37 | 25 | 23 | 41 | 41 | 25 | 48 | 51 | | No Threshold |

## EFFECTIVE

| | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referrals Received (Total) | 2,025 | 2,102 | 1,707 | 2,087 | 1,691 | 2,232 | 2,141 | 2,238 | 2,410 | 2,246 | 1,915 | 2,455 | 2,577 | | No Threshold |
| ED: 95% Treated within 4 Hours D | 96.8% | 97.1% | 98.6% | 98.5% | 97.8% | 95.3% | 92.5% | 81.1% | 85.5% | 67.9% | 87.7% | 73.4% | 72.5% | | >=95 % N/A <95 % |
| ED: Percentage Left without being seen W | 0.8% | 1.0% | 0.6% | 0.5% | 0.7% | 2.2% | 3.8% | 7.4% | 4.9% | 12.5% | 4.3% | 9.1% | 9.5% | | <=5 % N/A >5 % |
| ED: All handovers between ambulance and A & E - Waiting more than 30 minutes W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | 0 N/A >0 |
| ED: All handovers between ambulance and A & E - Waiting more than 60 minutes W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | 0 N/A >0 |
| ED: Re-attendance within 7 days of original attendance (%) W | 7.9% | 7.8% | 7.9% | 9.0% | 7.9% | 7.5% | 8.3% | 9.5% | 8.6% | 9.8% | 9.7% | 8.4% | 9.1% | | No Threshold |

# Medicine

D Drive W Watch P Programme

| | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED: Number of patients spending >12 hours from decision to admit to admission W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Theatre Utilisation - % of Session Utilised W | 84.1% | 82.2% | 84.0% | 84.3% | 87.8% | 86.3% | 86.6% | 81.9% | 80.1% | 82.4% | 80.2% | 82.4% | 80.8% | | >=90 % >=80 % <80 % |
| On the day Elective Cancelled Operations for Non Clinical Reasons D | 1 | 1 | 2 | 0 | 0 | 1 | 2 | 0 | 1 | 0 | 3 | 2 | 3 | | No Threshold |
| 28 Day Breaches W | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | | 0 N/A >0 |
| Hospital Initiated Clinic Cancellations < 6 weeks notice | 33 | 20 | 47 | 16 | 14 | 18 | 21 | 19 | 21 | 37 | 42 | 30 | 43 | | No Threshold |
| OP Appointments Cancelled by Hospital % | 11.3% | 12.4% | 13.8% | 12.2% | 12.2% | 11.8% | 9.8% | 10.2% | 11.3% | 14.4% | 14.1% | 13.3% | 15.2% | | <=5 % N/A >10 % |
| Was Not Brought Rate W P | 11.5% | 9.8% | 10.6% | 9.8% | 9.6% | 9.1% | 8.9% | 8.8% | 9.8% | 10.5% | 11.2% | 10.3% | 10.0% | | <=12 % <=14 % >14 % |
| Was Not Brought Rate (New Appts) W | 12.5% | 11.5% | 11.6% | 12.0% | 11.0% | 9.4% | 12.4% | 10.2% | 11.3% | 10.7% | 13.0% | 9.4% | 10.4% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) W | 11.2% | 9.3% | 10.4% | 9.4% | 9.3% | 9.0% | 8.1% | 8.4% | 9.5% | 10.5% | 10.8% | 10.5% | 9.9% | | <=14 % <=16 % >16 % |
| Coding average comorbidities | 5.31 | 5.45 | 5.50 | 5.45 | 5.54 | 5.41 | 5.14 | 5.17 | 5.59 | 5.47 | 5.58 | 5.48 | 5.67 | | No Threshold |

## RESPONSIVE

| | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IP Survey: % Received information enabling choices about their care W | 92.9% | 96.9% | 95.8% | 100.0% | 96.4% | 95.2% | 96.2% | 98.3% | 93.5% | 87.9% | 100.0% | 92.7% | 88.7% | | >=95 % >=90 % <90 % |
| IP Survey: % Treated with respect W | 97.2% | 100.0% | 95.8% | 100.0% | 100.0% | 95.2% | 98.1% | 100.0% | 89.1% | 87.9% | 97.9% | 92.7% | 94.3% | | >=95 % >=90 % <90 % |
| IP Survey: % Know their planned date of discharge D P | 88.9% | 100.0% | 91.7% | 96.9% | 98.2% | 91.9% | 96.2% | 91.5% | 95.7% | 86.2% | 91.5% | 92.7% | 86.8% | | >=90 % >=85 % <85 % |
| IP Survey: % Know who is in charge of their care W | 100.0% | 100.0% | 87.5% | 100.0% | 92.9% | 95.2% | 94.3% | 100.0% | 97.8% | 93.1% | 87.2% | 90.2% | 100.0% | | >=95 % >=90 % <90 % |
| IP Survey: % Patients involved in Play D | 77.8% | 84.4% | 81.2% | 75.0% | 89.3% | 85.5% | 84.9% | 88.1% | 71.7% | 81.0% | 72.3% | 75.6% | 73.6% | | >=90 % >=85 % <85 % |
| IP Survey: % Patients involved in Learning D | 63.9% | 62.5% | 81.2% | 93.8% | 94.6% | 80.0% | 90.6% | 89.8% | 80.4% | 87.9% | 74.5% | 85.4% | 86.8% | | >=90 % >=85 % <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks W | 68.0% | 81.0% | 88.1% | 89.5% | 90.8% | 92.9% | 92.0% | 93.1% | 92.5% | 86.8% | 83.3% | 77.5% | 65.4% | | >=92 % >=90 % <90 % |
| Waiting List Size W | 1,916 | 1,778 | 1,785 | 1,731 | 2,110 | 2,280 | 2,509 | 2,819 | 3,122 | 3,338 | 3,507 | 3,565 | 5,605 | | No Threshold |
| Waiting Greater than 52 weeks - Incomplete Pathways W | 0 | 0 | 0 | 1 | 16 | 4 | 4 | 3 | 6 | 11 | 7 | 13 | 23 | | 0 N/A >0 |
| Waiting Times - 40 weeks and above | 81 | 63 | 24 | 9 | 37 | 10 | 24 | 12 | 15 | | | | | | No Threshold |
| Cancer: 2 week wait from referral to date 1st seen - all urgent referrals W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.7% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % N/A <100 % |
| Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. W | 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 % N/A <100 % |
| All Cancers: 31 day wait until subsequent treatments W | 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 % N/A <100 % |
| Diagnostics: % Completed Within 6 Weeks W | 96.2% | 97.7% | 91.7% | 94.6% | 96.0% | 97.7% | 95.5% | 95.1% | 98.4% | 95.6% | 94.4% | 97.1% | 96.4% | | >=99 % N/A <99 % |
| 31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 0.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % N/A <100 % |
| Pathology - % Turnaround times for urgent requests < 1 hr | 90.0% | 90.6% | 90.4% | 90.4% | 90.4% | 91.9% | 91.1% | 92.6% | 91.1% | 91.6% | 91.9% | 89.8% | 89.8% | | >=90 % >=85 % <90 % |
| Pathology - % Turnaround times for non-urgent requests < 24hrs | 100.0% | 99.8% | 100.0% | 99.9% | 100.0% | 100.0% | 100.0% | 99.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | >=90 % >=85 % <90 % |
| Imaging - % Report Turnaround times GP referrals < 24 hrs | 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% | | >=95 % >=90 % <95 % |
| Imaging - % Reporting Turnaround Times - ED | 100.0% | 97.0% | 95.0% | 99.0% | 99.0% | 100.0% | 89.0% | 96.0% | 100.0% | 99.0% | 100.0% | 96.0% | 91.0% | | >=90 % >=85 % <90 % |
| Imaging - % Reporting Turnaround Times - Inpatients | 93.0% | 98.0% | 92.0% | 99.0% | 98.0% | 99.0% | 89.0% | 96.0% | 95.0% | 92.0% | 93.0% | 79.0% | 73.0% | | >=90 % >=85 % <90 % |
| Imaging - % Reporting Turnaround Times - Outpatients | 74.0% | 72.0% | 51.0% | 75.0% | 77.0% | 58.0% | 65.0% | 57.0% | 52.9% | 54.0% | 61.0% | 57.0% | 51.0% | | >=85 % N/A <85 % |
| Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks | 98.8% | 100.0% | 94.2% | 100.0% | 95.0% | 98.0% | 98.7% | 100.0% | 91.9% | 89.4% | 83.1% | 86.7% | 100.0% | | >=99 % N/A <99 % |
| Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks | 100.0% | 100.0% | 90.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 93.5% | 91.7% | 100.0% | 97.1% | | >=99 % N/A <99 % |
| Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.9% | 100.0% | 100.0% | 99.3% | 100.0% | 100.0% | 98.0% | | >=99 % N/A <99 % |

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# Medicine

D Drive W Watch P Programme

## WELL LED

| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | -264 | 153 | 41 | 189 | 160 | -586 | 263 | 200 | -1,036 | -347 | -58 | 253 | -127 | | | | |
| Income In Month Variance (£'000s) | W | -647 | 561 | 142 | 10 | 36 | 170 | 37 | -26 | -1 | 209 | -490 | 201 | -184 | | | | |
| Pay In Month Variance (£'000s) | W | -143 | 338 | 30 | -61 | -52 | -148 | -64 | 60 | -150 | 48 | 47 | 121 | -35 | | | | |
| AvP: IP - Non-Elective | W | 595 | 595 | 586 | 405 | 416 | 676 | -153 | -78 | 807 | -82 | -19 | -42 | 1,002 | | >=0 | N/A | <0 |
| AvP: IP Elective vs Plan | W | 121 | 147 | 136 | 123 | 138 | 154 | -16 | -10 | 157 | -25 | -58 | -26 | 119 | | >=0 | N/A | <0 |
| AvP: OP New | | 1,328.00 | 1,391.00 | 1,028.00 | 1,113.00 | 1,073.00 | 1,220.00 | -387.97 | -412.28 | 1,280.00 | -525.93 | -599.20 | -354.45 | 1,251.00 | | >=0 | N/A | <0 |
| AvP: OP FollowUp | | 4,840.00 | 4,908.00 | 4,422.00 | 4,932.00 | 4,566.00 | 5,373.00 | 940.17 | 558.80 | 5,553.00 | 293.46 | 302.03 | 749.47 | 4,516.00 | | >=0 | N/A | <0 |
| AvP: Daycase Activity vs Plan | W | 1,051 | 1,092 | 1,071 | 1,003 | 1,030 | 1,264 | 245 | 187 | 1,314 | 229 | 79 | 376 | 1,208 | | >=0 | N/A | <0 |
| AvP: Outpatient Activity vs Plan | W | 7,145 | 7,370 | 6,419 | 6,887 | 6,738 | 7,751 | 107 | -147 | 7,839 | -810 | -950 | -194 | 6,354 | | >=0 | N/A | <0 |
| PDR | W | 60.2% | 69.1% | 74.6% | 74.2% | 74.2% | 74.2% | 2.6% | 6.8% | 18.5% | 50.2% | 61.7% | 65.8% | 72.8% | | | | |
| Medical Appraisal | W | 96.0% | 96.0% | 94.1% | 94.1% | 94.1% | 94.1% | 23.4% | 28.6% | 33.9% | 42.0% | 75.9% | 52.2% | 81.8% | | | | |
| Mandatory Training | W | 90.2% | 88.9% | 86.7% | 88.1% | 87.1% | 88.5% | 89.1% | 87.6% | 87.9% | 87.2% | 86.9% | 87.0% | 86.1% | | >=90 % | >=80 % | <80 % |
| Sickness | D | 5.8% | 4.7% | 4.9% | 6.3% | 5.1% | 4.1% | 4.4% | 5.4% | 5.3% | 6.4% | 7.2% | 6.4% | 6.6% | | <=4 % | <=4.5 % | >4.5 % |
| Short Term Sickness | D | 2.2% | 1.5% | 1.3% | 2.0% | 1.4% | 1.1% | 1.2% | 1.5% | 1.5% | 2.0% | 1.9% | 1.8% | 2.3% | | <=1 % | N/A | >1 % |
| Long Term Sickness | D | 3.6% | 3.3% | 3.7% | 4.3% | 3.7% | 3.0% | 3.3% | 4.0% | 3.7% | 4.4% | 5.3% | 4.6% | 4.3% | | <=3 % | N/A | >3 % |
| Temporary Spend ('000s) | D | 235 | 239 | 213 | 247 | 267 | 261 | 210 | 262 | 230 | 265 | 263 | 292 | 311 | | | | |
| Staff Turnover | D | 6.5% | 6.9% | 7.2% | 6.6% | 6.5% | 6.0% | 6.5% | 6.8% | 7.3% | 7.5% | 8.1% | 9.2% | 9.5% | | <=10 % | <=11 % | >11 % |
| Safer Staffing (Shift Fill Rate) | W | 93.2% | 93.6% | 93.2% | 91.2% | 97.8% | 93.9% | 101.7% | 97.9% | 96.0% | 87.2% | 90.6% | 95.0% | 83.8% | | >=90 % | >=80 % | <90 % |







## Surgery Division

| | | |
|---|---|---|
| **SAFE** | • Reduced clinical incidents resulting in near misses.<br>• Marginal increase in clinical incidents resulting in no harm.<br>• 1 clinical incidents resulting in permanent harm.<br>• Consistently achieved no clinical incidents resulting in permanent harm.<br>• Reduction in medical errors resulting in harm.<br>• No pressure ulcers<br>• No never events.<br>• Increased occurrence of sepsis not treated within 60 minutes.<br>• No hospital acquired organisms relating to MRSA and C.Difficile.<br>• Maintained cleanliness scores. | **Highlight**<br>• Continued reduction in all medication errors<br>• No pressure ulcers, cat 3 & 4 since Dec 2020<br>• Cleanliness scores 99%>98%:98%<99%>98%<br>• 0 hospital acquired organisms for MRSA/C.Difficile<br>**Challenges**<br>• Ward Staffing levels as patient acuity increases. Increased staff sickness. Increased bed pressures due to emergency flow.<br>• 82.6% achievement of sepsis patients treated within 60 mins.<br>• 1 clinical incident resulting in permanent harm relating to delayed follow up. Trust wide action plan regarding delayed follow ups. |
| **CARING** | • Decrease in formal complaints<br>• Decrease in PALs from last month.<br>• | **Highlight**<br>• Below peak of complaints in May 21.<br>**Challenges**<br>• Providing access within a timely manner for elective patients |
| **EFFECTIVE** | • 0% readmissions to PICU within 48 hours.<br>• Decrease in number of referrals received.<br>• Increase in theatre utilisation.<br>• Reduced on the day elective cancellations for non clinical reasons..<br>• Increase in 28 day breaches.<br>• Increase in hospital initiated cancelled clinics.<br>• Reduced Hospital initiated cancelled outpatients but remains high.<br>• Increase in CCAD cases from last month. | **Highlight**<br>• 0 patients readmitted to PICU within 48 hours<br>• Increased theatre utilisation.<br>• Reduced on the day elective cancellations for non clinical reasons.<br>**Challenges**<br>• Increase in 28 day breaches. Challenges relating to covid/staff sickness and patient flow remain. |
| **RESPONSIVE** | • Positive patient feedback from all indicators except patients involved in play.<br>• Deterioration of performance in relation to RTT open pathway and patients waiting over 52 weeks.<br>• Significant increase in waiting list size.<br>• Decrease of diagnostics within 6 weeks from 100% last month to 88.9% in Oct. | **Highlight**<br>• Patients noted that they knew who was in charge of their care.<br>**Challenges**<br>• Significant increase in waiting list size.<br>• Decrease in RTT compliance 61.7% and increase in patients waiting over 52 weeks to commence treatment. (expected as part of safe waiting list validation). Surgery elective winter plan to progress with maximising use of daycase to support recovery.<br>• Increasing OP and IP capacity required to recover waiting time position.<br>• Decrease of diagnostics within 6 weeks from 100% last month to 88.9% in Oct. |

| | | |
|---|---|---|
| **WELL LED** | • Deteriorating position on control total.<br>• Significant increase in income<br>• Increase in PDRs completed<br>• Significant increase in medical appraisals from 59.5% in Sept to 87% in Oct.<br>• Mandatory training maintained at 88% | **Highlight**<br>• Increase income.<br>• Increase in medical appraisals<br>• Maintaining mandatory training position.<br>• Maintaining safer staffing levels.<br>**Challenges**<br>• Managing financial position. |

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# Surgery

D Drive W Watch P Programme

## SAFE

| | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss D | 27 | 46 | 31 | 24 | 25 | 46 | 23 | 32 | 43 | 27 | 25 | 42 | 32 | | No Threshold |
| Clinical Incidents resulting in No Harm D | 154 | 190 | 143 | 108 | 140 | 174 | 166 | 165 | 164 | 119 | 114 | 104 | 106 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm D | 37 | 45 | 42 | 38 | 27 | 33 | 35 | 28 | 38 | 32 | 49 | 41 | 42 | | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm D | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 2 | 0 | 0 | 1 | 0 | 1 | | No Threshold |
| Clinical Incidents resulting in severe, permanent harm D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | 0 N/A >0 |
| Clinical Incidents resulting in catastrophic, death D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Medication errors resulting in harm D | 1 | 11 | 0 | 1 | 2 | 2 | 4 | 2 | 1 | 2 | 3 | 2 | 1 | | No Threshold |
| Medication Errors (Incidents) | 38 | 68 | 44 | 23 | 40 | 45 | 43 | 36 | 30 | 24 | 27 | 26 | 23 | | No Threshold |
| Pressure Ulcers (Category 3) W | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Pressure Ulcers (Category 4) W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Never Events W | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients D P | 86.7% | 90.0% | 53.8% | 91.7% | 83.3% | 90.9% | 76.9% | 91.7% | 88.9% | 66.7% | 100.0% | 75.0% | 82.6% | | >=90 % N/A <90 % |
| Pressure Ulcers (Category 3 and above) | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - MRSA (BSI) D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - C.difficile D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - MSSA D | 0 | 1 | 0 | 2 | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 0 | | No Threshold |
| Cleanliness Scores | 98.0% | 96.0% | 97.9% | 98.9% | 97.0% | 97.9% | 98.9% | 98.4% | 98.2% | 98.7% | 98.2% | 98.6% | 98.5% | | No Threshold |

## CARING

| | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints W | 10 | 4 | 2 | 2 | 3 | 7 | 0 | 4 | 5 | 3 | 4 | 6 | 4 | | No Threshold |
| PALS W | 29 | 22 | 23 | 16 | 22 | 27 | 34 | 42 | 43 | 33 | 25 | 30 | 26 | | No Threshold |

## EFFECTIVE

| | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Readmissions to PICU within 48 hrs D | 1 | 2 | 1 | 0 | 0 | 1 | 0 | 2 | 0 | 1 | 2 | 0 | 0 | | No Threshold |
| % Readmissions to PICU within 48 hrs W | 1.6% | 4.2% | 1.4% | 0.0% | 0.0% | 1.6% | 0.0% | 2.6% | 0.0% | 1.4% | 2.7% | 0.0% | 0.0% | | No Threshold |
| Referrals Received (Total) | 3,052 | 2,986 | 2,809 | 2,695 | 2,905 | 4,043 | 3,959 | 4,111 | 4,364 | 3,715 | 3,214 | 3,872 | 3,498 | | No Threshold |
| Theatre Utilisation - % of Session Utilised W | 89.2% | 88.6% | 85.0% | 87.6% | 90.3% | 89.5% | 84.0% | 88.8% | 85.2% | 85.1% | 86.8% | 85.1% | 86.9% | | >=90 % >=80 % <80 % |
| On the day Elective Cancelled Operations for Non Clinical Reasons D | 18 | 15 | 8 | 5 | 7 | 11 | 11 | 7 | 12 | 13 | 9 | 30 | 20 | | No Threshold |
| 28 Day Breaches W | 0 | 1 | 3 | 2 | 1 | 2 | 4 | 3 | 0 | 3 | 8 | 4 | 10 | | 0 N/A >0 |
| Hospital Initiated Clinic Cancellations < 6 weeks notice | 58 | 38 | 45 | 38 | 50 | 37 | 47 | 46 | 59 | 63 | 74 | 54 | 78 | | No Threshold |
| OP Appointments Cancelled by Hospital % | 11.1% | 11.9% | 10.6% | 10.6% | 10.8% | 11.8% | 10.1% | 10.2% | 11.3% | 9.8% | 11.5% | 11.6% | 10.9% | | <=5 % <=10 % >10 % |
| Was Not Brought Rate W P | 9.1% | 8.8% | 10.0% | 10.5% | 8.0% | 7.4% | 6.6% | 7.5% | 7.4% | 9.1% | 10.0% | 8.8% | 9.2% | | <=12 % <=14 % >14 % |
| Was Not Brought Rate (New Appts) W | 9.5% | 9.5% | 11.7% | 11.5% | 10.4% | 8.5% | 7.1% | 9.4% | 8.6% | 11.4% | 11.8% | 9.9% | 9.7% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) W | 8.9% | 8.6% | 9.4% | 10.1% | 7.1% | 6.9% | 6.3% | 6.7% | 6.9% | 8.3% | 9.3% | 8.3% | 9.1% | | <=14 % <=16 % >16 % |
| Coding average comorbidities | 4.39 | 4.40 | 4.48 | 4.40 | 4.43 | 4.54 | 4.63 | 4.40 | 4.49 | 4.62 | 4.56 | 4.49 | 4.49 | | No Threshold |
| CCAD Cases | 31 | 27 | 28 | 25 | 29 | 34 | 34 | 31 | 39 | 28 | 19 | 23 | 29 | | No Threshold |

# Surgery

D Drive W Watch P Programme

## RESPONSIVE

| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IP Survey: % Received information enabling choices about their care | W | 96.2% | 95.3% | 99.2% | 99.0% | 92.0% | 95.8% | 95.9% | 97.9% | 94.7% | 97.1% | 95.0% | 99.1% | 99.1% | | >=95 % >=90 % <90 % |
| IP Survey: % Treated with respect | W | 98.8% | 98.1% | 99.2% | 100.0% | 97.0% | 94.4% | 98.6% | 98.6% | 96.8% | 97.1% | 97.8% | 98.3% | 99.1% | | >=95 % >=90 % <90 % |
| IP Survey: % Know their planned date of discharge | D P | 100.0% | 97.2% | 98.4% | 99.0% | 98.0% | 95.1% | 99.3% | 92.5% | 96.8% | 97.1% | 93.5% | 96.6% | 96.4% | | >=90 % >=85 % <85 % |
| IP Survey: % Know who is in charge of their care | W | 100.0% | 99.1% | 95.9% | 100.0% | 96.0% | 96.5% | 100.0% | 97.9% | 98.9% | 98.6% | 99.3% | 99.1% | 98.2% | | >=95 % >=90 % <90 % |
| IP Survey: % Patients involved in Play | D | 85.7% | 85.0% | 72.1% | 81.9% | 84.0% | 75.0% | 79.7% | 76.7% | 83.0% | 83.5% | 79.1% | 75.0% | 81.2% | | >=90 % >=85 % <85 % |
| IP Survey: % Patients involved in Learning | D | 98.8% | 74.8% | 82.0% | 95.2% | 92.0% | 95.8% | 91.2% | 92.5% | 93.6% | 93.5% | 92.1% | 90.5% | 95.5% | | >=90 % >=85 % <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 50.9% | 53.4% | 54.3% | 54.5% | 56.2% | 61.8% | 61.6% | 64.2% | 67.9% | 68.5% | 67.4% | 63.8% | 61.7% | | >=92 % >=90 % <90 % |
| Waiting List Size | W | 8,127 | 8,221 | 7,858 | 8,132 | 8,432 | 8,701 | 7,773 | 7,980 | 7,484 | 7,787 | 8,632 | 8,319 | 11,360 | | No Threshold |
| Waiting Greater than 52 weeks - Incomplete Pathways | W | 143 | 147 | 183 | 221 | 291 | 357 | 276 | 232 | 197 | 174 | 186 | 249 | 294 | | 0 N/A >0 |
| Diagnostics: % Completed Within 6 Weeks | W | 100.0% | 87.5% | 100.0% | 50.0% | 90.0% | 94.1% | 91.3% | 100.0% | 100.0% | 93.8% | 100.0% | 100.0% | 88.9% | | >=99 % N/A <99 % |

## WELL LED

| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | -487 | 54 | -502 | -245 | 11 | -857 | -734 | 199 | 90 | 636 | -5 | -136 | -349 | | |
| Income In Month Variance (£'000s) | W | 15 | 1 | 34 | 0 | 83 | 152 | 47 | 49 | 209 | 223 | 28 | -144 | -43 | | |
| Pay In Month Variance (£'000s) | W | -68 | -67 | -398 | -364 | -169 | -549 | -608 | 21 | -124 | 565 | -64 | -157 | -82 | | |
| AvP: IP - Non-Elective | W | 366 | 355 | 343 | 341 | 308 | 390 | 56 | -22 | 482 | -104 | -121 | -26 | 369 | | >=0 N/A <0 |
| AvP: IP Elective vs Plan | W | 279 | 262 | 254 | 217 | 215 | 300 | -74 | -51 | 290 | 2 | -55 | -57 | 278 | | >=0 N/A <0 |
| AvP: OP New | | 1,808.00 | 2,087.00 | 1,915.00 | 1,955.00 | 2,064.00 | 2,597.00 | 363.54 | -80.15 | 2,822.00 | 703.90 | -110.72 | 397.80 | 2,777.00 | | >=0 N/A <0 |
| AvP: OP FollowUp | | 6,810.00 | 6,831.00 | 5,828.00 | 6,171.00 | 6,405.00 | 7,868.00 | -2,457.10 | 540.79 | 8,020.00 | 1,734.00 | -1,031.90 | 1,248.00 | 7,380.00 | | >=0 N/A <0 |
| AvP: Daycase Activity vs Plan | W | 609 | 680 | 642 | 502 | 569 | 808 | -62 | -193 | 789 | 36 | -205 | -197 | 725 | | >=0 N/A <0 |
| AvP: Outpatient Activity vs Plan | W | 9,816 | 10,154 | 8,993 | 9,321 | 9,738 | 12,039 | -2,046 | 482 | 12,384 | 2,742 | -1,325 | 1,931 | 11,455 | | >=0 N/A <0 |
| PDR | W | 57.8% | 67.5% | 67.6% | 66.1% | 66.1% | 66.1% | 0.1% | 9.0% | 20.3% | 47.2% | 52.8% | 54.2% | 60.0% | | |
| Medical Appraisal | W | 94.1% | 94.1% | 96.8% | 96.8% | 96.8% | 96.8% | 24.0% | 34.8% | 37.8% | 44.2% | 66.7% | 59.5% | 87.0% | | |
| Mandatory Training | W | 87.1% | 84.8% | 85.6% | 86.7% | 86.9% | 87.8% | 89.0% | 87.1% | 87.8% | 88.2% | 88.4% | 88.9% | 88.4% | | >=90 % >=80 % <80 % |
| Sickness | D | 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% | | <=4 % <=4.5 % >4.5 % |
| Short Term Sickness | D | 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% | | <=1 % N/A >1 % |
| Long Term Sickness | D | 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% | | <=3 % N/A >3 % |
| Temporary Spend ('000s) | D | 446 | 505 | 415 | 434 | 382 | 560 | 518 | 459 | 334 | 447 | 469 | 532 | 363 | | |
| Safer Staffing (Shift Fill Rate) | W | 94.4% | 95.3% | 93.5% | 89.6% | 92.7% | 93.7% | 95.8% | 99.2% | 98.4% | 90.0% | 92.5% | 94.1% | 94.8% | | >=90 % >=80 % <90 % |





## Community & Mental Health Division

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| **SAFE** | **Lessons learnt from incidents include:**<br>• Reminder shared for medication quantities to be clearly spelled out when dictating and all clinic letters to be checked thoroughly before signing.<br>• Ensure that a child's skin should always be pre-checked prior to newly prescribed orthotics being provided. | **Highlight**<br>• Zero clinical incidents resulting in moderate harm, severe harm or death.<br>• Zero grade 3 or 4 pressure ulcers<br>• 104 incidents submitted in October, 76 clinical and 28 non-clinical<br>**Challenges**<br>• Vandalism incidents in the Catkin building – actions taken to secure building and support staff<br>• Paediatric acute admissions due to an Eating Disorder in 2021 has surpassed the total number for 2020 (55 admissions year to date). |
| **CARING** | **Lessons learnt from complaints include:**<br>• Further training to be provided to staff in the ADHD service when the referral form and Achenbach form results do not align | **Highlight**<br>• 29 Excellence Reports submitted<br>• 20 Compliments submitted<br>• Funding for 'trauma-informed classrooms' project across Liverpool and Sefton secured via Violence Reduction Programme<br>**Challenges**<br>• 2 formal complaints received in October – these relate to waiting time for Community Paediatrics and a communication concern in the ASD/ADHD service<br>• 50 PALS received in October. This is a reduction from September (62 PALS received) |
| **EFFECTIVE** | Two successful partnership bids for ASD commenced:<br>• Delivery of autism training in schools<br>• Provision of post diagnostic support for children and young people receiving an ASD diagnosis | **Highlight**<br>• Ongoing support provided from Community Nursing teams to virtual ward process<br>• Extension to Sefton Sensory Service commenced<br>**Challenges**<br>• Increase in outpatient admissions cancelled by the Trust and clinic cancellations <6 weeks' notice. This is due to an ongoing absence in the consultant community paediatrician team<br>• Significant increase in demand for Eating disorders service: 53 received in October 2021. |
| **RESPONSIVE** | Sensory environments project commenced with Contact and NHS England (national pilot) | **Highlight**<br>• 100% compliance with urgent Eating Disorder waiting time target. |

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| | | **Challenges** |
| | | • Reduction in Community Paediatrics RTT due to increase in referrals and consultant absence. A recovery trajectory has been created and shared through the Access to Care Delivery Group. |
| **WELL LED** | Learning Disability and Acute Liaison Team shortlisted as a finalist for RCN Learning Disability Nursing Award | **Highlight** |
| | | • Mandatory training remains above Trust target at 91.6%<br>• Staff survey response rate currently 59% |
| | | **Challenges** |
| | | • Sickness remains above Trust target at 6.1%. Management drop ins with HR continue to be provided to line managers on a weekly basis |

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# Community

D Drive W Watch P Programme

## SAFE

| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss | D | 16 | 10 | 16 | 5 | 5 | 9 | 7 | 12 | 7 | 11 | 5 | 8 | 5 | | No Threshold |
| Clinical Incidents resulting in No Harm | D | 84 | 76 | 53 | 63 | 75 | 84 | 74 | 54 | 51 | 92 | 64 | 51 | 64 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm | D | 11 | 12 | 9 | 11 | 21 | 35 | 28 | 19 | 11 | 20 | 10 | 13 | 7 | | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | No Threshold |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Medication Errors (Incidents) | | 33 | 26 | 16 | 19 | 17 | 23 | 17 | 9 | 9 | 10 | 8 | 12 | 18 | | No Threshold |
| Pressure Ulcers (Category 3) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Pressure Ulcers (Category 4) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Pressure Ulcers (Category 3 and above) | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Cleanliness Scores | | 98.8% | | | | | 100.0% | | 99.0% | 97.5% | | 86.8% | | | | No Threshold |
| CCNS: Advanced Care Plan for children with life limiting condition | | 0 | | | | | | | | | | | | | | No Threshold |
| CCNS: Prescriptions | | 0 | | | | | | | | | | | | | | No Threshold |

## CARING

| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints | W | 1 | 4 | 2 | 5 | 4 | 3 | 1 | 0 | 8 | 0 | 3 | 4 | 2 | | No Threshold |
| PALS | W | 32 | 17 | 15 | 14 | 39 | 41 | 40 | 50 | 55 | 39 | 35 | 62 | 50 | | No Threshold |

## EFFECTIVE

| | | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referrals Received (Total) | | 979 | 1,048 | 847 | 776 | 880 | 1,106 | 911 | 1,315 | 1,321 | 1,055 | 718 | 1,013 | 1,091 | | No Threshold |
| Hospital Initiated Clinic Cancellations < 6 weeks notice | | 18 | 2 | 5 | 7 | 10 | 7 | 11 | 5 | 9 | 21 | 22 | 17 | 25 | | No Threshold |
| OP Appointments Cancelled by Hospital % | | 10.0% | 11.4% | 8.1% | 12.7% | 9.8% | 12.3% | 11.6% | 8.9% | 10.4% | 12.0% | 13.7% | 10.7% | 14.8% | | <=5 % <=10 % >10 % |
| Was Not Brought Rate (New Appts) | W | 11.7% | 8.3% | 8.1% | 8.9% | 10.2% | 13.5% | 12.7% | 14.0% | 10.3% | 15.6% | 10.3% | 17.0% | 21.0% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) | W | 13.3% | 11.3% | 13.4% | 12.3% | 10.8% | 13.2% | 13.9% | 13.4% | 12.9% | 15.3% | 15.9% | 14.6% | 15.9% | | <=14 % <=16 % >16 % |
| Was Not Brought Rate (New Appts) - Community Paediatrics | | 16.4% | 10.6% | 9.3% | 10.8% | 15.1% | 17.5% | 16.7% | 17.7% | 13.7% | 18.5% | 15.0% | 16.8% | 15.8% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) - Community Paediatrics | | 16.0% | 12.3% | 16.2% | 17.5% | 14.6% | 17.7% | 17.4% | 16.7% | 18.6% | 22.1% | 24.1% | 23.9% | 22.0% | | <=14 % <=16 % >16 % |
| Was Not Brought Rate (CHOICE Appts) - CAMHS | | 12.8% | 13.3% | 13.5% | 20.3% | 11.5% | 15.1% | 6.9% | 15.8% | 11.7% | 23.4% | 19.7% | 12.6% | 16.8% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (All Other Appts) - CAMHS | | 13.2% | 11.9% | 13.8% | 11.9% | 10.8% | 13.3% | 14.4% | 14.0% | 13.3% | 16.0% | 16.2% | 12.6% | 14.0% | | <=14 % <=16 % >16 % |
| CAMHS: Tier 4 DJU % Bed Occupancy At Midday | | 107.8% | 91.0% | 109.7% | 110.1% | 106.6% | 114.3% | 113.3% | 114.3% | 112.9% | 100.0% | 99.5% | 101.4% | 122.6% | | No Threshold |
| CAMHS: Tier 4 DJU Bed Days | | 235 | 191 | 239 | 238 | 210 | 248 | 239 | 248 | 237 | 217 | 216 | 214 | 267 | | No Threshold |
| Coding average comorbidities | | 4.50 | 3.33 | 3.00 | 3.00 | | 4.00 | 9.00 | | 2.00 | | 8.00 | | | | No Threshold |
| CCNS: Number of commissioned packages | | 0 | | | | | | | | | | | | | | No Threshold |

## RESPONSIVE

| | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CAMHS: Tier 4 Admissions To DJU | | 2 | 2 | | 1 | | 1 | | | | | 1 | 1 | | No Threshold |
| CAMHS: Referrals Received | 348 | 417 | 340 | 268 | 351 | 469 | 396 | 536 | 638 | 373 | 297 | 475 | 526 | | No Threshold |
| CAMHS: Referrals Accepted By The Service | 193 | 232 | 198 | 158 | 182 | 251 | 198 | 254 | 316 | 172 | 141 | 233 | 302 | | No Threshold |

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# Community

D Drive W Watch P Programme

| | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CAMHS: % Referrals Accepted By The Service | 55.5% | 55.6% | 58.2% | 59.0% | 51.9% | 53.5% | 50.0% | 47.4% | 49.5% | 46.1% | 47.5% | 49.1% | 57.4% | | No Threshold |
| RTT: Open Pathway: % Waiting within 18 Weeks (W) | 49.2% | 64.3% | 64.4% | 66.2% | 64.5% | 66.0% | 63.3% | 74.0% | 69.6% | 57.1% | 61.2% | 52.8% | 53.3% | | >=92 % / >=90 % / <90 % |
| Waiting List Size (W) | 795 | 756 | 800 | 785 | 911 | 911 | 828 | 765 | 808 | 971 | 1,147 | 1,208 | 1,530 | | No Threshold |
| Waiting Greater than 52 weeks - Incomplete Pathways (W) | 2 | 1 | 1 | 0 | 0 | 0 | 3 | 0 | 1 | 2 | 2 | 1 | 1 | | 0 / N/A / >0 |
| CAMHS: Crisis / Duty Call Activity | 598 | 720 | 698 | 650 | 804 | 807 | 744 | 756 | 717 | 573 | 367 | 674 | 563 | | No Threshold |
| CAMHS: RTT (First Partnership) % waiting within 18 weeks (W) | 68.8% | 70.0% | 69.9% | 65.9% | 67.9% | 67.3% | 65.6% | 68.0% | 70.1% | 69.3% | 68.3% | 63.8% | 63.9% | | >=92 % / >=90 % / <88 % |
| ASD: Completed Pathways | 138 | 124 | 61 | 84 | 85 | 104 | 103 | 131 | 125 | 66 | 207 | 30 | 44 | | No Threshold |
| ASD: Completed Pathway Compliance (% within 18wks) | 94.2% | 90.3% | 85.2% | 63.1% | 78.8% | 68.3% | 24.3% | 20.6% | 16.0% | 7.6% | 3.9% | 13.3% | 6.8% | | >=92 % / >=90 % / <90 % |
| EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%) (P) | | | 100.0% | 91.7% | 100.0% | 46.2% | 16.7% | 23.5% | 28.6% | 6.7% | 21.4% | 10.5% | 23.8% | | No Threshold |
| EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%) (P) | | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 25.0% | 100.0% | 50.0% | 100.0% | 66.7% | 100.0% | | >=95 % / >=92 % / <92 % |
| CCNS: Number of Referrals (W) | 146 | 151 | 127 | 119 | 139 | 169 | 120 | 135 | 150 | 582 | 144 | 143 | 165 | | No Threshold |
| CCNS: Number of Contacts (D) | 1,038 | 877 | 844 | 783 | 826 | 896 | 791 | 821 | 835 | 959 | 809 | 736 | 931 | | No Threshold |

## WELL LED

| | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) (W) | 369 | 270 | 45 | 321 | 221 | -41 | 14 | 212 | -11 | 287 | 250 | 540 | 16 | | |
| Income In Month Variance (£'000s) (W) | 397 | 155 | 75 | 148 | 996 | 150 | 94 | 88 | 50 | 154 | 75 | 118 | -78 | | |
| Pay In Month Variance (£'000s) (W) | -81 | 30 | 12 | 65 | -81 | 137 | 5 | -49 | -87 | 260 | 167 | 15 | 142 | | |
| AvP: OP New | 758.00 | 781.00 | 589.00 | 643.00 | 522.00 | 614.00 | 113.50 | 351.95 | 654.00 | -102.00 | -2.30 | -134.00 | 557.00 | | >=0 / N/A / <0 |
| AvP: OP FollowUp | 3,555.00 | 3,799.00 | 3,377.00 | 3,814.00 | 3,794.00 | 4,105.00 | 1,433.90 | 1,396.84 | 4,192.00 | 1,004.00 | 668.30 | 1,171.00 | 3,290.00 | | >=0 / N/A / <0 |
| AvP: Outpatient Activity vs Plan (W) | 4,313 | 4,580 | 3,966 | 4,459 | 4,316 | 4,719 | 1,548 | 1,749 | 4,846 | 902 | 666 | 1,038 | 3,847 | | >=0 / N/A / <0 |
| PDR (W) | 73.4% | 81.9% | 81.9% | 83.1% | 83.1% | 83.1% | 0.0% | 1.5% | 21.5% | 71.5% | 78.8% | 81.0% | 80.9% | | |
| Medical Appraisal (W) | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 6.2% | 24.0% | 24.0% | 36.0% | 68.0% | 48.0% | 80.0% | | |
| Mandatory Training (W) | 91.7% | 89.2% | 88.4% | 89.2% | 88.6% | 89.3% | 91.8% | 91.0% | 92.3% | 92.1% | 91.9% | 91.4% | 91.6% | | >=90 % / >=80 % / <80 % |
| Sickness (D) | 4.0% | 4.3% | 4.5% | 5.7% | 4.7% | 3.9% | 3.1% | 3.9% | 4.9% | 5.6% | 6.4% | 5.7% | 6.0% | | <=4 % / <=4.5 % / >4.5 % |
| Short Term Sickness (D) | 1.6% | 1.2% | 0.9% | 1.9% | 1.0% | 1.0% | 0.9% | 1.2% | 1.5% | 1.4% | 1.5% | 1.4% | 2.1% | | <=1 % / N/A / >1 % |
| Long Term Sickness (D) | 2.5% | 3.2% | 3.6% | 3.8% | 3.7% | 2.9% | 2.2% | 2.7% | 3.5% | 4.2% | 4.9% | 4.3% | 4.0% | | <=3 % / N/A / >3 % |
| Temporary Spend ('000s) (D) | 173 | 212 | 355 | 226 | 169 | 141 | 183 | 192 | 229 | 171 | 127 | 168 | 192 | | |
| Staff Turnover (D) | 9.7% | 9.0% | 8.7% | 9.3% | 9.5% | 9.8% | 10.7% | 9.6% | 9.8% | 9.9% | 9.9% | 10.1% | 11.0% | | <=10 % / <=11 % / >11 % |
| Safer Staffing (Shift Fill Rate) (W) | 100.1% | 98.5% | 98.6% | 99.9% | 99.4% | 100.2% | 97.2% | 99.1% | | 99.2% | 98.9% | 96.3% | 108.0% | | >=90 % / >=80 % / <90 % |







# Research Division

| | | |
|---|---|---|
| **SAFE** | • Divisional Mandatory training demonstrates good compliance<br>• All current risks compliant with review dates<br>• CRF achieved 100% for perfect ward audit<br>• All patients continue to be screened for potential COVID 19 prior to hospital visit using telephone triage<br>• All Areas have been certified Covid Secure (all actions completed) | **Highlight**<br>• PDR Target of >90% met<br>• Mandatory Training > 94%<br>• GCP training 97%<br>• SOP compliance 98%<br>• ANTT compliance 100%<br>• CRD ICP compliant<br>• CRD involved in Trust Quality Rounds<br>**Challenges**<br>• Limited storage space on CRF causing H&S risk<br>• Research blood samples for multiple trials<br>• X1 incidents reported in month |
| **CARING** | • 0 complaints received<br>• Patient centred follow up care for patients on clinical trials<br>• Patient feedback used to improve quality of patient care and experience<br>• Plans underway to capture patient experience data<br>• Patient compliments received for CRF | **Highlight**<br>• X 0 Complaints or PALS concerns<br>• New Children's PRES developed for 21/22 ongoing<br>• Research participating in Trust PEG<br>**Challenges**<br>• More work to do on local patient internal audits<br>• Low numbers of electronic survey questionnaires from patients on system |
| **EFFECTIVE** | • Studies stratified and selected based on best possible outcomes for children and young people.<br>• Current portfolio regularly reviewed with monthly performance meetings<br>• No housekeeping allocated to CRF ward. Nursing staff arranging and collection meals for patients.<br>• Clinicians encourage children and young people to make informed decisions about participating in studies.<br>• CRD performance reports and meetings review the portfolio monthly<br>• Essential skills training approved for Division | **Highlight**<br>• Important Covid 19 studies remain open within Trust<br>• Trust participating in extension COV09 vaccine study with LSTM.<br>• Stop RSV in set up for site for Crit Care areas<br>• Portfolio growth in line with plan.<br>**Challenges**<br>• CRF housekeeping<br>• CRD working with local system partners to improve research participation.<br>• Significant issues with recruitment process has delayed backfilling a number of vacancies affecting timely opening of new studies |
| **RESPONSIVE** | • All Staff Risk Assessments completed as required<br>• New local systems and processes have been implemented to improve safety of staff, promote better team working to ensure safe staffing and cover for sickness, leave.<br>• H&S Covid RA's completed for all areas of research<br>• Coordinated and partnership working with local providers to offer joint training programmes. | **Highlight**<br>• Agile working implemented to reduce footfall<br>• Collaborative working with external partners<br>• TNA requests for CPD training approved for all applicants<br>• Staff engagement sessions held following service re-org<br>**Challenges**<br>• Storage for site files and equipment is insufficient for research department<br>• Research team supporting Trust seasonal vaccine programme |

| | | |
|---|---|---|
| **WELL LED** | • Staff are supported through line managers and staff support.<br>• Thematic review has been completed for reasons of sickness (non-work related)<br>• LTS numbers have reduced.<br>• Engagement with partners in relation to upcoming starting well initiatives.<br>• Recruitment programme was successful with a number of staff appointed to vacancies<br>• Service Re-organisation process now complete<br>• FAQ to be shared with affected staff.<br>• A number of bids submitted from Trust to CRN under contingency funding to support performance with recovery plan. | **Highlight**<br>• Division supporting staff with Flexible working (hybrid model)<br>• Big Conversation action plan in progress<br>• CRN feedback re finances better managed received working within healthy vacancy control factor.<br>• CRN 21/22 forecast stable in Q2<br>• A number of bids submitted from Trust to CRN under contingency funding to support performance with recovery plan where successful<br>• CRD engaging staff with SALS<br>• All staff being offered protected time to complete staff survey<br>• Core business hours established through recent service re-org<br>• Digital business partner identified<br>**Challenges**<br>• CRD overall financial deficit to be reduced following recovery from pandemic<br>• Correct model for the future working to be established<br>• Some staff will experience changes to working patterns period of adjustment needed<br>• Some staff who have recently returned to work are completing phased return which reduces capacity<br>• Increase in long term sickness absence is currently above Trust Target. |

Alder Hey Children's NHS
NHS Foundation Trust

# BOARD OF DIRECTORS

**Thursday, 25th November 2021**

| | |
|---|---|
| **Paper Title:** | **Wellbeing Pledge** |
| **Report of:** | **Melissa Swindell – Chief People Officer** |
| **Paper Prepared by:** | Melissa Swindell |

| | |
|---|---|
| **Purpose of Paper:** | Decision x<br>Assurance ☐<br>Information ☐<br>Regulation ☐ |
| **Background Papers and/or supporting information:** | North West Wellbeing Pledge Slides |
| **Action/Decision Required:** | To note ☐<br>To approve x |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ☐<br>**The best people** doing their best work x<br>Sustainability through **external partnerships** ☐<br>Game-changing **research and innovation** ☐<br>**Strong Foundations** ☐ |
| **Resource Impact:** | n/a |

# Our pledge for the **wellbeing of our NHS people**

Insert organisation logo

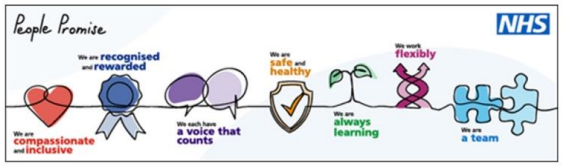
Signed……

Name……

**We pledge to shifting the focus from sickness absence (the 5%) to holistic wellbeing for everyone:**

- **preparing our board for the change** to take a more holistic, person-centred individual and flexible approach, which is driven through policy and aligns with embedding a just culture.
- **evidencing that wellbeing is a priority with our board by** understanding the wellbeing of our people, giving them a voice, making sure all decisions have a wellbeing lens applied and addressing any issues.
- **committing to the three North West's themes of enabling work**
  - Holistic wellbeing services that support all of our colleagues
  - a new person-centred wellbeing approach and an attendance management policy framework
  - leadership development that supports managers in our new approach.

NHS Employers in association with NHS RAND EUROPE social partnership forum



# North West

- ✓ Pledges
- ✓ Timescales
- ✓ Next steps

# Pledges to make the change a reality

**We pledge to shifting the focus from sickness absence (the 5%) to holistic well-being for everyone:**

- **Preparing our Board for the change:**
  -Why presenteeism is of at least equal importance to sickness absence
  -Significant policy shift - from a focus on sickness absence to holistic well-being and from rigid attendance management to a more person centred & flexible approach
  -Considerations for ethics, equality, diversity and inclusion - moving away from treating everyone the same to more individualised and person-centred approaches
  -How the approach aligns with embedding a just culture

- **Evidencing that well-being is a priority at our Trust Board by:**
  -Understanding the well-being of our people and how we are meeting their needs, giving staff a safe voice
  -Showing how a well-being lens is applied to all decisions
  -Understanding our organisation's culture, including what has been normalised, taking positive action to address the issues and support our People

- **Committing to the three NW themes of enabling work:**
  -Holistic well-being services that support all of our colleagues
  -A new person-centred well-being and attendance management policy framework
  -Leadership development that supports managers in our new approach

# Timescales and Next steps

**Timescales**

By the end of November 2021 - Pledges and your reflections from today discussed at Board

By the end of December 2021 - Agree your organisation's enabling action plan at Board

Monitor progress at Board and sub-committees on at least a quarterly basis

**How HRD's, staff side and well-being experts will help:**

- Sharing systems / processes to help organisations gain a better understanding of well-being

- Develop evidence-based NW frameworks that take forward the three regional enabling programmes of work
  - Develop a service framework to deliver holistic high quality well-being services for all of our colleagues
  - Develop a NW well-being and attendance management policy framework that supports flexibility and considers individual circumstances
  - Develop a well-being leadership development framework that enables line managers to lead with confidence

- Develop robust evaluation arrangements, working with an independent research partner

Alder Hey Children's NHS
NHS Foundation Trust

**Trust Board**

**Thursday 25th November 2021**

| | |
|---|---|
| **Paper Title:** | **21/22 H2 Financial Plan** |
| **Report of:** | **Director of Finance** |
| **Paper Prepared by:** | **Rachel Lea**<br>**Acting Director of Finance** |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ☒<br>Information ☐<br>Regulation ☐ |
| **Background Papers and/or supporting information:** | Paper provides background reading and key information. |
| **Action/Decision Required:** | To note ☒<br>To approve ☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ☐<br>**The best people** doing their best work ☐<br>Sustainability through **external partnerships** ☐<br>Game-changing **research and innovation** ☐ |
| **Resource Impact:** | |

Alder Hey Children's NHS
NHS Foundation Trust

# 21/22 H2 Financial Plan

## Executive Summary

The purpose of this paper is to provide an update on the H2 financial plan that has been submitted as part of the C&M final plan. The paper will outline the changes since the last Trust Board meeting, highlighting the movements in the system allocations along with further mitigations that have happened to improve the overall H2 plan.

The key points to highlight from this paper are:

1. The movement from a forecast H2 deficit of £8.8m to a breakeven plan submitted.
2. Revisions in activity forecasts both from Alder Hey and C&M which has now resulted in an ERF potential income source for H2.
3. Submission of national bids over the most recent weeks and the mitigation that this funding provides if approved.
4. Risks regarding the delivery of activity plans but also the uncertainty regarding winter pressures and Urgent Care.

## Alder Hey 21/22 I&E H2 Position

The first draft H2 plan was presented to the Trust Board in October and at this stage the forecast shown was a £8.8m deficit which was driven largely by shortfalls in income to cover areas such as pay award and loss ERF contribution.

Table 1.1 – H2 Forecast Position as at October 21

| | £m |
|---|---|
| H1 Reported Position | 0 |
| Remove ERF contribution | -4.4 |
| Reduction system top up from H1 | -1.8 |
| Pay award pressure | -1.4 |
| Cost increases (winter/activity) | -1.2 |
| **Current Draft H2 position** | **-8.8** |

Further work has been undertaken both internally and across C&M and a further two submissions made taking the deficit from £8.8m a £4.7m deficit, largely driven by a validation and increase in our projected income for H2.

The bridge and movements are shown in table 1.2 below:

Table 1.2 – Bridge of movements since October position

| | £`000 |
|---|---|
| **H2 Deficit October TB** | **-8,800** |
| | |
| *Changes:* | |
| Pay award recalculation | 1400 |
| Block income recalculation | 400 |
| **H2 Deficit submission 9/11** | **-7,000** |
| | |
| *Changes:* | |
| Increase CIP to 2.5%* | 620 |
| ERF Income H2** | 1000 |
| TIF funding critical care*** | 685 |
| **H2 Revised position as at 15/11** | **-4,695** |

Notes to explain the movements:

*C&M requested all providers to increase H2 CIP in plans to 2.5% from the 2.17% set out in the national planning guidance to reduce the overall system deficit.

**Latest activity plans indicate that both Alder Hey and the C&M system, will achieve above the 89% ERF threshold and therefore an estimated income level has been included in line with all other C&M providers.

***Confirmation has been received that the recent bid made for revenue funding to support critical care nursing has been successful and therefore will offset costs included in the plan.

Latest position

We, along with the other specialist trusts, have been actively lobbying with C&M ICS regarding the inequitable distribution of system funds and not resolving the ERF loss contribution, inherent in our forecast due to the H1 methodology.

In response to this, a proposal was shared by the ICS which reallocated contingency funding out to providers, in a bid to rectify the issues raised and to improve the deficit positions across providers,

Financial principles have been outlined in this proposal and the full detail can be shared, however the headlines of the revised distributions methodology include:

- 100% coverage of existing system-level commitments
- Rectification of any H2 funding shortfall in respect of agenda for change staff
- Compensation of Specialist Providers for the impact of the ERF contribution loss on H1
- Distribution of the remaining balance amongst all Providers in proportion to Total Operating income from patient care services as per H2 Finance Plan.

Although this initial proposal reallocated a higher amount of income to specialist providers, a recalculation was carried out due to discussions held across C&M with all providers. The re-calculation for Alder Hey results in a further £1.3m of system allocation reducing our potential deficit to £3.4m.

Whilst this redistribution does not resolve the full £4.7m issue, it has been noted and recognised with ICS and across C&M that there is still work to be done on ensuring that all organisations can achieve a breakeven position and that this will be the fundamental principle on which H2 plans are made. On this basis all organisations was requested to submit a breakeven plan with the following areas still to be resolved:

- ERF – C&M are likely to receive ERF, however there are issues with several organisations data including Alder Hey which means it is currently difficult to accurately forecast the full distribution that could be paid. Once resolved this could increase the system income and allow for further distributing.
- National funding – further system or national funding to be used to support residual risk.

Risks and Mitigations to be considered

Risks:

- Continuation and escalation of winter and urgent care pressures, reducing the ability to deliver the elective recovery plans and generate £1m ERF assumed
- Delivery of the £6m CIP programme assumed in the plan as only 50% achievement to date.
- Deterioration of current expenditure run rate to meet peaks in demand and elective recovery plans.
- Reduction in cash if the gap is not resolved through either cost reduction or increase in system income allocation.

Mitigations and Opportunities:

- Slippage in system funds and new funding received, allows for further redistribution to trusts.
- Opportunity to review technical charges to reduce the in-year cost and impact for H2 with release of reserve held for annual leave and other technical charges.
- National funding and bids continue to be released almost daily, and the Trust are actively submitting bids to secure funding for current and emerging pressures which if successful will cover existing spend in the plan reducing the gap.

**Conclusion**

A scenario analysis has been carried out based on the latest position and, on this basis and noting the risks and mitigations outlined above and given the clear direction of the ICS, the Trust did submit a breakeven plan with a number of caveats and assumption.

The Trust Board are asked to note the contents of this paper.

Alder Hey Children's NHS Foundation Trust

**BOARD OF DIRECTORS**

**Thursday, 25th November 2021**

| | |
|---|---|
| **Paper Title:** | **Board Assurance Framework 2021/22 (October)** |
| **Report of:** | Erica Saunders, Director of Corporate Affairs |
| **Paper Prepared by:** | Executive Team and Governance Manager |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ■<br>Information ☐<br>Regulation ☐ |
| **Background Papers and/or supporting information:** | Monthly BAF Reports |
| **Action/Decision Required:** | To note ■<br>To approve ☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ■<br>**The best people** doing their best work ■<br>Sustainability through **external partnerships** ■<br>Game-changing **research and innovation** ■<br>**Strong Foundations** ■ |
| **Resource Impact:** | Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust. |

# Board Assurance Framework 2020/21

## 1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 12 principal risks aligned to the Trust's strategic objectives.

A properly used BAF will drive the agendas for the Board and its Committees. The Board Assurance Committees therefore review the BAF in advance of its presentation to the Trust Board and propose any further changes following Exec Lead monthly reviews to ensure that it remains current, that the appropriate strategic risks are captured and that the planned actions and controls are sufficient to mitigate the risks being identified.

The newly formed Risk Management Forum (monthly risk management meeting) is responsible for the Corporate Risk Register and for oversight of the Divisional Risk Registers and reports into the Audit and Risk Committee.

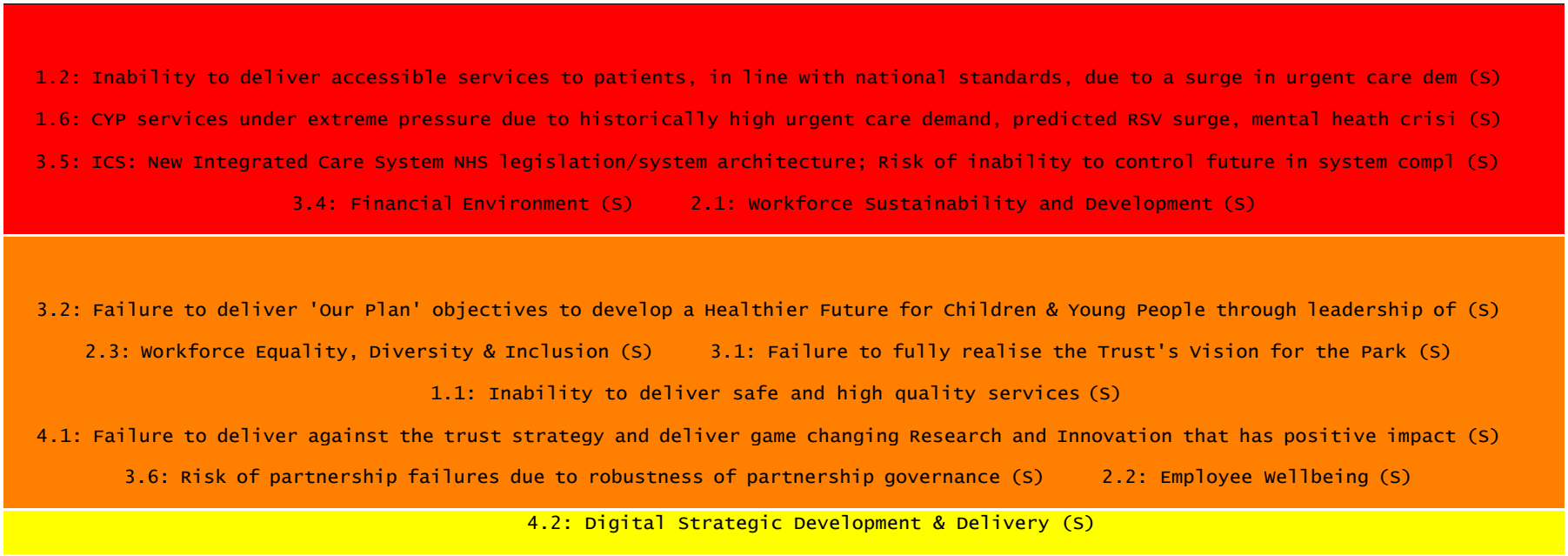
## 2. Review of the BAF

Strategic risks can often span across more than one area of accountability. The Board Committees are therefore provided with the whole BAF in case they need to refer to areas of potential overlap or duplication with other BAF risks ensuring a holistic joined-up approach. Responsibility to review and gain assurance to controls and any required actions are detailed below:

| BAF Risk | | Reviewed By |
|---|---|---|
| 1.1 | Inability to deliver safe and high quality services | Safety & Quality Assurance Committee |
| 1.2 | Inability to deliver accessible services to patients, in line with national standards, due to a surge in urgent care demand, respiratory infections and the impact of COVID-19 | Safety & Quality Assurance Committee |
| 1.6 | CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of COVID. | Safety & Quality Assurance Committee |
| 2.1 | Workforce Sustainability and Development | People & Wellbeing Committee |
| 2.2 | Employee Wellbeing | People & Wellbeing Committee |
| 2.3 | Workforce Equality, Diversity & Inclusion | People & Wellbeing Committee |
| 3.1 | Failure to fully realise the Trust's Vision for the Park | Resources and Business Development Committee |
| 3.2 | Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships. | Resources and Business Development Committee |
| 3.4 | Financial Environment | Resources and Business Development Committee |
| 3.5 | ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment | Resources and Business Development Committee |
| 3.6 | Risk of partnership failures due to robustness of partnership governance | Resources and Business Development Committee |
| 4.2 | Digital Strategic Development and Delivery | Resources and Business Development Committee |
| 4.1 | Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People. | Innovation Committee |

### 3. Overview at 12th November 2021

The diagram below gives a high level heliview of the current version, followed by a summary and a brief on the changes since the last Board meeting.




**Trend of risk rating indicated by: NEW, B - Better, S - Static, W – Worse**
***Report generated by Ulysses***

Corporate risks are linked to BAF Risks – a summary of these risks can be found at appendix A. The full BAF document is included as Appendix B which reflects the active review of risks, any changes to risk ratings, progress against existing actions, gaps in controls and review of the adequacy of mitigations.

## 4. Summary of BAF - at the 12th November 2021

The diagram below shows that all risks remained static in-month.

| Ref, Owner | Risk Title | Board Cttee | Risk Rating: I x L | | Monthly Trend | |
|---|---|---|---|---|---|---|
| | | | Current | Target | Last | Now |
| **STRATEGIC PILLAR:** Delivery of Outstanding Care | | | | | | |
| 1.1 NA | **Inability to deliver safe and high quality services.** | SQAC | 3x3 | 2x2 | STATIC | STATIC |
| 1.2 AB | **Inability to deliver accessible services to patients, in line with national standards, due to a surge in urgent care demand, respiratory infections and the impact of COVID-19** | SQAC | **4x5** | 3x2 | STATIC | STATIC |
| 1.6 JG | **CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of COVID.** | SQAC | **4x5** | 4 x3 | STATIC | STATIC |
| **STRATEGIC PILLAR:** The Best People Doing Their Best Work | | | | | | |
| 2.1 MS | **Workforce Sustainability and Development.** | PAWC | 4x4 | 3x2 | STATIC | STATIC |
| 2.2 MS | **Employee Wellbeing.** | PAWC | 3x3 | 3x2 | STATIC | STATIC |
| 2.3 MS | **Workforce Equality, Diversity & Inclusion.** | PAWC | 4x3 | 3x2 | STATIC | STATIC |
| **STRATEGIC PILLAR:** Sustainability Through External Partnerships | | | | | | |
| 3.1 DP | **Failure to fully realise the Trust's Vision for the Park.** | RABD | 3x3 | 3x2 | STATIC | STATIC |
| 3.2 DJ | **Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships.** | RABD | 4x3 | 4x2 | STATIC | STATIC |
| 3.4 JG | **Financial Environment.** | RABD | **4x4** | 4x3 | STATIC | STATIC |
| 3.5 DJ | **ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.** | RABD | 4 x4 | 3 x3 | **INCREASED** | STATIC |
| 3.6 DJ | **Risk of partnership failures due to robustness of partnership governance.** | RABD | 3x3 | 3 x2 | STATIC | STATIC |
| **STRATEGIC PILLAR:** Game-Changing Research And Innovation | | | | | | |
| 4.1 CL | **Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People.** | Innovation | 3x3 | 3x2 | STATIC | STATIC |
| 4.2 KW | **Digital Strategic Development and Delivery.** | RABD | 4x1 | 4x1 | STATIC | STATIC |

## 5. Summary of October's updates:

### External risks

- ***Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children and Young People through leadership of 'Starting Well' and Children and Young People's systems partnerships (DJ).***
  Risk reviewed; no change to score in month. Recognition that this risk will develop alongside evolving 2030 Strategy in the new year. Action re CYP programme complete.

- ***ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment (DJ).***
  Risk reviewed; no change to score in month. MIAA assurance undertaken to calibrate risk. Controls, evidence and actions updated.

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk reviewed; no change to score in month. Partnership Assurance Framework developed; identification of partner to test approach underway. Executive review of draft framework complete; NED discussion pending.

- ***Workforce Equality, Diversity & Inclusion (MS).***
  Risk reviewed and actions updated.

### Internal risks:

- ***Inability to deliver accessible services to patients, in line with national standards, due to a surge in urgent care demand, respiratory infections and the impact of COVID-19 (AB).***
  In October there was a positive increase in the recovery of services. Elective care was 103% of 2019 activity levels, and outpatient care 94% (provisional figure). In month there has been a reduction in the number of children and young people, but this will increase in November as we have deployed the new outpatient waiting list w/c 8th November and concluded the outpatient validation work through the safe waiting list management programme. As contained in our previous 52 week performance there has been an increase in the number of long wait patients from the Safe Waiting List Management programme. We finalised our half 2 autumn and winter plan to keep staff safe and to deliver safe care. This includes a number of interventions designed to protect access to elective care, critical care and improve the timeliness of urgent care.

- ***CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of COVID (AB).***

In October attendances were 16.5% above 2019 levels. The number of children treated within 4 hrs was 72.5%. We have observed an increase in acuity (as indicated by triage scores) and higher respiratory infections. We are testing a number of enhanced processes including an increased use of rapid senior assessment ('dr in a box'). We have received an external report on Emergency Department demand, staffing profile and departmental processes. We are prioritising the implementation of a recommendation to increase clinical cover overnight (due date January 2022). We have submitted two significant schemes to the ICS to create more paediatric urgent care capacity: respiratory clinics in two community hubs in the community and a multi-disciplinary (health visitor and GP) urgent care service at Alder Hey. We are aiming to start both services with partners in January 2022.

- ***Inability to deliver safe and high quality services (NA).***
  The risk has been reviewed. Current controls in place remain on track with particular improvement in all 3 quality priorities. Quality work across the organisation continues to recover following Covid-19 and will provide additional assurance against the gaps detailed.

- ***Financial Environment (JG).***
  Risk reviewed and updated with latest position and progress on actions. Key area still remains H2 uncertainty and capital plans.

- ***Failure to fully realise the Trust's Vision for the Park (DP).***
  Updated prior to November's Trust Board.

- ***Digital Strategic Development and Delivery (KW).***
  Risk reviewed, good progress against actions.

- ***Workforce Sustainability and Development (MS).***
  Risk score remains high. Risk of lower staff availability due to potential national strike action added to this risk.

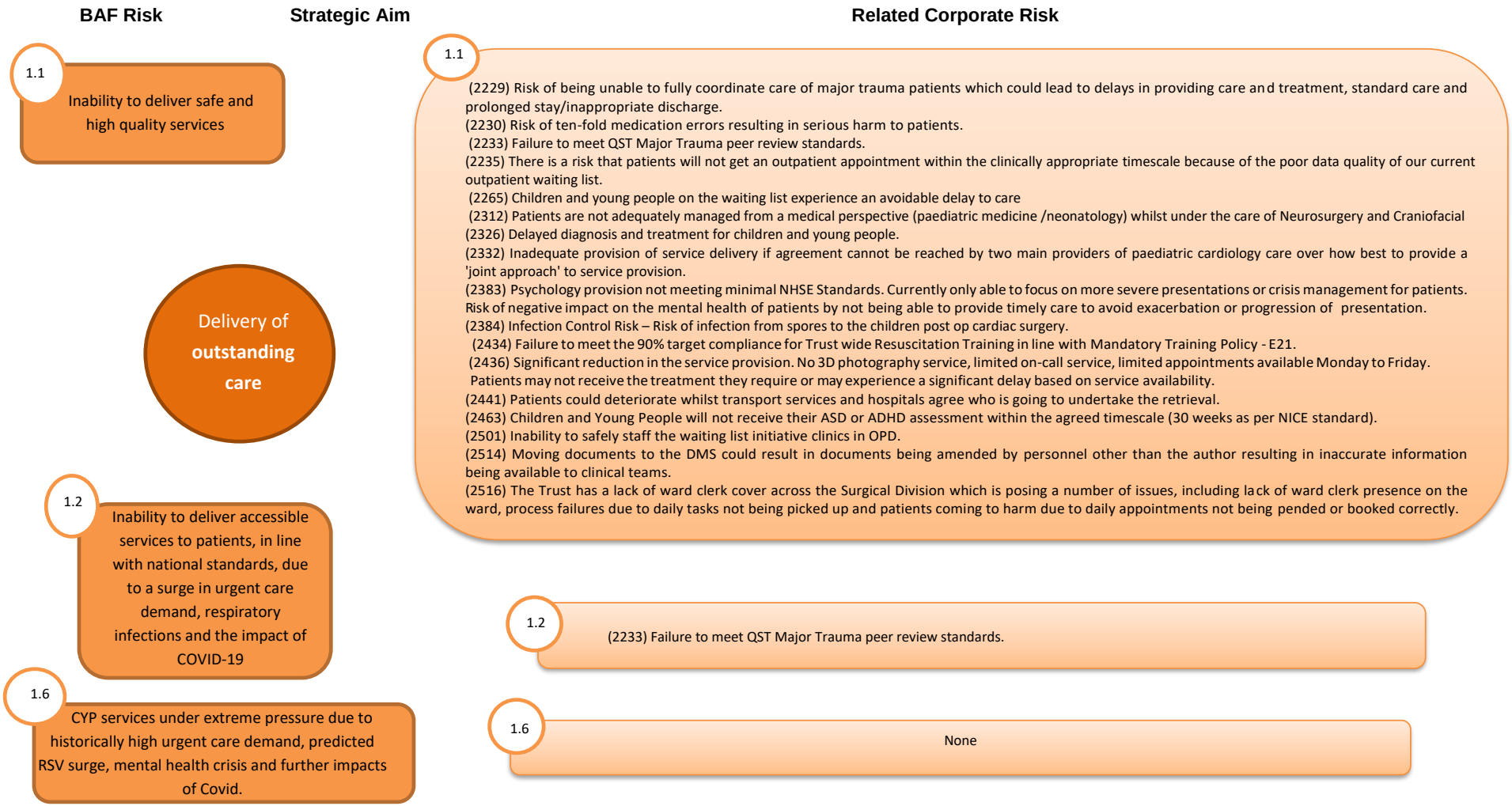
- ***Employee Wellbeing (MS).***
  Risk reviewed and controls and actions reviewed. Action added regarding additional support for ED through the winter period and other actions updated. No change to overall risk rating.

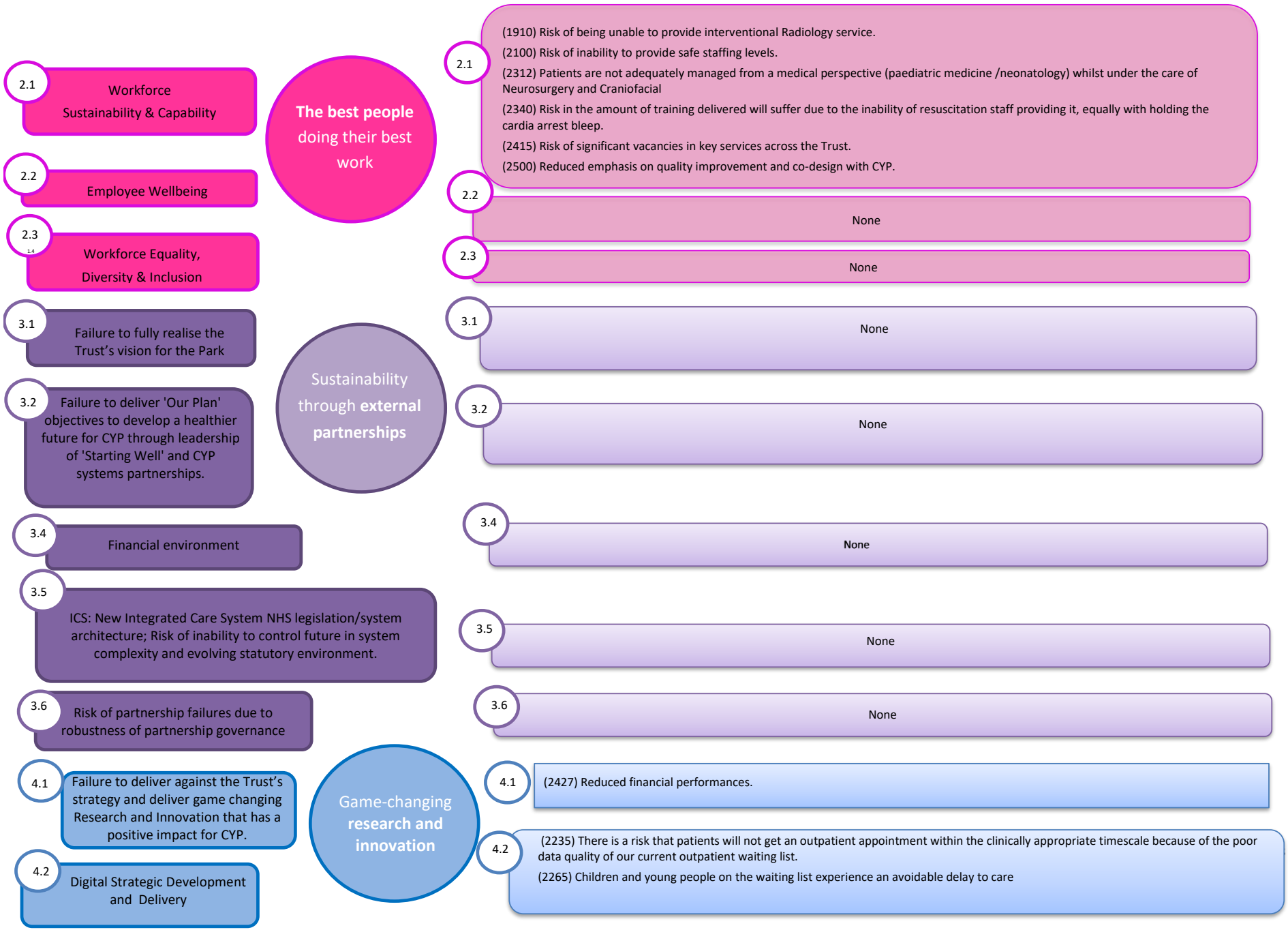
- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People (CL).***
  November review – Risk static.

**Erica Saunders**
**Director of Corporate Affairs**

## Appendix A

## Links between BAF and high scored risks – as at 12th November 2021




2.1 Workforce Sustainability & Capability
2.2 Employee Wellbeing
2.3 Workforce Equality, Diversity & Inclusion
The best people doing their best work
(1910) Risk of being unable to provide interventional Radiology service.
(2100) Risk of inability to provide safe staffing levels.
(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial
(2340) Risk in the amount of training delivered will suffer due to the inability of resuscitation staff providing it, equally with holding the cardia arrest bleep.
(2415) Risk of significant vacancies in key services across the Trust.
(2500) Reduced emphasis on quality improvement and co-design with CYP.
2.1
2.2
None
2.3
None
3.1 Failure to fully realise the Trust's vision for the Park
3.2 Failure to deliver 'Our Plan' objectives to develop a healthier future for CYP through leadership of 'Starting Well' and CYP systems partnerships.
3.4 Financial environment
3.5 ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.
3.6 Risk of partnership failures due to robustness of partnership governance
Sustainability through external partnerships
3.1
None
3.2
None
3.4
None
3.5
None
3.6
None
4.1 Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for CYP.
4.2 Digital Strategic Development and Delivery
Game-changing research and innovation
4.1
(2427) Reduced financial performances.
4.2
(2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list.
(2265) Children and young people on the waiting list experience an avoidable delay to care

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| BAF 1.1 | Strategic Objective: Delivery Of Outstanding Care | Risk Title: Inability to deliver safe and high quality services | | |
|---|---|---|---|---|
| Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led | | Link to Corporate risk/s: 2265, 2383, 2427, 2326, 2384, 2436, 2332, 2415, 2100, 2501, 2312, 2441, 1560, 2414, 2461, 2340, 2229, 2434, 2233, 2463, 2235, 2475 | | |
| Exec Lead: Nathan Askew | Type: Internal, Known | Current IxL: 3x3 | Target IxL: 2x2 | Trend: STATIC |

**Assurance Committee:** Safety & Quality Assurance Commitee

**Risk Description**

Not having sufficiently robust, clear systems and processes in place to deliver high quality care and consistent achievement of relevant local, national and regulatory quality and experience standards.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I). | Annual QIA assurance report |
| Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance. | Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed vis Audit & Risk Committee minutes. |
| The Quality & Safety sections of the Corporate Report are reviewed and managed through SQAC and reported up to Trust Board | Safety & Quality Assurance Committee, Trust Board and Risk Management Forum. |
| Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide. | Patient safety meeting actions monitored through CQSG, learning bulletin produced. |
| Programme of quality assurance rounds is in place at service level which provides assurance against a range of local and national metrics. | Reports and minutes from Safety & Quality Assurance Committee |
| Under 'Building Brilliant Basics' programme, the Trust has developed three quality priorities and associated improvement programmes to demonstrate increased quality and safety outcomes | Improvement hub to generate monthly reports to SQAC |
| Ward to Board processes are linked to NHSI Oversight Framework | Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care. |
| Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement. | IPC action plan and Trust Board, Safety & Quality Assurance Committee, Divisional Quality Board minutes. |
| The Trust has a Patient Experience Group that reports against the workplan based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people. | Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures. |
| CQC regulation compliance | Progress against the CQC Action Plan monitoring via Board and sub-committees |
| monthly review meetings with each division are held with the Medical Director and Chief Nurse to provide assurance relating to the progress of RCA investigations and completion of subsequent action plans. | Monitoring reports will be available from each review meeting |
| The STAT education and training program is in place in theatre to improve safety awareness and culture | monitoring of the AfPP action plan and STAT program outcomes monitored through the Surgery Divisional Board |

**Gaps in Controls / Assurance**

1. Failure to meet administration of IV antibiotics within 1hr for C&YP with suspected sepsis
2. Patients with Mental Health needs are identified, risk assessed and appropriately managed within the organisation
3. Robust reduction programme in the number of medication incidents and near misses

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| The Quality Hub will work with the Trust Medication Safety Group to identify areas for improvement across a range of areas relating to prescribing, dispensing and administration of medication | 01/10/2021 | |

**Executive Leads Assessment**

November 2021 - Nathan Askew
The risk has been reviewed. Current control in place remain on track with particular improvement in all 3 quality priorities. Quality work across the organisation continues to recover following covid 19 and will provide additional assurance against the gaps detailed

October 2021 - Nathan Askew
This risk has been reviewed, controls for haps in assurance continue. There has been progress with all 3 safety priority workstreams with clear plans in place across medication safety, deterioration and parity of esteem.

September 2021 - Nathan Askew
the risk as been reviewed and updates undertaken of some control actions. Work continues in relation to gaps in assurance relating to medication safety. Other controls remain in place

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| BAF 1.2 | Strategic Objective: Delivery Of Outstanding Care | Risk Title: Inability to deliver accessible services to patients, in line with national standards, due to a surge in urgent care demand, respiratory infections and the impact of COVID-19 | | |
|---|---|---|---|---|
| Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective | | Link to Corporate risk/s: 2270, 2233 | | |
| Exec Lead: Adam Bateman | Type: Internal, Known | Current IxL: 4x5 | Target IxL: 3x2 | Trend: STATIC |

**Assurance Committee:** Safety & Quality Assurance Commitee

**Risk Description**

Failure to meet targets and internal performance metrics due to a lack of capacity relative to demand; a loss of capacity during COVID-19 has made access to care extremely challenging. Challenges with data quality could lead to sub-optimal waiting list management and delays to care.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Controls for waiting time in the Emergency Department (ED):<br>- Winter Plan with additional staffing and bed capacity<br>- ED Escalation & Surge Procedure<br>- Additional shifts to increase staffing levels to deal with higher demand<br>- Trust-wide support to ED, including new in-reach services (physiotherapy, Gen Paeds & CAMHS) | - Daily reports to NHS England<br>- Daily performance summary<br>- Monthly performance report to Operational Delivery Group<br>- Performance reports to RABD Board Sub-Committee<br>- Bed occupancy is good |
| Controls for referral-to-treatment times for planned care:<br>- Weekly oversight and management of waiting times by specialty<br>- Weekly oversight and management of long wait patients<br>- Use of electronic system, Pathway Manager, to track patient pathways<br>- Additional capacity in challenged specialties<br>- Access to follow-up is prioritised using clinical urgent signified by tolerance for delay | - Corporate report and Divisional Dashboards<br>- Performance reports to RABD Board Sub-Committee<br>- Use of electronic patient pathway forms to signify follow-up clinical urgency and time-frame |
| Controls for access to care in Community Paediatrics:<br>- Use of external partner to increase capacity and reduce waiting times for ASD assessments<br>- Investment in additional workforce for Speech & Language service in Sefton<br>- Weekly oversight and management of long wait patients | - Significant decrease in waiting times for Sefton SALT<br>- Corporate report and Divisional Dashboards<br>- Performance reports to RABD Board Sub-Committee |
| Controls for access to care in Specialist Mental Health Services:<br>- Investment in additional workforce in Specialist Mental Health Services<br>- Extension of crisis service to 7 days<br>- Weekly oversight and management of long wait patients | - Monthly performance report to Operational Delivery Group<br>- Corporate report and Divisional Dashboards |
| Use of Challenged Area Action Boards for collective improvement in waiting times | Challenge boards live for ED, Radiology and community paediatrics |
| Transformation programme:<br>- SAFER<br>- Best in Acute Care<br>- Best in Outpatient Care<br>- Best in Mental Health care | - Monthly oversight of project delivery at Programme Board<br>- Bi-monthly transformation project update to SQAC |
| Performance management system with strong joint working between Divisional management and Executives | - Bi-monthly Divisional Performance Review meetings with Executives<br>- Weekly 'Executive Comm Cell' meeting held<br>- SDG forum to address challenged areas and approve cases for investment where access to care is challenged. |
| Urgent clinic appointment service established for patients who are clinically urgent and where a face-to-face appointment is essential | New outpatient schedule in situ |
| Digital outpatient channel established - 'Attend Anywhere' | Weekly tracking of training compliance and number of patients consulted via a digital appointment |
| Urgent operating lists | |
| Weekly access to care meeting to review waiting times | Minutes |
| Winter & COVID-19 Plan, including staffing plan | |
| Additional weekend working in outpatients and theatres to increase capacity | |
| Safe waiting list management programme to ensure no child experiences harm whilst on a waiting list for treatment | |
| Clinical review of long waiting patients, and harm review SOP for patients who were not tracked optimally | |

**Gaps in Controls / Assurance**

1. addressing data quality and waiting list reporting issues through the actions contained in the 'Safe Waiting-list Management' programme: enhanced training programme; accurate waiting list and reports; validation of records affected by data quality issues; enhanced awareness through a communication and cultural piece on safe waiting list management.
2. 12 month elective restoration plan informed by modelling on capacity, demand, waiting times and workforce
3. Transformational projects in outpatients and theatres deliver increase in productivity to improve capacity, access to care and reduce waiting times
4. Provide additional capacity by sourcing capacity from the independent sector

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Alder Hey is one of five children's hospitals forming part of the "accelerator" programme, which aims to clear NHS backlogs at pace. The programme aspires to short-term delivery of 120% pre-Covid activity levels coupled with a legacy that will offer long-lasting sustainable benefits. Delivery in the 5 priority specialties to commence from July 2021. | 30/11/2021 | The accelerator scheme has been extended to the end of November as trusts have struggled to achieve high levels of activity. Specifically at Alder Hey there have been staffing challenges in theatres and OPs and a decision was taken not to undertake WLIs during July and August 2021 to give staff a rest. WLIs have resumed in September although take-up has been low, but more WLIs are planned for October and November.<br>Work has focussed on transformation and specifically theatres productivity, by putting in place a new theatre utilisation policy and tightening up on the scheduling processes. The new process is due to start early October. There has also been work undertaken to restore clinic templates to pre-Covid levels and talks with some of the specialties - whom are reluctant - are ongoing. |
| Safe Waiting List Management programme plan to deliver good data quality, clinical reviews, clinical harm review, accurate waiting list reporting and additional RTT training. | 31/10/2021 | The new OP PTL is due to be deployed first week in October 2021 following extensive operational review of a large number of validation queries. Data quality dashboard is well developed for IPs with OPs to be completed after the new OP PTL is "live". |
| Weekly specialty meetings to focus on booking IP TCI dates.<br>Provision of additional capacity - including Accelerator Bid.<br>Chronological booking.<br>Theatre transformation to focus on Day Case and start times with expectation to increase number of patients per list. | 30/09/2021 | |

**Executive Leads Assessment**

0 - No Reviewer Entered
In October we have seen a positive increase in the level of service recovery: elective care was 103% and outpatient services 94% (provisional data) relative to 2019. The increase was driven in part by an increase in weekend sessions.. Nonetheless, there are risks to in-week throughput and recovery: firstly, PICU surge requiring volunteers to move from elective care to critical care. Secondly, high bed occupancy caused by a 20% rise in attendances to ED. As contained in our previous 52 week performance there has been an increase in the number of long wait patients from the Safe Waiting List Management programme. Our recovery plan in quarter 3 is focused on in-week productivity through the new theatre scheduling policy, additional sessions and recruitment through the accelerator investment.

November 2021 - Adam Bateman
In October there was a positive increase in the recovery of services. Elective care was 103% of 2019 activity levels, and outpatient care 94% (provisional figure).
In month there has been a reduction in the number of children and youn pep, but this will increase in November as we have deployed the new outpatient waiting list w/c 8 November and concluded the outpatient validation work through the safe waiting list management programme. througAs contained in our previous 52 week performance there has been an increase in the number of long wait patients from the Safe Waiting List Management programme.
We finalised our half 2 autumn & winter plan to keep staff safe and to deliver safe care. This includes a number of interventions designed to protect access to elective care, critical care and improve the timeliness of urgent care.

October 2021 - Adam Bateman
In September the level of recovery against 2019 was 89% for elective care and 92% for outpatient care. Our recovery performance is stable. Due to staff absence, fatigue and vacancies we have not secured a high number of additional sessions in September to increase recovery. However, we do have scheduled more weekend and evening sessions in October. Nonetheless, there are risks to in-week throughput and recovery: firstly, PICU surge requiring volunteers to move from elective care to critical care. Secondly, high bed occupancy caused by a 20% rise in attendances to ED. As contained in our previous 52 week performance there has been an increase in the number of long wait patients from the Safe Waiting List Management programme. Our recovery plan in quarter 3 is focused on in-week productivity through the new theatre scheduling policy, additional sessions and recruitment through the accelerator investment.

# Board Assurance Framework 2021-22

NHS Alder Hey Children's NHS Foundation Trust

| BAF 1.6 | Strategic Objective: Delivery Of Outstanding Care | | Risk Title: CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental heath crisis and further impacts of COVID. | | |
|---|---|---|---|---|---|
| Related CQC Themes: No Themes Identified | | | Link to Corporate risk/s: No Risks Linked | | |
| Exec Lead: Adam Bateman | Type: Internal, | | Current IxL: 4x5 | Target IxL: 3x4 | Trend: STATIC |

**Assurance Committee:** Safety & Quality Assurance Commitee

**Risk Description**

Services will become overwhelmed curtailing elective capacity.
CYP in wider system become overwhelmed putting pressure onto AH services.
Staff availability through fatigue/isolation risks service delivery.
Staff wellbeing.
Risks to patient safety through extended waits (elective and urgent care) and potential infection control policies compromised.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Regional incident response triggered. | Executive lead participation in system level discussions and ensuring focus on CYP |
| C & M GOLD oversight. | |
| C & M Urgent Care Board oversight. | COO successful in securing walk in centre support for ED |
| C & M Paediatric Gold Instigated with AH COO leadership. | |
| AH triggered GOLD response with resources re prioritised. | Weekly meetings ongoing led by COO with full Exec attendance; actions agreed and monitored |
| Detailed plans in place for Urgent Care, RSV Surge and MH response. | Plans reviewed and updated via Gold Command |
| Previous COVID response mechanisms in place. | DIPC remains sighted on wider system issues; providing regular updates to Executive and Board |
| IPC oversight through CAG. | CAG advice feeding through to Gold decision-making |
| Wellbeing programme in place. | Staff contacts with SALS |
| Governance Lite approach enacted to free up time and resources. | Streamlined agendas focused on key risks and priorities; shorter meetings to free up time |
| Board and Sub-Committee oversight in place. | Agendas and substantive reports reflect risks to delivery and mitigations |
| | |

**Gaps in Controls / Assurance**

Growing absence rates is an increasing concern regarding staff availability to respond. Director of HR & OD is developing an absence management response.

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Improved internal cascade and associated comms for winter 21/22 now being planned against centrally monitored winter plan. | 19/11/2021 | |
| Revised Communication Strategy. | 18/11/2021 | |
| Develop Mitigation Strategy for areas of workforce fragility. | 15/10/2021 | |
| Shift clinical cover to later into the evening and overnight; implement a specific recommendation to have 3 doctors on shift overnight | 17/01/2022 | |

**Executive Leads Assessment**

November 2021 - Adam Bateman
In October attendances were 16.5% above 2019 levels. The number of children treated within 4 hrs was 72.5%. We have observed an increase in acuity (as indicated by triage scores) and higher respiratory infections. We are testing a number of enhanced including increase use of rapid senior assessment ('dr in a box') We have received an external report on Emergency Department demand, staffing profile and departmental processes. We are prioritising the implementation of a recommendation to increase clinical cover overnight (due date January 2022) We have submitted two significant schemes to the ICS to create more paediatric urgent care capacity: respiratory clinics in two community hubs in the community and a multi-disciplinary (health visitor and GP) urgent care service at Alder Hey. We are aiming to start both services with partners in January 2022.

October 2021 - Adam Bateman
The 20% rise in emergency attendances to the Emergency Department is generating significant pressure on staff. There is high bed occupancy and challenges to patient flow.

In response to this we will look after staff by providing a winter toolkit of measures that covers refreshments, more rest facilities and psychological support.

In response to the high demand for urgent care and criticacl care we are implementing the escalation measures contained in our Autumn & Winter

| |
|---|
| Plan. In October we will reduce elective activity and increase PICU capacity by 2 beds. In urgent care, we have increased acute care clinics and community pharmacy cover. We have also submitted a business case to the CCG to fund on a priority basis the establishment of a paediatric urgent care service in Alder Hey for this winter. |
| September 2021 - John Grinnell<br>Robust plans are in place including an emerging booster jab programme. Increased absence levels are a concern in ensuring elective recovery is maintained. A detailed staff wellbeing, absence management plan and key recruitment of staff will be critical in managing the winter. |
| August 2021 - John Grinnell<br>RSV Plan further strengthened including Virtual Ward Model and medical cover approved. Urgent Care Action Plan enacted, awaiting evaluation of impact. Predicted next pressure point in September therefore teams are being encouraged to strengthen resilience during this quieter period. |
| July 2021 - John Grinnell<br>Urgent care is under significant pressure and RSV levels are rising, coupled with some staffing areas of fragility. Gold Command structure has been triggered both internally and via Cheshire and Merseyside. |

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| BAF 2.1 | Strategic Objective: The Best People Doing Their Best Work | Risk Title: Workforce Sustainability and Development | | |
|---|---|---|---|---|
| Related CQC Themes: Safe, Effective, Responsive, Well Led | | Link to Corporate risk/s: 2312, 2500 | | |
| Exec Lead: Melissa Swindell | Type: Internal, Known | Current IxL: 4x4 | Target IxL: 3x2 | Trend: STATIC |

**Assurance Committee:** People & Wellbeing Committee

**Risk Description**

Failure to deliver consistent, high quality patient centred services due to
1. Not having workforce pipelines to ensure the Trust has the right people, with the right skills and knowledge, in the right place, at the right time.
2. Not supporting the conditions under which people can continuously learn, develop and grow in order to keep pace with the strategic development of the organisation.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Workforce KPIs tracked through the corporate report and divisional dashboards | Corporate Report and KPI Report to PAWC |
| Bi-monthly Divisional Performance Meetings. | Regular reporting of delivery against compliance targets via divisional reports |
| High quality mandatory training delivered and reporting linked to competencies on ESR | -Monthly reporting to the Board via the Corporate Report<br>-Reporting at ward level which supports Ward to Board |
| Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device. | ESR self-service rolled out |
| Permanent nurse staffing pool to support nurse staffing numbers | Large-scale nurse recruitment event 4 times per year |
| HR Workforce Policies | All Trust Policies available for staff to access on intratet |
| Attendance management process to reduce short & long term absence | Sickness Absence Policy |
| Wellbeing Steering Group established | Wellbeing Steering Group Terms of Reference |
| Training Needs Analysis linked to CPD requirements | New Learning and & development Prospectus Launched - June 2019 |
| Apprenticeship Strategy implemented | Bi-monthly reports to PAWC and associated minutes |
| Engaged in pre-employment programmes with local job centres to support supply routes | Bi-monthly reports to PAWC and associated minutes |
| Engagement with HEENW in support of new role development | Reporting to HEE |
| People Plan Implementation | People Strategy report monthly to Board |
| International Nurse Recruitment | 75 skilled nurses to join the organisation across 2020/21 |
| PDR and appraisal process in place | Monthly reporting to Board |
| Apprenticeship Strategy implementation | Bi-monthly reports to PAWC<br>OFSTEAD Inspection |
| Leadership Strategy Implementation | Bi-monthly reports to PAWC |
| Recruitment and Apprenticeship strategy currently in development | progress to be reported to BAME task force and People and Wellbeing Committee |
| Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed | Staff employment checks all on personnel files |

**Gaps in Controls / Assurance**

1. Not meeting compliance target in relation to some mandatory training topics
2. Sickness Absence levels higher than target.
3. Lack of workforce planning across the organisation
4. Talent and succession planning
5. Lack of a robust Trust wide Recruitment Strategy
6. DBS renewal programme incomplete- meaning some staff in post do not hold a valid DBS certificate until the programme ahs been complete ( April 2021)
7. Impact of potential Industrial Action on staff availability

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 1. Continue with regular reporting of data<br>target hotspot areas and staff groups<br>review methodology of accessing training | 31/12/2021 | Continued focus on mandatory training compliance; currently at 87.76% as of 29/10/2021.<br><br>Additional resources in place for Resus and Moving and Handling training should see some improvements in these key areas of lower compliance and the team are working closely with Estates leads to improve this area of the Trust compliance. |

| | | |
|---|---|---|
| 3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019 | 31/12/2021 | Delayed as a result of needing to respond to covid. workforce planning happening in response to backlog and nre pressures (accelerator and RSV) |
| 5. Recruitment and Apprenticeship Strategy currently being developed in line with the actions set out in the NHS people plan | 31/12/2021 | This group continues to meet to progress actions, and will expanded membership to ensure the education strategy is fully incorporated. Progress has been impacted whilst significant issues with recruitment transactional services remain. The impact of unprecedented levels of recruitment and a depleted team have significantly impact service delivery which has to be prioritised.. The recruitment service is on the risk register currently. There are numerous actions in place to address the service impact and once mitigated and removed from the register this will enable a refocus back to the recruitment strategy, planning and development. |

| **Executive Leads Assessment** |
|---|
| November 2021 - Melissa Swindell<br>Risk score remains high. Risk of lower staff availability due to potential national strike action added to this risk. |
| October 2021 - Sharon Owen<br>Risk score remains high, whilst recruitment activity has increased by 150% and service is under resourced. Recovery plan in place. |
| September 2021 - Sharon Owen<br>Risk score has been increased due to impact of unprecedented levels of activity on recruitment service and team capacity unable to match demand, subsequently impacting on Trust wide recruitment. |

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| BAF 2.2 | Strategic Objective: The Best People Doing Their Best Work | Risk Title: Employee Wellbeing | | |
|---|---|---|---|---|
| Related CQC Themes: Effective, Well Led | | Link to Corporate risk/s: No Risks Linked | | |
| Exec Lead: Melissa Swindell | Type: Internal, Known | Current IxL: 3x3 | Target IxL: 3x2 | Trend: STATIC |

**Assurance Committee:** People & Wellbeing Committee

**Risk Description**

Failure to support employee health and wellbeing and address mental health which can impact upon operational performance and achievement of strategic aims.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| The People Plan Implementation | Monthly Board reports |
| Wellbeing Strategy implementation | Wellbeing Strategy. Wellbeing Steering Group ToRs |
| Action Plans for Staff Survey | Monitored through PAWC (agendas and minutes) |
| Values and Behaviours Framework | Stored on the Trust intranet for staff to readily access |
| People Pulse results to People and Wellbeing Committee quarterly | PAWC reports and mintues |
| Values based PDR process | New template implemented and available on intranet. Training for managers (appraisers) delivered. |
| Staff surveys analysed and followed up (shows improvement) | 2019 Staff Survey Report |
| Reward and Recognition Group schemes in place: Annual Awards, Star of the Month and quarterly Long Service Recognition Event, Annual Fab Staff Change Week. | Reward and Recognition Meetings established; reports to Wellbeing Steering Group |
| Leadership Strategy | Strategy implemented October 2018 |
| Freedom to Speak Up programme | Board reports and minutes |
| Occupational Health Service | Monitored at H&S Committee |
| Time to Change implementation | Time to Change implementation |
| Staff advice and Liaison Service (SALS) - staff support service | |
| Care first - online Employees Assistance programme | |
| Counselling and Psychological support - Alder Centre | |
| Trust Briefs - keeping staff informed | |
| Spiritual Care Support | |
| Trust Wellbeing Team | Wellbeing Action Plan |
| Clinical Health Psychology service support for staff (including ICU) | |
| Resilience hub now live offering additional psychoeducational support to all staff in the region and taking self-referrals from frontline staff since 12th April | |
| Ongoing monitoring of wellbeing activities and resources via monthly Wellbeing Steering Group | Minutes presented to PAWC |
| Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work | Report in development to assess progress against 9 WB principles outlined in national guidance document. Action plan monitored via bi-monthly Wellbeing Action Group |
| Health and Wellbeing Conversations launched | |
| Ground TRUTH session at execs (monthly) to feedback outcomes of team debriefings, surveys and targeted listening events, agree actions and communicate to the organisation via briefings and Ground Truth bulletin | Minutes of exec meetings |

**Gaps in Controls / Assurance**

1. Need to review staff counselling provision and ensure fit for purpose, coordinated with SALS and sufficient to meet demand going forward
2. Significant gap in predicting what the likely demand for staff support will be over the coming months given the unprecedented nature of this pandemic

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Referrals, triage systems and pathways to be reviewed for all staff counselling between January and March 2021 to | 30/11/2021 | Meeting with SALS & Alder Centre to finalise proposal details and confirm resource needed for counselling provision. Proposal to |

| | | |
|---|---|---|
| determine future service development and delivery that meets demand and is integrated with internal and external counselling provision. | | finalised and discussed with HRD as next step. |
| Recruit to SALS/OD fixed term psychology post and permanent admin post. | 30/11/2021 | Admin post recruited to and successful candidate starting with SALS on 15th November. Psychology sessions interviewed for and two candidates to be offered sessions. To be finalised at end November and sessions confirmed. |
| Winter wellbeing plan developed and shared with Trust Board focussing on organisational health and wellbeing and additional support needed for staff through the winter period. Plan shared with Brilliant Basics team for support in enabling changes needed to be made to support staff (e.g. enabling staff to take breaks and increasing leadership visibility). Plan to be monitored via bi-monthly wellbeing action group and outcomes assessed through whole organisation debriefing programme to begin in the next quarter | 30/11/2021 | Meeting with Brilliant Basics team to agree plan and discuss risks and support needed to implement. Plan submitted to Board |
| Agree a develop a SALS Pals (HWB champion) model across the organisation | 30/11/2021 | SALS Pals JD a developed. Training plan and supervision structure to be developed. Plan to be presented at the next People and Wellbeing Committee |
| Action plan developed with ED including SALS drop ins in ED, weekly support sessions for senior leadership team, SALS support for wellbeing lead in ED and wellbeing champions, support for Wellbeing week in ED w/c 8th Nov, Wingman on Wheels, Massage van. | 01/03/2022 | |

| **Executive Leads Assessment** |
|---|
| November 2021 - Jo Potier<br>Risk reviewed and controls and actions reviewed. Action added regarding additional support for ED through the winter period and other actions updated. No change to overall risk rating. |
| October 2021 - Jo Potier<br>Risk reviewed and controls and actions reviewed. Two new actions added relating to Winter Plan for wellbeing and development of a SALS pals model. No change to current risk score |
| September 2021 - Jo Potier<br>Risk reviewed and controls and actions reviewed and updated. No change to current risk score given ongoing uncertainty around emotional and social impacts of Covid |

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| BAF 2.3 | Strategic Objective: The Best People Doing Their Best Work | Risk Title: Workforce Equality, Diversity & Inclusion | | |
|---|---|---|---|---|
| Related CQC Themes: Well Led, Effective | | Link to Corporate risk/s: No Risks Linked | | |
| Exec Lead: Melissa Swindell | Type: External, Known | Current IxL: 4x3 | Target IxL: 3x2 | Trend: STATIC |

**Assurance Committee:** People & Wellbeing Committee

**Risk Description**

Failure to have a diverse and inclusive workforce which represents the local population.
Failure to take steps to become an inclusive and anti-racist work place where all staff feel their contribution as an individual is recognised and valued.
Failure to provide equal opportunities for career development and growth.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| PAWC Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting. | -Bi-monthly reporting to Board via PAWC on diversity and inclusion issues<br>-Monthly Corporate Report (including workforce KPIs) to the Board |
| Wellbeing Steering Group | Wellbeing Steering Group ToRs, monitored through PAWC |
| Staff Survey results analysed by protected characteristics and actions taken by EDI Manager | monitored through PAWC |
| HR Workforce Policies | HR Workforce Policies (held on intranet for staff to access) |
| Equality Analysis Policy | - Equality Impact Assessments undertaken for every policy & project<br>- EDS Publication |
| Equality, Diversity & Human Rights Policy | - Equality Impact Assessments undertaken for every policy & project<br>- Equality Objectives |
| BME Network established, sponsored by Director of HR & OD | BME Network minutes |
| Disability Network established, sponsored by Director of HR & OD | Disability Network minutes |
| Actions taken in response to the WRES | -Monthly recruitment reports provided by HR to divisions.<br>-Workforce Race Equality Standards.<br>- Bi-monthly report to PAWC. |
| Action plan specifically in response to increasing the diversity of the workforce, and improving the experience of BME staff who work at Alder Hey | Diversity and Inclusion Action Plan reported to Board |
| LGBTQIA+ Network established, sponsored by Director of HR & OD | LGBTQIA+ Network Minutes |
| Time to Change Plan | Time to Change Plan |
| Actions taken in response to WDES | - Monthly recruitment reports provided by HR to divisions.<br>- Workforce Disability Equality Standards.<br>- Bi-monthly report to PAWC. |
| Leadership Strategy; Strong Foundations Programme includes inclusive leadership development | 11 cohorts of the programme fully booked until Nov 2020 |
| BAME Risk assessments during COVID19. Evidence suggests that our BAME staff are potentially at greater risk if they contract covid 19- enhanced risk assessments have been conducted to date with 90% of BAME STAFF. Outstanding risk assessments are currently being addressed with departmental leads and managers. | 90% completion of BAME risk assessments to date |

**Gaps in Controls / Assurance**

1. Need to establish a robust action plan through the work of the BAME Inclusion Taskforce
2. Need to review the resource available to support the EDI agenda

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| action plan to be developed | 31/07/2021 | |
| require appointment to EDI role | 11/11/2021 | |

**Executive Leads Assessment**

0 - Sharon Owen
Risk reviewed and actions progressing. Temporary collaborative EDI Lead now in place, progressing actions.

November 2021 - Melissa Swindell
Risk reviewed, actions updated

September 2021 - Melissa Swindell
Risk reviewed, actions updated

# Board Assurance Framework 2021-22

NHS Alder Hey Children's NHS Foundation Trust

| BAF 3.1 | Strategic Objective: Sustainability Through External Partnerships | Risk Title: Failure to fully realise the Trust's Vision for the Park | | |
|---|---|---|---|---|
| Related CQC Themes: Responsive, Well Led | | Link to Corporate risk/s: No Risks Linked | | |
| Exec Lead: David Powell | Type: Internal, Known | Current IxL: 3x3 | Target IxL: 3x2 | Trend: STATIC |

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

The Alder Hey long term vision for the Park and Campus development which will support the health and wellbeing of both our patients, families , staff and local communities will not be deliverable within the planned timescale and in partnership with the local community and other key stakeholders as a legacy for future generations

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Business Cases developed for various elements of the Park & Campus | Approved business cases for various elements of the Park & Campus |
| Monitoring reports on progress | Monthly report to Board<br>Stakeholder events / reported to Trust Board |
| Heads of Terms agreed with LCC for joint venture approved | |
| Campus Steering Group | Reports into Trust Board |
| Monthly reports to Board & RABD | Highlight reports to relevant assurance committees and through to Board |
| Planning application for full park development. | Full planning permission gained in December 2019 for the park development in line with the vision, awaiting written confirmation. |
| The impact of Covid-19 is both on physical progress on site and from an inability to engage with community stakeholders however the team continue to pursue works liaising with the appointed contractor. | The Trust is in contact with the City Council to discharge pre-commencement conditions so that once demolition is completed the Phase 1 park reinstatement works can commence in late summer. |
| The Trust Development team continues to liaise closely with Liverpool City Council and the planning department to discharge pre-commencement conditions | Minutes of park development meeting |
| The Trust has appointed Capacity Lab for an 18 month period, they are responsible for working with the local community, planning activities in the park, supporting the local community to form an Enterprise/Community Interest Company. Whilst completing this work they will be engaging with Liverpool City council and local councillors. The work has already begun and feedback from the community is positive | Minutes of meetings<br>SLA |
| Exec Design Group | Minutes of Exec Design Reviews to Campus Steering Group |
| We are working with a designer and a QS to review the Remediation Strategy which has now been submitted to LCC. This should lead to a reduction in estimated costs, if approved. In addition we are looking at alternative suppliers that meet the LCC specification. | Planning submission and the estimated costs. Estimated costs provided by Landscape Contractor and QS. |

**Gaps in Controls / Assurance**

1. Risk quantification around the development projects.
2. Absence of final Stakeholder plan
3. COVID 19 is impacting on the project milestones
4. Knotty Ash Nursing Home Fire means Histopathology building is reused prolonging the park reinstatement

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Review and update Space Strategy | 29/10/2021 | Space strategy complete |
| Create opportunities analysis for Park/campus | 31/10/2021 | |
| Appoint PM and legal team to review NE plot and produce Business Cases/Board papers | 19/11/2021 | Archus appointed to support business cases for submission in December 2021/January 2022 |
| Create oversight group with staff governor and LCC input | 19/11/2021 | |

**Executive Leads Assessment**

November 2021 - David Powell
Prior to November Board

October 2021 - David Powell
Prior to October Board

September 2021 - David Powell
Prior to Sept Board

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| BAF 3.2 | Strategic Objective: Sustainability Through External Partnerships | Risk Title: Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships. | | |
|---|---|---|---|---|
| Related CQC Themes: Caring, Effective, Responsive, Safe, Well Led | | Link to Corporate risk/s: No Risks Linked | | |
| Exec Lead: Dani Jones | Type: External, Known | Current IxL: 4x3 | Target IxL: 4x2 | Trend: STATIC |

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

Risk of failure to:
- Deliver care close to home, in partnerships
- Develop our excellent services to their optimum and grow our services sustainably
- Contribute to the Public Health and economic prosperity of Liverpool / Cheshire & Merseyside

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Divisional Performance Management Framework - includes clear trajectories for challenged specialties to deliver | Monthly to Board via RABD and Board. (Example of monthly divisional-level detail attached) |
| Compliance with All Age ACHD Standard | ACHD Level 1 service now up and running; developing wider all-age network to support - agreement to host at Alder Hey |
| Capacity Plan identifies beds and theatres required to deliver BD plan | Daily activity tracker and forecast monitoring performance for all activity. |
| Sustainability through external partnerships is a key theme in the Change Programme: assurance received through Programme Board and Trust Board | Growth of specialist services through partnerships included in approved trust strategic plan to 2024 (Our Plan). Monitored at Programme Board and via Strategy and Operations Delivery Board. |
| Internal review of service specification as part of Specialist Commissioning review | Compliance with final national specifications |
| Compliance with Neonatal Standards | Single Neonatal Services Business Case approved by NHS England. |
| Alder Hey working in partnership with Manchester Children's to ensure collaboration/sustainability where appropriate, and support North West in national centralisation agenda | MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (quarterly) |
| 'Our Plan' - Final - Strategic Plan to 2024: Explicit and clear about partnership plans, our role in the system and growth that supports children and young people's needs as well as system needs | 'Our Plan' approved at Trust Board October 2019 |
| 'One Liverpool' plan to 2024: system plan detailing clear strategic intent re: Starting Well and children and young people's services | Evidences alignment of Alder Hey's plan with those of our integrated care system and evidences the drivers for key partnerships within. |
| Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements | ToR & minutes - NW Paediatric Partnership Board |
| Gap / risk analysis against all draft national service specification undertaken and action plans developed | Annual assessment against all service specifications led through quality team; SDIPs put in place in agreement with commissioners as a result to reach compliance |
| Involvement of Trust Executives in partnership governance arrangements | ToR & minutes - NW Paediatric Partnership Board. Hosted ODN Assurance reporting to RABD (2 x per year) |
| Implementation of the 'Starting Well' partnership group for One Liverpool(developing - replaces Children's Transformation Board). SRO Louise Shepherd confirmed. | |
| C&M C&YP Recovery Plan - Alder Hey Leadership ensures alignment with Our Plan | C&M C&YP Recovery Plan Narrative |
| One Liverpool - Provider Alliance action plan | Agreed plan per Provider Alliance 25.9.20 - inclusive of Children, Young People and Families priorities. |
| C&M Children's Transformation Programme - AH hosting agreed and new programme for 2021+ under implementation | Presentation to C&M W&C Programme to agree C&M priorities - led by Alder Hey (Dec 20). Approved paper to C&M HCP re establishment of the new C&M CYP Programme (Nov 20). Programme submission to C&M HCP for set up of new CYP Programme (Mar 21) supported by HCP (ICS)<br><br>4.10.21 - C&M CYP Programme now in full flight & progressing positively. New system initiatives re: THRIVE MH model & Obesity underway; LD / Autism & Respiratory in planning. Recruitment to CYP team underway. |
| Coordinated system-wide action planning for predicted RSV surge | NW & C&M Surge Plans |
| ICPG led Refreshed One Liverpool Delivery Plan - under development | |

**Gaps in Controls / Assurance**

1. Inability to recruit to highly specialist roles due to skill shortages nationally.
2. Trust has sought derogation in a number of service areas where it does not meet certain standards and is progressing actions to ensure compliance by due date.

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 6.Develop Operational and Business Model to support International and Private Patients | 17/12/2021 | Refresh of Trust Strategic plan scheduled for Q4 21/22 - planning for non-NHS income to form part of this refresh |
| 1. Strengthening the paediatric workforce | 17/12/2021 | Alder Hey making strong strides re: Physicians Associates as the largest employer of PA's in England - demonstrating new approaches to staffing skill mix. Requirement for system-based workforce planning outlined in new Gov't guidance 'Build Back Better' in September; local implementation timelines as yet unknown but Alder Hey will ensure positioning for CYP workforce played in. |
| Full programme proposal implementation;<br>Funding flows into AH from C&M/NHSE<br>Recruit to all key programme roles - beginning with Programme Director<br>Establish C&M CYP Transformation Board | 29/10/2021 | Action Complete<br>- Funding flows into AH from C&M/NHSE secured<br>- Recruitment to key programme roles complete or with start date<br>- C&M CYP Transformation Board established and pending 3rd formal meeting. |

| Executive Leads Assessment |
|---|
| November 2021 - Dani Jones<br>Risk reviewed; no change to score in month. Recognition that this risk will develop alongside evolving 2030 Strategy in the new year. Action re CYP programme complete. |
| October 2021 - Dani Jones<br>Risk reviewed; no change to score in month. Actions updated and & new evidence for C&M CYP control added. |
| September 2021 - Dani Jones<br>Risk reviewed; no change to score in month; actions updated. |

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| BAF 3.4 | Strategic Objective: Sustainability Through External Partnerships | Risk Title: Financial Environment | | |
|---|---|---|---|---|
| Related CQC Themes: Safe, Effective, Responsive, Well Led | | Link to Corporate risk/s: No Risks Linked | | |
| Exec Lead: John Grinnell | Type: Internal, Known | Current IxL: 4x4 | Target IxL: 4x3 | Trend: STATIC |

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

Failure to meet NHSI target and affordability of Trust ongoing Capital requirements.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Organisation-wide financial plan. | Monitored through Corporate Report |
| NHSi financial regime and Use of Resources risk rating. | Specific Reports (i.e. NHSI Plan Review by RABD) |
| Financial systems, budgetary control and financial reporting processes. | - Daily activity tracker to support divisional performance management of activity delivery<br>- Full electronic access to budgets & specialty performance results<br>- Financial in-month and forecast position reported through SDG, Exec Team, RABD, and Trust Board<br>- Financial recovery plans reported through SDG and RABD<br>- Internal and External Audit reporting through Audit Committee. |
| Capital Planning Review Group | 5 Year capital plan ratified by Trust Board |
| Monthly performance review meetings with Divisional Clinical/Management Team and the Executive | Monthly Performance Management Reporting with '3 at the Top' |
| Weekly meeting with divisions to review forward look bookings for elective and day case procedures to ensure activity booked meets contract and recovery plans. Also review of status of outpatient slot utilisation | Monitored through Exec Comm Cell and Exec Team |
| Weekly Sustainability Delivery Group overseeing efficiency programme | Weekly Financial Sustainability delivery meeting papers |
| CIP subject to programme assessment and sub-committee performance management | Tracked through Execs / RABD |
| RABD deep dive into key financial risk areas at every meeting | RABD Agendas, Reports & Minutes |
| Weekly COVID financial update to Strategic Command | Agenda and Presentations |

**Gaps in Controls / Assurance**

1. Uncertainty of H2 21/22 framework and beyond
2. Affordability of Capital Plans
3. Cost of recovery, winter & RSV escalating
4. Long Term Plan shows £3-5m shortfall against breakeven
5. Long Term tariff arrangements for complex children
6. Potential system restraint on capital plans

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 2. Five Year capital plan | 31/12/2021 | Capital prioritisation with nominated executive leads underway due to be completed with output being an executive review panel. Output to be presented to Trust Board and RABD to agree plans based on affordability. External capital funding also being maximised with bids submitted where appropriate. |
| 1. Uncertainty of H2 21/22 framework and beyond | 30/11/2021 | H2 financial plans are not yet agreed across C&M and remains significant risk in achieving a break-even position. Expected final plans to be agreed mid november. |
| 4. Long Term Financial Plan | 31/12/2021 | As part of specialist trusts collaboration, agreement to commission a 5 year financial modelling piece across 4 trusts to understand the underlying exit position and allow for benchmark and to inform the respective boards of future sustainability. Expected work will inform 22/23 planning and presented to boards in Q3. Interim updates to be presented to RABD as part of monthly update. |

**Executive Leads Assessment**

November 2021 - Rachel Lea
Risk reviewed and updated with latest position and progress on actions. Key area still remains H2 uncertainty and capital plans.

October 2021 - Rachel Lea
Risk reviewed and actions updated

September 2021 - Rachel Lea

| |
|---|
| Risk reviewed and actions updated |
| August 2021 - Rachel Lea<br>Risk reviewed and actions updated with latest progress |
| July 2021 - Rachel Lea<br>Risk reviewed and actions updated |
| June 2021 - Rachel Lea<br>Risk reviewed and actions updated to reflect latest position. |

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| BAF 3.5 | Strategic Objective: Sustainability Through External Partnerships | | Risk Title: ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment | | |
|---|---|---|---|---|---|
| Related CQC Themes: No Themes Identified | | | Link to Corporate risk/s: No Risks Linked | | |
| Exec Lead: Dani Jones | Type: External, | | Current IxL: 4x4 | Target IxL: 3x3 | Trend: STATIC |

**Assurance Committee:** Trust Board

| Risk Description |
|---|
| NHS White Paper Innovation and Integration creating Integrated Care Systems (ICSs) and new statutory NHS body, including transformed system governance, finance, quality, provider collaboratives etc. - under definition & rapidly evolving. Uncertainty of governance arrangements at system level and implications for providers. |

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Membership of C&M Provider Collaboratives x 2 - to ensure CYP voice high on agenda | Letter confirming Alder Hey support to LDMHC Provider Collaborative MOU (Aug 21)<br><br>CEO engagement in 1st of 3 CMAST Provider Collaborative workshops (Oct 21) |
| Specialist Trust Alliance membership of C&M ICS (HCP) Board - to ensure Specialist Trusts have a voice to influence | |
| C&M CYP Transformation Programme hosted at Alder Hey | ICS Programme Highlight Report |
| Uncertainty over System Finance planning, commissioning intentions and response to H2 (described in BAF 3.4) | See BAF 3.4 (financial environment) |
| Trust Board & Council of Governors - tracking of system / legislative developments, continued engagement and action planning | Presentations to Trust Board & CoG - updated July & Sept |
| C&M CEO Provider Collaborative - Membership - sustain collaborative working arrangements with C&M-wide colleagues to shape system and ensure influence | |
| C&M ICS Finance Committee - play an integral role and ensure fair share of funding for CYP services | TOR & System Finance Principles in development (to be attached once finalised) |
| Maintain effective existing relationships with key system leaders and regulators | |
| Lead Provider and partnership arrangements; development of new models of care | |

**Gaps in Controls / Assurance**

NHS Bill not yet read in Parliament; final statutory arrangements cannot take place until this is completed (clarity will follow)
H2 Planning Guidance landed October 21: Review of impact and associated action plan for Alder Hey to be undertaken early Oct 21
Uncertainty over future commissioning intentions (see BAF 3.4)

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| H2 Planning Guidance / Associated Finance strategy for H2 to be developed (See BAF 3.4) | 30/11/2021 | |
| Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services | 28/04/2022 | |
| Defined roles for ICS/Systems engagement for key Execs and Senior Managers | 30/09/2021 | Various system group leadership allocated to key named Execs in September 21 |
| Continue to develop collaborative arrangements with key partners and shape the service offering | 31/03/2022 | |

**Executive Leads Assessment**

November 2021 - Dani Jones
Risk reviewed; no change to score in month. MIAA assurance undertaken to calibrate risk. Controls, evidence and actions updated.

October 2021 - Dani Jones
Risk reviewed; score increased in month to 4 x 4 - reflecting the continued uncertainty of the ICS / system development arrangements at this time - as reflected at Trust Board Sept 21, action plan in place and agreed

September 2021 - Dani Jones
Risk reviewed; no change to score in month. Continued commitment to key ICS development working groups. Ongoing engagement with Trust Board & Council of Governors.

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| BAF 3.6 | Strategic Objective: Sustainability Through External Partnerships | | Risk Title: Risk of partnership failures due to robustness of partnership governance | | |
|---|---|---|---|---|---|
| Related CQC Themes: No Themes Identified | | | Link to Corporate risk/s: No Risks Linked | | |
| Exec Lead: Dani Jones | Type: External, | | Current IxL: 3x3 | Target IxL: 3x2 | Trend: STATIC |

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

Partnerships vary in their shape, foundation, membership and governance arrangements; but issues experienced in partnerships can have operational, clinical and financial risks, layered with the potential for reputational risks (varies depending on the partnership) and risks/issues can be harder to resolve across multiple organisations.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| NW NorCESS Escalation Plan - approved through NW Paediatric Partnership Board and adopted by the NorCESS service group | |
| Escalation process for risks and issues pertaining to ODNs and Joint Services | |
| Partnership Quality Assurance Framework | P'ship Quality Assurance Framework in development. Initial review with Alder Hey Execs (MD, Chief Nurse, Corp Gov Exec) complete; awaiting comments then further work with partners to identify pilot area. Update to Risk Management Forum Nov / Jan (dependent on partner engagement) |
| Identification of 'pilot' partner to co-design the Framework | |
| Governance of Framework to be overseen at Risk Management Forum, and to involve NED's from both parties in any given Partnership | |

**Gaps in Controls / Assurance**

Partnership Governance Framework to be devised and approved through Alder Hey governance.
Assessment of core new and existing partnerships against the Framework once approved; any gaps addressed through individual partnership oversight groups.

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Develop the Alder Hey Partnership Quality Assurance Round Framework - for approvals in Alder Hey & co-creation with key identified partners. Assess core pre-existing and new partnerships against the framework and address any gaps through individual partnership governance groups. | 30/11/2021 | Partnership Quality Assurance Framework - initial draft developed and shared with MD, Chief Nurse and Corporate Governance Exec for comments. Identification of initial 'pilot' partnership underway. Update to be scheduled for Risk Management FOrum either Nov or Jan (dependent on sign up of key partner to test approach; discussions underway) |

**Executive Leads Assessment**

November 2021 - Dani Jones
Risk reviewed; no change to score in month. Partnership Assurance Framework developed; identification of partner to test approach underway. Executive review of draft framework complete; NED discussion pending.

October 2021 - Dani Jones
Risk reviewed; no change to score in month, though progress made with development and engagement on the Framework.

September 2021 - Dani Jones
Risk reviewed; no change to score in month. Partnership framework under development during Q3

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| BAF 4.1 | Strategic Objective: Game-Changing Research And Innovation | Risk Title: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People. | | |
|---|---|---|---|---|
| Related CQC Themes: Well Led | | Link to Corporate risk/s: 2427 | | |
| Exec Lead: Claire Liddy | Type: Internal, Known | Current IxL: 3x3 | Target IxL: 3x2 | Trend: STATIC |

**Assurance Committee:** Innovation Committee

**Risk Description**

The trust strategy requires the growth of game changing research and innovation activities to enable an increase in R&D investment levels and generate commercial opportunity. The failure to deliver R&I strategies could result in an inability to achieve growth and new partnerships plans which will limit R&D investments and delay new discoveries.

The delivery of the R&I activities may also expose the Trust to contractual and reputation risks due to the need to enter into legal agreements with academia, large corporate's, SMEs and investors.

The delivery of the R&I activities will lead to industry data collaborations and AI with commercial contracts which will require robust data governance and ethics.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| R&I: RABD review of commercial issues per Corporate governance manuals, oversight of Innovation Ltd Corporate governance manual and oversight of deal diligence (commercial and reputational) . Trust Board oversight of shareholding and equity investments and intellectual property. | Reports to RABD / Trust Board and associated minutes |
| R: Establishment of Research Management Board | Research Management Board papers. |
| I: Innovation Committee and RABD Committee | Committee oversight of Innovation strategy with NED expertise |
| I: Clear Management Structure and accountability within Innovation Division | ESR Divisional Hierarchies |
| R&I: Plans for joint research & innovation clinical leadership | Job Description and Hierarchy |
| R: Clinical trials Covid recovery plan operational. | Trust Board papers |
| R: Research Division monthly focus on research at the Research Management Board to support strategy delivery. | Research Management Board papers |
| I: Legal Partner now in contract to advise on partnership structure and intellectual property | Letter of engagement |
| R&I: Trust Policies and online declaration portal (gifts & hospitality, sponsorship etc.) | Trust Policies and digital audit trail to audit committee |
| R&I: Formal Press Releases and external communications facilitated through communications department | Communications Strategy and Brand Guide |
| R&I: Industry Partner and AI Data governance. To adopt Trust DPIA's/DSA's and IG Steering Group standard process and approvals | Policy and SOPs |

**Gaps in Controls / Assurance**

1. Availability and incentivisation model for resources to deliver strategy.
2. Capacity for business development and inward investment.
3. External factors such a Covid and Brexit creating delays in expansion plans.
4. Capacity of clinical staff to participate in research/innovation activity.
5. Capacity of clinical services to support research/innovation activity.
6. Availability of space for expansion of commercial research/innovation growth.

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| LCR/BOOM engagement and collaboration for public funding and investment. | 31/08/2021 | this action is now closed. |
| Operationalise new strategy including programme and project prioritisation and associated resource requirement and planning. | 31/08/2021 | |
| Work with new dedicated finance resource to prepare financial forecast and investment/growth strategy. | 30/09/2021 | |
| Agree coordinated plan with LCR and other national R&D funders eg UKRI to bring investment into child health innovation | 08/11/2023 | |
| Board approval of a joint R&I strategy with encompasses the new 2030 innovation Strategy and promotes a growth plan and brings inward investment. | 31/03/2022 | |
| Agree an MoU to outline the partnership - value based shared purpose and also commercial upside sharing | 31/03/2022 | |
| Agree IP policy to cover whole Trust and include incentivisation | 31/03/2022 | |

## Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| Executive Leads Assessment |
| --- |
| November 2021 - Claire Liddy<br>NOV review - risk static |
| October 2021 - Claire Liddy<br>OCT review - no change |
| September 2021 - Claire Liddy<br>risk review SEPT. no change |

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| BAF 4.2 | Strategic Objective: Delivery Of Outstanding Care | Risk Title: Digital Strategic Development & Delivery | | |
|---|---|---|---|---|
| Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led | | Link to Corporate risk/s: 2143, 2265, 2235 | | |
| Exec Lead: Kate Warriner | Type: Internal, Known | Current IxL: 4x1 | Target IxL: 4x1 | Trend: STATIC |

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

Failure to deliver a Digital Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare, failure to provide high quality, resilient digital and Information Technology services to staff.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Improvement scheduled training provision including refresher training and workshops to address data quality issues | Working towards Informatics Skills and Development Accreditation (Aug 2019). Training improvements identified through refreshed Digital Strategy<br>Update Sept: ISD Excellence in Informatics Level 1 accreditation achieved |
| Formal change control processes in place | Exec agreed change process for IT and Clinical System Changes |
| Executive level CIO in place | Commenced in post April 2019 |
| Quarterly update to Trust Board on digital developments, Monthly update to RABD | Board agendas, reports and minutes |
| Digital Oversight Collaborative in place & fully resourced - Chaired by Medical Director | Digital Oversight Collaborative tracking delivery |
| Clinical and Divisional Engagement in Digital Strategy | Implementation of fortnightly huddle with divisions from April 2019. Divisional CCIOs recruited. Divisional IT Leads in place. |
| NHSE & NHS Digital external oversight of programme | NHSD tracking of Programme through attendance at Programme Board and bi-monthly assurance reports. |
| Digital Strategy approved by Board July 2019, mobilisation in place to new governance and implementation arrangements | Digital Futures Strategy |
| Disaster Recovery approach agreed and progressed | Disaster recovery plans in place |
| Monthly digital performance SMT meeting in place | ToRs, performance reports (standard agenda items) KPIs developed |
| Capital investment plan for IT including operational IT, cyber, IT resilience | Capital Plan |

**Gaps in Controls / Assurance**

Cyber security investment for additional controls approved - dashboards and specialist resource in place
Transformation delivery at pace - integration with divisional teams and leadership from divisional CCIOs
Approach to training under review

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Development of new strategy from 22/23 | 01/04/2022 | |
| Implementation of Alder Care Programme | 01/05/2022 | Programme progressing, a number of work streams with challenges being progressed. |

**Executive Leads Assessment**

November 2021 - Kate Warriner
BAF reviewed. Good progress against key actions.

October 2021 - Kate Warriner
Risk reviewed, good progress against actions

September 2021 - Kate Warriner
Risk reviewed, good progress against actions. New strategy work to commence in Q3.

Alder Hey Children's NHS
NHS Foundation Trust

# BOARD OF DIRECTORS

**Thursday, 25th November 2021**

| | |
|---|---|
| **Paper Title:** | **Audit and Risk Committee – Chair's Highlight Report** |
| **Report of:** | Kerry Byrne, Committee Chair |
| **Paper Prepared by:** | Kerry Byrne, Committee Chair |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ■<br>Information ☐<br>Regulation ☐ |
| **Summary and/or supporting information:** | This paper provides a summary from the Audit and Risk Committee meeting that was held on the 18th November 2021, along with the approved minutes from the Audit and Risk Committee meeting that was held on the 23rd September 2021. |
| **Action/Decision Required:** | To note ■<br>To approve ☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ☐<br>**The best people** doing their best work ☐<br>Sustainability through **external partnerships** ■<br>Game-changing **research and innovation** ☐<br>**Strong Foundations** ■ |
| **Resource Impact:** | None |

## 1. Introduction

The Audit & Risk Committee (ARC) is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its Terms of Reference, the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

## 2. Agenda items received, discussed / approved at the meeting

- Board Assurance Framework
- Update from the Risk Management Forum (RMF) including the Corporate Risk Register
- Analysis of the Trust Risk Register
- CQC Action Plan (for the action overseen by ARC)
- Presentation on risk management processes within the Division of Surgery
- Internal Audit Progress Report
- Internal Audit Follow Up Report
- Presentation on project assurance by the Delivery Management Office (DMO)
- ARC Terms of Reference
- ARC Workplan
- Waiver Activity Report

## 3. Key risks / matters of concern to escalate to the Board (include mitigations)

None

## 4. Positive highlights of note

Over the coming months the Committee will look at how we will gain assurance in the future in due the expected increase in collaborative working within the Cheshire & Merseyside region. There will be services for which we are lead provider, and therefore may be required to provide assurance to member trusts and others where we are a partnership member and may require assurance from the lead provider.

Management have agreed to look at risk management processes across Divisions and Corporate Services to identify areas of good practice that can be shared across the trust. This work will be overseen by the RMF.

Following a recent focus on long standing (>12 months) high risks (score 15+) the RMF is currently repeating the exercise on high moderate risks (score 12). This is important in minimising the number of risks that that escalate to high.

Following on from prior presentations on Clinical Audit and Data Quality we received presentation from the DMO on project assurance. Throughout the year the Committee has looked across the Trust to identify any further functions

that can provide assurance to the Committee on key areas of risk. The Committee looks forward to receiving an annual report from the DMO on the effectiveness of project governance.

The Committee is planning to undertake a self-assessment of its effectiveness in the coming quarter. This will be the first assessment of the Committee since responsibility for risk was added to it's remit. Separate assessments of Audit Committee and Integrated Governance Committee were previously undertaken.

A review of the work of the Committee and the RMF (and previously the Care Delivery Board) is also taking place following just over 12 months of their operation. This will consider whether they are functioning as intended, if there are any overlaps or gaps between the two groups and whether there are any changes that would be useful going forward.

## 5. Issues for other committees

None

## 6. Recommendations

The Board is asked to note the Committee's report.

Alder Hey Children's NHS Foundation Trust

# The Audit and Risk Committee

**Confirmed** Minutes of the meeting held on **Thursday 23rd September 2021**
**Via Microsoft Teams**

| | | | |
|---|---|---|---|
| **Present:** | Mrs. K. Byrne (Chair) | Non-Executive Director | (KB) |
| | Mrs. A. Marsland | Non-Executive Director | (AM) |
| | Mrs. F. Marston | Non-Executive Director | (FM) |
| **In Attendance:** | Mr. G. Baines | Assistant Director, MIAA | (GB) |
| | Mr. A. Bass | Director of Surgery | (ABASS) |
| | Dr. U. Das | Director of Medicine | (UD) |
| | Mr. K. Jones | Associate Finance Director | (KJ) |
| | Mrs. R. Lea | Associate Director of Finance | (RL) |
| | Ms. V. Martin | Anti-Fraud Specialist, MIAA | (VM) |
| | Mrs. K. McKeown | Committee Administrator | (KMC) |
| | Ms. E. Saunders | Director of Corporate Affairs | (ES) |
| | Ms. K. Stott | Senior Audit Manager, MIAA | (KS) |
| | Ms. C. Umbers | Assoc. Director of Nursing and Governance | (CU) |
| **Apologies:** | Mr. A. Bateman | Chief Operating Officer | (AB) |
| | Ms. L. Cooper | Director of Community Services | (LC) |
| | Mr. J. Grinnell | Director of Finance | (JG) |
| | Mr. H. Rohimun | Executive Director, Ernst and Young | (HR) |
| **Item 21/22/63** | Mrs. K. Warriner | Chief Digital and Information Officer | (KW) |
| **Item 21/22/72** | Mrs. M. Swindell | Director of HR & OD | (MS) |
| **Item 21/22/76** | Mr. G. Murphy | Local Security Management Specialist | (GM) |

**21/22/56 Introductions and Apologies**

The Chair welcomed everyone to the meeting and noted the apologies that were received.

**21/22/57 Declarations of Interest**

The Audit and Risk Committee noted the declaration received from Fiona Marston in relation to her association with the Liverpool School of Tropical Medicine.

**21/22/58 Minutes from the Meeting held on the 22nd July 2021**
**Resolved:**
The minutes from the meeting that took place on the 22nd of July were agreed as an accurate record of the meeting.

**21/22/59 Matters Arising and Action Log**

**Action 19/20/50.6:** *Progress Report MIAA To suggest a mechanism to review the effectiveness of External Audit for 2019/20 accounts* - It was reported that there is very little intelligence in terms of a mechanism to review the effectiveness of external audit. It

was suggested that the Trust revert back to using the tender criteria when governors select external auditors, and from a performance and quality lens demonstrate whether Ernst and Young have fulfilled what was required of them along with any additional value that they have added. This information could be used as a benchmark when the organisation goes out to tender in 2022. Rachel Lea felt that it would be worthwhile using this approach when going out to tender in order to measure criteria, look at areas that the Trust would like to build into a new contract thus ensuring additional benefits. It was pointed out that organisations are struggling to re-appoint external auditors due to the state of the market therefore the Trust is having discussions with other specialist trusts in terms of what a collaboration might look like or how Alder Hey might best position itself. A plan is also in the process of being compiled to mitigate the risks relating to this area of work. It was agreed to submit a report in April 2022, six months prior to going out to tender**.**
**ACTION TO REMAIN OPEN**

**Action 20/21/45.1:** *Update on the Recommendations within the Acorn Report (Agree a date via the Innovation Committee in which to provide assurance to the Audit and Risk Committee on any new arrangements that have been made in respect to the three live companies)* - This item has been included on September's agenda. **ACTION CLOSED**

**Action 20/21/49.1:** *Fraud Risk Matrix* (*Provide an update to the Committee following Deloitte's review of VFM in purchasing PPE).* – This item has been included on September's agenda. **ACTION CLOSED**

**Action 20/21/57.1:** *Non-Clinical Claims/Clinical Claims (Initial discussion to take place between ES/JG re the examining of clinical and non-clinical claims jointly from a value for money lens to see what the Trust is obtaining from NHS Resolution versus the Trust's solicitors. Following discussion, arrange for a meeting to take place with the Chair to discuss the progression of this piece of work)* - NHS Resolution are due to publish new scorecards that will cover the gamut of clinical/non-clinical claims. Following publication, work will take place to examine clinical/non-clinical claims jointly from a value for money lens to see what the Trust is obtaining from NHS Resolution versus the Trust's solicitors. It was agreed to provide an update in November 2021.
**ACTION TO REMAIN OPEN**

**Action 20/21/59.1:** *Update on Outstanding Actions from the Consultant Job Planning Audit (Provide an update once the new job planning portal is in operation)* - This item has been included on September's agenda. **ACTION CLOSED**

**Action 20/21/76.1:** *Internal Audit Progress Report (Submit a report on the next steps for the Trust's Informatics and Data Quality Service and provide a draft outline of the Data Quality Strategy. Provide a regular update to the Audit and Risk Committee on Data Quality*) – This item has been included on September's agenda. **ACTION CLOSED**

**Action 20/21/72.2: :** *Board Assurance Framework Report (Refer BAF Risk 2.1 to the People and Wellbeing Committee (PAWC). Audit and Risk Committee to receive an update on the mitigations in place for this risk in the next six months)* - Risk 2.1 was discussed during the People and Wellbeing Committee on the 21.9.21. The score for this risk has been increased and a meeting is to take place between Erica Saunders and Melissa Swindell to discuss the inclusion of additional detail that will sit behind this risk.
**ACTION CLOSED**

**Action 21/22/08.1:** *Care Delivery Board; including Corporate Risk Register (Provide an update to the Trust Board on the risk relating to the pipework across the hospital once the working group has met)* It was confirmed that an update will be provided to the Trust Board on the 28.10.21. **ACTION CLOSED**

**Action 21/22/15.1:** *Final Internal Audit Plan for 2021/22 (Review the Internal 2021/22 Audit Plan in September to decide as to whether an alternative audit should be promoted in the available slot due to the deferral of the consent audit)* - This item has been included on September's agenda. **ACTION CLOSED**

**Action 21/22/33.1:** Analysis of Client Satisfaction Questionnaires and KPIs 2020/21 (Submit a proposal and the six questions for conducting the 2021/22 Client Satisfaction Questionnaires, for discussion and approval) - This item has been included on September's agenda. **ACTION CLOSED**

**Action 21/22/35.1:** *Annual Accounts for 2020/21 (Look into the increase in expenses that relate to internal audit (£57k > £102k) and provide an update)* - The Trust had charges of £102k in 2019/20 and £57k in 2020/21 in terms of an accrual in the 2019/20 accounts for cyber support from MIAA. The Trust was invoiced for £20k which created an artificially high position in 2019/20 and an artificially low position in 2021. MIAA's usual charges are approximately £80k per annum and therefore will represent this figure in 2021/22 going forward. **ACTION CLOSED**

**Action 21/22/35.2:** *ISA 260 (Provide details on the outcome of the Trust's 'Nil Net Assets' Review)* - This item has been included on September's agenda.
**ACTION CLOSED**

**Action 21/22/42.1:** *Brilliant Basics Programme (Circulate the presentation from the meeting that took place between Cathy Umbers and KPMG as it includes the ideas that were discussed for incorporating risk management in elements of the Brilliant Basics Programme)* - The presentation was circulated to Committee members**.**
**ACTION CLOSED**

**Action 21/22/43.1:** *Board Assurance Framework (Refer BAF risk 2.3 to PAWC for review to ensure that it reflects the mitigations that have been put in place as a result of the establishment of the BAME Taskforce)* – It was confirmed that the risk around inclusion is discussed on a regular basis at the People and Wellbeing Committee.
**ACTION CLOSED**

**Action 21/22/46.1** *Trust Risk Register Analysis (Look into a process for tracking the progress of overdue risks/risks without an action plan rather than displaying this information via a graph/chart in the Trust Risk Register Analysis report)* - A deep dive took place to look at the high percentage of moderate/high moderate risks that are on the risk register. The outcome of the deep dive has been included in the Trust Risk Register Analysis Report, and it is showing that 29% of those risks have been static for more than twelve months. This information has been shared with the respective divisions/corporate functions for review and will be tracked by the Risk Management Forum going forward and will be reviewed as part of the risk validation process. Reports will be produced on a more regular basis and shared with the Divisions in addition to the validation meetings.
**ACTION CLOSED**

**Action 21/22/47.1:** *CQC Action Plan (Review recommendation 8 in the CQC Action Plan to see what else can be done in terms of emphasis for rolling out the e-learning package for risk management across the Trust)* - A meeting has been scheduled to take place on the 30.9.21 between Erica Saunders and Cathy Umbers in order to discuss what else can be done in terms of emphasis for rolling out the e-Learning package for Risk Management across the Trust. It was confirmed that the e-Learning package will be available in November, but it was pointed out that risk management training is already available for staff. The e-Learning package will be a reflection of the Trust's Risk Management Strategy and the new policy/procedures. **ACTION CLOSED**

**Action 21/22/48.1:** *Clinical Audit Presentation (Agree the timings of clinical audit updates that are to be submitted to the Audit and Risk Committee in 2021/22)* - A meeting is to be scheduled in November between Kerry Byrne, Erica Saunders and Steve Riley to discuss this action. **ACTION TO REMAIN OPEN**

**Action 21/22/48.2:** *Clinical Audit Presentation (Meeting to take place in September to discuss the progress of the Clinical Audit Plan)* - Refer to action 21/22/48.1
**ACTION TO REMAIN OPEN**

**21/22/49.1:** *Development of a Robust Process for Gifts and Hospitality. Meeting to take place to look at what else can be done to promote declaration of interest (DoI) compliance across the Trust* - A meeting has taken place to look at what else can be done to promote DoI compliance across the Trust. The following suggestions were made; discuss DoI on a regular basis during Divisional governance sessions, circulate regular communications, discussion to take place with Virginia Martin (MIAA) about promoting this area of work
**ACTION CLOSED**

**21/22/60 Board Assurance Framework (BAF) Report**

The Audit and Risk Committee received an overview of the BAF as at the 31.8.21. The following points were highlighted:

- A lot of scrutiny and focus has been given to the high scoring risks during the last month by the Execs and Assurance Committees.
- It was reported that there has been an emphasis on workforce risks in terms of staff availability and staff absence which have been linked into the risk relating to wellbeing (2.2). Sharon Owen has also conducted a piece of work to drill down and provide a clearer picture. The outcome of this work was shared with the members of PAWC during September's meeting.
- *Access to Care* – The Trust is reviewing the impact that the lack of workforce is having on access to care. This risk is also being discussed at Board level as the organisation starts to look at its winter plans. It was pointed out that risks which are very broad may require the overview of more than one Assurance Committee and a deep dive at Board level.
- *Financial Environment* – It was reported that the Exec Team received an update on the Trust's finances earlier in the day via Rachel Lea.
- The Committee was advised that all BAF risks are being scrutinised and there is a high level of review in terms of the three main areas of risk reported.

- Fiona Marston queried as to whether the risks relating to the new ICS will be incorporated on the BAF to enable oversight of on-going actions. It was confirmed that risks 3.5 and 3.6 relate to this area of work in terms of the architecture rather than specific ICS issues. Dani Jones is leading on this work and will be providing the Trust Board with an update on a monthly basis for the foreseeable future. As the work of the ICS progresses the BAF will include greater detail.
- The Chair referred to the broader partnership of the ICS and queried the Trust's process for agreeing the governance for these partnerships in terms of appropriateness and proportionate for size, risk, etc. to enable respective Committees to gain assurance. The Committee was advised that Dani Jones has attended the Risk Management Forum to gain the views of members about using the Quality Assurance Round framework for the governance of ICS partnerships, which was received well. It was confirmed that Erica Saunders is going to work alongside Dani Jones to develop this in terms of taking it forward. The Chair pointed out that this could be a future audit for MIAA once the work has been completed and assurance can be provided. MIAA advised that this audit will be more suited to 2022.
- Fiona Marston drew attention to the increase in the risk rating for risk 2.1 (*Workforce Sustainability and Development*) and advised of her surprise that risk 2.2 and 2.3 remained static, especially as the organisation is seeing a substantial increase in staff absence. The Committee was informed that the increase in the rating for risk 2.1 came about due to an agreed action by PAWC. It is felt that risk 2.2 will increase as there is enough to warrant further scrutiny and attention to the gaps in control. Fiona Marston pointed out that there are a lot of actions in place in terms of the Ground Truth Tool/PDR wellbeing discussions and felt that it is important that action plans are enhanced to reflect the risk register.

**Resolved:**
The Audit and Risk Committee received and noted the BAF update as at the 31.8.21.

**21/22/61 Risk Management Forum Update; including Corporate Risk Register**

The Committee received an overview of the Risk Management Forum that took place on the 7.9.21. It was reported that high quality discussions took place during the meeting with three main themes framing this discussion; access to services, people and building services.

There are 48 risks across the Trust relating to staffing levels and HR risks, nine of these sit directly in the HR department, seven with a risk rating between 4 and 9 and two high risks with a score of 16. It was pointed out that these risks impact Trust wide.

A deep dive took place during the Forum around the pipework risks and the potential additional emerging risks in terms of the overall defects. An executive meeting is to take place between the Trust and Laing O'Rourke in the next two weeks to discuss a way forward and look at how they will support the Trust to minimise the impact. Work is also taking place in order to get some traction on the longstanding risks.

It was reported that during the next meeting the Forum will focus on the Trust's plans for winter and a deep dive will take place into the 10x medication errors to see if progress is

being made, especially as it is one of the organisation's top three safety and quality priorities.

The Committee was advised that Dani Jones is going to establish a working group, with NED involvement to develop a partnership governance framework and a practical approach to address the four identified priorities.

The Chair of the Risk Management Forum concluded that there was good engagement from the Divisions during the meeting and an in depth conversation took place in terms of the risks on the Corporate Risk Register which it is felt is gaining pace and momentum.

The Chair of the Audit and Risk Committee felt that the Committee is receiving sufficient information via the Risk Management Forum route to feel assured that issues are being addressed, especially since deep dives have been implemented. This also enables Non-Executive Directors who sit on the Audit & Risk Committee to request deep dives into specific areas if necessary. The Chair raised two points in terms of the Corporate Risk Register; 1. The acronyms in the access to services section were difficult to understand and 2. Queried as to whether the risk relating to a funding model for research was a new one. It was reported that this relates to a request for additional funding as a result of the pandemic (and therefore was new). It was confirmed that progress has been made in terms of agreeing funding.

Fiona Marston referred to the risk relating to 10x medication errors and queried as to whether there would be an opportunity to reflect back on the Trust's journey around prescribing/medicine administration to understand the context of the issue and review progression, rather than just referring to the narrative in the risk register. It was reported that this information appears in the Quality Account and, in past years the Trust has included a 5-year series on some of the organisation's safety metrics.

Fiona Marston asked as to what is causing medication errors to occur. It was reported that one of the main reasons is human error, for example, being disturbed whilst writing up a patient's medication, difference in measurements (microgram/milligram), etc. The Committee was advised of some of the mitigations that have been implemented; prescribing in Meditech, nurses wearing red tabards whilst conducting medication ward rounds with 'do not disturb' written on them. Attention was also drawn to the range of closed loop technology at the bedside that has been built in for electronic prescribing and the administering of medication to enable staff to check that they have the respective patient, the right prescription and are administering the correct medication. This is done via the scanning of bar codes that link in with the system and is part of the additional safety element of the HIMMS work that the Trust is conducting. It was pointed out that further work is required in terms of a range of technology improvements to support the administration of medicines.

Fiona Marston felt that the organisation should start to see a reduction in medication errors rather than an increase, as a result of the processes that are being implemented. The Committee was advised that the Chief Nurse has highlighted medication errors as a high priority area. Following an invitation to attend a 'Medication Safety' meeting, Fiona Marston confirmed her acceptance.

**Resolved:**
The Audit and Risk Committee noted the update from the Risk Management Forum.

**21/22/62 Trust Risk Management Report**

The Audit and Risk Committee received the Trust Risk Management Report in order to scrutinise the effectiveness of risk management in the Trust. The Committee was advised that the assurance presented in this report is a direct reflection of the evidence available on the electronic Ulysses risk management system. The following points were highlighted:

- A deep dive has taken place for high moderate/moderate risks with the outcome pointing towards a better position. There is a significant movement of these risks on the register with most having a downward trend. It was reported that there are a small number of risks that have increased that could be due to external factors rather than the lack of mitigation, this matter has been discussed during the Risk Management Forum and it was confirmed that work will continue to reduce high moderate/moderate risks.
- The position of overdue risks, overdue action plans and risks with no action plans has improved during this reporting period. The Chair drew attention to a number of teams who still need to address this matter. The Committee was informed that work is taking place with individuals to provide support to help reduce risks and Kate Warriner advised that the risks detailed in the report table appertaining to IM&T have since been reduced to zero. Regular IM&T performance meetings are also taking place to ensure the department achieves standards.
- The Chair drew attention to the category of 'other risks' that are incorporated in the Report and asked as to whether these risks could be included in the appropriate Division/service. It was agreed to look into this matter.

**21/22/62.1 Action: CU**

**Resolved:**
The Audit and Risk Committee received and noted the Trust's Risk Management Report.

**21/22/63 Data Quality Update**

The Audit and Risk Committee received an update on the current position and future developments with regards to data quality in Alder Hey.

It was reported that the Trust has had a small Data Quality service in place for a number of years largely fulfilling the organisation's statutory obligations and requirements. Over the last 12 months there has been a focus on the issues relating to safe waiting list management which has drawn attention to a number of areas that required strengthening thus, resulting in a number of developments in this area.

There has been a refresh of the Data Quality Policy which was signed off in July 2021, and operational work has been conducted in terms of deploying a data quality dashboard and reinforcing data quality activities from a validation perspective. There have been some significant investments made to support the validation work which has resulted in the establishment of an operational Data Assurance Team that sits within the Divisions.

The Committee was advised that there are plans in place to develop a new Data Quality Strategy maximising the opportunities via the iDigital partnership across Alder Hey and Liverpool Heart and Chest Hospital (LHCH). Governance around data quality at Alder Hey

has recently been strengthened with a reporting structure that feeds into the Resources and Business Development Committee. In addition, from an audit and risk assurance perspective, an annual report for Data Quality will be presented to the Audit and Risk Committee. MIAA are also going to conduct an audit during Q3 on data quality.

The Committee was advised that the current resource that is assigned to data quality is not fit for purpose therefore a proposal has been submitted for additional support across both trusts in terms of a leadership role and extra WTEs. This proposal has been approved by both Executive Teams and will be progressed via the iDigital partnership.

The Chair pointed out that the focus on waiting list management is understandable at the present time but queried as to whether assurance will be provided on other areas of work going forward. It was confirmed that opportunities in terms of other service areas will occur as each phase of the strategy progresses. The Chair concluded this item by advising that the Audit and Risk Committee will receive the Data Quality Annual Report in April 2022 and recognising at this point that the Data Quality Service is in the development stage in terms of the team that will evolve over the next two years.

**Resolved:**
The Audit and Risk Committee noted the current position and future developments with regards to data quality.

**21/22/64** **CQC Action Plan, 2020/21**

**Resolved:**
The Audit and Risk Committee received and noted the CQC Action Plan.

**21/22/65** **Update on Risk Management Process within the Division of Medicine**

The Committee was provided with an overview of the process that is in place to manage risk in the Division of Medicine (DoM), in order to draw attention to any barriers/issues that the Division is experiencing and escalate them to the Committee.

It was pointed out that each service has a triumvirate to manage risk which consists of a Clinical Facilities Director, Service Manager and Matron. In terms of therapies the Associate Chief Nurse liaises with all of the therapy leads.

Regular weekly meetings usually take place between the Governance Lead and the Associate Chief Nurse, but at the present time the Trust is in the process of appointing a new medical Governance Lead. It was confirmed that each service has a named Lead, but recent discussions have highlighted the importance of having a dedicated Governance Lead for each service across the three divisions. It was reported that weekly staff huddles take place on the wards to discuss any issues which if required can be escalated via a chain of command; Ward Manager, Matron, Governance Lead.

There is a forum where risks can be raised, and a governance hour takes place every four weeks to enable the leads to come together and receive training/education. The Committee was advised that the DoM also have monthly meetings in order to discuss risks and governance issues. During the last performance review, it was confirmed that the DoM had no overdue risks or actions outstanding but is aware of the moderate risks that need addressing. A plan has been implemented which will review two risks per week as well as carrying out a deep dive to look at reducing these risks.

In terms of challenges, it was felt that once Governance Leads have been trained to a high level they tend to move on to a better paid job, and voluntary leads are only able to offer a limited amount of time due to the commitments of their day job. The Chair drew attention to the importance of the Governance Lead role and suggested that the Exec Team review the job description and remuneration in order to support the retention of staff in this role. Cathy Umbers advised the Committee that this is the second group of staff members who have left the organisation and pointed out that this role is really broad and pressurised therefore it is necessary for the organisation to look at how it values these staff members. Following discussion, Erica Saunders agreed to lead on the discussions relating to this matter and provide feedback.

**21/22/65.1** **Action: ES**

**Resolved:**
The Audit and Risk Committee received the Update on Risk Management Process within the Division of Medicine.

**21/22/66** **Job Planning Portal Update**

The Committee was advised that the Trust has recently signed up with a company called Licenced to Practice (L2P) for both appraisal and job planning for Consultants, Associate Specialists and Speciality Doctors. The following points were raised:

- Training sessions have been held and attended by a number of clinical leads, service managers and others with a management role to enable them to support their staff with the new platform for job planning and appraisals. A training video has also been made available to all consultants within the Trust.
- L2P are currently working on the system build based on Trust information and each service is looking at their respective job planning. It was reported that 27% of job planning for the DoM has already been completed and the majority of services have had a team job planning meeting.
- There are 20 medics in the Community Division of which 35% have a current agreed job plan in place.
- The Trust is looking to open the portal during the first week of October, any existing agreed job plans will be uploaded onto the system to enable staff to populate the job planning.
- All job plans will be reviewed by a Consistency Panel before they are considered to be agreed. It was reported that consideration is to be given to removing the third sign off requirement by the Medical Director.
- A full job planning round will be undertaken from the 1.4.22, with the aim being an agreed job plan for all Consultants, Associate Specialists and Speciality Doctors.
- The Committee was advised that personal objectives are discussed and reviewed during annual appraisals and therefore don't always align with job planning. Kath Stott referred to recommendation 5 in the MIAA report and advised that the objective was slightly at odds with the report submitted by Urmi Das and agreed to amend this information in the MIAA report, ahead of November's Audit and Risk Committee meeting.

The Chair thanked Urmi Das for the work that has been conducted to drive this huge piece of work forward. It was felt that great strides have been made and assurance has been provided in terms of the momentum around job planning.

**Resolved:**
The Audit and Risk Committee noted the job planning portal update

**21/22/67 Internal Audit Progress Report**

The Internal Audit Progress Report was submitted to the Committee to provide an update on the progress that has been made against the Internal Audit Plan for 2021/22 during the period of July 2021 to September 2021. The following points were highlighted:

- MIAA issued three final reports during the reporting period; Waiting List Management which received moderate assurance, Data Security and Protection Toolkit (DSPT) of which the self-assessment received substantial assurance and the assessment against the National Data Guardian Standards received moderate assurance.

  It was reported that the Trust has accepted the conclusion of the Waiting List Management Review and have shared a very robust action plan to address the issues raised by MIAA, which has been agreed.

  Attention was drawn to the two different opinions that were received following a review of the DSPT and a discussion took place around the two areas that resulted in a moderate assurance in terms of the assessment against the National Data Guardian Standards. The Committee was advised of the difficulties that the Trust has experienced over a period of time from an IG resource/training perspective which has led the organisation to take forward a collaboration with LHCH. The collaboration has provided Alder Hey with access to additional resources; Data Protection Officer, Band 7 role that sits across both trusts and a number of apprentices which will help towards improving the Trust's position on IG training, data flow mapping, cyber training, etc.

  It was reported that the Trust has also recruited an Information Security Officer, Paul Grimes, who is progressing the work required to meet the respective standards for cyber security/National Data Guardian Standards, etc. There is an action plan in place to support this work and the Data Protection Officer; Wyn Taylor is addressing data mapping and information assets. Following discussion, ES and KB agreed to meet to discuss the possibility of inviting Paul Grimes to November's meeting to provide an update and share the action plan that supports the DSPT work that is taking place at the present time. The Chair felt that the update had provided assurance to the Committee that mitigations have been implemented to address the gaps in this area of work.

**21/22/67.1 Action: ES/KB**

- *Risk Management Thematic Reviews* – There are three reviews to be progressed which are currently at the scoping stage; Lessons Learnt, Key Financial Control and IT Service Continuity and Resilience which are scheduled to commence in Q3. It was confirmed that recruitment has been deferred to Q4. The Chair pointed out

that there are some challenges in the Recruitment Team at the present time and therefore felt that it was appropriate for this review to be deferred to Q4.

Kath Stott advised the Committee that following a discussion with the Medical Director and Chief Nurse about the reserve list in the Audit Plan, it was confirmed that Complaints and PALS is going to be the review that will be taken forward. The Chair reported that during the discussion the group looked at current issues and other potential priorities in addition to those on the reserve list. The Chair confirmed her agreement for this review to be progressed.

- *Assurance Framework Opinion Stage 1* – There has been Board engagement in the review and use of the Assurance Framework so far in the year. Review of the Assurance Framework is also reflected in the Board work programme for the year.

**Resolved:**
The Audit and Risk Committee received and noted the contents of the Internal Audit Progress Report.

**21/22/68 Internal Audit Follow Up Report**

The Committee received an update on the latest position regarding the most recent phase of follow-up reviews and the progress that has been made during the reporting period; April to August 2021. The following points were highlighted:

- The next Internal Audit Follow-up Report will include data on the percentage of recommendations implemented/not implemented. It was pointed out that this information has been omitted in error as a result of the new formatting.
- It was reported that 19 of the 56 agreed actions have been implemented, and 2 recommendations relating to mandatory training were superseded; the Mandatory Training Policy that was uploaded onto the Trust's external website was slightly different than the policy on the Trust's intranet and the core mandatory topics differed slightly too. Following a review of these documents it was confirmed that they shouldn't have been uploaded onto the external website and therefore were removed hence the reason for these recommendations having been superseded. The Committee was advised that narrative is to be included in the Follow-up Report for every recommendation that has been implemented and for those that have been superseded. The Chair drew attention to the importance of formally noting and agreeing when the Committee agreed extended deadlines. Gary Baines felt that both of these points should be taken forward as part of MIAA's standard practice.

  For clarity purposes, Anita Marsland queried as to whether the Trust usually publishes its Mandatory Training Policy on its external website. It was confirmed that the Trust doesn't publish any of its policies on its external website but will provide a copy of any policy upon receiving a FoI request.

- There are 5 recommendations that haven't been implemented to date; one relates to clinical audit processes and four relate to mandatory training. The Committee was advised that the Trust has moved the responsibility of its learning and

development to the new Academy therefore these recommendations will be re-visited with the Academy Director, Katherine Birch.

**Resolved:**
The Audit and Risk Committee received and noted that contents of the Internal Audit Follow-up Report.

**21/22/69 2021/22 Client Satisfaction Questionnaire**

**Resolved:**
The Audit and Risk Committee received and approved the six questions included in the 2021/22 Client Satisfaction Questionnaire.

**21/22/70 Anti-Fraud Progress Report**

The Committee received an update on the work undertaken during the period from the 1.4.21 to the 14.09.21. The following points were highlighted:

- *Baseline Assessment* – A baseline assessment setting out the initial level of compliance with the new Government Counter Fraud Functional Standards GovS 013 was prepared and submitted via the NHSCFA online portal on the 30.5.21 in line with the national deadline of the 31.5.21. The submission comprised of 9 green and 4 amber components out of a total of 13. The baseline assessment was reviewed and approved by the Director of Finance and the Chair of the Audit and Risk Committee prior to submission.
- Attention was drawn to the 4 new functional standards that were rated amber:
  - *Component 1b – Fraud Champion :* It has been agreed that the Anti-Fraud Service (AFS) will work with the Trust's Fraud Champion, Ken Jones, to progress this role and agree a suitable programme of awareness activities.
  - *Component 2 - Counter Fraud Bribery and Corruption Strategy:* This has been moved to green following the approval of the Counter Fraud Policy during June's Audit and Risk Committee.
  - *Component 3 -Organisations undertaking a risk assessment in line with the new Government Counter Fraud Profession (GCFP) methodology:* It was reported that all of MIAA's clients have been rated amber for this component as guidance relating to this change has only just been released. An overview of the methodology was provided, and it was reported that the AFS will work with the Trust to update the risk assessment in line with the GCFP. This work has to be conducted in line with the organisation's Risk Management Policy therefore the AFS has updated its toolkit to accommodate the changes to the new risk assessment work.

    In light of the additional expectations in terms of fraud risk assessment, the Chair raised her concerns about the Trust's current process for recording risks relating to fraud; one risk on the register with a detailed Excel spreadsheet of 7 thematic risks sitting behind it and asked that risks be included on the risk register on an individual basis. MIAA advised that the initial work will need to take place first in order to gain advice on the process that the Trust should implement going forward.
  - *Component 12 – Conflicts of Interest:* The Committee was advised that the Trust has a good policy, procedure and reminders in place for Conflicts of Interest, but

this component has remained amber as the Trust reported 78% compliance at the time of assessment with a 137 members of staff still yet to make a declaration. A discussion took place around the percentage for achieving a green rating. Virginia Martin advised that there isn't a specific target but suggested having a score of a high 80% and above. Concerns were raised about the lack of a set target and it was suggested that MIAA refer to the Centre regarding this matter and liaise with other specialist trusts in terms of acquiring a benchmark figure. Following this conversation, it was agreed that a meeting will take place to agree a percentage for achieving a green rating.

**21/22/70.1** **Action: ES/RL/VM**

- An update was provided on inform and involve, prevent and deter and hold to account, as detailed in the report.
- There have been zero fraud referrals during this reporting period and there is one open case that is to be submitted to the CPS for consideration. The internal element of this case was completed within the reporting period and the individual was dismissed at a hearing on the 21.7.21.
- The Committee was advised that CFS has assisted the Home Office with an investigation into an illegal immigrant who had no right to work or live in the UK. It was reported that this individual had worked at Alder Hey and other NHS organisations around the UK. This case went to court on the 10.9.21 and the individual was sentenced to 27 months in prison and is likely to be deported after serving his sentence. The Director of Corporate Affairs advised the Committee that this person was a contractor at Alder Hey and had not been appointed by the Trust.

The Chair thanked Virginia Martin for the work that has taken place during the reporting period.

**Resolved:**
The Audit and Risk Committee received and approved the Anti-Fraud Progress Report.

**21/22/71** **Progress against actions from the Audit and Risk Committee Self-Assessment**

The Committee was advised that it has been agreed that a meeting will take place to review the operation of the Audit and Risk Committee versus the Risk Management Forum meeting and the interaction between them. This will address the main outstanding Recommendations.

**21/22/71.1** **Action: KMC**

The Chair felt that it was time in which to conduct a self-assessment of the Audit and Risk Committee and agreed to submit a questionnaire during November's meeting for approval in order to take this forward.

**21/22/71.2** **Action: KB**

**21/22/72** **Non-Clinical Claims Report**

The Committee received the Non-Clinical Claims Report for 2019/20 which contained information on new claims received between the 1.9.19 and 30.9.20; including claims closed during this period.

The Chair asked as to whether the timing is appropriate in terms of the Audit and Risk Committee receiving the Non-Clinical Claims Annual Report during the month of September as the report presented is over 12 months old. The Committee was advised that the report is usually submitted to respective committees during November to enable data to be shared in a timely manner. Following discussion, it was agreed to amend the work plan to reflect a November submission.

**21/22/72.1** **Action: KMC**

The Chair raised two questions; 1. *Section 3, reference M19LT502* – Why did it take so long to fix the root cause of the issue and 2. *Section 8, comparison of the numbers of non-clinical claims and incidents reported to NHSR by paediatric trusts* – Why does the Trust have a lot more claims in comparison to GOSH/Sheffield and yet the value of the claims are smaller?

It was reported that the Trust has a culture of claim with particular individuals submitting claims on more than one occasion. The Committee was advised that Weightmans have helped Alder Hey transform the way it manages, monitors and reduces the timeframes of claims. It was felt that the Trust now has a greater oversight of non-clinical claims but will continue to progress this area of work in terms of looking at trends, education/training for staff and determining the reason for repeat claims. MIAA reiterated Melissa Swindell's comments in terms of Weightmans supporting the Trust and confirmed that a number of actions from the recent audit had been closed over the summer period.

**Resolved:**
The Audit and Risk Committee received and noted the contents of the 2019/20 Annual Report for Non-Clinical Claims.

**21/22/73** **Alder Hey Innovation Company Structure; including Acorn Action Plan**

The Committee was provided with an update on the governance structure of all the companies that Alder Hey has an equity interest in, along with an update on the Acorn Action Plan that was developed following a review undertaken by KPMG. The following points were highlighted:

- It was reported that Alder Hey Living Hospital was originally a joint venture with the Charity but is now a wholly owned subsidiary of Alder Hey. This company was established to develop the Alder Hey app that was created with the Charity. The app has been completed and is taking on another role within the organisation's Digital Workplan therefore a proposal is in the process of being submitted to the Innovation Committee to agree the future of this company.
- Alder Hey Ventures is a wholly Alder Hey owned subsidiary that was set up in 2017 and has lain dormant ever since. As a result of the recent growth in innovation and a number of commercial areas the organisation is looking to make it live. It was confirmed that a proposal is being submitted to RABD and the Innovation Committee to agree a way forward.
- It was reported that the Trust is looking to continue with two of the companies under the Acorn Limited partnership; Hand Hygiene and Audiology Metrics. It was confirmed that the majority of the spin out companies under the partnership did not succeed to the next stage. The Committee was advised that the Trust will be exiting the Acorn agreement therefore the bulk of the recommendations/actions

that were made by KPMG in terms of the partnership have either been closed or will be once the exit is finalised.

- Attention was drawn to the element of the action plan that addresses governance in terms of innovation. The three actions that are not fully complete relate to the governance of innovation and link in with corporate governance. A significant amount of work has already been undertaken in establishing appropriate governance and structure within the innovation activities with some final areas to be completed. Once complete and agreed the appropriate documents can be finalised and taken to the relevant Committees for approval which will close the three remaining actions on the plan.
- It was proposed that the Audit & Risk Committee looks to engage with an external body to undertake a follow up review in Q1 of 2022/23, similar to the review conducted by KPMG, when the newly established processes will have been embedded. This will also allow for any best practice to be shared with the Trust's commercial areas and provide assurance to the Committee of the controls that are in place.

Fiona Marston raised concerns around oversight in terms of the companies that the Trust has an equity interest in, as responsibility and decision making is divided between RABD and the Innovation Committee. Fiona Marston also felt that there might not always be the right experience within both Committee structures to address specific matters. Erica Saunders provided an overview of the rationale that was used when agreeing the workplan for both Committees and pointed out that a number of core management decision makers sit on both Committees. Rachel Lea drew attention to the importance of having clarity in the Innovation Governance Manual in terms of the areas that each Committee covers, what is reported and the expertise that is required to make decisions.

Fiona Marston advised of her sense of separation from discussions and decisions which she feels are key to the Innovation Strategy, as a result of not sitting on RABD. In terms of risk this raises the question as to whether the right decisions are being made due to the lack of oversight for specific items by both Committees. Fiona Marston drew attention to the importance of the Trust challenging itself to ensure that it's not disjointing strategy from key decisions that will have an impact on this area of work, especially as Alder Hey is looking towards the Innovation Strategy contributing to income.

The Chair suggested conducting an operational review of RABD versus the Innovation Committee and the interaction between them. It was agreed to look into this matter in terms of reporting structures, Fiona Marston's comments, and reflecting upon any changes that might need to be implemented. Fiona Marston offered to support this work if required.

**21/22/74.1 Action: ES/RL**

**21/22/74 Review of PPE Purchased During Covid**

Initially Deloitte were going to conduct a review of VFM in purchasing PPE during the pandemic. This review was not progressed therefore it was agreed that the Trust would carry out an internal piece of work in terms of reviewing a small number of cases using a conflicts of interest lens. The following points were highlighted:

- The Associate Director of Financial Control and Assurance along with the Procurement and Contracts Manager revisited the processes implemented at the time following the initial outbreak of the pandemic, reviewed the waiver lists and the independent review of Covid expenditure undertaken by MIAA in the summer of 2021.
- Consideration was given as to whether the money that was spent on PPE at the time gave the organisation value for money and delivered the Trust's aspirations in terms of maintaining a secure working environment to keep patients and staff safe throughout the pandemic. The Committee was advised that it was an extremely challenging period and under exceptional circumstances the Trust made a conscious decision to secure PPE supplies when they were available in order to maintain safe service delivery.
- The overall conclusion of the review is that the Trust may have paid a little extra for supplies but it was felt that value gained from these purchases enabled the Trust to maintain its critical services in a safe manner, protect its staff, patients and their families and to significantly reduce the risk of serious illness and potentially loss of life.

Fiona Marston queried as to whether the organisation has fully considered the learning from the pandemic and asked as to whether Alder Hey would be better prepared in the event of another pandemic. It was reported that there have been lots of lessons learnt and the Procurement Team have processes in place that they didn't prior to the pandemic. It was felt that the System would be more prepared if faced with another pandemic and trusts would work in collaboration.

The Chair thanked Ken Jones for the update and agreed with the overall conclusion in terms of value for money, pointing out that there were no issues raised with regards to conflicts of interest.

**Resolved:**
The Audit and Risk Committee noted the outcome of the review that was conducted of PPE purchased during the pandemic.

**21/22/75 CARS Review – Net Nil Value Fixed Assets**

The Chair advised the Committee that following completion of the annual accounts for 2020/21 the ISA 260 report highlighted an entry relating to an item of equipment which was found to have been disposed of in 2018 yet remained on the Trust's asset register with a nil value. While this had no effect on the Statement of Financial Position, and the net book value was nil, the disclosure note has overstated cost and accumulated depreciation. It was confirmed that this was a minor control issue with no financial exposure to the organisation.

It was reported that the majority of the Trust nil value assets are in the medical devices area. Work is taking place with the Medical Devices Team in order to review their asset log and cross reference it with the CARS system to identify items that may have been disposed of in a previous period that are still included on the asset register. This piece of work is currently being progressed and once complete, the CARS asset register will be updated and any items which are no longer in use will be removed. A further piece of work

is also taking place to introduce a process which will enable any disposals to be recorded as 'disposed of' on a monthly/quarterly basis going forward.

The Committee was advised that a number of areas have been identified for demolition as part of the campus programme development. Any buildings in this group which have been physically demolished in year will be removed from the CARS register as part of the year-end closedown process.

The Chair drew attention to the importance of implementing a process following this exercise to maintain this process going forward.

**Resolved:**
The Audit and Risk Committee received and noted the outcome of the CARS review of the Trust's net nil value fixed assets.

**21/22/76 Bomb Threat and Suspicious Packages/Persons Incident Plan**

The Committee received the Bomb Threat and Suspicious Packages/Persons Incident Plan, and an overview of the exercise that took place to test the Plan was provided. It was confirmed that there were 38 issues that required amending in the policy which have been actioned, it was also pointed out that the exercise helped to identify certain areas which are being progressed.

The plan was approved by the Emergency Planning Group on the 27.7.21 and has been submitted to the Audit and Risk Committee for ratification.

The Chair asked that a summary of changes be included in any future version of the plan prior to submission and queried the name of the interim Emergency Preparedness and Business Continuity Manager. It was confirmed that Nathan Askew would be able to provide this information.

**21/22/76.1 Action: NA**

**Resolved:**
The Audit and Risk Committee agreed to ratify the Bomb Threat and Suspicious Packages/Persons Incident Plan

**21/22/77 Information Governance Policies**

The Committee received the following policies for ratification, following an annual review:

- ICT Network Security Policy.
- Overarching Information Security Policy.
- Records Management Policy
- Bring Your Own Device Policy.

The Chair pointed out that the Audit and Risk Committee has received a large number of policies for approval since the disbanding of the IGC and queried as to whether a list could be collated in terms of the forthcoming policies that are to be submitted to enable the Committee to manage them. It was reported that Wyn Taylor is going to review the the suite of policies and share it with the Committee to enable it to be streamlined.

**21/22/7.1** **Action: WT**

**Resolved:**
The Audit and Risk Committee ratified the ICT Network Security Policy, the Overarching Information Security Policy, the Records Management Policy and the Bring Your Own Device Policy.

**21/22/78** **Corporate Governance Manual**

The Committee received an update on the amendments that have been made to the Corporate Governance Manual. The changes relate to:

- Job titles.
- Procurement rules.
- The names of those who are responsible for requisitions of goods and services for non-pay expenditure as the Trust is operating as a collaborative within a specialist trust group.
- Thresholds and dates for public regulations.
- Quotation thresholds.
- National framework agreement.
- Reference to NHS supply chain as opposed to NHS logistics.

It was pointed out that the review was more analytical as opposed to a complete review with the main changes relating to job titles and roles. Once the track changes have been made this will form part of the formal agreement of the document and will be submitted to the Committee in January 2022 for ratification. It was requested that MIAA review the overall document prior to submission and a summary sheet be included at the front of the document to highlight the changes that have been made.

**21/22/78.1** **Action: KS**

**21/22/79** **Any Other Business**

There was none to discuss.

**21/22/80** **Meeting Review**

It was felt that the Committee had a number of really good discussions in terms of data quality, innovation governance, risk management in the DoM and L2P. The Chair advised that during the next meeting a conversation will take place around the starring of items on the agenda which will be taken as read with questions only.

**21/22/80.1** **Action: KB**

**Date and Time of the Next Meeting:** Thursday 18th November, 2:00pm-5:00pm, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

**Resources and Business Development Committee**
**Confirmed Minutes of the meeting held on Monday 21st October at 10:00am, via Teams**

| | | | |
|---|---|---|---|
| **Present:** | Ian Quinlan (Chair) | Non-Executive Director | (IQ) |
| | Shalni Arora | Non-Executive Director | (SA) |
| | Adam Bateman | Chief Operating Officer | (AB) |
| | Kate Warriner | Chief Digital & Information Officer | (KW) |
| **In attendance:** | Mark Flannagan | Director of Communications | (MF) |
| | Russell Gates | Associate Commercial Director Development | (RG) |
| | Emily Kirkpatrick | Associate Director Commercial Finance | (EK) |
| | Abby Prendergast | Associate Director Strategy & Partnerships | (AP) |
| | Clare Shelley | Associate Director Operational Finance | (CS) |
| | Amanda Graham | Executive Assistant (*minutes*) | (AG) |
| **Joined late :** | John Grinnell | Acting CEO | (JG) |
| | Nathan Askew | Chief Nursing Officer | (NA) |
| | Nicki Murdock | Chief Medical Officer | (NM) |
| | Melissa Swindell | Director of HR & OD | (MS) |

**20/21/293** **Apologies:**
Apologies were received from Rachel Lea, Erica Saunders, Dani Jones and Claire Liddy.

**20/21/294** **Minutes from the meeting held on 27th September 2021.**
The minutes of the last meeting were approved as an accurate record.

IQ asked when the Green Plan would be brought for discussion; MF confirmed this would be in January 2022.
IQ asked whether the Division of Medicine would also be undergoing a deep-dive into their financial position; CS noted that this work is ongoing and would be brought to the November meeting.

**20/21/295** **Matters Arising and Action log**
There were no updates for the Action Log.

**20/21/296** **Declarations of Interest**
There were no declarations of interest.

**20/21/297** **Finance Report**
**Month 6 Financial Position**
CS presented the Month 6 Financial report, noting that the Trust had achieved a break-even position for H1. With the ERF threshold changes and C&M performance, there has been an overall loss of -£2.9m which was offset by lower expenditure than planned.

The Month 6 position is £1.9m surplus, £753k ahead of plan, achieving break-even YTD and in line with both Alder Hey's plan and the C&M control total.

CIP still remains a challenge, with a shortfall of £2.5m (41%) and focus remains on the progress of schemes. Cash at bank is £89m with capital spend YTD of £9.3m.

Divisionally, Medicine retains an overspend mainly related to ED pressures, non-PBR drugs and unachieved CIP, and a deep-dive is being undertaken which will be

reported on at the next RABD; Transformation has also under achieved on CIP by £1.6m; Facilities is at -£1m from loss of catering & car-park income; whilst Surgery and Community are both ahead of plan due to patient income and vacancy slippage.

The NHS pay award of 3% has resulted in the majority of the adverse position against Pay but has been captured within the Income position and will be received as part of the Month 7 block payment. The associated spend for the Paediatric Accelerator bid of £2.6m relates to a large part of the adverse variance within Non-Pay, which has also been accounted for against income.

Key risks remain similar to previous months, with the addition of the following key changes:

- the Trust's future capital expenditure is undergoing further focus and analysis and discussions continue as part of the C&M Capital Management Group;
- work is underway to assess the impact of H2 planning guidance across C&M of £36.6m less than H1 and which includes: a requirement for systems to be at break even by March 2022; an inflation of 1.16% (incorporating the pay award & 0.82% CIP); reductions in COVID & lost income funding and targeted efficiency.

KW asked for confirmation around the status of the Transformation CIP as it was believed unlikely that this would be achieved until 2022/23; CS noted that this requires concerted effort and focus remains on 2022/23, but believes this should also be understood and managed across C&M to begin to make CIP savings across the system.

**Resolved:**
RABD received and noted the M6 Finance report.

**Write-offs for Month 6**
There were two main areas affected by write-offs for Month 6: firstly, the historic challenges on VAT charged on Research invoices, for which the Division have been reluctant to compromise their relationship with the grant provider and it is recommended that the sum of £5725 is written off. Secondly, an historic claim for the excess applied to an insurance claim following the Echo Arena car-park fire, where a patient's wheelchair was destroyed and it is recommended that the sum of £494.11 is written off to avoid negative publicity and / or a formal complaint.

**Resolved:**
The Committee approved the Month 6 write-offs as detailed in the Finance Report.

**20/21/298** **2021/22 H2 Plan**
CS gave an overview of the Planning Guidance for H2, noting that the six aims & their associated priorities have remained the same and shared the Key Operational Metrics for H2. The ERF threshold has changed to 89% of 2019/20 completed RTT activity, making completed pathways more of a focus. Brief details were given of funding opportunities and the potential impact of reduced income for C&M. The Specialist Trusts are challenging allocations of system top-up due to ERF being unavailable for H2, along with lobbying Spec Comm for fair allocations of funding and NHSE for full reimbursement of the pay award.

Work is ongoing with all Divisions to ensure forecasts are as accurate as possible and to develop mitigations for the loss of funding in H2. For H2, activity is based on

completed RTT pathways and if up to 94% is achieved then 100% of tariff will be received, with 120% received if over 95% is achieved; however this is system-wide and the initial analysis of H1 is that C&M achieved 82% and are expected to achieve below the 89% threshold for H2. Details of the submission timescales were also shared.

Key operational priorities remain the same as H1, with clearer guidance and KPIs to be attained, noting that it will be extremely challenging for C&M.

IQ noted that it will be very difficult for the Trust to work in an environment where income is based on the work of someone else; CS noted that the DoF for LHCH is representing the Specialist Trusts and is challenging the ICS to ensure they get their fair share of allocations.

**Resolved:**
RABD received and noted a brief update against the 2021/22 Annual Plan.

**20/21/299** **Capital & Cash Updates**

KJ gave an overview of the current Cash & Capital position, noting that a refresh of Capital requests has been completed with the outcome that the 5-year Capital plan is currently oversubscribed. As a result, Exec Leads will be allocated, and prioritisation & RAG ratings will be applied to all proposed projects to capture any associated risks if investment were not to take place. It is understood that CDEL and capital allocations will be under pressure in future years, but it is not yet known in what form; there is some belief that future allocations may be limited to a Trust's own generated depreciation. This has also been taken into account in the Capital refresh and has identified several areas of planned investment totalling around £17m that may need to either be removed from the plan or moved to Managed Services, having a different accounting method & financial impact.

There is a relatively high Cash balance, mainly due to the Paediatric Accelerator monies for our own schemes and those which are being hosted by the Trust. The 5-year forecast takes into account the refresh of capital plans and shows a need for savings and a challenging time ahead to maintain the minimum headroom required and the break-even position.

IQ asked what plans are being made to mitigate the eventual overall shortfall detailed on the slides; KJ noted that a large amount of that figure will be found from reducing the Capital programme by removing those projects that are not must-do's and to reallocate some areas to managed services.

**Resolved:**
RABD received and noted the Cash and Capital updates.

**20/21/300** **Campus & Park Updates**

RG gave a brief update on the Campus and Park developments, noting that Phase 1 of the Park is now open, the new Neonatal unit has been granted planning permission and occupation of the office space at Innovation Park has now begun. The landscaping for Phase 2 of the Park has now commenced and discussions are ongoing with loss adjusters regarding the claim for the Knotty Ash Nursing Home.

**Resolved:**
RABD received and noted the Campus update.

**20/21/302** **ODN Networks Update**

AP gave a brief update on the ODNs, noting that this update is part of the obligation as host organisation. The Neuroscience ODN has now been decommissioned following NHSE's withdrawal of funding. The Cancer network will be hosted by RMCH and jointly accountable through the North West Paediatric Partnership Board. The Paediatric Critical Care & Surgery network went live on 2nd August.

The paper also provides assurance that the CHD and Neonatal Networks are managing their resources and risks effectively, Finally information is waited from NHSE/I on their review of some services & networks and how the expected changes to future funding and commissioning will impact those. Until such time as there are any decisions the networks will be run as effectively as possible to provide stability for the services and staff.

**Resolved:**
RABD received and noted the ODN Networks Update paper.

**20/21/303** **Communications Update**

MF noted that the paper is within the meeting pack, highlighting three main points: the team are continuing to support delivery of the Winter Plan; the ICS is now beginning to build a Communications team; and there are two business cases being worked up, to reconcile the current Comms overspend and to progress the new website / Intranet.

**Resolved:**
RABD received and noted the Marketing & Communications update

**20/21/304** **Recovery & Urgent Care Update**

AB noted that a detailed report was within the papers circulated and gave a brief presentation to provide an update, noting the very high demand in some areas especially within ED and PICU. Occupation is currently at around 92% with high staff absence and vacancy levels. Attendance within ED is on average 17% higher on a daily basis than 2019, with 60% in Referrals having already attempted to access other services but had been redirected to ED. An external review of staffing has been commissioned and the content is being reviewed. Staff welfare & pastoral support is being given to support staff through the increased activity and acuity.

The Trust has had Gold Command running for several weeks now and the on-site Community Pharmacy service is running 7-days, acute Paediatric clinics are being held daily and the CAMHS crisis care team continues to run a 24/7 service. The Winter Plan has now been approved with its four key deliverables of escalating capacity in critical & emergency care; patient flow; staff wellbeing support & advice; and the staff vaccination programme. System-wide there has been a new Paediatric Assessment Service through NHS111; Paediatric Gold & Silver Commands are now both running every week; partnership work with Mersey Care for Health Visitor service and walk-in centre access.

Recovery-wise, levels have reduced through September due to the pressures noted above. If emergency admissions continue to increase, there will be a negative impact on recovery as staffing will need to be reassigned to support the increased activity.

**Resolved:**
RABD received and noted the Recovery & Urgent Care update.

**20/21/305** **Safe Waiting List Management Update**
AB gave a brief update on the current position with the Safe Waiting list work, noting that validation of the 45,000 outpatient records is now almost complete with c.300 patients to be reported and their treatment is being expedited.

IQ commented that from the starting point last year this is not a bad outcome; AB responded that it is a good outcome but wanted to note that in the next few weeks there will be approximately 300 additional patients who will come through as long-wait patients, equating to 0.14% of records.

**Resolved:**
RABD received an update on Safe Waiting List Management.

**20/21/306** **Month 6 Corporate Report**
AB presented a brief update on the M6 Corporate Report, noting that the report was within the papers circulated. The key operational challenges currently are the demand upon ED and the 52w wait position which have been reported on earlier.

**Resolved:**
RABD received and noted the M6 Corporate report.

**20/21/307** **Digital Update**
KW gave an update for Digital, noting that operational performance remains good, with several awards and commendations recently from the Health Tech Awards for Digital Team, Cyber Security and for a joint working programme with Innovation and the Community Division. Strategically, work is beginning on the next version of the Digital Strategy in 2022/23. The HIMMS Level 7 assessment is due on 16th November and a successful accreditation is hoped for.

The Alder Care program continues being probably the largest digital change program undertaken, with a few risks which are being carefully managed. Additional senior resource has been brought in to manage both the program and the customer / supplier relationship with Meditech.

The Digital update now includes reporting information from BI and Information Governance Service which fall within the wider Digital team; work is progressing with LHCH on a joint data quality team and also with IG collaboration.

**20/21/308** **PFI Report**
It was noted that the report was within the papers circulated.

IQ asked whether the green roof works were at Alder Hey's cost; RG assured the committee that the repair works were at the cost of the developer as a construction defect.

**Resolved:**
RABD received and noted the M6 PFI report.

**20/21/309** **Board Assurance Framework**
It was noted that the Board Assurance Framework report was within the papers circulated .

**Resolved:**
RABD received and noted the BAF update for September 2021.

**20/21/301** **Neonatal & PAU Development**
*(Taken out of sequence - discussions commenced in the absence of JG, MS, NA & NM)*

RG gave an overview of the Capital paper for the Neo / PAU development, advising that tenders have come back over budget and that the purpose was to seek approval to either increase the budget or go back to redesign within the current financial envelope. Detail was shared around the proposals to reduce costs along with detail of the equipment schedules that have been fully costed by the medical engineering team. The construction industry is also experiencing pressures across the sector due to unavailability of supplies and the increasing price of steel.

AB gave an overview of the business case for an urgent and acute care facility within the development for the new NICU. Ground floor would consist of an 8-bed urgent care facility, to respond to a need for reassurance for families outside of an A&E department. Alongside that would be a 12-bed paediatric assessment unit (PAU) also on the ground floor, with the neonatal ICU on the first floor. Illustrations were shared giving an impression of the design and space, showing the flexibility of the rooms and space.

AB noted that there is a detailed paper on the PAU within the business case. It is a common model of care within paediatrics, which is proven to deliver a reduction in length of stay, thus protecting some elective capacity. The Urgent Care facility would enable up to 61 low-acuity patients a day to have a consultation with a multi-professional service of GPs, Health Visitors & Community Pharmacists and then be streamed to receive care at home, taking medication with them.

AB noted that future ICS / CCG funding may include some capital availability which could be bid against, which would enable investment to be released in a staged process; while the revenue position is detailed within the business case it is currently not felt appropriate to seek formal agreement of recurrent funding, but future negotiation of the block contract needs to be considered to offset the increased emergency activity that has been delivered through existing income.

*(JG joined the meeting)*
Discussion took place around the capital funding. IQ summarised that to recoup the £1m shortfall there are three options: to seek further funding from the charity; to increase the budget; and to decrease the size of the project. JG noted the risk that a redesign may not result in the necessary out the cost savings as there will be a cost to it along with fluctuating market conditions; there is a possibility of applying for central capital funding; and finally a preliminary conversation has been held with the Charity but any decision to increase funding would need the agreement of their Trustees. JG observed that cost management will continue without any guaranteed funding for the time being, but that all available funding streams should be explored and applied for.

*(MS, NA & NM joined the meeting)*
KJ noted that the intention to go ahead with the scheme has been part of all the conversations with the ICS; if a decision is made not to go ahead this financial year that could impact capital funding for the next year.

SA asked whether contractors are working on a fixed-price contract basis going forward as that would help to manage costs; RG noted that because there is a requirement to go through the PFI, fixed price budgets have to be agreed anyway.

SA noted that her view would be to make the cost savings and press on – if the Charity cannot deliver further fund then a way will have to be found to absorb the costs; IQ agreed with SA's view. IQ also asked for confirmation of the approval level for the Committee; JG confirmed that for completeness this on the agenda for Trust Board due to the high value.

JG commented that there are some pieces of work to refine this further: working on cost reduction; assessing what the urgent care demand will be & how to best meet that demand by differing levels of acuity; seeking additional funding for those services; assessing what business development opportunities can be progressed. Recruitment will need to be planned which will give a timeline that may well allow those other pieces of work to develop and to allow the system dynamics to play out a little further.

SA asked for clarification whether this PAU development is the same space as the PPU that was proposed at a previous meeting; AB responded that it was not, but this PAU facility would free up space elsewhere that could become a PPU.

IQ asked that this item be brought back to RABD in December for further discussion.

**Action**: Business case to be brought back to RABD in December 2021 (AB)

**Resolved:**
RABD received an update on the proposed Neonatal & PAU development.

**20/21/310** **Any Other Business**
No other business was reported.

**20/21/311** **Review of Meeting**
IQ noted that the main discussions were around the H2 forecast and the PAU; all other items were updates.

**Date and Time of Next Meeting: Monday 22nd November 2021, 10am – 12pm, via Teams.**

Alder Hey Children's NHS Foundation Trust

**Safety and Quality Assurance Committee**
**Confirmed Minutes of the meeting held on**
**Wednesday 20th October 2021**
**Via Microsoft Teams**

| | | | |
|---|---|---|---|
| **Present:** | Fiona Beveridge | Non-Executive Director (Chair of SQAC) | (FB) |
| | Nathan Askew | Chief Nursing Officer | (NA) |
| | Adam Bateman | Chief Operating Officer | (AB) |
| | Pauline Brown | Director of Nursing | (PB) |
| | Robin Clout | Interim Deputy CIO | (RC) |
| | John Grinnell | Acting Chief Executive | (JG) |
| | Dani Jones | Director of Strategy & Partnerships | (DJ) |
| | Beatrice Larru | Consultant, Infectious Diseases | (BL) |
| | Erica Saunders | Director of Corporate Affairs | (ES) |
| | Dame Jo Williams | Chair of Alder Hey Children's NHS Foundation Trust | (JW) |
| | Jacqui Pointon | Associate Chief Nurse, Community & MH Division | (JP) |

**In attendance:**

| | | | |
|---|---|---|---|
| | Kelly Black | Matron, Division of Surgery | (KB) |
| | Julie Creevy | Executive Assistant (Minutes) | (JC) |
| | Andrew Hanson | Service Manager, Division of Medicine | (AH) |
| | Cathy Umbers | Associate Director of Nursing & Governance | (CU) |
| **21/22/111** | Jennie Williams | Head of Quality Hub | (JW) |

**21/21/107 Apologies:**

| | | |
|---|---|---|
| Kerry Byrne | Non-Executive Director | (KB) |
| Lisa Cooper | Director - Community & Mental Health Division | (LC) |
| Urmi Das | Divisional Director for Medicine | (UD) |
| Nicki Murdock | Medical Director | (NM) |
| Melissa Swindell | Director of HR & OD | (MS) |
| Christopher Talbot | Safety Lead, Surgery Division | (CT) |
| Kate Warriner | Chief Digital & Information Officer | (KW) |

FB welcomed all members and attendees to the Safety and Quality Assurance Committee (SQAC).

**21/22/108 Declarations of Interest**
SQAC noted that there were no items to declare.

**21/21/109 Minutes of the previous meeting held on 22nd September 2021 –**
**Resolved:** Committee members were content to **APPROVE** the minutes of the meeting held on 22nd September 2021.

**21/21/110 Matters Arising and Action Log**
**Action Log**
The action log was updated accordingly.

**Resolved:- SQAC noted that discussion had taken place regarding action 21/22/95 relating to Patient Information Leaflets. Following discussion agreement had been reached that this item related to the Trust website and the intranet project. SQAC agreed that this item should be monitored through that programme of work.**
**SQAC NOTED that this item would be closed and removed from SQAC action log and transferred to the Trust website project action log.**
**NA provided assurance regarding Patient Information leaflets and confirmed that 97-98% of leaflets are currently in date.**
**SQAC NOTED the significant progress made to date with regards to Patient Information Leaflets.**

FB reminded committee members that the Committee are still operating under the governance light approach, and as such those starred items would be taken as read, with any questions addressed as required.

**Matters Arising**

***Quality Improvement Progress Reports***

**21/22/111 Quality Priorities Monthly update**

JW presented the Quality Priorities Monthly update, which included highlight reports on the Deteriorating Patient & Medication Safety. SQAC **NOTED** the progress made in month.

A key issue was highlighted which related to pharmacy resource with regards to Consolidated IV guidelines.

JW referred to Medication Safety and confirmed that the Project Steering Group would be amalgamated into the Medication Safety Committee, in order to drive forward ownership, assurance and mitigations through Medication Safety Committee.

FB referred to deadlines and questioned whether they remain realistic and referred to Pharmacy resource. NA advised that he is happy to undertake an offline discussion with Mo Azar, with regards to Pharmacy Resource. NA advised that he is of the opinion that there is appropriate resource within the Pharmacy team, and that resource is required to be directed as appropriate. NA confirmed that he would follow up offline with MA.

**Resolved Offline discussion with NA & MA**

NA referred to Meditech and advised that the most appropriate option is to wait until EXPANSE, given that a number of issues cannot be resolved within the current version of meditech, and if the Trust aims to address some of the issues, it would not be a complete solution.

Dame Jo stated that great progress had been made, and referred to target dates for achievement, and requested deadline dates to be clarified in future updates. NA advised that future deadlines would be included within the November update.

DJ welcomed the report and the evolvement of the report, and requested that the report is amended to clearly show RAG rating aligned to milestones and progress dates. NA confirmed that this would be detailed within the next report at November 2021 SQAC meeting.

JG alluded to understanding the importance of items within the highlight report, and

questioned whether they measured against critical issues, JW advised that future reports would be specifically prioritised in order to ensure that there is a clear understanding of those critical projects and milestones.

SQAC **NOTED** good progress made regarding the Deterioration Patient Project. Care flow training would be undertaken on the current handheld device, and roll out of training on 4A and 4C. JW confirmed that this is on trajectory. The current functionality of care flow would be incorporated into expanse once a release date is identified.
JW advised that there would be a decision made with regards to whether to use EXPANSE handheld device, or whether a decision to continue with care flow connect on 5th November 2021. If the EXPANSE handheld device is the preferred method JW had received assurance from NA & P White that there are a team of nursing and AHP colleagues who would train workforce staff, with firm plans to be made once a decision is reached on 5th November 2021.

Operational leadership had made progress in month, operational leadership would fall within ACT team, testing of the pathway hoping to continue in November 2021.

Dame Jo – queried when the decision on DETECT would be made. JW advised that the DETECT study had come to a close, and G Sefton is working on integration of the success points as business as usual, ongoing work is planned until August 2022, to ensure that the benefits realised from DETECT would be incorporated into business as usual.

The Deep Dive focussed on Parity of Esteem, SQAC **NOTED** the good progress made in September 2021. A Self-Harm Suicide Prevention collaborative planning session was held.

Ongoing work continues regarding on raising awareness with good engagement from colleagues.

Mental Health Champion Event, had also taken place during the end of September 2021, with 18 mental health champions in attendance, good discussions held. Time and training was identified as a main area of future focus, with strong ongoing engagement to date.

B Pettorini and J Pointon had attended Medical Board, and a 4th workstream had been identified relating to commissioning of surgical interventions deemed as cosmetic reasons, however, a number of procedures have an impact on mental mental health, Quality team are working with colleagues to review and address this workstream.

FB questioned whether there are appropriate MH champions across the organisation, JW stated that the spread of MH champions does currently have some gaps, and advised that one of the co design requirements for MH Champions is to understand and address the current spread across the organisation and ensure gaps are filled.

JW confirmed that positive behavioural support training programme is in place and that the team are attempting to take a co-design approach, from parents and carers.

SQAC **NOTED** the clear progress made in all three areas, with continued strong engagement from teams, together with detailed plans and targets. It was felt there was strong momentum on the workstreams, and the projects

associated with them.

NA expressed his thanks to the Quality hub team and acknowledged the continued hard work and support taken place to date to adapt to frequent changes.

FB and Dame Jo echoed and endorsed comments from NA and expressed gratitude to the Quality Hub Team. FB welcomed significant progress relating to the project streams.

SQAC received and **NOTED** the Quality Priorities Monthly Update

**21/22/112 CQC Action Plan**

SQAC received and **NOTED** the CQC Action plan.

**21/22/113 DIPC Exception Report**

SQAC received and **NOTED** the DIPC Exception Report.

**21/22/114 Transition update**

JP presented the Transition Update, with regards to Trust compliance with NICE Guideline 43 (NG43): Transition from Children to adults' services for young people using health or social care. SQAC **NOTED** the current challenges, with further work required to fully embed the responsibility for transition of young people to adult services across the Divisions.

SQAC **NOTED** the short-term actions identified in order to support compliance with NG43 and which had been approved by SQAC in March 2021. Compliance with NG43 is currently 16.3%, from 9.3% in July 2021, compared to 4.7% in March 2021.

JP requested SQAC to consider and approve the revised deadline dates for actions 2 (each division to undertake a self-assessment of NICE guideline NG 43, and for action 3 with regards to each service/speciality to undertake a self-assessment of NICE Guideline NG43). SQAC were in agreement to agree to the revised deadlines (31st December 2021 for Action 2) and (31st January 2022 for action 3), with the clear expectation that these deadlines would not be extended further. SQAC looked forward to seeing clear progress made when receiving the Transition update at January 2022 SQAC meeting.

FB referred to a Trust lead, in terms of ownership, and questioned whether there needed to be a further recommendation included to identify an appropriate Executive Lead to accelerate sustained progress in reaching compliance. NA advised that LC is Exec Lead for Transition and that it is envisaged that progress would be made over the coming months. Discussion took place regarding the importance of ownership, to ensure that progress is accelerated and appropriate monitored and tracked, NA advised that this would be discussed further offline at Executive Team, in order to ensure that progress is accelerated to achieve compliance.

**Resolved: SQAC received and NOTED the Transition update.**
**SQAC Approved the revised deadline date for actions 2 and 3.**
**Executive Team would discuss Transition lead in order to accelerate progress with regards to the Trust achieving compliance of NICE Guideline 43**

**21/22/115 ED Quarter 1 MH Update**

SQAC received the ED Quarter 1 MH Update which provided an overview of Quarter 1 data, JP advised that Q2 data was not currently available, and would be presented at the November SQAC meeting.

FB queried whether the Division had been in negotiation with colleagues with regards to achieving the required actions within the report, JP confirmed that colleagues had been consulted with.

DJ alluded to patients who had attended ED and queried whether figures are good in comparison to other Trusts. JP advised that this was difficult to confirm,as there is inconsistency nationally with regards to standardised services. JP agreed to review offline and feedback to DJ offline.

JG advised that it would be helpful in the future to explore the heightened number of patients who require crisis care, and queried whether this could be included in future MH ED updates. SQAC agreed it would also be helpful to include C&M views in future updates.

Discussion took place regarding C&M system, and AB alluded to the inequality within the service, which is different from provider to provider, and the importance of advocate role in terms of children receiving 24/7 access. AB advised it would be helpful to include in future updates.

NA expressed thanks to LC & JP for detailed report and advised that the next reiteration would include C&M data which would show data as trends and would include information reflecting Parity of esteem, safe/equality of access. NA confirmed that he is happy to support LC & JP offline, if any support is required with regards to ensuring data is available for future update.

**Resolved: JP to feedback to DJ offline**
**Resolved: SQAC received and NOTED the ED Quarter 1 MH update and the improvement actions identified.**
**SQAC NOTED that Quarter 2 ED MH data would be presented to November SQAC meeting**

**21/22//116 Assurance ED Activity Monthly Update**

SQAC received and **NOTED** the Assurance ED Activity Monthly update.
SQAC **NOTED** the contents of the report, and the wider actions required to address current ongoing position of increased attendances.
Q1 data demonstrates that 5,500 of patients could have been seen in alternative services.

Community Pharmacy provision is available as a 7 day service, Rapid Assessment clinic in ED remains in place each day with small amount of ring fenced capacity at local Walk in Centre.

AB confirmed that a meeting is scheduled with CCG on 21.10.2021 when colleagues envisage an update with regards to the Business Case submitted requesting additional support.

Dame Jo queried whether analysis of data of information was available and questioned whether the Trust are in a position to share with the CCG and

the Region. AH confirmed that this information could be shared with CCG and the Region if helpful.
Dame Jo stated that families want the reassurance of face to face appointments and advised of the importance of making this point known.

AB advised on the importance of signalling other interventions that the Trust is taking and recognising that this is beyond the ED Department. AB described ongoing actions across the Trust regarding a range of additional interventions to better support flow out of ED.

**Resolved DJ and A Hanson to undertake offline discussion regarding mechanism for reviewing/auditing requests for face to face consultations**

**RESOLVED: SQAC received and NOTED the Assurance ED Activity Monthly Update Report and NOTED future reports would include holistic view.**

**21/22/117 Aggregated Analysis report including incidents, complaints, PALS, Claims and Inquests**

CU presented the Aggregated Analysis report which reviewed key themes from April to September 2021, regarding incidents, complaints, PALS, Claims and Inquests, report detailed themes and lessons learned. Key issues as follows:-

- Top themes:
  Treatment/Procedure/access/admission/transfer and discharge feature across four of the five workstreams, consent/communication/confidentiality, medical devices, medication, documentation and clinical assessment feature in two workstreams. The report outlines the trends within the workstreams, and cites relevant associated assurance reporting, where details of performance management to minimise risk is evident.
- Proactive analysis of data across the five workstreams ensure that the trends can be early identified enabling assessment and implementation of actions for improvement, thus minimising risk to patients, staff and others.

NA expressed thanks to CU for comprehensive report. NA referred to learning and the approach regarding shared learning, and advised on the need for continued development.

FB thanked CU for remarkable update, and the detailed data which clearly demonstrated strong oversight and improvements within technology.

Dame Jo welcomed comprehensive report, and highlighted the importance of ensuring any lessons learned are fully embedded across the organisation and is tracked over time as appropriate.

**Resolved: Clinical Legal Services report to be circulated following the meeting by email to SQAC members.**

**Resolved: SQAC received and NOTED the Aggregated Analysis report including incidents, complaints, PALS, Claims and Inquests**

**21/22/118 RCPCH Invited review update report**

SQAC received and **NOTED** the comprehensive RCPCH Invited Review which made 4 Recommendations, to ensure all lessons had been fully addressed.

Dame Jo raised the importance of ensuring clarity on who is leading and co-ordinating issues for children and families and ensuring this is known to patients and families, and reminded on the importance of embedding this across the Trust.

PB confirmed that this is part of the Action plan and information from Divisions was that each person has a lead consultant, and medical and clinical teams should have access to that information readily.

**Resolved**: SQAC received and **NOTED** the RCPCH Invited Review update Report and **NOTED** the recommendations from the RCPCH Invited Review update report.

**Resolved: Offline discussion with NA & NM to take place in order to agree next steps and agree appropriate timing for further assurance**

ES advised that the Trust is required to share this report with CQC, this had been discussed at Executive Team, with the focus taken on actions taken, and the associated learning, with any updates to be shared as appropriate at future SQAC meeting.

FB stated that she welcomed the clear allocation of actions between the SIRI report and the Corporate report SIRI spreadsheets model and suggested this could be a model to potentially adopt for the Quality Assurance Rounds.

**22/22/119 Proposal for Interpreting provision at Alder Hey Children's NHS Foundation Trust**

SQAC received the proposal for the use of the new Interpreting Providers. SQAC were requested to confirm the award of Framework Arrangements to providers of Language Services. SQAC supported and approved the move to DA Languages for the provision of spoken interpreting services.

FB requested assurance regarding those groups not included in the review.
The following assurance was noted in order to ensure that there is no gap in service provision.

- Creation of Information for People with Learning Disabilities: The Trust will continue with current arrangements and use in-house Picture Exchange System (PECS) and digital software supported by our LD practitioners and used by our Learning and Development team. No external provider currently provides a service to the Trust
- Creation of Information for Blind and Partially Sighted People: The Trust would continue with current arrangements provided through Language Empire

PB advised that once the CCG collaborative has awarded the services, a further briefing report would be presented to SCAQ, to seek approval to move to the new service provider(s)

**Resolved: SQAC received, NOTED, supported and approved the Proposal for Interpreting provision at Alder Hey Children's NHS Foundation Trust.**

***Clinical Governance Effectiveness***

**21/22/120 CQSG Key issues update**

NA advised that with regards to the Governance light approach that there had been no CQSG meeting in month, review of meeting papers had taken place. Several policies had been approved. Overall theme from Divisions related to pressure and challenges of the busy current environment. NA confirmed that there are no current issues to raise to SQAC, and stated that CQSG would continue to virtually review meeting papers on a monthly basis, with the aim of reinstating CQSG virtual meetings in 2022.

**SQAC received and NOTED CQSG Key issues verbal update.**

**21/22/121 Quality Assurance Rounds, themes and risks report**

CU presented the Quality Assurance Rounds, themes and risk report, which provided a detailed overview of the themes and key risks. Committee **NOTED** that there had been outstanding achievements before, during and since the pandemic, to support patient and staff.

Further work is required to ensure that all issues raised are resolved and teams demonstrate learning from this.

Strong evidence that children and young people are at the heart and focus of staff practice, with good assurance evidence of outstanding practice in many services.

QAR's had shown that risks identified on the risk register, particularly the high risks and those on the BAF are aligned to many of the issues identified in the QAR's. Good understanding in some areas about required standards within key lines of enquiry to meet regulation requirements, however this is not consistent across the Trust.

**Resolved: SQAC NOTED the outstanding achievements before, during and since the pandemic, to support patient and staff.**

FB thanked CU for comprehensive update. It was felt beneficial for Executive Colleagues and Non Executive Directors to receive a briefing on a page for those colleagues attending the Quality Assurance Rounds, in order to remind colleagues of purpose and obligations, linking to risks. Discussion took place regarding importance of clarity on risk, ensuring clear information regarding who is leading/tracking/following up actions.

Dame Jo advised that she is delighted with report detailing emerging themes. Dame Jo also welcomed short briefing for Non Executive Directors/Execs and highlighted the importance of Comms. Dame JW advised that a general review of the Quality Assurance form would be helpful, in order to ensure that the correct information is included. KB offered support to CU.

**21/22/122 Board Assurance Framework**

SQAC received and **NOTED** the Board Assurance Framework.

**Resolved: SQAC received and NOTED the Board Assurance Framework update**

**21/22/123 Divisional Reports by exception/Quality Metrics**

**Community & Mental Health Division – JP provided key issues as follows:-**

- Lack of availability of beds nationally for eating disorder patients remains challenging.
- Division are continuing to see an increased number of referral rates, with impact on waiting list and staff wellbeing.
- Division are preparing to move from the Catkin building to the new build over the coming months, ongoing work to maintain the Catkin building which has experienced issues resulting from the weather and from recent vandalism.

**Medicine Division – AH provided an update on key issues as follows:-**

- Ongoing challenges noted regarding ED pressures – performance currently 73.4%, with a range of activities focussed on increasing this.
- Cancer performance is good, resulting in faster diagnosis
- RTT compliance decreased to 76% for RTT for outpatients, driven by two high volume specialties: dermatology and radiology.

**Surgery Division – KB provided an update on key issues, as follows:-**

- Division had implemented the 'Super Saturday' initiative to treat orthopaedic/spinal patients.
- Division had welcomed a new cohort of nurses, and the division are focussed on on positively supporting this new cohort of staff to support them over the winter period and beyond.
- The Division had no Grade 3 or Grade 4 Pressure Ulcers since December 2020

Committee **NOTED** the pressures across the Divisions within services resulting from high clinical workload coupled with staffing issues. FB welcomed Divisional updates and thanked colleagues for updates.
SQAC received and **NOTED** Divisional updates.

**21/22/124 Any other business**
None received.

**21/22/125 Review the key assurances and highlight to report to the Board**
Positive updates were received regarding: -

- Quality Priorities update received, with good progress for Medication errors and the Deteriorating Patients. Parity of Esteem Deep dive update received which demonstrated significant ongoing work.
- Transition update received, SQAC accepted and approved the request to extend the deadlines of actions 2 and 3, with the clear expectations that these deadlines would not be extended any further, with expectation of clear progress at next Transition Update in January 2022.
- ED Quarter 1 MH update - Good discussion with clarity within report on the current position regarding linking to broader inequalities across Cheshire & Mersey.
- Assurance ED Activity Monthly update – Good analysis received, SQAC recognised progress made, with the need for continued focus through monthly updates at SQAC.
- Aggregated Analysis report – SQAC received and noted the Aggregated Analysis Report which reviewed key themes from April to September 2021.
- RCPCH Invite Review Update report was received and **NOTED**

- Proposal for Interpreting Provision at Alder Hey – SQAC received the proposal for use of new Interpreting Providers and request to confirm the award of Framework Arrangements for providers of Language Services. SQAC supported and approved the move to DA Languages for the provision of spoken interpreting services. SQAC **NOTED** next steps.
- Quality Assurance Rounds, themes and risks report – SQAC received this report and **NOTED** good progress made with regards to closing the loop following Quality Assurance Rounds, with further ongoing work required.
- Divisional updates which included highlights received, with resounding themes across all three divisions related to pressures within services, resulting from high clinical load, coupled with staffing issues, Covid, sickness etc.

**20/21/126 Date and Time of Next meeting**

24th November 2021 at 9.30 via Microsoft Teams

Alder Hey Children's NHS Foundation Trust

# People and Wellbeing Committee
## Confirmed Minutes of the last meeting held on 21st September 2021
## Via Microsoft Teams

| | | |
|---|---|---|
| **Present:** | Claire Dove | Non-Executive Director (Chair) |
| | Fiona Beveridge | Non-Executive Director (Deputy Chair) |
| | Melissa Swindell | Director of HR & OD |
| | Ian Quinlan | Non-Executive Director |
| | Mark Flannagan | Director of Communications & Marketing |
| | Nicki Murdock | Medical Director |
| | Erica Saunders | Director of Corporate Affairs |
| | Adam Bateman | Chief Operating Officer (Part attendance) |
| | Nathan Askew | Chief Nurse |
| | Racheal Greer | ACOO – Community |

**In attendance:**

| | |
|---|---|
| Jo Potier | Associate Director of Organisational Development |
| Angela Ditchfield | Interim Head of Equality, Diversity & Inclusion |
| Clare Shelley | Associate Director of Operational Finance |
| Jason Taylor | Acting Associate Chief Operating Officer |
| Declan Judge | Management Graduate Trainee (Observing) |
| Katherine Birch | Director – Alder Hey Academy |
| Gill Foden | HR Business Partner – Medicine |
| Maria Salcedo | HR Business Partner – Surgery |
| Pauline Brown | Director of Nursing |
| Nicola Norris | E Roster Manager |
| Tony Johnson | Staff Side Chair |
| Jackie Friday | Executive Assistant (Minutes) |

**Apologies:**

| | |
|---|---|
| John Chester | Director of Research & Innovation |
| Andrew Hanson | Service Manager – Surgery Division |
| Cath Wardell | Associate Chief Nurse – Medicine |
| Sharon Owen | Deputy Director of HR&OD |

**21/22/37** **Declarations of Interest**

No declarations of Interest.

**Introductions**

Received for Angela Ditchfield, Interim Head of Equality, Diversity & Inclusion

**21/22/38** **Minutes of the previous meeting held on 20th July 2021**

**Resolved : The minutes of the last meeting were approved as an accurate record.**

**21/22/39 Matters Arising and Action Log**

**Matters Arising**
The Committee noted the non attendance of divisional senior representation with input in relation Corporate Metrics being received by HRBP's on this occasion and acknowledged the importance of attendance at this Committee.

**Action 21/22/39 – MKS to raise the requirement of senior representation with the 3 at the top in the Divisions.**

**Action Log**
20/28 – Sickness Absence/Shielding Update/Agile Working – MKS noted that a number of updates have been received by the Committee and suggested this action be closed. The Agile working guidance is up and running. A number of significant changes were made to the flexible working policy following changes made to national terms and conditions to allow people to request flexible working from day one of their employment. MKS advised we have good frameworks in place to enable people to do this and each team is working through that on a team by team basis, this will be monitored going forward. CD agreed that we should keep it monitored to ensure it still works going forward (i.e. at the height of the pandemic people started to work more at home, but working as a team and that team getting together is also important so you feel fully part of an organisation). **The Committee agreed this action is noted as closed**.

21/22/11-01 – Share an update on PDR/Mandatory Training process and compliance at a future PAWC – MKS advised regular updates are received and discussed at the Committee (via the People Plan overview) and suggested as a specific action that it be closed. **The Committee agreed this action is noted as closed.**

20/20, 17/13, 19/68 Equality & Diversity - MKS advised the 20/20 & 17/13 have been reviewed as part of the EDI Plan at the BAME Taskforce. Following discussion at today's Committee (WRES & WDES) it is hoped the actions will be updated with what is required to take them forward.

19/51 - Modern slavery – CD advised that government policy has just been updated and will be shared with MKS.

21/22/23 – Education Governance committee notes – MKS advised the notes have been received. **This action is noted as closed.** The Committee noted that the Education Activity Update will be an agenda item at November 2021 Committee.

**Trust People Plan 2019-2024**

**21/2240 People Plan Report July 2021**
The Committee received the People Plan Update Report, this report is a regular report presented to the Trust Board and is noted as read by the Committee. No questions raised. The following were brought to the Committees attention:

**21/22/41 BAME Task Force**
MKS shared the outcome of the recent Task Force, update of which will be reported to the Board. Particular attention was paid to the review of the recruitment of 10 nurse apprenticeships. A good piece of work has been completed by the apprenticeship team to analyse this data (one of the aims when recruiting was to try get people from

BAME background into those positions and this was not achieved). The team shared with the BAME Taskforce a detailed analysis of that data that helped inform the reasons why the recruitment was not achievable. The data will impact on the way recruitment is progressed in the future (i.e. what programs do we think about implementing when we target particular areas of Liverpool and particular staff groups). CD agreed good information was received and that it demonstrated some of the hurdles faced by BAME community (i.e. a requirement to have certain qualifications in place prior to gaining an apprenticeship).

CD suggested an action plan is required to address this (i.e. opening up the nurse associates offer to external applicants). KB echoed the points raised and noted there were 500 applications for the nurse degree apprenticeship, so clearly a huge amount of interest from across local communities in this type of apprenticeship offer. The deep dive analysis at various applicant levels showed the various degrees at which people were not able to be progressed.

KB highlighted that there are some real skill gaps/qualifications/challenges (also been picked up by the City region) with English/maths qualifications whereby because of the nature of the professional program it is not possible to be accepted onto a degree apprenticeship. KB advised that inclusive of our own staff and if we are looking to be more inclusive in our recruitment strategy, then we need to think about how we work with our local colleges with the Liverpool City region to be able to put together a program that allows that (career ladder/projection). The complexities were discussed in depth by the Committee whilst acknowledging that the analysis did highlight some of the challenges that many individuals face when seeking access to certain careers and we don't have the answers as yet, the conversations that have taken place have given a better understanding.

CD shared the conversations she had had with educational establishments who all run access courses in social care and advised it really is about the planning in place going forward and the time to progress this further with those contacts. CD referred to the possibility of having compact agreements in place with individual institutions to ensure their students meet the criteria required to apply for specific roles. KB fully supported this, but brought to the Committees attention that one of the issues is that the nurse degree is offered by a higher education partner and whilst many have widening partition ethos around access courses and equivalency of qualification, you might have your access course and your maths and English wrapped up in that. Lessons to be learned about what we expect from our HEI partners and how we position ourselves in relation to the broader routes through opportunities for those on the non-traditional routes is key.

CD shared with the Committee that Liverpool City Council are running a BAME Commission (following Black Lives Matter), specifically focussed on race. A meeting has taken place with hospital Trust. A paper will be sent to them outlining the work that has taken place at Alder Hey and the ongoing work that will continue to support a diverse workforce and the community at large. MKS confirmed they are really interested to hear about the work we have been progressing with the BAME Taskforce and we have some really good practice/feedback to share with them.

**21/22/42** **Draft Workforce Race Equality Scheme Report (WRES) & Workforce Disability Equality Scheme Report (WDES)**

MKS introduced and welcomed AD to the Committee, who has joined the Trust recently (part time/temporary, split between Alder Hey & Clatterbridge) as Equality Diversity & Inclusion lead until the end of the year and has pulled together both reports presented today. AD has drafted two reports, both of which require an action plan. These reports

are ultimately published on the Trust internet and seen by the public. Some actions AD suggested and outlined have been implemented. MKS would welcome Committee feedback.

NM questioned some of the data around diverse groups/disability groups for medics and acknowledged it's a great piece of work, but just needs tidying up. NM and AD to meet off-line. MKS advised the data will be checked but confirmed that we are reliant on the data that has been shared by individuals and some people chose not to share (i.e. if not recorded on the system, it is recorded as unknown).

TJ asked how this data is updated/shared – how is it registered on the system. MKS advised it is updated via ESR, all staff have access to this and can update their individual details at any time. A drive to encourage staff to declare their personal information has been completed in the past and this may need looking at again to remind staff to share their data. AD concurred and advised that one of the actions is about trying to encourage people, particular in certain departments, as there was a lot of 'unknowns' in the data. A campaign will be launched to engage staff and inform understanding of the importance of the data.

CD referred to the proposed action plan and suggested that departments with 0% diversity need to have a plan on how to increase diversity going forward. CD pointed out that it would be good overall to see if there have been any changes from the previous year and what has happened as a result of that, since the taskforce came into place. CD suggested this report go to the Task Force for the next meeting to look at some of the areas that we need to see improvement/support. MKS agreed and thanked the Committee for the feedback, work will take place to tidy the data up and the action plan will be progressed with AD. As this report will be externally published MKS gauged opinion of the Committee as to the framework of the report and how it looks. It was agreed the presentation report is very important and it was easy to read/understand.

The Committee **approved** the framework of the report.

**21/22/43** **Staff Survey**

MKS advised the National Staff Survey was launched today and will be issued to all staff. The survey nationally has changed slightly this year. The Comms Team have put together a really good comms package, to encourage staff to complete and share their views. It will be launched at the weekly brief the following day. The majority of staff will receive the survey via email, with a small cohort of staff receiving paper copies. The survey is open until the end of November and an update will be brought to the next Committee and will be monitored at the weekly Executive meeting. An ambitious target of 65% has been set (achieved 51% last year – national average was 45% - which was a good result considering the circumstances). No questions were raised by Committee members.

**21/22/44** **National Pay Update & NHS Corrective Payments Framework in Relation to Overtime Payment and Pay During Annual Leave**

The Committee received a presentation shared by MKS. Highlights are:

- Nationally a 3% uplift was agreed to be received in September 2021, backdated to 1st April 2021 for the following terms and conditions – Agenda for Change, Medical & Dental, Speciality Doctors/Associates Specialists. A number of trade unions are in discussion with their members, in particular BMA & RCN. Both are dissatisfied with the 3% pay deal. Views were shared by the Committee and it was recognised

that RCN had articulated well the reasoning why the 3% was not acceptable. All unions are currently in the process of balloting members. MKS advised this is something we need to keep sighted on in terms of risk (availability of staff) and await the outcomes of discussions with their members.

CD asked what the plan of action would be if industrial action did take place. NA shared for clarification/assurance purposes there is a range of possible industrial actions. RCN do not support an all-out strike; in a worst-case scenario they would support a minimal day service (i.e. Xmas day provision of care). We would then need to decide what we can and can't do as an organisation at that time, should it go ahead. Whilst that doesn't negate risk completely, we are not looking at an all-out walkout of RCN staff. Key thing to note they do not offer an all-out down tools part of the strike process.

CD thanked NA for clarifying and recommended that this be added to the risk register. FB advised that the key risk is access to care and this could be picked up at SQAC, CD agreed.

**Action – 21/22/44-01 – FB to raise at SQAC - key risk – access to care in the event of industrial action**

MKS shared that a communication had been sent to staff about the NHS Corrective Payments Framework in Relation to Overtime Payments and Pay During Annual Leave and thought it was important to note at the Committee. Highlights are:

- Longstanding debate on how the Agenda for Change handbook has interpreted what happens when employees takes annual leave, culminating in a number of staff being underpaid. A couple of high-profile cases have taken place. Latest one was called 'Flowers'. Discussions have taken place nationally with Trade Unions, to remedy this. In March 2021 the NHS Staff Council (includes representatives from employers and Unions) agreed to a framework to make corrective payments for the periods 1st April 2019 and 31st March 2021 to include regularly worked overtime or additional basic hours for part-time staff in the calculation of pay during annual leave, as they have not previously been included. It was agreed by the NHS Staff Council that this agreement is considered to be the best resolution for this issue.
- A significant amount of work has taken place in the background with Finance & Payroll Teams to ensure these payments are processed for September. This payment has been funded by the centre for all Trusts.
- A piece of work will take place (September/October) to look at any staff who are on long term sick, maternity leave or shielding who might be eligible for one of these corrective payments.

MKS added that in reference to the national pay deal – we have some staff that are on local contracts and work is taking place to decide what the 3% means for those contracts.

The Committee discussed in depth the complexities of the national systems in relation to overtime calculations. A resolution is still to be received from the Centre as to how staff will be paid from March 2021, although E-roster will help going forward.

**Action – 21/22/44-02 – MKS to share with Committee - National Pay Update & NHS Corrective Payments Framework in Relation to Overtime Payment and Pay During Annual Leave**

**Resolved : PAWC received and noted the People Plan**

**Governance**

**22/22/45** **Corporate Report Metrics – July2021**

The paper is noted as read, this paper contains an overview of workforce KPI's along with divisional updates. Highlights as follows:

**Trust Metrics**

**Medicine Division Metrics** – GF shared a summary – Sickness - As of 13th September 91 people were off, as of yesterday this has been reduced to 78. A number of long-term sick are returning to work and receiving support from SALS. PDR's - Currently at 78.9% compliance and continues to be a work in progress. Mandatory Training – currently at 86.9%. Some reviews (i.e. Sepsis content) have taken place to assist with completion rates, as for medicine this is one of the areas of risks. Targeted piece of work is taking place relating to workforce planning (attracting and retaining employees, linking into Radiology). A number of conversations are taking place with the EDI lead support. Progress to be shared at a later date. Also a targeted piece of work has commenced in ED (wellbeing issues). An attendance action plan is in place.

CD asked for an update on the reasons for **sickness during the summer period** and for an update on what are the plans for the Trust to **roll out the Covid Booster** at the Trust.

GF advised there are a number of reasons for sickness such as Covid, musculoskeletal, anxiety and aspects of depression. Some areas are now using E-roster, and we are expmoring whether mandatory compliance with this system is providing us with greater accuracy of sickness absence reporting.

PB shared an update on the Covid Booster. Commences at Alder Hey on 27th September. Running of the clinic for just under two weeks. A further clinic for staff to attend will take place at LHCH. Key is that staff need to be 26 weeks between their 2nd dose and booster. The Pfizer vaccine, appropriate for most people, is being offered. The booking system goes live today.

**Community & Mental Health Division** - RG shared a summary – Mandatory training position remains above 90% at 91.03%, continue to support managers and share data and target individuals were mandatory training falls below 90%. Increased PDR compliance to 77%, some work still to do on that, again looking at areas where we have gaps. Sickness absence rates continues to be a challenge for the division. It has come down slightly at 5.6% (at end of August 6.3%). A number of areas where we have concerns, particularly Dewi Jones Unit, Outpatients and Home Care, working really closely with team managers with support from HRBP's. Looking at some things that can be done to support, particularly those teams with higher levels of absence. Outpatients is causing most concern, due to the impact on the rest of the Trust in terms of restoration of activity. The challenge is trying and maintain good levels of support in Outpatients.

CD advised it will be interesting to hear going forward to the winter period what we will be doing for **health and wellbeing** to try and keep people in work where we possibly can.

**Surgery Division** – MS shared an overview – sickness – at end of August a small downward trajectory was reached 6.1% (compared to July at 6.7%). Although pleased to see a reduction, mindful we may see an increase in September. Reasons for sickness are very similar to medicine, chest and respiratory conditions are still a factor, musculoskeletal conditions still a factor (although reduced) and Covid related absences have reduced slightly in that period. Continued support in terms of deep dive/hot spot areas across surgery, incl. of HDU, Critical Care etc. Early interventions continue with the Wellbeing Officers and the HR Team via weekly review of Occupational Health reports, follow-up reports, chasing early referrals, ensuring KPI meetings happen across the Division. Working very closely with HR Team and SALS colleagues to identify where interventions are needed e.g. Photography and the Laser Team. Mandatory training - current rates are at 88.64%. Managers are reporting that areas that require face to face training is a struggle (i.e. basic life support/health & safety support etc) those areas need more focus. PDR compliance stands at 59.94%, but as at last week reported at 61.4% and is increasing, but more work needed in terms of focusing on managers to ensure compliance improves.

MKS emphasised what it is thought to be happening with E-roster – effectively it mandates you to put sickness absence into the system in order to calculate peoples pay etc. It is thought that we may be seeing a slight increase in reporting. This needs to be looked at further and the HR Team are looking at it to see if the increases we are seeing over the last weeks is as a direct result of better reporting or if it is genuinely more sickness absence.

**R&I Division** – The Committee noted it was the first time representation had attended the Committee and it was agreed that metrics will be presented at the next Committee.

**Action 21/22/45 – JT to present R&I Division metrics at November 2021 meeting**

CD shared there had been a lot on the news about the vaccine becoming compulsory especially for those in health and social care. CD asked what the Trust stance is on this.

NA acknowledged the challenges faced in the past with unions etc. about compulsory vaccines (i.e. flu) and noted as a Trust we have to go with the national recommendations. The Trust has really high volumes of high compliance with staff, whilst a small % have opted out. Some opt outs were due to confusion around pregnancy, which has subsequently been clearly clarified. Further in-depth discussion took place around Hepatitis B being compulsory, but the Government have chosen not to make compulsory with Covid or flu. CD suggested that it would be interesting to get an understanding of the reasons behind the non-take up of vaccines.

**Health & Wellbeing - Winter Plan**
CD asked for an update on plans to support staff to stay as healthy as we can. JP shared an overview with the Committee. Supporting and encouraging people to do a range of activities that would be considered early intervention and prevention continues. Lower PDR rates means lower rates of health & wellbeing conversations

that have taken place. It is known that these conversations are working well, but nationally more effective measures are required to measure this. The staff survey will have questions about health & wellbeing, so feedback from that will be helpful.

The general intervention that is offered through SALS, alluded to in the past Committees, a process is in place were referrals are received for anybody who is off sick be it stress etc and interventions continue with a lot of people. Gathering of data through the service is taking place to support staff prior to going of sick. Targeted interventions are taking place (i.e. to support the menopause, specific teams in distress because of covid, conflict between people). Topics such as recent suicides in the region need further discussion – linking in with other organisations, but a lot more work to do, thinking carefully about that. Looking at expanding the service (recruiting to admin role and additional psychology in SALS) and also looking to streamline the whole staff support pathway between SALS and the Alder Centre. Currently at the planning stage for a whole organisational debrief, the first team to be debriefed will be Executive Team.

MF shared the headlines of the internal communication plan that partly dovetails the work outlined above around the winter plan and challenges faced by the Trust. The new internal communication plan will lock in the acting CEO and the leadership team more, to be clear on reassurance about what the next few months are going to look like at the Trust. (areas of challenge are increasing visibility of Executives, connecting the acting CEO/reconnecting the CEO on return & ensuring the cascade of information is improved). A number of developments are being progressed, highlighted as follows:

- Brilliant basics – empowerment for staff, to make a difference and see improvements.
- Basic actions such as improving the weekly broadcast, looking to introduce an AH news channel, blogs, looking for a better cascade on the meetings. New intranet launching early in 2022.
- Some considered work around communicating what is going on (happy events that bring people together), improving the way information lands – a paper will be shared once signed off by Execs.

FB referred to the Trust seeing more team related issues and wondered whether there was more that could be done to support leaders and managers to resolve local disputes before the conflicts emerge. Also in relation to hybrid environment – does it require a refreshed set of skills for team leaders to manage in the hybrid environment as well. How can we understand what the cause of conflicts are and who is best placed to get in earlier and prevent any developing conflict (is it Hybrid playing any part in conflict or is it the physical kind coming back into the hospital).

FB also brought attention to good communication by local team leaders (the importance of team leaders being able to communicate effectively with their teams) and queried how this would be done at the Trust.

JP advised that the strong foundations programme is still running to support team leaders and is still well attended. Looking at those skills as part of that programme. As part of growth round this, team leaders are now accessing an internal coaching pool, with specific support for leaders where teams related issues are flagged up. In relation to hybrid working issues, there tends to be more issues with smaller teams (i.e. staff shortages/exhaustion, plus recovering services etc.) small teams really feel it so more of an issue.

MF shared discussions that took place recently with local Comms Directors. The common theme being that no matter how hard you try getting people to share and cascade communications to staff (from middle managers etc), no one as yet has resolved this, so work continues. The Brilliant Basics work currently taking place may help support communications, by locking into teams that it is their responsibility to cascade.

JP brought attention to a crucial point in relation to sickness data. A good piece of work has been completed to drill down into the data and look at in a lot of detail. It shows it is highest for stress in our younger age group/lower banded staff (i.e. nursing staff in their late 20's early 30's who we know have been really vulnerable to the impacts of covid. Concerns as there is a need to reach this group with what we have to offer in terms of support, but they wouldn't necessarily hear about it or can't access the information available.

CD asked when the flu vaccine will be rolled out, NA confirmed live from 4th October and will be rolled out over 3 weeks, 2nd batch will be delivered in November, with a roving vaccinator clinic visiting clinics/depts.

**Resolved: PAWC received and noted the update on the content of the Corporate Report & Workforce KPI's.**

**20/22/46** **Board Assurance Framework – July 2021 & HR & Workforce Risk Presentation**

The Committee received a full BAF report for July, noted as read. ES advised there has been a huge focus on workforce risk for quite some time. Particular attention was brought to 2.1 Workforce Sustainability and Development, this area sees a risk increase to 16. ES advised this increase is appropriate and fits the scale of the issues that are currently being faced and assured the Committee that the Executive are extremely focussed on this. There are a number of issues that are all emerging together to form a significant concern. Risk 2.2 Employee Wellbeing – ES advised that JP has just shared a superb outline of the focus that is now needed on this risk. Conversations have been had with ES and MKS about the BAF scoring in general in terms of work around if it has the right level/focus. It is timely we do a piece of work on this whole area and horizon scanning.

ES endorsed the view of reporting the pay award as a strategic risk, perhaps not on a standalone basis until it emerges more clearly. ES to pick up with MKS.

**Action 20/21/46 – ES to discuss with MKS inclusion of Pay Award as a strategic risk**

MKS confirmed there is a slide deck in with the Committee papers to share with Committee and provide assurance. The slides have been presented to the Executive Team. Two specific actions/risks are being focussed on - recovery plan for recruitment service, challenges being faced in the recruitment team are - long term sickness/increase in recruitment activity - this has caused a backlog. This has impacted on certain parts of the organisation. The risk has been increased 16. MKS advised that the Deputy Director of HR is taking the lead on managing this (i.e. daily huddle with team, additional resources have been put in the team). At the same time the HR team are attempting to implement a new recruitment system called Trac. This will help streamline processes and will of course need to be embedded at the Trust. The DMO team is on hand to help project manage this.

MKS confirmed that the second risk is the catchall risk, the inability to provide safe staffing, in terms of absence at the Trust. Absence is a key reason. A side piece of work is to really get underneath sickness absence and keep a focus on it in a practical way (i.e. to make sure return to works are taking place, referrals, and wellbeing). The potential for strike action comes into this. And is one of the items that could impact on the Trust at the end of year/new year. Working with ES to review the risks within the BAF to reassess the risk rating and share an update at the next Trust Board.

MKS advised there is a really clear recovery plan for mandatory training as well. A recent meeting has taken place with lead nurses for all of the divisions to ensure they have a really clear plan particularly around resus training.

CD emphasised that communication is going to be key, especially in relation to health & welling at the Trust. Coming up with a really strong plan of action will be key to inform the Trust understanding of what support is is available and team leaders being fully appraised of it so they can make those interventions that they think is needed in their particular team.

**Resolved: PAWC received and noted the latest position of the Board Assurance Framework**

**21/22/47 CQC Action Plan – July 2021**

The Committee received a report outlining CQC regulatory requirements, monitored at PAWC. ES advised this is very much a maintenance task just now and will look to close it down with the new CQC Inspector of which good relations have been developed. ES advised she does not see any reason to bring this back to the Committee, once agreed, as metrics are seen elsewhere.

**Resolved: PAWC received and noted the content of the CQC Action Plan**

**21/22/48 E Roster**

The Committee received a report prepared by the E Roster Manager; the paper is noted as read. The purpose of the paper is to provide a brief overview of what is E Roster, a summary of benefits and a high-level update of the Trusts E Roster project. Highlights are:

- The Trusts E Roster system 'Healthroster' (Allocate) gives an overview across the organisation, not only month by month but day to day and even shift to shift, highlighting hotspots needing intervention for staffing levels to remain safe and efficient. An effective e-roster empowers senior staff to make informed decisions.
- E Roster is an up to date live system (rosters are released up to 6 weeks in advance – so any gaps can be resolved). The benefits of this type of system are a reduction in temporary staffing; improved care delivery via effective alignment of staffing and clinical need; improved flexibility for employees; improved governance controls for audit and safe staffing levels; improved payroll accuracy; annual leave allocation etc. Also E roster interfaces with ESR & NHSP

NN outlined progress reached so far, statistics reached as of 31st August 2021 and what's next (as outlined in the report).

CD thanked NN for a great presentation. NA wanted to publicly thank NN and the team. NA commented that he has seen a number of rollouts of E roster programs in

the past and never seen it run so smoothly. The whole process has been led brilliantly and what has been achieve is fantastic. NN thanked NA and the Committee.

PB thanked NN, very informative and echoed what had been said. PB added it would be helpful for NM to meet with the ward managers again, to iron out some further training and questions they have. MKS echoed NA's comments. NN has done a fantastic job.

**Resolved: PAWC received and noted the content of the E-Roster Update**

**21/22/49** **Policies**

The Committee received the following policy and Equality Assessment for formal ratification/approval.

**Induction Policy**

In the absence of the Deputy Director of HR&OD, MKS advised the policy has had some updates to processes in terms of using virtual methods and updates to reflect current process to make sure the policy is in date

JP reflected on conversations that have taken place re induction. JP shared concerns that it is not adapted for the current climate, (i.e. people joining now during Covid - . does the policy go far enough for the world we live in now)? JP pointed out that we have people who have never stepped foot on site and so much of local induction language suggests it's being with people. JP wanted to flag that the policy doesn't reflect this.

IQ asked if any thoughts had been given to inclusion of board level induction process in the policy. IQ shared his experience of when he joined the Trust and felt that it would have helped if there had been a formal induction programme in place when he joined the Trust. CD suggested this maybe an area that ES can look at. ES agreed it was time to review and confirmed it has been discussed at Committee Chairs meetings and is under active discussion. ES asked IQ/CD to feed into that and share any specific ideas they may have.

CD agreed with JP and acknowledged we are in a totally different world now and need to look at how we induct people (some have only met online). CD suggested MKS take offline and report back to the Committee.

MKS suggested we take this policy off the agenda and convene a meeting to discuss further. Both KB/MF indicated the offer to be involved with this. MKS confirmed there is a huge element of comms in this too. KB echoed JP's points and would fully support a more holistic review in terms of medical/nursing students/trainees. KB advised there are a number of groups who are inducted through various processes and there is some wider learning that we need to do in terms of that broader process about how the people feel part of the organisation and how they are supported to do that given the variety of roles and work experiences that they have. KB shared that a local review on trainee induction had been completed (with Comms involvement) and this can be fed into the review. CD agreed all of this will be useful when the policy is reviewed.

JP raised a final point – health & wellbeing conversations should to be included as standard when looking at different types of inductions

**Action 21/22/48 – MKS to convene a meeting with JP/KB/MF to review Inductions at the Trust (outcomes will inform an updated Induction Policy to adapt/reflect the current climate)**

**Outstanding : PAWC noted the Induction Policy to be developed further**

**21/22/50** **HEE monitoring status**

NM informed the Committee that the Trust is no longer under enhanced monitoring from the GMC, this means that Health Education England have also taken the Trust off the monitoring list. This is due to the enormous amount of work by the Medical Education Team, NM commended them for the work they have done (assisted by many of the trainees to try and get things right). To remain off monitoring is an ongoing piece of work, to do that we need to look at how we improve the medical education and training experience for all the people who come to the Trust. Getting KB on board is one of those steps that can really impact on the experience our trainees have.

KB echoed NM's point about the work that had taken place over a long period of time for this. KB advised that the key turning point for this (comes back to education governance/assurance) is that the turning point from a GMC perspective was the results from the national survey trainee results for 202/21 which reinforced all of the insights that have been given to HEE and GMC. The value of data in terms of assurance is something we will have to be carefully sighted on, both in terms of undergraduate student and trainee experience. Whilst this is a fabulous achievement we can't rest on our laurels and have to be vigilant of any trends.

**21/22/51** **Board of Directors Summary**

- Assurance - Key risks at today's Committee to be noted:
- Pay Deal – FB to raise at SQAC
- WRES & WDES – go to board next
- Workforce Risks.
- Keep sighted on the wider Health & Wellbeing package

**Resolved: PAWC agreed the Board of Directors Summary**

**Sub Committee/ Working Groups reporting to Committee**

**21/22/52** The Committee received the minutes for the following for information.

- Local Negotiating Committee – 09.06.21
- Health & Safety Committee – 10.06.21
- JCNC – 25.05.21
- Education Governance – 24.06.21
- BAME Task Force Action Plan – 12.07.21

MKS advised the above are shared for information – No questions raised.

**Resolved: PAWC noted the content of the minutes**

**21/22/53** **Any other business**

- JP raised an item on behalf of Fiona Marston, the Wellbeing Guardian who has asked under AOB if she could be agendered for the next Committee to present

about the Wellbeing Guardian Role and progress against the 9 principles that we are being monitored against.

- The Committee acknowledge this was the Chairs last PAWC. MKS thanked CD for the leadership with this Committee and thanked CD for the personal and professional support and humour over the years and will look forward continue to work with CD going forward with the Task Force. IQ echoed MKS's comments. JP thanked CD for all the support in relation to SALS. CD reflected on her time with the Trust and what has been achieved and agreed it's been a great journey and great to see how MKS has grown into the role of HR Director over the years, along with all the support received from everybody, it's been a privilege and thanked everyone.

**Action 21/22/53 – FM to present about the Wellbeing Guardian Role and progress against the 9 principles that the Trust is being monitored against.**

**PAWC noted the items raised under AOB.**

**21/22/54 Review of Meeting**

The effectiveness of the meeting, it was agreed by all some good conversations had taken place to progress issues raised today.

**21/22/55 Date and Time of Next meeting**

23rd November 2021, 10am-12noon, via Teams

| Minute Reference | Action | Who | When | Status |
|---|---|---|---|---|
| **Matters Arising** | | | | |
| **21/22/39** | Raise the requirement of senior representation with the 3 at the top in the Divisions | MKS | September 2021 | |
| **Trust People Plan 2019-24** | | | | |
| **21/22/44-01**<br><br>**21/22/44-02** | National Pay Update<br>• Raise at SQAC – key risk – access to care in the event of industrial action<br>• Share with the Committee – The presentation on National Pay Update & NHS Corrective Payments Framework in relation to overtime payment and pay during annual leave | FB<br><br>MKS | Next SQAC<br><br>Immediate | |
| | | | | |
| **Health & Wellbeing** | | | | |
| **20/28** | Sickness Absence/Shielding/Agile Working<br>• Working from home – update on review | MKS | March 2020 | Noted on 21.09.2021 good frameworks in place and will be monitored going forward - Closed |
| **Governance** | | | | |
| 21/22/11-01 | • Share an update on PDR/Mandatory Training process and compliance at a future PAWC | SO | May 2021 | Noted on 21.09.2021 regular updates received - Closed |
| 21/22/45 | • R&I Division present metrics | JT | November 2021 - ongoing | |
| 21/22/46 | BAF<br>• Discuss inclusion of pay award as a strategic risk | ES/MKS | September 2021 | |
| **Equality, Diversity & Inclusion** | | | | |
| 20/20<br><br>17/13 | • Review a new approach to EDI - CD & MKS to meet to discuss to ensure clear measures/actions are in place | MKS/CD | TBC<br><br>1/4ly Update | <br><br>WRES/WDES action plans completed |

| | | | | |
|---|---|---|---|---|
| 19/68 | • Equality Objectives Plan for 2018-2021 – Quarterly Update required & Objectives to be reviewed every 6 months<br>• Equality Metrics Report to be brought back to next Committee<br>• WRES/WDES Updated Plan | SM | 6 monthly Review | BAME Taskforce Action Plans completed |
| **Education Governance Update** | | | | |
| 21/22/23 | • Education Governance Committee notes June 2021<br><br>• Education Activity Update | KB<br><br>KB | September 2021<br><br>November 2021 | Noted on 21.09.2021 notes received - Closed |
| **Policies** | | | | |
| 21/22/49 | • Convene a meeting with JP/KB/MF to review Inductions at the Trust (outcomes will inform an updated Induction Policy to adapt/reflect the current climate) | MKS | TBC | |
| AOB | | | | |
| 21/22/53 | • Present about the Wellbeing Guardian role and the progress against the 9 principles that the Trust is being monitored against. | FM | November 2021 | Deferred to January 2021 |
| | | | | |