BOARD OF DIRECTORS PUBLIC MEETING
Thursday 30th September 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
STAFF STORY (9:00am-9:15am)							
1.	**21/22/116**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**21/22/117**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**21/22/118**	**9:17 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Thursday 29th July 2021.**	**D**	Read enclosure
4.	**21/22/119**	**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
POST COVID-19 Recovery Plan 2021/22							
5.	**21/22/120**	**9:25 (35 mins)**	• **Operational Update; including:** - **Update on restoration and recovery.** - **Winter preparedness.** - **Update on the Accelerator Programme.** - **Key risks to delivery.**	A. Bateman E. Saunders	To receive an operational update ahead of the 2021 winter period. To receive an update on the key risks to delivery.	**A** **A**	Read report Presentation

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			• **Staff/Patient Safety:** - **Staff safety and support.** - **Investment in recruitment.**	M. Swindell M. Swindell	To receive an update on staff safety and welfare. To receive an update on investment in recruitment.	**A** **A**	Presentation Presentation
Strategic Update							
6.	**21/22/121**	**10:00 (10 mins)**	**Build Back Better.**	D. Jones	Overview of the Government's plan for health and social care.	**N**	Presentation
7.	**21/22/122**	**10:10 (10 mins)**	**ICS Development Update.**	D. Jones	To receive an update on the development of ICSs.	**A**	Presentation
8.	**21/22/123**	**10:20 (5 mins)**	**CQC's 5 Year Strategy.**	E. Saunders	To receive an update on CQC's 5 year strategy.	**N**	Presentation
9.	**21/22/124**	**10:25 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	R. Gates	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
10.	**21/22/125**	**10:35 (10 mins)**	**Brilliant Basics Programme Update.**	N. Askew	To receive an update on the Brilliant Basics programme.	**A**	Presentation
11.	**21/22/126**	**10:45 (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
12.	**21/22/127**	**10:55 (5 mins)**	**Q1 Mortality Report; including:** • **Outcome of the deep dive into the seven Covid-19 adult deaths.**	N. Murdock	To receive the mortality report for Q1 and the outcome of the deep dive into the seven Covid-19 adult deaths.	**A**	Read report
13.	**21/22/128**	**11:00 (5 mins)**	**Q1 PALS and Complaints Report.**	N. Askew	To receive the PALS and complaints report for Q1.	**A**	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
14.	**21/22/129**	**11:05 (10 mins)**	**Q1 DIPC Report.**	B. Larru	To receive the DIPC report for Q1.	**A**	Presentation
15.	**21/22/130**	**11:15 (5 mins)**	**EPRR Core Standards.**	N. Askew	To sign off the EPPR core standards ahead of external submission.	**D**	Read report
16.	**21/22/131**	**11:20 (40 mins)**	**Corporate Report – Divisional updates:** - **Medicine.** - **Community & Mental Health.** - **Surgery.** **Cumulative Corporate Report Metrics – Top Line Indicators:** • **Quality.** • **Safety.** • **Effective/Responsive.**	 U. Das L. Cooper A Bass N. Murdock N. Askew A. Bateman	To receive a report on Trust performance for scrutiny and discussion, highlighting any critical issues.	**A**	Read report
Lunch (12:00pm-12:20pm)							
The Best People Doing Their Best Work							
17.	**21/22/132**	**12:20 (5 mins)**	**Cumulative Corporate Report Metrics – Top Line Indicators:** • **People.**	M. Swindell	To receive a report on Trust performance for scrutiny and discussion, highlighting any critical issues.	**A**	*Refer to item 16*
18.	**21/22/133**	**12:25 (10 mins)**	**Alder Hey People Plan Update:** • **BAME Inclusion Taskforce update.**	M. Swindell C. Dove	To receive an update on the Alder Hey People Plan. To receive an update on the work conducted by the BAME Inclusion Taskforce.	**A** **A**	Read report Presentation
19.	**21/22/134**	**12:35 (5 mins)**	**Freedom to Speak Up Review Tool for NHS Trusts and Foundation Trusts**	E. Saunders	For information and discussion.	N	Read report
20.	**21/22/135**	**12:40 (5 mins)**	**Award Nominations Summary.**	M. Flannagan	To receive an update.	**N**	*This item has been deferred to October*

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21.	21/22/136	12:45 (10 mins)	**Enhanced Monitoring Update.**	N. Murdock	To receive an update.	A	Read report
Game Changing Research and Innovation							
22.	21/22/137	12:55 (10 mins)	**Future Directions for Research and Innovation.**	J. Chester/ C. Liddy	To provide an update on the future directions for research and innovation.	A	Read report
Strong Foundations (Board Assurance)							
23.	21/22/138	13:05 (10 mins)	**2021/22 H2 Update:** - **Financial Update, M5 2021/22.**	R. Lea	To provide an overview of the position for Month 5 and the latest financial guidance.	A	Presentation
24.	21/22/139	13:15 (10 mins)	**Board Assurance Framework Report; including Corporate Risk Register 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
25.	21/22/140	13:25 (10 mins)	**Board Assurance Committees; report by exception:** • **Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 23.9.21.** - **Approved minutes from the meeting held on the 22.7.21.** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 27.9.21.** - **Approved minutes from the meeting held on the 21.6.21** - **Approved minutes from**	K. Byrne I Quinlan	To escalate any key risks, receive updates and note approved minutes.	A	Verbal/ read approved minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			the meeting held on the 26.7.21 • **Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 22.9.21.** - **Approved minutes from the meeting held on the 21.7.21.** • **People and Wellbeing Committee:** - **Chair's Highlight Report from the meeting held on the 21.9.21** - **Approved minutes from the meeting held on the 20.7.21.**	F. Beveridge C. Dove			
Items for information							
26.	**22/22/141**	**13:35 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
27.	**21/22/142**	**13:39 (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, 28th October 2021, 9:00am-1:00pm, via Microsoft Teams.							

REGISTER OF TRUST SEAL
The Trust Seal was not used in August 2021

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
CQC Action Plan	E. Saunders
Financial Metrics, M5, 2021/22	R. Lea
DIPC Monthly Exception Report	B. Larru
Cheshire and Merseyside Cancer Alliance Performance Report for August 2021	A. Bateman
Governor Election Results.	E. Saunders
EPRR Annual Report, 2020/21	N. Askew
Build Back Better – Our Plan for Health and Social Care	D. Jones
The National Guardian Office's Freedom To Speak Up Strategic Framework	E. Saunders
CQC - Our Strategy from 2021	E. Saunders

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 29th July 2021**
via Microsoft Teams

Present:	Dame Jo Williams	Chair	(DJW)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mrs. C. Dove	Non-Executive Director	(CD)
	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. L. Shepherd	Chief Executive	(LS)
	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)
	Mr. J. Chester	Director of Research	(JC)
	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. C. Liddy	Director of Innovation	(CL)
	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:	Mr. S. Hooker	Lead Governor	(SH)
Apologies	Mrs. S. Arora	Non-Executive Director	(SA)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Ms. L. Cooper	Director of Community Services	(LC)
	Mr. J. Grinnell	Director of Finance/Deputy CEO	(JG)
Patient Story	Ms. C. Martin	LHCRE Programme Manager	(CM)
	Ms. R. Miah	Business Intelligence Developer	(RM)
Item 21/22/93	Ms. J. Pointon	Associate Chief Nurse	(JP)
Item 21/22/94	Ms. S. Robertson	Clinical Psychologist	(SR)
Item 21/22/98	Ms. K. Turner	Listening into Action Lead	(KT)
Item 21/22/99	Ms. R. Lea	Assoc. Director of Finance	(RL)

Staff Story

The Chair welcomed Charlee Martin and Rushownara Miah, who had been invited to July's Trust Board to share the presentation that they submitted during the last BAME listening event to highlight what they thought the Trust should be doing to support zero tolerance at Alder Hey.

Charlee shared her story with the Board, which she explained was a 'very 'Liverpool' story and provided the details of her journey into inclusivity, ethnicity and the challenges that she faced. Charlee drew attention to the first few months of her journey at Alder Hey, where she witnessed discrimination and encountered racist remarks from senior colleagues. These

comments were not necessarily directed at Charlee but at similar cultures. It was during these situations that Charlee required great mental resilience as it deterred her from becoming involved and joining in with colleagues. During her time with the Trust, Charlee has manged to build up a fantastic support network with colleagues, and her advice to the Trust is to ensure that support mechanisms are in place, where everyone can have open and honest conversations to end the fear of speaking out.

Rushownara Miah informed the Board of her journey with Alder Hey over the past year and presented a number of slides detailing her involvement in the following:

- Islamophobia awareness month.
- Black history month.
- Finance team away day which led to the team discussing feelings of exclusion or being excluded.
- Networking with BAME NHS colleagues across the UK.
- Asked digital colleagues to fast for a day during Ramadan which raised £400 for charity.
- Digital EDI working group established which has seven members.
- NHSX visit which resulted in good feedback.
- Mentoring.

Rushownara felt that her career progression is limited at Alder Hey and highlighted the importance of ensuring that Equality, Diversity and Inclusion is an essential criterion in job specifications for senior positions.

The Chair thanked Charlee and Rushownara for sharing their presentation and thoughts with the Board and highlighted the importance of having mechanisms in place to tackle the issues that have been raised during the meeting. The Chair felt that Charlee and Rushownara are inspirational speakers who have underlined the need for change and further support for the next generation of staff members. Kate Warriner added that she was very proud of the guest speakers and pointed out that it is imperative to raise the profile both regionally and nationally in terms of the work that is being conducted by the BAME Taskforce/network.

21/22/84 Welcome and Apologies

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

21/22/85 Declarations of Interest

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

21/22/86 Minutes of the previous meeting
Resolved:
The minutes from the meeting held on the 24.6.21 were agreed as an accurate record of the meeting.

21/22/87 Matters Arising and Action Log

There were no items to discuss

21/22/88 Post COVID-19 Recovery Plan 2021/22

Preparedness Plan for ED Surge, RSV and Elective Care; including an update on restoration and recovery

The Board received an overview of the work that has taken place to compile and deliver an integrated and adaptive preparedness plan for an RSV epidemic, high urgent and emergency care demand and access to elective care. The following points were highlighted:

- It was reported that a number of services are under significant pressure at the present time. Paediatric attendances to emergency departments are at 136% of 2019 levels and referrals to the CAMHS service are 154% of 2019 levels. It is predicted that an RSV epidemic will put unprecedented pressure on paediatric services, with a possible 50% - 100% rise in RSV admissions. At the same time, there is huge focus on access to planned care.
- The plan has recognised the competing demands and pressures that these developments are already having on staff and services, and how demand could grow further within the next six months as RSV, flu and other viruses become more prevalent. The Trust's planning exercises have confirmed that the Trust cannot sustain current levels of elective recovery and create additional surge capacity. Therefore, an adaptable plan has been created that will adjust levels of elective care in accordance to the surge in RSV cases and emergency care. The Trust has also committed additional investment in staff and teams to support Alder Hey's response to the rise in service demand.
- Attention was drawn to the RSV cases by region which shows a significant surge in cases, earlier than expected, in the North West and it was advised that it is the first area of the country that RSV has hit. In response to the this the Trust has established a preparedness plan which will address 5 scenarios. The framework for each scenario was shared with the Board.
- *Urgent and Emergency Care Support Plan* - In response to the high level of demand which has led to an increase in waiting times in the Emergency Department (ED), the Trust has taken the decision to adapt its service model for urgent paediatric and emergency care needs in order to mitigate the risk the current pressures represent to safe and high-quality care. The high impact changes that have been made to address low acuity attendance where it's not appropriate to treat some presenting conditions in ED are as follows;
  - Services in different settings have been identified where families can receive the care they require.
  - Urgent care clinics have been established in the Outpatient Department in order to sign post patients, where appropriate.
  - The Trust has increased its use of local community Pharmacy services, and Alder Hey is also going to set up its own community Pharmacy service from August 2021.
  - The Trust has received mutual aid from colleagues at Mersey Care who have agreed to deliver an on-site Health Visitor service to support families, and they have also offered access to Walk-in Centre appointments.
  - It was reported that all of these are urgent short term actions. In terms of medium term actions, the Trust is working on a symptom tracker and virtual urgent care consultations which will take slightly longer to set up.
- *Progress in the recovery of services* – The Trust has continued to sustain extremely high levels of recovery; in outpatients and elective care Alder Hey has treated more patients than the corresponding month in 2019. During July and August, the Trust will be stepping down some weekend working in response to reduced staff availability caused by higher levels of Covid-19 and to support staff rest. It was pointed out that this will reduce recovery performance over the next few months.
- *Access times* – It was reported that numbers of children and young people (CYP) waiting over 52 weeks for treatment has reduced from 385 at the peak in March 2021 to 189 in July 2021.

- *Revised forecast for elective recovery and paediatric accelerator* – The Board was advised of the impact that RSV could have on the Trust's Elective Recovery Programme; with a possible reduction in extreme pressures to 98% recovery from a 104% in the original trajectories. Attention was drawn to the impact that this could have on income levels.
- *Investment in staffing and services* – The Board was provided with an overview of the workforce expansion and the new models of care that have been implemented via the use of the Accelerator Programme funding; which includes a large number of new appointments, an increase in bed capacity to support an anticipated increase in RSV admissions and thereby prevent cancellation of theatre activity due to medical outliers on surgical wards, and transformational change through the use of technology.

The Chair and Louise Shepherd thanked Adam Bateman and all those involved in this truly outstanding work, and it was pointed out that the Board recognises the immense pressures that Alder Hey is currently experiencing.

Fiona Marston advised the Board of the collaboration between Alder Hey, LSTM and a pharmaceutical company that has an RSV vaccine on the market. It was reported that this is a surveillance study that will provide data that can be used going forward.

Fiona Marston drew attention to the importance of communicating with staff in terms of how the Trust is dealing with incidents or spikes in Covid/RSV and queried the staff communications around RSV. It was reported that the Trust learnt a lot following the first wave of the pandemic, but it was pointed out that caring for patients with RSV will be slightly different as only a small percentage will need to be cared for in ICU. A training package has been developed for medical and nursing staff by the Education Team from PICU and is being rolled out to enable staff to refresh their training to support patients with RSV. Feedback from staff about the refresher course/support has been really positive. The Trust is also in communication with the two different groups of staff on a regular basis.

Staff Safety and Support

An update was provided to the Board on the figures relating to staff absence as at the 23.7.21. The following points were highlighted:

- It was reported that there were 22 members of staff absent as a result of having Covid-19 symptoms, and there were 30 members of staff self-isolating.
- The Board was informed that the Trust is promoting the Smart Release System, but this is not mandatory. HR and the Track and Trace team are conducting a lot of work to encourage colleagues who deliver patient care to return to work, of which, there are a few people who have chosen not to which is challenging. Staff are being made aware that this option is available to them along with support from the organisation in terms of returning to work safely. Further guidance is due to be published confirming as to whether the original guidance is to be strengthened.

IPC Assurance Update

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

- The current status across the Trust is green with the exception of C. Diff. This relates to a patient with Acute Lymphoblastic leukaemia. An RCA has taken place as it was felt that the patient should have been tested earlier for C. Diff as part of the patient's clinical care.
- *Vaccination rates* - Based on the current workforce from June 2021, the number of staff who have received 2 doses of the vaccine is 90%, staff who have received one dose of the vaccination is 9% and there are 44 members of staff, which equates to 1%, who haven't had the vaccine .
- *Fit Testing* – The Board was advised of the number of staff who have been fit tested within the Divisions; Surgery 94.5%, Medicine 94.1%, Community 79.4% and Corporate 96.5%. There is a strategy in place that has commenced for the twelve monthly updates of all staff.
- *HCID* - The Board was advised on the admission of a patient to the HCID facility at the Royal with Monkeypox. A multidisciplinary team covered a 24/7 rota with a minimum of two staff on site at the RLUH throughout the patients' stay, as per the protocol.
- *Track, Trace and Swabbing Team* - There were no Covid outbreaks reported in June but three were reported in July; one on HDU, 1 on Ward 4A and 1 Ward 4B. All of the outbreaks were reported externally.

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

21/22/89 Draft Patient Safety Strategy

The Board received the draft Patient Safety Strategy and was provided with an overview of the report. The following points were highlighted:

- It was reported that in 2019 the NHS centrally released their Patient Safety Strategy but as a result of the pandemic delays were experienced in terms of implementing it. When the Trust reviewed the NHS strategy it was agreed that it was logical for Alder Hey to base its approach in line with the national Patient Safety Strategy.
- The Board was advised that there are three areas of focus; 1. Insight in terms of the use of data to understand where the organisation needs to focus its efforts. 2. Create a safe culture to enable staff to raise safety issues. 3. Create a culture of willingness to want to improve patient safety across the Trust.
- It was pointed out that there is a huge emphasis on involvement in the education of staff in line with the national learning academy work that's been conducted. There is also a strong commitment to having CYP and their families as part of that safety team.
- The use of QI is to be used as an improvement tool to demonstrate learning and improvement across a range of areas. The strategy brings together a lot of work that is already in place and is broadly in line with most of the work that has been suggested and recommended within the national strategy.
- The next steps are to develop an action plan and monitoring schedule that will be submitted to SQAC on a regular basis and Board as required.
- It was reported that there has been a request to strengthen the narrative in the document in terms of the commitments that the organisation has made therefore there will be a further review of the layout of the document.
- The Board was advised that the external reporting that the Trust undertakes at the present time will change as the NHS is re-evaluating its score cards to make them more relevant and is also developing a system that will enable trusts to extract data for use in reports. There will be some re-naming of various items, for example, RCAs will become patient safety investigations.

The Chair summarised the update that was provided and advised the Board that it is being asked to approve the strategy, whilst recognising that there may be some further amendments/revisions to documentation during the coming weeks. This will be followed by an implementation plan which will be submitted to SQAC on a regular basis. The Chair thanked everyone involved in this area of work and felt that the implementation of the strategy was a significant step forward for the organisation.

Resolved:
The Board received and approved the Patient Safety Strategy.

21/22/90 Serious Incident Report

The Serious Incident report was submitted to the 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). Attention was drawn to the following points:

- It was reported that there were two new incidents opened during the month of June and two incidents closed. With five ongoing incidents currently under investigation.
- *StEIS Reference 2020/1919 (patient treatment pathway issues*) – This is a joint investigation between the Trust and Bangor which was due to be concluded by the 23.7.21. There has been a further delay in terms of information being provided by Bangor. A discussion has taken place with the CCG and it has been agreed to extend the deadline until the end of the July 2021.
- *StEIS Reference 2021/12203 (Delay in treatment, delay in transfer to HDU. Transferred to PICU shortly following transfer to HDU)* – As a result of this incident the organisation has reviewed its pathway for deteriorating patients along with the interactions between different teams in the Trust.
- StEIS Reference 2021/12387 (*Patient ingested large overdoes of tablets at home, including Omeprazole and Colchicine. Patient brought to ED and was admitted to PICU. Unfortunately, the patient died due to the impact of Colchicine toxicity)* – The Board was advised that the Trust is looking at the pathway of this young person as a whole. This incident will also be addressed as part of the National Safeguarding Review. Further details will be provided following the conclusion of the investigation.
- *StEIS Reference 2021/7300 (wrong site block)* – The final report was completed and submitted within the agreed timeframe and shared with family on the 21st of July 2021. The investigation report, including findings and actions for improvement, was presented to the Safety and Quality Assurance Committee (SQAC) for discussion. It was reported that since the action plan has been established significant improvements have been made in a short space of time.
- *StEIS Reference 2020/23828 (Waiting list data quality issues)* – The final report has been completed and submitted to the CCG within the agreed timeframe. It was confirmed that the actions for improvement are progressing in line with expected timeframes.
- Louise Shepherd referred to StEIS reference 2021/12387 and asked that the report be updated prior to publishing to reflect that the young person took the overdose at home.

21/22/90.1 Action: NA

Resolved
The Board received and noted the contents of the Serious Incident report.

21/22/91 Nurse Workforce Annual Report 2020/21

The Board received the Nurse Workforce Annual Report for 2020/21. The aim of the paper is to provide assurance to the Board that safe nurse staffing levels are being maintained across all in-patient and day case wards and appropriate systems are in place to manage the demand for nursing staff. Attention was drawn to a number of key points:

- It was reported that there has been a significant increase in terms of compliance with the RCN safe staffing requirements. The Trust is now compliant with 15 of the 16 core standards with an improved position in the standard rated partial compliance which relates to the supernumerary status of a Band 6 nurse in charge which only affects a small number of the organisation's wards.
- There has been a huge improvement in the Trust's vacancy rate for nursing which is 2%, and staff turnover has halved compared to this time last year which is from around 9% to 4.5%.
- Alder Hey has retained all of its third year nursing students who qualified. These students were part of the extended clinical placement, which was initiated by the Government in response to COVID-19 and became paid members of the Trust's workforce during their third year of training. All of the students enjoyed their time with Alder Hey and wanted to continue their career with the Trust.
- The Trust's mandated monthly submission of staffing levels to NHS website presented was consistently higher than 90% throughout the year against the nationally accepted level of 90%.
- E-roster has been rolled out to all the wards and departments across the Trust and PNA has been implemented too. PNA is a support role that looks at implementing restorative supervision to staff throughout the organisation. Alder Hey was allocated eight places to train respective staff members who have since commenced work in terms of a supervisional approach across the organisation.
- Attention was drawn to the workforce plan for nursing and support workers which was approved by the Executive team. This plan brings together a range of items, particularly focusing on routes of entry and attracting a more diverse workforce into various roles such as healthcare support workers as well as new models of working.
- There has been a real focus on extended and enhanced education, especially around Band 6 & Band 7 leadership roles within Nursing. The Equality, Diversity and Inclusion agenda is also progressing.
- The Board was advised that the Trust is looking to develop the clinical academic careers of nurses that the organisation has supported to achieve a PhD to enable staff to continue their academic work for the organisation.

The Chair felt that the outcome of the report was really positive, especially in terms of the high retention figures. The Chair thanked Nathan Askew and Pauline Brown for the work undertaken to produce the 2020/21 Nurse Workforce Annual Report.

Resolved:
The Board received and noted the contents of the Nurse Workforce Annual Report, 2020/21

21/22/92 Digital and Information Technology Update

The Board received a digital update which included the national digital direction of travel and local progress with Digital Futures. Attention was drawn to the following

headlines:

- It was reported that there is a lot of activity nationally in the digital and IT field particularly around the ICS framework. There are also a number of key publications due to be released from an NHSX perspective.
- Alder Hey is well placed in terms of the national framework and has received positive feedback from the National CIO following a recent visit. The National CIO referred to the Trust when reporting upon what good looks like.
- The Board was advised that the Trust is continuing to make good progress operationally and programme wise, with a number of key programmes being cited in the paper link to HIMMS 7. The organisation is also working towards an EPR upgrade in 2022.
- Alder Hey is in the final year of its Digital Futures Strategy and is looking to refresh the Digital Strategy which will be submitted to the Board towards the end of 2021.
- Attention was drawn to the successful management of the e-Digital Service which now has a twitter account to enable people to follow the service; Twitter@idigitalNHS.
- It was reported that progress has been made with regards to bringing the team together across the new service. Going forward, work will continue to develop the joint service.

Fiona Marston queried the new appointment of a Digital Director within the ICS leadership team and queried as to how this role will work. It was reported that this is a full time role in the new ICS structure which came as a recommendation and is part of the guidance for ICSs. The person who has been appointed has a broad range of experience of working with systems but was also a key leader in the national digital developments for providers. This person will commence in post in October 2021.

The Chair thanked Kate Warriner for the work that has taken place and acknowledged the progress that has been made, pointing out how positive it is to see a real partnership working.

Resolved:
The Board noted the Digital and Information Technology operational update and the progress that has been made to date.

21/22/93 Corporate Report – Divisional Updates

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.

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.

21/22/94 Alder Hey Wellbeing Guardian

The Board received a follow-up report as proposed in the presentation that was submitted by the Wellbeing Guardian on the 27.5.21.

A number of slides were shared with the Board that provided the following information:

- A summary of the meeting that took place on the 27.5.21.

- Alder Hey's current status in terms of enablers and health interventions.
- Wellbeing Guardian dashboard which illustrates all of the nine principles, the responsible lead for each principle, the progress that has been made and the current actions.
- Summary – The Board is asked to:
  - Review and provide feedback on the format of the dashboard.
  - Approve the actions planned as described in the dashboard.
  - Consider and approve the proposed frequency of formal presentations by the Wellbeing Guardian to the People and Wellbeing Committee quarterly and to the Board on an annual basis.

Dani Jones referred to ICS developments and pointed out that much of the language around how organisations measure their values is starting to evolve into a quadruple aim rather than a triple aim; effectiveness, quality, value and health and wellbeing, and it was felt that the data in the dashboard could help the Trust demonstrate a quadruple response, if asked, in terms of measuring and connecting these points. Sarah Robertson offered Dani Jones the opportunity to attend the Wellbeing Action Group meeting in order to have a lens on activities and the work that is taking place around wellbeing across the Trust.

Claire Liddy offered her support with this area of work and advised of the local innovations that are being conducted by staff in relation to digital platforms and how they can be used for health and wellbeing.

The Chair felt that the presentation was very clear and thanked Fiona Marston for taking on the role of Wellbeing Guardian. Fiona Marston thanked Jo Potier, Jeanette Chamberlain and Sarah Robertson for their support and hard work.

Resolved:
The Board noted the presentation and approved the proposals for submitting a formal Wellbeing Guardian presentation to the People and Wellbeing Committee quarterly and to the Board on an annual basis.

21/22/95 Cumulative Corporate Report Metrics – Top Line Indicators: People
Resolved:
The Board noted the people update that is highlighted in the Corporate Report and the cumulative Corporate Report top line metrics.

21/22/96 Alder Hey People Plan Update
Resolved:
The Board received and noted the strategic update on the Alder Hey People Plan and the Trust's response to the requirements of the national NHS People Promise.

BAME Inclusion Taskforce update

The Board received an update from the Chair of the BAME Inclusion Taskforce, Claire Dove. The following points were highlighted:

- *Charity Board Meeting* – The Trust shared a presentation with members of the Charity's Board on the work of the BAME Inclusion Taskforce. The Charity felt that it is imperative that they take on the same mantle in order to make changes in the Charity. It was confirmed that the Charity have been invited to send a representative to sit on the taskforce.
- *Nurse Apprentices* - The Trust has piloted 10 nurse apprentices as a result of advertising via the NHS recruitment website and a number of organisations in the community. It was reported that the Trust received a large number of

applications but there were no BAME candidates appointed. The taskforce have asked for a report to be compiled to advise as to whether there were any BAME applications submitted and if so, the reasons as to why these candidates weren't appointed. It was confirmed that feedback on this matter will be provided during September's update.

- *Volunteers* – There has been a significant improvement in the diversity of the Trust's volunteers; of the 167 volunteers, the Trust now has 22 BAME volunteers, of which, 15 have been appointed following a recruitment process and 8 are on probation.
- The Board was advised of the work that is taking place in terms of ideas around CPD to help on the leadership programme for BAME staff, a forthcoming newsletter for staff and the Black History Programme for October. The Trust is also liaising with staff to agree which zero tolerance poster should be used across the organisation.
- Claire Dove drew attention to the cultural shift in Alder Hey and advised that the taskforce will work with all departments to ensure that staff who wish to take an active role around EDI have the right skills.
- It was reported that racism awareness training will commence in September via an external organisation, and the BAME network will be working closely with Rush, Charlee and Anne Marie from Community to establish a network that can be driven forward.
- Following on from the discussion that took place during June's Trust Board it was advised that listening events have taken place for LGBT and disabled colleagues. Staff feedback from both of these groups is that a network for each respective group would be welcome. An overview of the LGBT listening event was provided to the Board and it was pointed out that as well as making sure that issues affecting LGBT staff are being made known and understood, there is a real desire for change in culture around this topic for CYP in terms of developing a much more open environment for them when they visit the Trust to enable them to discuss matters such as sexuality, sexual identity, sexual orientation and gender identity. The next steps is to have a more formal plan by the autumn which will be shared with the Board in due course.

Louise Shepherd advised that the Mayoral office has recently made contact with the Trust to enquire about the action that Alder Hey is taking in terms of EDI, particularly to race. This is a new initiative across the City which is particularly aimed at service. Alder Hey will responding to this request and will share some of the work that the Trust has been doing following the establishment of the BAME Inclusion Taskforce. It was reported that the Trust is going to engage in this fantastic initiative to make sure it is prominent in terms of supporting CYP in the City.

Fiona Marston pointed out that as other networks start to form a lot of learning can be taken from the establishment of the taskforce, especially in terms of listening events as this allows staff to talk openly in a safe environment. Nathan Askew advised that the staff members who were present at the recent LGBT listening event were keen to meet on a face to face basis as well as offer their thoughts, and it has been agreed to conduct a survey to provide an opportunity for staff members to provide feedback especially those who wish to share their thoughts anonymously. It was confirmed that further listening events are going to be planned.

The Chair thanked Claire Dove for her work and leadership in establishing the BAME Inclusion Taskforce and for creating a model that can be used across the Trust. Attention was drawn to the importance of keeping the momentum going to ensure further progress.

Resolved:
The Board noted the BAME Inclusion Taskforce update.

21/22/97 Medical Revalidation Update

The Board was provided with an update on the current uptake/status of appraisals and revalidation for medical staff. The following points were raised:

- It was reported that there are 339 clinicians that required an appraisal during 2021.
- The Trust implemented a new appraisal system L2P in January 2021.
- Following discussions with the Responsible Officer and the Appraisal Lead the decision was made to move appraisal dates to clinician's birth months.
- It was pointed out that revalidation figures are far better than those provided in the report as most clinicians have been revalidated but are awaiting sign-off.
- There have been five GMC letters sent to consultants, four of which have been acknowledged. The outstanding respondent is being supported by the Trust.

Resolved:
The Board received and noted the Medical Revalidation update.

21/22/98 Freedom to Speak Up (FTSU) Update

The Board was provided with an overview of the actions that have been taken by the FTSU team in the last quarter and an outline the actions planned for the coming six to twelve-month period. An update was provided on the key points of the report; recruitment of further FTSU Champions, the Communication Plan, FTSU training, FTSU Index and National Guardian Report content.

FTSU Champions - Attention was drawn to the work that has taken place to develop a diverse FTSU Champions' Network across the organisation. It was reported that some of the recruited Champions have found it difficult to attend training and monthly meetings due to the pressures of their day jobs. It has been recognised that it is difficult for staff to secure time to attend meetings, therefore it is necessary to quantify the amount of time that is required to carry out the duties of an FTSU Champion going forward. It was confirmed that ad hoc sessions will be available for staff to complete FTSU Champion training. Champions have also been advised to undertake the Speak Up and Listen Up training that has been developed by the National Guardian's Office which can be conducted via e-Learning.

Training – E-Learning modules were released by the National Guardian's office early in 2021; Speak Up, Listen Up and Follow-up. It was reported that the organisation as a whole should look towards completing the Speak Up module, with all managers completing the Listen-Up module. The Board was advised that this training is not mandated and it was queried as to whether it should be included as part of the Corporate Induction session as it was felt that it would be beneficial to capture staff as they commence in post with the Trust.

Anita Marsland felt that FTSU is still not getting the visibility that it should at Board level and advised that discussions have commenced around

communications generally and how FTSU can be reported to the Board going forward.

The Chair advised that Board members felt that it would be beneficial for the e-Learning module to be included in Corporate Induction sessions and it was agreed that a meeting should take place between Kerry Turner and Melissa Swindell to discuss this matter further.

21/22/99.1 **Action: KT**

Resolved:
The Board received and noted the FTSU progress update.

21/22/99 **2021/22 H2 Update**

Month 5 YTD Financial Position

The Trust is reporting a break even plan for H1 assuming a £4m ERF contribution and a delivery of £3m CIP. The Trust's performance at the end of Q1 is in line with plan with £0.4 ahead of plan, but with an overall YTD £652k deficit. The ERF position at the end of Q1 is £0.4m ahead of plan with a YTD income of £6.4m. This has not been validated to date and is predicated on Cheshire and Merseyside achieving their thresholds. An update on the final ERF funding for Q1 will be provided during September's meeting. It was confirmed that cash in the bank is £82m and Capital Spend YTD is £4m which is on track to spend £23m.

Key areas to note:

- Surgery are £0.4m behind plan – Additional costs not in budget related to unfunded historical cost pressures. A deep dive is underway which will be reported via RABD and an action plan is due in August.
- Facilities are £0.7m behind plan – This relates to a catering and car parking income shortfall and portering pay costs. An action plan has been produced for the switch on of car park income and to agree a recovery trajectory for income.

H1 and H2 Plan and Changes

H1 breakeven plan based on key assumptions:

- CIP/Efficiency £3m (full year £6m) - £2.2m has been achieved and £1.1m opportunity has been identified. This has been static for the last month therefore the SDG group are liaising with the Transformation Team to look at other opportunities in terms of benefits realisation to support the CIP programme.
- ERF additional income £10m – Q1 £6.4m has been achieved but there are a number of risks, as detailed in the presentation.
- Cap on costs to deliver ERF at £6m = £4m contribution.
- Non-clinical income restored to 2019/20 levels – Q1 £0.5m gap. Work is continuing to address this matter.

H1 Plan, changes and impact to Alder Hey

- Increase in activity thresholds July to September. There is an expectation nationally to deliver 95% of activity in comparison to 85% previously.
- ERF revised to 95% = loss of £2.4m to £4.5m = loss of cash.

- Emerging RSV surge - £1m to invest in critical roles, RSV plan NHSE £3m to £8m risk.
- Medium/high risk to delivery of breakeven for H1 – The Trust will continue to lobby funding and cost control.

H2 Plan

- Block contracts to continue but the funding envelope hasn't been shared to date.
- There will be a greater focus on efficiency with a CIP Waste Reduction minimum target of 3%. This target will be greater for ICSs which is a real challenge for Cheshire and Merseyside (C&M).
- Growth/inflation funding will be above H1 levels and Covid funding will reduce.
- The ERF incentive will continue but at a higher rate – 95% minimum.

Areas of focus

- Clinical income.
- Research, education and income growth.
- Hospital optimisation.
- Cost base.

The Board was asked to note the contents of the update and in particular the following key points:

- Q1 position is in line with plan with achievement of ERF targets.
- H1 national planning changes place high risk on delivery in Q2, with minimal loss of income (£2.4m) due to ERF threshold changes.
- RSV surge further compounds the risk for Q2. An investment was made at risk to support response.
- H2 framework has not yet been confirmed however there won't be a return to PBR/commissioner contracts. Blocks will continue with reduced system envelopes.
- The Trust needs to focus on areas within its control to protect cash and drive sustainability via four key areas.

The Chair queried the funding for the pay agreement. It was confirmed that there will be additional funding for pay awards but there hasn't been any indication of how this will be addressed, for example, via an efficiency.

Resolved:
The Board received and noted the contents of the financial update.

21/22/100 **Directors' Register of Interest**
Resolved:
The Board received and noted the Directors' Register of Interest.

21/22/101 **Board Assurance Framework (BAF) Report**

The Board received a summary of the monthly updates to the BAF for review and discussion. The 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:

- Attention was drawn to the risks relating to ICS development and associated legislative changes.
- It was reported that the risks on the BAF have been scrutinised by the respective Assurance Committee.

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

21/22/102 Board Assurance Committees

RABD – During the meeting on the 26.7.21 there was a focus on the Division of Surgery and the reinstatement of the Park. The Board was advised that the Trust is trying to address the historical issues in Surgery, but it was felt that the Division would be back on plan if it remedied the two main cost variances relating to anaesthetists and theatres. In terms of the reinstatement of the Park it was pointed out that the core issue relates back to 2009 when the first estimate was produced.

SQAC – The approved minutes from the meeting that took place on the 23.6.21 were submitted to the Trust Board for information and assurance purposes. During the meeting on the 21.7.21 the Committee discussed the RSV surge, capacity and the potential issues around access and delivery to care. The Board was advised that the Committee received a very good presentation and report from the Quality Improvement Programme. In terms of sepsis, a bi-annual update was provided which highlighted the positive work that has taken place. It was reported that aggregated analysis was included in the Management of High Profile Inquests, Complaints, Incidents, Claims including Lessons Learnt, Near Misses, Improvement Actions, Legal Cases and Clinical Claims Report. This is the first time that the Committee has seen all of this data as a whole, with comparisons between Alder Hey, children's Centres and other Trusts in the NHS. It was pointed out that there is still a need for Transition Leads in the Division of Surgery and Medicine. It was confirmed that this matter is being addressed.

PAWC – The approved minutes from the meeting that took place on the 18.5.21 were submitted to the Trust Board for information and assurance purposes. During the meeting on the 20.7.21 the Committee focussed on burnout within the Divisions and what the Trust is doing to respond to this, supporting operational managers, the roll out of the DBS, guidelines on revalidation/appraisal and the work that needs to be done to progress the Equality Plan. The Committee noted the positive Nursing Workforce Report and welcomed the new Director of the Academy, Kathryn Birch onto the People and Wellbeing Committee.

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

21/22/103 ICS Development Update

Louise Shepherd provided a brief introduction for this item and advised that the Board will be presented with the scope for the Cheshire and Merseyside Mental Health, Learning and Disability and Community Provider Collaborative (MHLDC)

Memorandum of Understanding (MoU) to enable members to discuss and approve this document.

The Board received a strategy and system update in terms of how Alder Hey is shaping its role in the System and the next steps for the Trust's strategy. A number of slides were submitted to the Board which provided information on the following areas:

- What's happening in the System:
  - ICS Development and Design Framework was published in June 2021.
  - The second reading of the Health Bill took place on the 14.7.21. This sets out the next phase of guidelines in respect to how the reforms in the NHS are going to progress.
  - Interim C&M ICS Leadership. It has been announced that David Flory is to be the interim Chair for Cheshire and Merseyside, and Sheena Cumiskey is to be the interim Chief Executive for the next three months.
- White paper Themes.
- Overview – It was reported that the key differential between the Integrated Care Board, which is the new C&M statutory NHS body and the Health Care Partnership, involves the local authority and other partners working with the NHS.
- ICS Design Framework:
  - The second reading of the bill focuses on the development of the NHS statutory body element and therefore it is really important for Alder Hey to continue to work effectively with a group of authorities in the system.
- Revision of commissioning functions from April 2022.
- Route map for the new Health and Care System.
- Potential ICS structure.
- Direct commissioning function:
  - It was pointed out that delegated commissioning responsibility for a proportion of specialised services (subject to system and service readiness) with national standards and access policies remaining at a national level, is being planned for April 2023.
- What this means locally:
  - Health and Care Partnership.
  - ICS Board.
  - Place Arrangements.
  - Provider collaboratives.
  - Relationships.
- The latest System finance; including C&M's proposed approach.

MHLDC MOU

- MOU Scope
  - Help plan services balancing the needs of Place against the provisions and sustainability of high quality MH/LD/C services.
  - Explore opportunities for the best use of resources supporting the delivery of MH/LD/C services.
  - Tackle variation through transparent data, peer review and support arrangements.
  - Equalise access and pressures on individual organisations.

- Maximise the expertise, knowledge and learning opportunities between and across the Parties, to help improve MH/LD/C services culture and service provision locally.
- Provide opportunities for innovation at scale.
- Work collaboratively to meet workforce challenges.

- Shared agenda.
- Alder Hey's response to LDMHC MOU.

Fiona Marston queried the implications for the Board in terms of how it operates now versus how it will operate in the future. It was reported that the only clarification that has been received to date is that there are to be no formal implications to the statutory function of the Trust Board, for example, governance and leadership arrangements. It was felt that the Board will have to be oriented towards its relationship with the System as the Board will be held to account for the Trust and the System.

The Board was advised that the forthcoming guidance will be key, and it will be necessary to scrutinise this carefully. Once this scrutiny has taken place, if necessary, a report will be submitted to the Board to provide detail on the implications. It was suggested that the Governors be updated on this matter during September's Council of Governors meeting.

Louise Shepherd pointed out that there has always been a requirement for trusts to collaborate, but this has now been stipulated in the legislation. A discussion took place around what this means for the Trust going forward and how Alder Hey is going to position itself. It was felt that it is important for the Trust to make sure there is a lead provider for CYP incorporated in the MOU. Attention was drawn to the issues of funding, financial flows, efficiencies and the financial gap in C&M. The Board was advised of the importance of the Trust being able to demonstrate efficiencies, and the implications for the Specialist Trust Alliance in terms of extracting value as a group.

Anita Marsland felt that the difference with the new architecture is the focus on Place and the delegation of responsibilities and advised that there is real concern at local authority level about how the budget is going to be brought together.

The Chair concluded the discussion by providing an overview of the main points. It was pointed out that as a Foundation Trust, Alder Hey will be held to account in terms of performance, management of finances, participation as a member of several collaboratives, partnerships and leadership. This has implications for all with regard to time, working together as a group of people with those clearer accountabilities and also some of the less clear accountabilities. Further clarity may emerge over the coming months, but it was felt that progressing the 9 Places will be challenging for the whole System. Following discussion, it was agreed to approve the MHLDC MOU, taking into account the caveats highlighted in the presentation.

A number of slides were shared with the Board in preparation for September's strategy session with attention being drawn to the reframing of the Trust's commitment through its vision around 'Our Healthier Future for CYP'. It was felt that the key message for September's discussion is 'What does Alder Hey want to be known for in 2030'.

Resolved:
The Board noted the ICS development update and approved the MHLDC MOU, taking into account the Caveats highlighted in the presentation.

21/22/105 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:

- *Park Reinstatement* - It was reported that the park explorers' initiative is going to come to Springfield Park. This entails up to fifty children and their parents per day coming to the park to take part in activities. Phase 1 of the park is now complete and is ready to be transferred to Council ownership.
- It was reported that there are four issues that need to be addressed in terms of the overall Campus; engaging with the Council in order to agree a handover date, issues with the market from a supply chain perspective, funding/budget and relocations.
- *Schemes* – It was confirmed the relocation of staff to Liverpool Innovation Park is progressing as is the construction of the Catkin Building. Tenders for the Neonatal scheme are due to be submitted by three parties interested in the construction.
- *North East Plot* – Discussions are on-going around the options for new family/patient accommodation and Heads of Terms are in the process of being developed. A meeting is due to take place early August to progress this matter.
- The Board was advised of forthcoming items that need to be addressed in terms of the Science Building and the Green Transport Plan.

The Chair thanked David Powell for the update and asked the Board to note the issue with supply chains that may affect the completion of buildings on the Campus. The Chair drew attention to the importance of engaging with the Council and agreeing a handover date.

With regards to the gap in accommodation for staff it was agreed to submit an update in October 2021.

21/22/105.1 Action: DP

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

21/22/106 Any Other Business

There was none to discuss.

21/22/107 Review of Meeting

The Chair felt that there is a lot to celebrate in terms of the positive position that the Trust is in at the present time, whilst recognising the challenges of the front door issues. The shift in culture across the Trust was also acknowledged as highlighted in the various presentations and discussions during Board.

Date and Time of Next Meeting: Thursday the 30th September 2021 at 9:00 am via Teams.

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

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for the 29th July 2021							
24.6.21		Staff Story	Meeting to take place with Nathan Askew, Alfie Bass and Vittoria Bucknall to discuss a process for reporting via CQSG and SQAC the learning from the STAT programme and the issues captured in the STAT CV that can't be resolved.	Nathan Askew	29.7.21	Closed	**23.7.21** - An update in relation to this action will be provided during the Divisional update on the 29.7.21. **28.9.21** - It was confirmed that the STAT program will report through the theatres improvement work and the report has been changed. **ACTION CLOSED**
24.6.21	21/22/68.1	BAME Inclusion Taskforce	Circulate a communication advising staff of the programme of work that the Trust has planned to ensure inclusivity for all.	Mark Flannagan	29.7.21	Closed	**23.7.21** - This action is in the process of being addressed. **28.9.21** - This action has been addressed. It was confirmed that this information is included each time Comms post a blog. **ACTION CLOSED**
Actions for the 30th September 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	30.9.21	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. **28.9.21** - An update will be provided on the 30.9.21. **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	30.9.21	On Track	28.9.21 - An update will be provided on the 30.9.21.
29.7.21	21/22/90.1	Serious Incident Report	*StEIS reference 2021/12387* - Update the report to reflect that the young person took the overdose at home	Nathan Askew	30.9.21	Closed	**28.9.21** - The Serious Incident report was updated to reflect that the young person took the overdose at home. **ACTION CLOSED**
29.7.21	21/22/99.1	FTSU Update	Meeting to take place to discuss the plans for including the Speak Up e-Learning module as part of the Trust's Corporate Induction.	Kerry Turner/ Melissa Swindell	30.9.21	On Track	28.9.21 - An update will be provided on the 30.9.21.
Actions for the 28th October 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.
29.7.21	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.	David Powell	28.10.21		
Actions for June 2022							
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	

BOARD OF DIRECTORS

Thursday 30th September 2021

Paper Title:	**Operational update: recovery of services & winter planning**
Report of:	**Adam Bateman, Chief Operating Officer**
Paper Prepared by:	Adam Bateman, Chief Operating Officer Ronnie Viner, Safe Waiting List Management Advisor Andy Hanson, Acting Associate Chief Operating Officer Chloe Lee, General Manager

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

1. Introduction

Alder Hey's progress in recovering services in 2021-22 has been outstanding and is testament to the hard-work and ingenuity of staff. In quarter 2 we have sustained high levels of recovery (a range of 90- 100% relative to 2019 across service type), although this is at a lower level than was achieved in quarter 1. There are strong headwinds to increasing levels of recovery: a surge in urgent care attendances to the Emergency Department; higher emergency admissions, driven in part by respiratory infections; and staff fatigue and absence.

Our planning exercises for winter have confirmed that we cannot sustain higher levels of elective recovery *and* create additional surge capacity required in a scenario demand for critical care and medical emergencies. Thus, we have created an adaptable plan that will adjust levels of elective care in accordance to the surge in emergency care.

Our plans are built around deep consideration of staff wellbeing and staffing levels. We are investing in additional staff and infrastructure to deal with higher demand and we are providing a range of wellbeing measures to keep staff safe.

2. Recovery of elective care

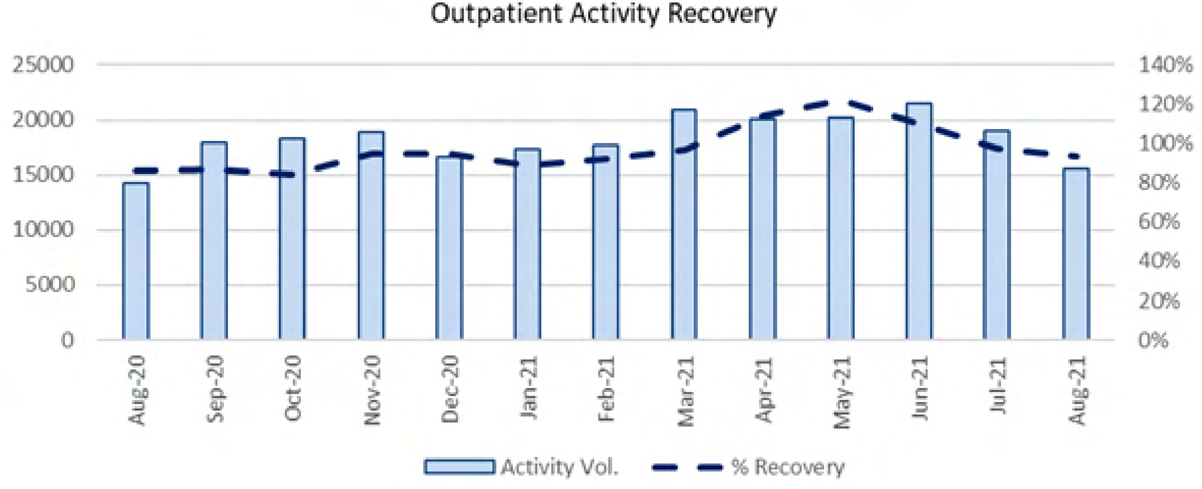
2.1 Progress in recovery of services

Our levels of recovery of planned services remains high, however, in July and August this has reduced as we stepped down addition weekend working to support staff rest.

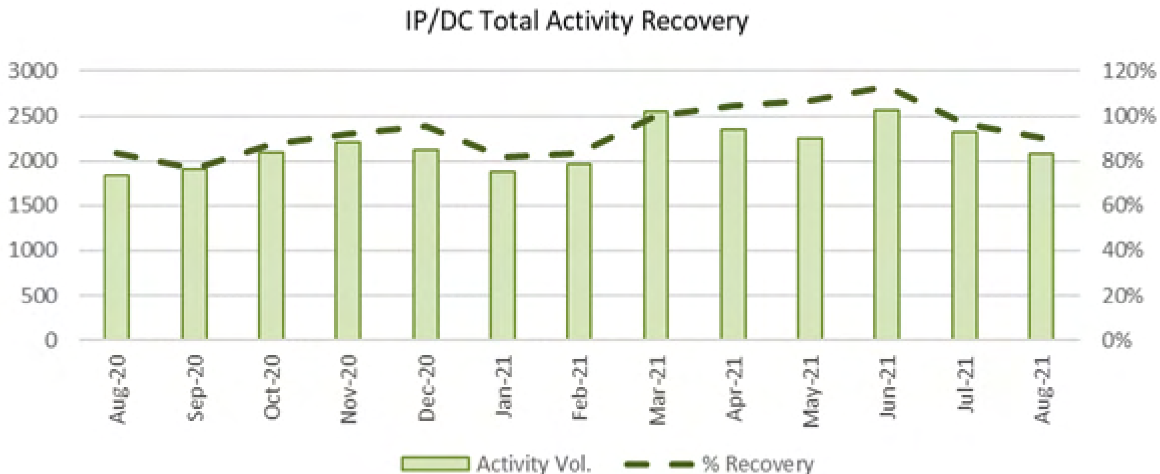
In diagnostics a 100% recovery of service was achieved in August 2021.

Service area	ERF Target 2021/22	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Outpatients	95%	86%	87%	84%	95%	95%	89%	92%	97%	114%	122%	110%	98%	93%
Inpatients & day case	95%	84%	76%	87%	92%	95%	82%	84%	100%	105%	107%	113%	96%	90%
Diagnostics	n/a	91%	90%	87%	91%	103%	97%	95%	87%	91%	97%	96%	93%	100%

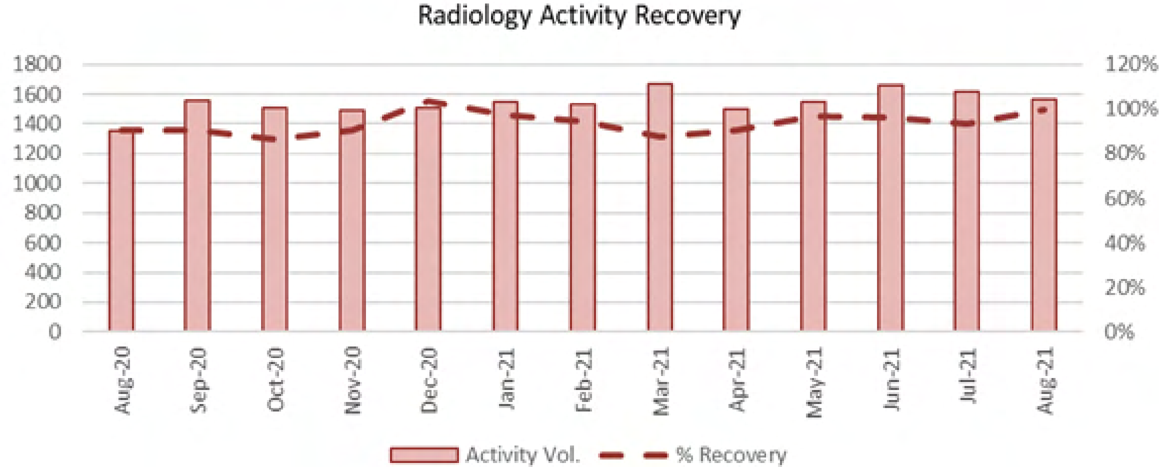
Our outpatient recovery progress and profile are shown below:



Our combined elective (inpatient and day case) recovery progress and profile is shown in the chart below:



Our radiology recovery progress and profile are shown below:



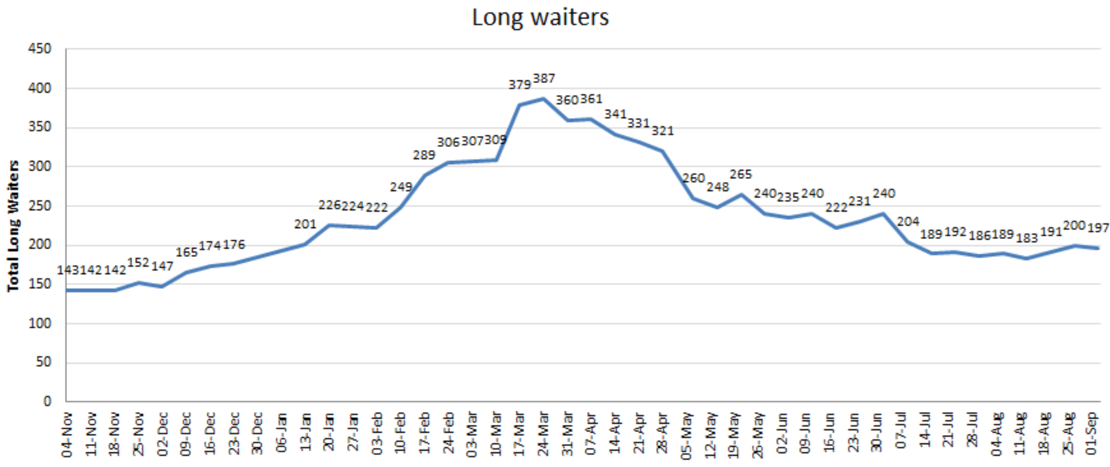
2.2 Recovery levels benchmarked against Trusts in the paediatric accelerator programme

There are nine other Trusts participating in the national paediatric accelerator. In the latest available data, which is for July, it showed that whilst Alder Hey's progress in the five accelerator specialties was lower than planned, our performance overall for all specialties during July 2021 was strong (106% for outpatients; 113% for elective and day case). Our progress in enhancing recovery in the 5 accelerator specialties has been inhibited by difficulties in staff availability (absence and vacancies) and a moratorium on waiting list initiatives during in July.

Recovery Status Across the Accelerator - July 2021			
POD/Specialties	% Recovery		
	Alder Hey	Core Trusts	Additional Trusts
Outpatients - 5 specialties	99%	111%	96%
Outpatients - all specialties	106%	100%	98%
IPs/DCs - 5 specialties	78%	82%	92%
IPs/DCs - all specialties	113%	92%	93%

2.3 Waiting times

In July to August the number of children waiting over 52 weeks for treatment has plateaued, this trend is associated with the reduction in additional sessions and in August in-week activity levels reduce reflecting the higher levels of annual leave.



Looking ahead, we expect that at the beginning of quarter 3 we will report an increase in the number of long wait patients as we conclude the safe waiting list management programme. Our forward look for access times has a range of scenarios: in a low RSV and winter surge scenario we expect to deliver at least a 50% reduction in the number of 52 week wait patients. Staff fatigue and workforce availability (affected by absence and vacancies) will also affect recovery. Our mitigation strategy includes a focus on recruitment and in-week productivity of outpatient and theatre sessions

2.4 Risks to the recovery of services

The revised forecast for elective recovery and accelerator is predicated on the current staffing challenges and an anticipated RSV surge. It should be noted however that the workforce risks in particular, may be more significant and prolonged than first anticipated, which could have a greater adverse impact on restoration and performance. Some of the specific challenges include:

- Shortage of radiographers to support theatre lists and some clinics accentuated by an inability to recruit to vacant posts and a poor take up of additional sessions/overtime

- A lower take-up by theatre staff and clinicians of waiting list initiatives despite the rest period provided July-August 2021
- Unable to staff all in-week theatre sessions due to vacancies, staff sickness and staff having to isolate

Work is ongoing to try to mitigate the risks including active recruitment, a theatre utilisation policy - which will help to drive up theatre productivity during core hours - and a review with some specialties of their clinic templates to return them to pre-Covid levels.

2.5 Investment in staffing and services

We are making the following investments to support teams:

Workforce expansion and new models of care:

- Additional clinical staff in anaesthesia and radiology to support sedation pathways, pre-op. assessment pathways and radiographer support in OPs and theatres.
  - **1 x consultant anaesthetist (position successfully recruited to)**
  - **2 x senior clinic fellows in anaesthesia (positions successfully recruited to)**
  - **1 x consultant radiologist (position successfully recruited to)**
  - **2 x radiographers (positions currently out to advert)**
- Appointment of physician associates to undertake some of the minor theatre work and outpatient follow-up work, and thereby free up consultants' time to focus on the more complex work.
  - **10 x physician associates (all are in post)**
- Additional OP staff to help minimise existing bottlenecks in patient pathways including the plaster room, chaperoning and basic observations.
  - **1 x registered nurse (position successfully recruited to)**
  - **1 x plaster technician (position successfully recruited to)**
  - **5 x healthcare assistants (position successfully recruited to)**

Stepped release of bed capacity

- Additional beds (expected to be deployed from October 2021) to support an anticipated increase in RSV admissions and thereby prevent cancellation of theatre activity due to medical outliers on surgical wards.
  - **4 x fully staffed beds**

Transformational change through the use of technology

- o Virtual consultations ("Attend Anywhere").
- o Robotic process automation to better manage waiting lists to deliver equality of access and risk stratification.
- o Electronic visual data capture tool (ISLA) to support patient monitoring.

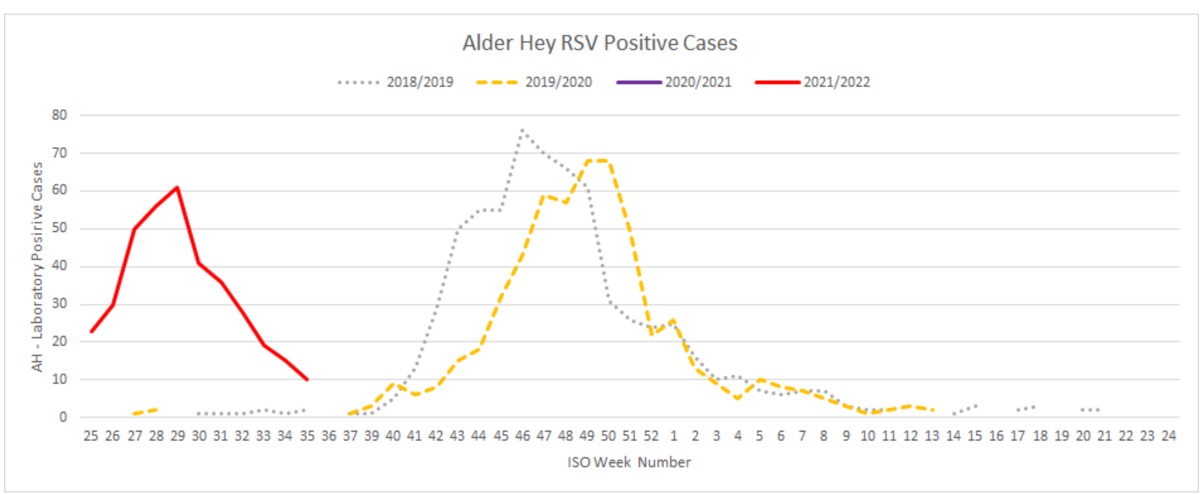
- The use of capital as an enabler to support an increase in clinic capacity:
  - o New seating in OP clinic area to help facilitate a greater footfall.
  - o **Six additional virtual booths** to support an increase in virtual clinics

3. Winter planning

3.1 Respiratory Syncytial Virus

National modelling from Public Health England indicated a possible RSV epidemic this year. A range of scenarios were modelled including an earlier onset of an RSV season and/ or a 20%, 50% and 100% increase in the total number of RSV cases / admissions.

The graph below demonstrates positive RSV lab detections at Alder Hey up to week 35, the week commencing 30 August 2021. We experienced a surge in infections which peaked in mid-July. demonstrates the earlier onset of the RSV season in 2021-22 and is based on positive lab detections up to week 29. In response, we need to be ready to bring forward the start of our actions contained in the preparedness plan (see section 2.3 below).



3.2 Winter plan capacity & escalation plan

Our model for winter preparedness is adapted from our preparedness plan for RSV and flu. We have prepared for five scenarios and the escalation framework for each is summarised in the table below:

Escalation Status	1 Low Pressure (mild winter pressures with mild RSV)	2 Moderate Pressure (20% RSV Surge)	3 Severe Pressure (50% RSV Surge)	4 Extreme Pressure (100% RSV Surge)	5 Maximum Surge
Escalation status triggers (one of the triggers below is met)					
Ward or critical care occupancy	<85%	>85%	>92%	>95%	>98%
Staff unavailability	<6%	7-10%	10-17.5%	>17.5%	>20%
Surge capacity required to meet demand					
Surge medical ward (G&A) beds	7	12	16	23	33
Surge PICU beds	0	5	5	7	9
Surge HDU Bed requirement	0	3	4	5	8
Total surge	7	20	25	35	50
Total capacity					
Medical ward (G&A) beds	111	123	127	134	144
Surgical ward (G&A) beds	100	88	84	77	67
PICU	21	26	26	28	30
HDU	15	18	19	20	23
Response					
Service Provision	Routine & Emergency	Routine & Emergency	Urgent & Emergency, very limited routine	Urgent & Emergency Only	Emergency Only
Staffing Arrangements	Staff medical ward surge beds	*Level 1 plus* covering absence	Level 1&2 plus: · medical escalation ward · staff to critical care	Level 1- 3 plus additional staff to: · medical escalation ward · critical care	Level 1-4 plus additional staff to: · medical escalation ward · critical care
Weekly Theatre sessions	139 (daycase and Inpatient)	120 (more daycase with reduced inpatient)	95-105	50	40
Nursing WTE staff allocation to surge areas	0	59.4	75.6	97.2	138.9
% Theatre Capacity	100%	100%	64%	34%	34%
% Elective Theatre	93%	93%	47%	0%	0%
% Emergency / Urgent Theatre	7%	7%	53%	100%	100%
Financial Impact	[illegible]	[illegible]	[illegible]	[illegible]	

In the maximum surge scenario, our capacity plans provide 50 medical and critical care surge beds (although this is partly achieved by a contraction of 33 surgical beds and the number of theatre sessions we can operate). Escalation in response to severe pressures impacts upon the elective care programme through both the use of surgical ward capacity for medical patients and staff to support providing support to HDU and PICU.

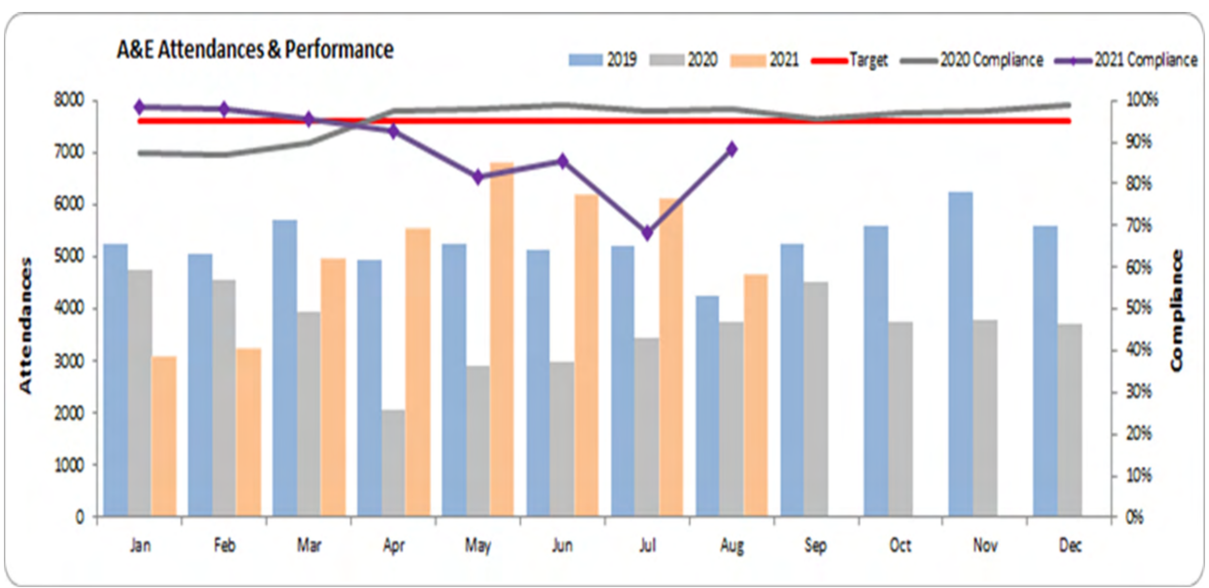
Our winter plan is built upon additional investment and identifying staff ready and skilled to be deployed in surge areas. The additional resources we are deploying includes:

- Additional nursing staffing requirement to open 7 general beds
- Deployment of clinical staff from other areas of the hospital, on a staffing requirement to open to 17 critical care beds (9 PICU/ 8HDU)
- Additional equipment and consumables associated with increased activity
- Additional medical staffing in respiratory, General Paediatrics, Emergency Medicine and HDU required to support with a surge in emergency care

4. Urgent & emergency care

4.1 Overview of attendances and demand

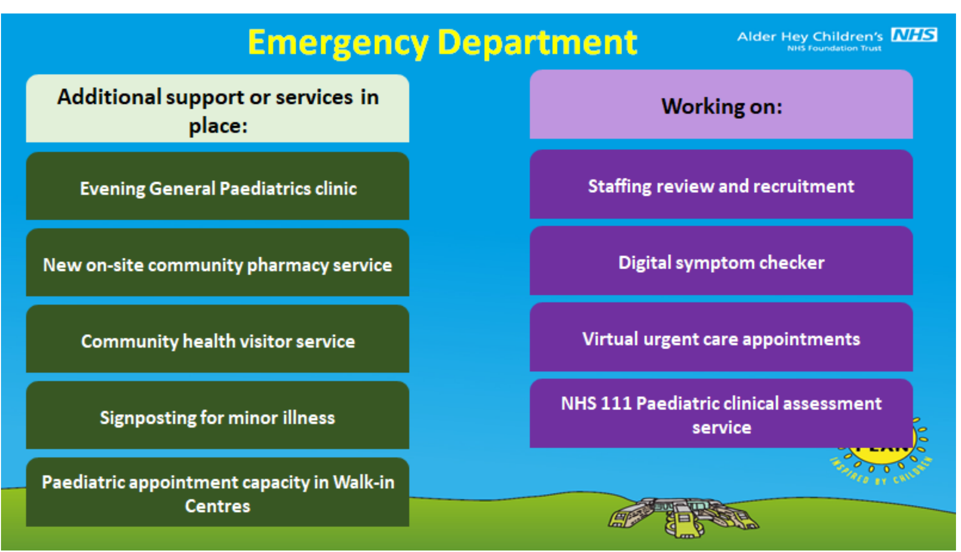
We have seen a surge in presentations to the Emergency Department and attendances in May - August 2021 are significantly higher than 2019 levels, as illustrated in the graph below.



An audit in relation to acuity was conducted which demonstrated that 65% of all attendances are triaged as 'green' patients, which includes patients with minor injuries and minor ailments that can be treated in community services. In July and August, we have observed an increase in acuity and more respiratory presentations.

4.2 Urgent & emergency care support plan

We have established a Gold Command structure to oversee our response to the pressures on urgent care, our staff and recovery of services. Through this framework we have oversight of an urgent and emergency care action plan that includes the following:



Intervention	Update
Acute Paediatric clinics	▪ Additional sessions Monday – Friday 15.00 – 19.00 hrs ▪ From the w/c 27 September daily clinics to be established by converting general clinics to acute clinics ▪ Recruitment to an additional General Paediatric consultant to sustain an increase in acute clinic capacity
Walk in Centre appointments	▪ 8 paediatric slots per day made available for ED clinical staff to book directly into
Community Pharmacist service	▪ Service in place Monday – Friday 11.00 hrs – 19.00 hrs ▪ 50 patients treated per week ▪ Extend service to weekends in October
ED workforce review	▪ Weekend junior doctor staffing challenged due to new contract. Locums out for 6 weeks. ▪ New junior rotation has allowed for additional staffing in the evening with 8 medics now on until midnight
Symptom Checker	▪ Virtual symptom checker, to support self-care and signposting, to go-live on our website in October
Staff wellbeing	▪ Ground Truths: invest in department facilitator to support additional reflection sessions for colleagues in the team ▪ Refreshments to be provided to staff in ED and other areas

BOARD OF DIRECTORS

Thursday, 30th September 2021

Report of	Development Director
Paper prepared by	Associate Development Director- (24/09/2021) Russell Gates
Subject/Title	Development Directorate 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: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ Sustainability through external partnerships
Resource Impact	Capital projects budget.

Campus Development report on the Programme for Delivery

June 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 3 in Quarter 2 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										

3. Project updates

Park Reinstatement Phase 1

Current status	Risks & Issues	Actions/next steps
The handover to the council is still awaiting a date from the council. This has now been escalated to senior officers in the Council for resolution. We understand that the legal drafting is underway but have not seen a document as yet. The formation of the Multi-Use Games Area (MUGA) is still in delay and materials are currently in storage for when a decision is reached. The planning application for siting the MUGA is imminent. 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) Public perception that the park phase one is not being delivered.	Continued meetings with planners, residents and LCC parks officers to resolve the location. Handover has been escalated to senior council officers for resolution.

Acquired Buildings Occupation (neighbouring sites)

Current Status- on hold	Risks/issues	Action/next steps
Knotty Ash Nursing Home **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
Recent negotiations with senior officers of the police has potentially released the ground floor of the building for Trust occupation at the end of 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)	The Trust are working with the police to get necessary agreements in place to enable early occupation to happen.

Relocations

Current status	Risks/issues	Actions
The fit out works to the Innovation park offices is proceeding well and occupation is expected to be mid-October. Design is proceeding for the additional space to allow the CAMHs team along with some therapy space to relocate and expand.	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. Complete the design of the additional space and issue tenders.

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
The new formation levels are complete and landscaping works will commence during w/c 27th September. 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)	Landscaping to commence 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
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) 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. The key elements of the	Early indication is that to complete all of the work will exceed budget.	The works remain on programme but close monitoring is being continued to watch for slippage.

electrical infrastructure work have been absorbed into the Sunflower House construction contract to avoid clashes of 2 contractors on the same site.	Must maintain programme to avoid delays to the cluster and neonates projects	

Catkin Centre and Sunflower House Construction

Current status	Risks/issues	Actions
Contract with Galliford Try remains on programme with good visible progress. The Corten cladding is now being fixed, M & E activities continue and progress is being made with the infrastructure connections. Planning of the occupational commissioning continues with representation of the users, clinical staff, FM and estates. Changes to the roof specification to meet insurance requirements and changes to the police accommodation are putting the budget under pressure. Savings are being sought from other project budgets.	Ongoing design development potentially could raise issues of quality leading to increases on cost. Late change leads to delays and additional costs. Budget for furniture is inadequate	Continue with weekly meetings with Galliford Try and challenge design where necessary. 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
Tenders have been received from the 3 contractors and are being evaluated. Previous raised concerns around inflation in the market have materialised and costs exceed budget. A value engineering exercise is under way.	Project Co engagement extending the programme and increasing costs. Planning and any unknown Section.106 or section S.278 costs Planning permission fails to be achieved within the timescale of the overall programme delivery. 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. Work with LCC planners to minimise impact Maintain open communication with the LCC planning departments. Value engineering exercise is underway.

North East Plot Development

Current status- static	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. StepPlaces planning application decision has been postponed again to a 28th September committee	Change process with Staff will present some challenges	Maximise our offering/ support /negotiation on development content and opportunities. Work through each work stream and provide a business case for each to demonstrate requirements, sustainability and affordability.

[redacted].		Produce robust business cases to highlight any issues/risks. Ensure Colleagues from HR are involved in any proposed changes along with all stakeholders.

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. Fortnightly meetings established to discuss wider campus development progress.	Loss of reputation, locally and regionally. 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 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. A new member of staff is being sought commence work on the implementation of a green travel plan.	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. Recruit a travel plan co-ordinator. Car parking group to continue to work with Mott MacDonald and

	Travel plan from Mott MacDonald does not provide realistic and evidenced solution.	internal group members to produce an overall green travel plan.

4. Trust Board of Directors

The Trust Board of Directors is requested to receive and acknowledge the update provided as of 24th September 2021.

BOARD OF DIRECTORS
Thursday, 30th September 2021

Paper Title:	Serious Incident Board Report (1st July 2021 – 31st August 2021
Report of:	Nathan Askew, Chief Nursing Officer
Paper Prepared by:	Cathy Umbers Associate Director of Nursing and Governance

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☑
Background Papers and/or supporting information:	Seven Steps to Patient Safety. National Patient Safety Agency 2004. Health and Social Care Act 2008 (Regulated Activities). Regulation 20 'Duty of Candour'. Serious Incident Framework. Supporting learning to prevent recurrence. NHS England 2015. Serious Incident Framework. Frequently asked questions NHS England 2016. NHS Patient Safety Strategy. NHS Improvement. July 2019. Never Events List (revised February 2021)
Action/Decision Required:	The action required is both to note and approve the report. To note ☑ To approve ☑
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **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 August 2021, i.e. 2021/17974 and zero 'Never Events' reported.

Table 2 (appendix 1) provides an overview of the current open StEIS investigations There are four StEIS ongoing investigations progressing at time of reporting, including one new reported incident. Duty of candour has been completed for all incidents, in line with regulation 20.

Table 3 (Appendix 1) provides an overview of the two closed investigations in reporting period. There were two incidents investigations completed during this reporting period, i.e. 2021/1919 & 2021/10050.

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**							
Open (Total)	**5**	**5**	**5**	**5**	**4**							
Closed	**0**	**1**	**2**	**0**	**2**							
Never Events												
Month	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
New	**0**	**0**	**0**	**0**	**0**							
Open (Total)	**1**	**1**	**0**	**0**	**0**							
Closed	**0**	**0**	**1**	**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
2021/17974	16/07/2021	Severe Haemophilia A: Treatment outside usual clinical pathway.	24/11/2021
2021/1899	24/01/2021	Unexpected death of a patient (HDU). Joint Perinatal review (PMRT) with Warrington and Halton Hospitals underway. (Warrington leading)	27/09/2021
2021/12203	27/06/2021	Delay in treatment. Delay in transfer to HDU.	29/10/2021
2021/12387	12/06/2021	Patient ingested large overdoes of tablets at home. Patient died due to impact of Colchicine toxicity.	01/10/2021

Table 3 closed investigations

StEIS Reference	Date reported	Investigation completion date	Incident Title	Comment
2021/1919	02/01/2020	20/08/2021	Delay in recognition and treatment of idiopathic intracranial hypertension	Completed and submitted within agreed date. Meeting with parents held post investigation completion to discuss findings and actions for improvement. Actions for improvements progressing in line with action plan expectations.
20210050	07/05/2021	20/08/2021	Cardiac arrest transferred to PICU. Complex medical history	Completed and submitted within agreed date. Investigation report shared with family. Meeting to be arranged at the convenience of the family. Actions for improvements progressing in line with action plan expectations

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY

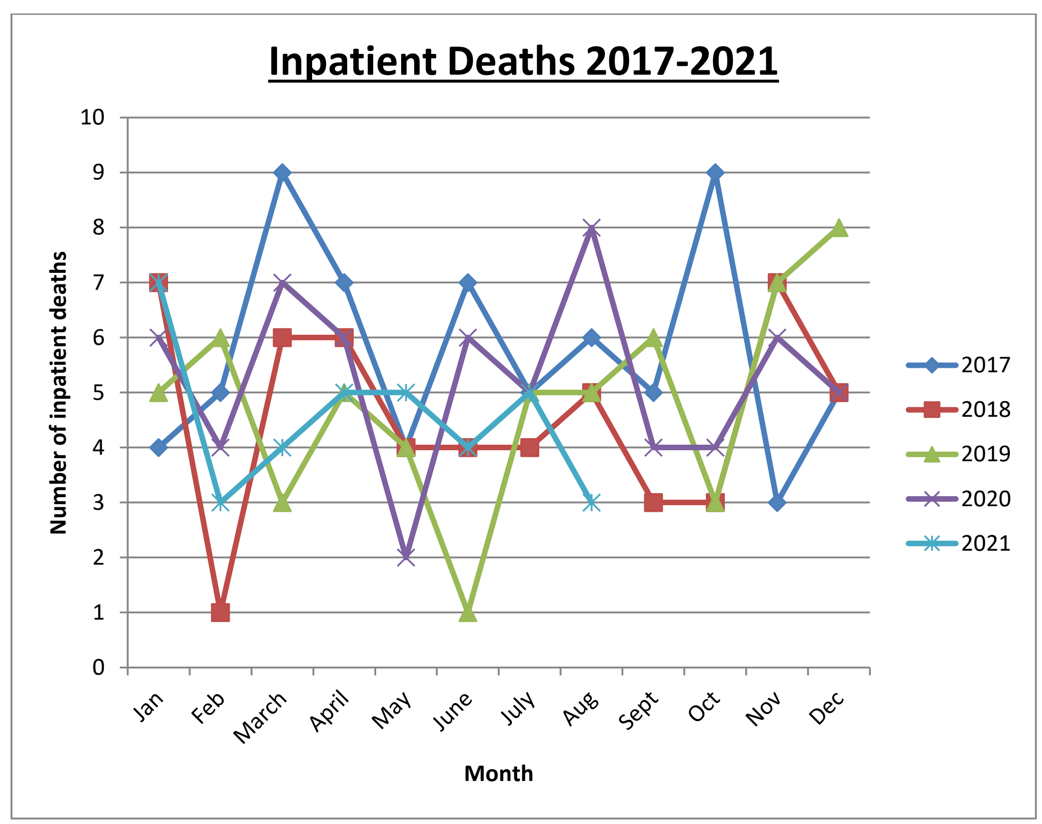
Medical Director's Mortality Report

The report is split into two sections. Section one is a review of the Hospital Mortality Review Group (HMRG) including the number and types of death at Alder Hey during the calendar year to date and how the HMRG is meeting its aims.

Section two is the Quarter 1 Mortality report which includes a review of statistical analysis in PICU, followed by more detailed analysis of the place of death, teams involved and specifics about expected vs observed deaths.

Section 1: Report from the Hospital Mortality Review Group (HMRG)

In common with the rest of the NHS, Alder Hey has been coping with unprecedented times and pressures. There have been no further adult COVID patients admitted to the Trust but in this report, there is a deep dive into the adult patients that sadly died during their admission
On a positive note, the potential August peak of RSV has not impacted as much as feared although respiratory illnesses are now increasing again. This is shown in the graph below which demonstrates the inpatient deaths over the last 5 years in Alder Hey. Up to September this year, the number of deaths were less than usual from February onwards probably due to COVID measures – social distancing, masks and lockdowns. Currently we have lower mortality numbers for the year, but this winter is predicted to be particularly challenging with RSV, Influenza and the lack of exposure to respiratory illnesses over the last two winters reducing patient immunity, thus this may cause an unusually higher spike in mortality in the months ahead .



There are interesting times ahead for the mortality process in the Trust and needs to continue to evolve as a result of issues identified by HMRG members and bereaved families, plus external changes:

1) One of the most significant changes will be the introduction of the Medical Examiner (ME) process. This will be a legal requirement by April 2022 providing scrutiny for all deaths. There are several reasons for the ME legislation – 'enabling families to have a voice', improving accuracy of death certificates and ensuring every death is reviewed. Since we are a Paediatric Trust and, our mortality numbers are significantly less than our adult peers we are already able to scrutinize all deaths. The death certificates are completed by senior clinicians and in a very timely manner. In addition, if there are any concerns regarding a child death, the case follows the coronial process. Lastly, we are very fortunate in having the bereavement team who support and engage with families, so we have contact and are currently working on formalizing the feedback we receive. The main challenge for AHCH introducing the ME process is ensuring that it doesn't slow down the current process and impact negatively on the families. Currently, options are being considered as to how to achieve this.

2) The complexity of the Child death review (CDR) is increasing and

although we were one of the first organisations to complete this process the time pressures of ensuring reviews are done in a timely manner may be limited by these demands. There are meetings planned over the next few months to discuss the progression of this within the region. Other trusts have separated the hospital mortality process and the CDR meetings although are currently not achieved high figures for the completion of full CDR's.

3) An aim for there to be one post bereavement meeting including all teams involved with the care of the child at the time of death. This improvement only became apparent following family feedback and is clearly a very logical step but was not always occurring.

4) There needs to be a clear consistent bereavement process followed by all teams in the Trust including offering a follow up appointment following the loss of a child /young person.

Whilst still work in progress the correct people are involved and working to ensure we provide the best support and care that we can in such a difficult time to families, whilst fulfilling the legal and administration requirements.

Current Performance of HMRG

Number of deaths (Jan. 2021 – Aug 2021)	34
Number of deaths reviewed	10
Departmental/Service Group mortality reviews within 2 months (standard)	26/29 (90%)
HMRG Primary Reviews within 4 months (standard)	9/15 (60%)
HMRG Primary Reviews within 6 months	5/7 (71%)

Unfortunately, the percentage of the cases reviewed by the group within the 4-month target have continued to decrease, despite the best efforts of the group. The reviews have become much lengthier as a result of the child death review (CDR) process, involving a much wider group to ensure that the case is reviewed as completely as possible. There is now input from NWTS (the regional paediatric transfer team) and LWH so we can undertake a robust

review. Some of the cases involve very complex medical conditions or situations requiring more than one discussion. The meetings are once a month and held on TEAMS enabling more people to attend including the DGH's if they wish.

Another significant factor for the decrease was the need to review the further adult COVID deaths that occurred in the Trust which required the majority of one meeting to ensure full discussion.

The members of the group have had considerable pressures on their time, which has meant that the review preparation has taken longer, all contributing to the missed the 4- month target.

There are several options to improve this figure and if necessary, an extra meeting will be held, but the first solution has been extending the meetings and this should improve the situation.

Outputs of the mortality review process for hospital deaths for 2021

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2 month timescale	HMRG Reviews within 4 month timescale	HMRG Reviews within 6 month timescale	Discrepancies HMRG – Dept.	HMRG Review – Death Potentially Avoidable		RCA/72 Hour Review /	Learning Disability
							INT	EXT	AAR	
Jan-21	7	5	6	5	5	1			1	1
Feb-21	4	3	4	2		1		2		3
Mar-21	4	2	3	2		1			1	
Apr-21	5		4							
May 21	5		5							
Jun-21	4		4							
Jul-21	5									
Aug-21										
Sep-21										

Potentially Avoidable Deaths

Over this quarter there have been no potentially avoidable deaths caused by internal causes (relating to AHCH care) in the cases that the group have reviewed**.** However, there are 2 cases where the group decided the death could have been avoided due to external causes. One was a likely non accidental injury resulting in very significant head injuries and the other was the use of a medicine that had been advised against in view of the existing medical condition**.**

Learning disabilities

The output table of the mortality process above records any children/YP that were identified as having learning disabilities. Out of the 9 cases reviewed, 4 have been identified as having learning disabilities. The HMRG policy states that the death register is reviewed every month for any patients who are recorded to have learning disabilities and are reported to the LeDeR (Learning Disabilities Mortality Review) database as soon as they are identified. This is a legal requirement for the Trust.

In the 'Mortality Report Output table', we record all the children/YP that have learning disabilities, regardless of age, whereas the LeDeR requirement is for cases where they are over the age of 4 years. The reason we record all ages is to check there is no trend /issues in patients with learning disabilities which can occur at any age not just over 4.

It is of note that the 2 cases mentioned in the potentially avoidable deaths of external factors both potentially had learning disabilities. The causative factors of both cases are completely different, but it is important that the stress and impact of looking after children with complex medical issues is not forgotten.

Family

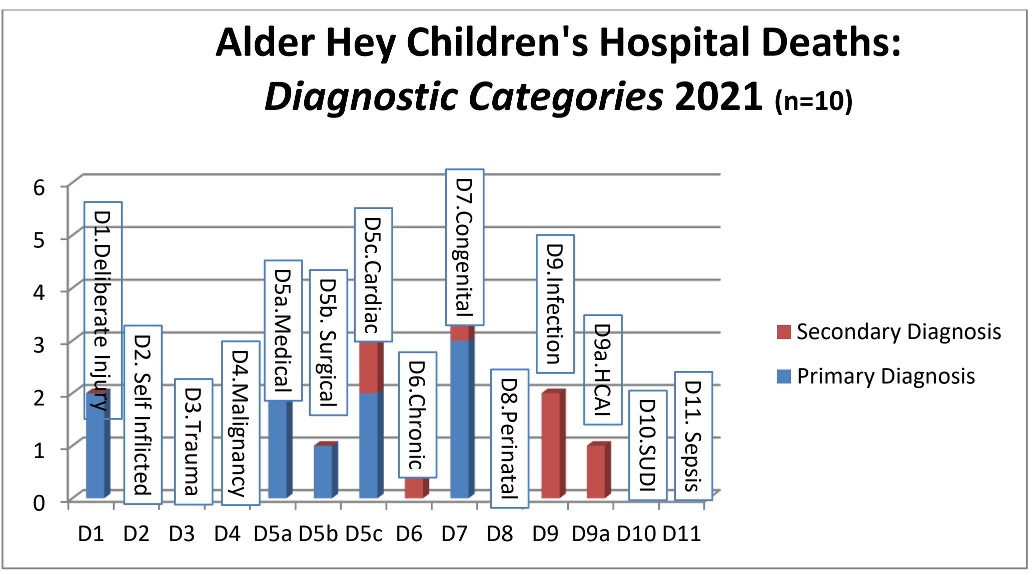
The bereavement team at Alder Hey provide an exceptional service, supporting the family for a considerable time period after a patient has passed away (if wanted). There is ongoing work between HMRG, the palliative care team and the bereavement team to improve the feedback that the group receives from families, to continue to improve the care we provide.

The Operational Bereavement group which has been inactive due to the Chair retiring has now been restarted. This should help in consistency of the bereavement process across the Trust covering the letter sent out to bereaved families to the meetings.

The last report reported delays with medical records being received by bereaved families after they are requested. This has been addressed and there has been no reoccurrence.

In addition, visiting difficulties during the COVID period had been raised by several families and highlighted in previous mortality reports. Due to hard work by the clinicians involved and the whole managerial team this appears to be less problematic than previously, which is vital as it was having a significant impact on all concerned.

Primary Diagnostic Categories



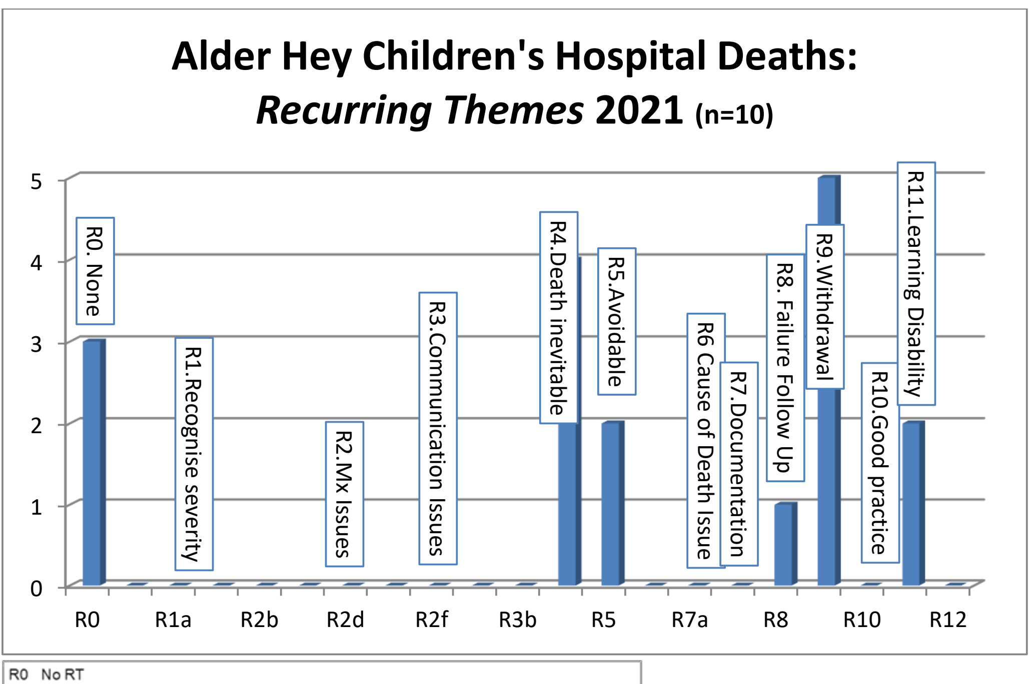
Diagnostic /Disease Categories (based on CEMACH categories - ref Arch Dis Child 2011; 96:922-6 + 927-31)

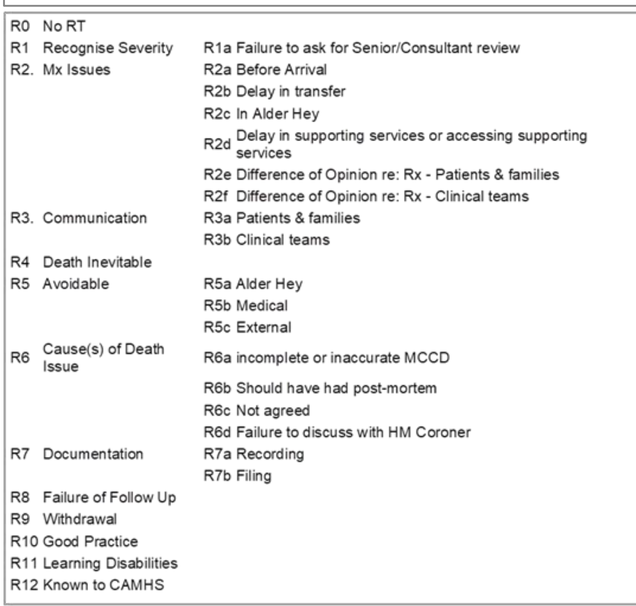
Code	Category
D1	Deliberately inflicted injury, abuse or neglect
D2	Suicide or deliberately self-inflicted harm
D3	Trauma & other external factors (excludes deliberate self-harm (D2)
D4	Malignancy
D5	Acute Medical or Surgical condition subcategory D5a. Medical D5b. Surgical D5c. Cardiac
D6	Chronic Medical Condition
D7	Chromosomal, genetic & congenital anomalies
D8	Perinatal/Neonatal Event
D9	Infection/Sepsis (proven or clinical) subcategory D9a. Healthcare-associated infection (home or away)
D10	Sudden unexplained, unexpected death/SUDI/SUDC - excludes SUDE (D5)
D11	Sepsis

The number of cases reviewed so far in 2021 are relatively low so there are no clear patterns with the diagnostic codes as shown by the bar chart. There is an equal spread across medical, surgical and cardiac presentations, the highest being children with underlying congenital conditions (30 %). These are often the most complex cases with several issues that need to be identified, monitored and treated.

Importantly, there were no sepsis deaths or hospital acquired infections over this period. There were some sudden expected deaths of infants /children (SUDI's /SUDIC's) but these cases have not been closed yet as they have been delayed whilst waiting for the inquests to be held. They will then be re discussed and the coding confirmed.

Recurrent themes





R0	No RT	
R1	Recognise Severity	R1a Failure to ask for Senior/Consultant review
R2.	Mx Issues	R2a Before Arrival
		R2b Delay in transfer
		R2c In Alder Hey
		R2d Delay in supporting services or accessing supporting services
		R2e Difference of Opinion re: Rx - Patients & families
		R2f Difference of Opinion re: Rx - Clinical teams
R3.	Communication	R3a Patients & families
		R3b Clinical teams
R4	Death Inevitable	
R5	Avoidable	R5a Alder Hey
		R5b Medical
		R5c External
R6	Cause(s) of Death Issue	R6a incomplete or inaccurate MCCD
		R6b Should have had post-mortem
		R6c Not agreed
		R6d Failure to discuss with HM Coroner
R7	Documentation	R7a Recording
		R7b Filing
R8	Failure of Follow Up	
R9	Withdrawal	
R10	Good Practice	
R11	Learning Disabilities	
R12	Known to CAMHS	

The recurrent codes that are the commonest are withdrawal of care (50% of cases), which demonstrates that the intensive care team are working with families to ensure that no child /young person suffers unnecessarily when all treatment options are explored but are not suitable. Death was concluded to be inevitable in 40 %, regardless of the care and expertise that was provided in AHCH. This category also includes the cases where death was inevitable with hindsight. The reason these cases were included were that it has no reflection on the care AHCH provides and several children are transferred for investigations which then indicate conditions which are palliative.

Adult COVID deaths

Alder Hey, despite being a paediatric Trust, agreed to take adult COVID patients in the peak of the two waves to support the regional intensive care network. Clearly, this was an exceptional time in the NHS and since the paediatric population did not seem to be as impacted as adults the Trust decided to offer support due to the incredible pressures the region was facing. There were concerns expressed across the organisation as many staff were not familiar in treating adults due to the nature of their work at AHCH. Elective surgical lists were cancelled, staff redeployed, training relative to adults rapidly introduced and equipment needs identified and then fulfilled.

The first group of patients arrived in April 2020 and the plan was for AHCH to receive the 'fittest of the Intensive care patients' at the time of their transfer. At the beginning the transfer were staggered so that the team here could identify any issues before receiving more. In the first wave, there were 10 adult patients treated at AHCH of whom 4 died. As a result of a reporting process being specifically organised the deaths were all reported to the national database as required in a timely manner.

The deaths were reviewed in the HMRG meeting in October, when the only deaths covered in that meeting were adult ones because this was an area that we were unfamiliar with. Adult expertise was present to ensure all learning possible was achieved. The deaths were all reviewed and recorded on the structured judgement review paperwork that is required for the adult mortality process.

There were no concerning factors identified, the patients all died of recognised COVID complications and there was nothing that the team could have done differently to alter outcome.

Learning points:

1) Family liaison role worked extremely well with the families appreciating a clear point of contact, especially in the context of such limited visiting in accordance with national guidelines. Conversations were well documented in the notes. Psychology had considerable input to the family which was recognized and would be done again in such cases.

2) Bereavement team input was identical to a child death and this was greatly valued and commented on by the relatives. This level of support

was much greater than would have been possible in an adult Trust where such a resource would not have been available

3) For ventilatory support the adult patients were initially placed on the theatre ventilators but were soon changed to Evita (ICU models) which are designed to run for longer periods without maintenance. All the patients were changed onto these and would be the first choice in the same situation. At the time, this was not clear and there was uncertainty as to how many paediatric ICU patients would be arriving who would have required the Evitas. These theatre ventilators were used in adult Trusts and there was no evidence that patients were ventilated more effectively on them.

4) This was the first time an adult patient had been proned in this setting in Alder Hey. It was a steep learning curve, but with the help of video teaching aids and the support of colleagues from other areas within the Trust, a "proning team' was established with twice daily shifts to prone patients in the afternoon and turn them back supine in the mornings. This was an example of good teamwork.

5) It was identified that there was clotting problems with these patients for example they clotted on CVVH (renal replacement therapy) despite adequate heparinisation (blood thinning) of the patient. Initially there was concern that there were issues with the equipment but after discussion with other units it was quickly appreciated that this was a well-documented problem with managing patients with Covid-19 infections on ICU. In the future it would be prudent to formally heparinise patients at an earlier stage if kidney function was worsening

6) There were blood sampling issues when the laboratory analyser for coagulation samples showed an error message. Normally the lab would simply analyse the sample manually, but because of 'Covid restrictions' this could not be done. Thus, whist trying to get the heparin treatment fine-tuned, reliable APPT results were not readily available. An alternative was offered and a backup plan for testing samples at RLUH was put in place. This did not impact on patient care negatively but resulted in a second (and third) backup system being established going forward to prevent it occurring again.

7) Poor documentation of discussions with adult colleagues in electronic notes which although they occurred regularly, they care not recorded in notes.

8) Psychological support for staff who were often isolated in full PPE with their patients and facing situations outside the 'normal' for them. It caused a raised stress levels and feeling vulnerable

9) Limited visiting caused distress to both families and staff due to COVID restrictions as usually visiting for families especially when patient is so unwell is as unrestricted as possible, but this all changed with COVID.

So, after the first wave and the HMRG meeting there were a number of learning points and a number of these had already been recognised and acted upon by the ICU team.

For the second wave, when there were 3 deaths, there was clearly learning from the points stated above. The staff received psychology support and were more confident and experienced with the equipment and the situation. The visiting was addressed to the best of the Trust's capabilities so that relatives could see their loved ones before they died. The positive aspects were continued with the family liaison officer, bereavement team and psychologists all supporting the family.
The only different aspect that was raised in these reviews was some of the families asked why their relative had been moved after a few days in their local ICU to a hospital which was distance away. It was explained that this was a decision made by the critical care network and, at the time the patient seemed relatively stable but as with other COVID cases unfortunately they then deteriorated and died in AHCH.

There were no concerns identified with these cases and again all were notified nationally and one of the patients had mental health issues, but this had no relevance on the case but needed to be recorded on the form.

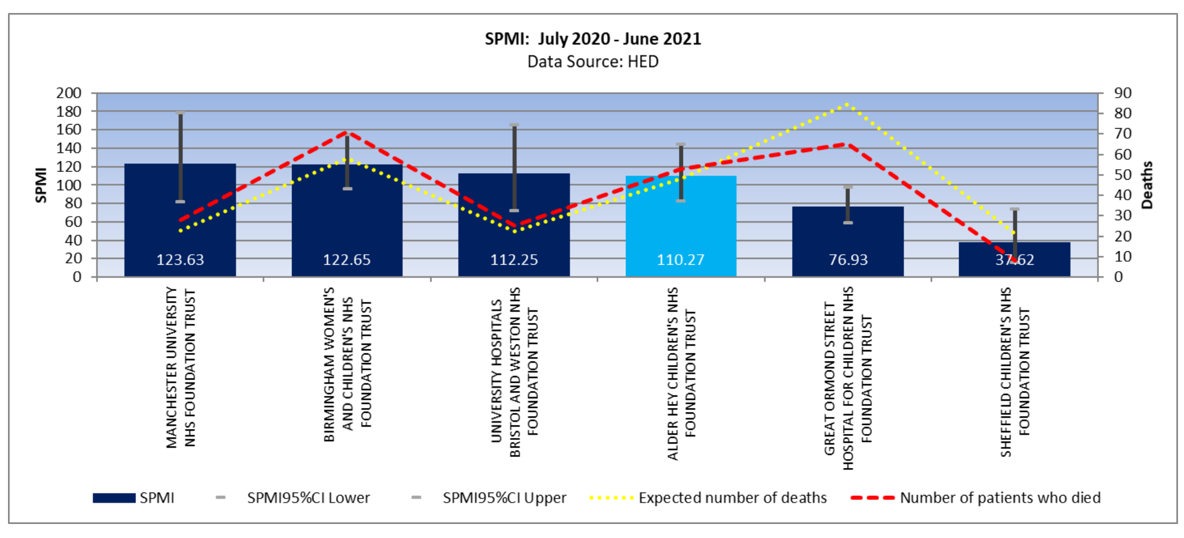
To summarise, the care provided to the adult patients received at AHCH was of a high standard with the support provided to the families outstanding. There were issues from the first wave that were dealt with at the time so not impacting on the patients but as an organisation we learnt to ensure that the process was improved upon the next time it was required.

Section 2: Quarter 1 Mortality Report: April 2021 – June 2021

External Benchmarking

Standardised Paediatric Mortality Index (SPMI); – HED

HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. This is for the most recent available period covering July 2020 to June 2021.

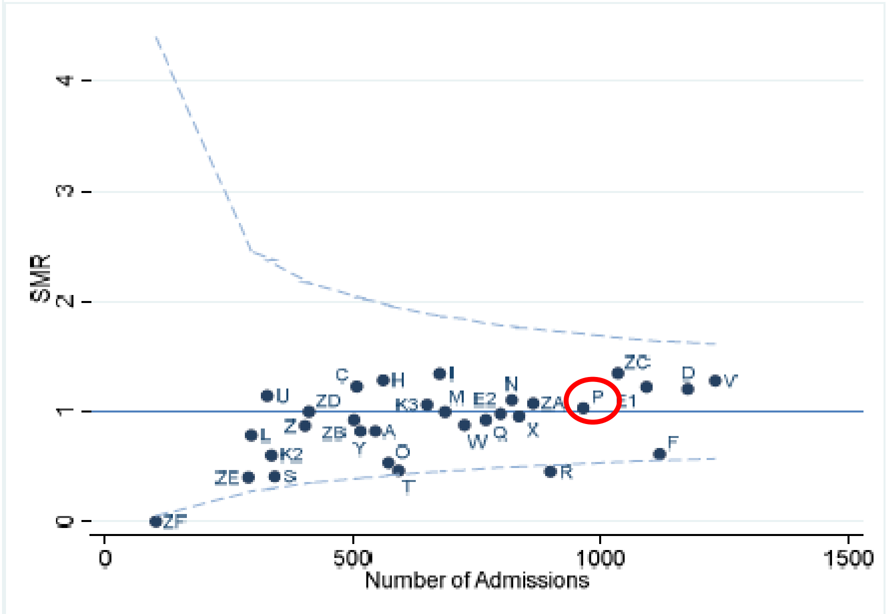


The chart shows that Alder Hey has performance of 53 deaths against 48.1 expected deaths. Although this shows a figure that is slightly higher this is probably as a result of COVID, when the workload that AHCH undertook had to be prioritised. This resulted in the higher risk, more urgent admissions and less of the 'cold case /lower risk workload'. The numbers of admissions also decreased due to the COVID pandemic with only the 'sickest' patients attending and being admitted. It is a similar picture to Birmingham which is the best Trust to compare AHCH with similar caseload and demographics.

-PICU

It is important to recognise that 85-90% of our deaths occur in PICU as in other Children's Trusts. In the most recent PICANet report (2019 Annual Report of the Paediatric Intensive Care Audit Network January 2016-December 2018),

mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions.
The chart below is taken from PICANet's most recent report and shows the PICU SMRs by organisation with 99.9% control limits, 2016: PIM3 adjusted.

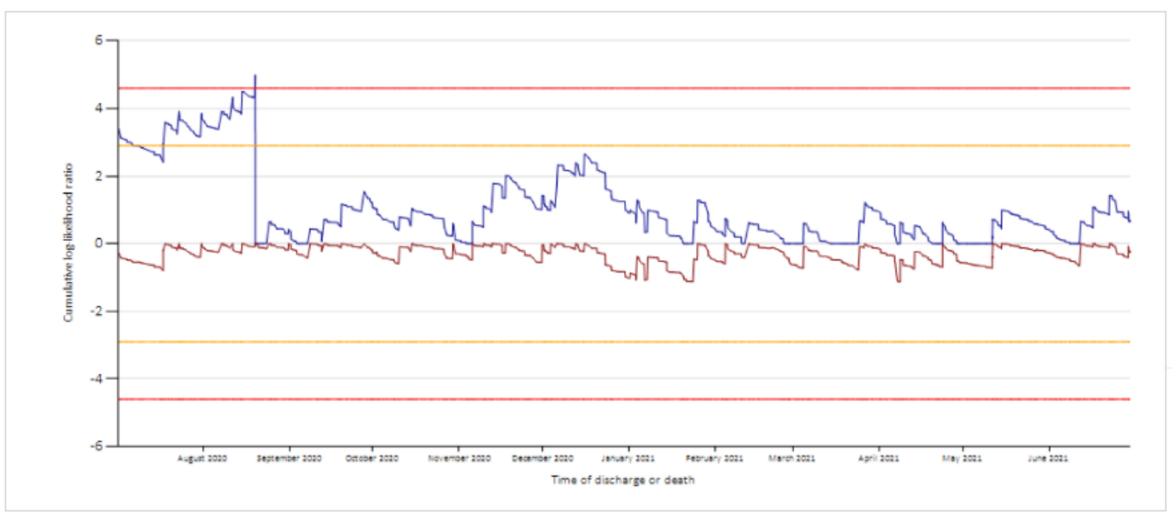


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control.

Statistical analysis of mortality:

a) RSPRT (Risk-adjusted resetting probability ratio test)

In the RSPRT (Risk-adjusted resetting probability ratio test) Plots present the mortality of your unit cumulatively, based on what is predicted by PIM3 score. Between the orange lines is a 'safe zone' with the variability you might expect day to day. Between the red lines at the top of the chart can be regarded as a 'warning zone'. Until there is a death, the top line stays flat and the bottom line gradually drops. When a death occurs, the top line moves up and the bottom line moves closer to zero. When either line touches the red line, the graph resets to zero. This data is nationally validated because it is generated by PICANet.

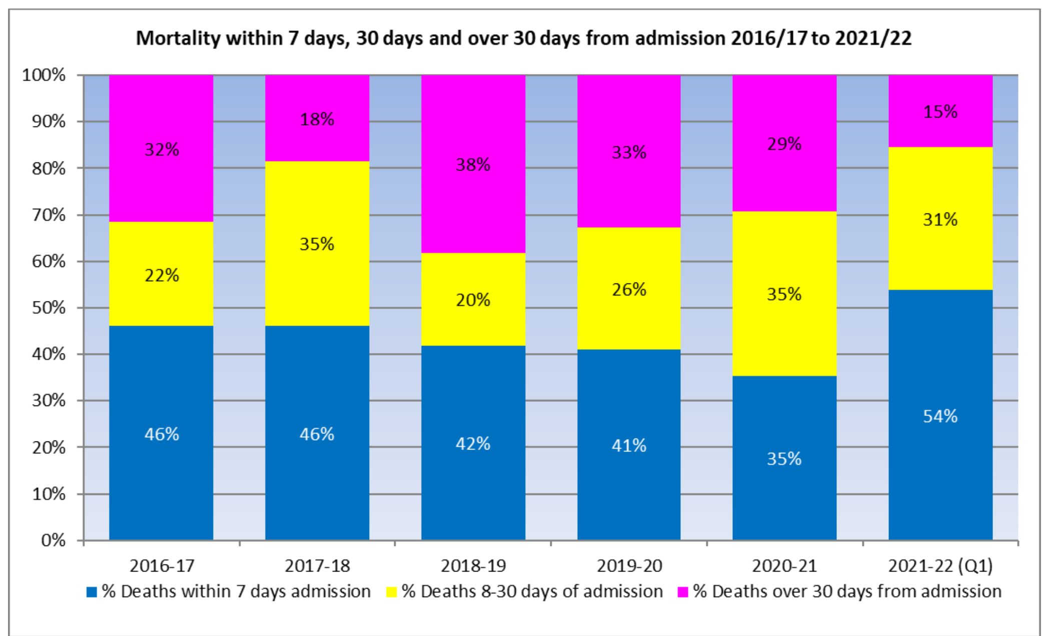


In the last quarter ICU discussed 12 deaths. Age at death showed a mean and mode of 3.7 years and 1.2 years respectively. Admission organ dysfunction and primary diagnostic categories at death are shown in the charts below. At the time of admission 50% (6/12) had more than 1 organ dysfunction, classified as multi-organ system failure (MOSF). 'Other' includes profound hypoglycaemia, accidental strangulation, and overdose, all of which followed the coronial pathway.

Real time monitoring of mortality

Mortality is now being monitored in real time and analysed by year, ward, specialty, deaths within 30 days from admission and over 30 days from admission.

i) Below the chart shows mortality broken down by the time from admission to death, mortality within 7 days, 30 days and over 30 days from admission.



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 42-46% of deaths occur within this time frame. However, in the current financial year (April 2021 – June 2021) 54% occurred within 7 days of admission, 31% occurred within 8-30 days from admission, and 15% deaths occurred over 30 days from admission.

Conclusion

HMRG is providing effective and comprehensive reviews in a timely manner, although the 4-month target has fallen for the reasons stated above. There are plans in place to facilitate this improving over the next few months.
There are no concerning trends that have been identified for patient deaths and the issues that have been raised by staff or families there is work underway to try and resolve them.
Clear learning has been demonstrated by the organisation between the two waves of adult COVID patients which shows the review process was useful.
The future of the process will be the integration of the ME process and the new CDR forms which again will be a period of change without impact except in a positive manner for the bereaved families.

References

SPMI - The expected deaths are calculated from logistic regression models with a case-mix of: age, sex, ethnicity, trust type, emergency surgery flag, chronic condition flag, paediatric risk category, paediatric life-limiting conditions flag and diagnosis group. Diagnosis groups where there are less than 10 death events are excluded from the model. Children up to and including the age of 15 are included. **Pg 9**

Benchmarking - As previously reported Alder Hey benchmarks externally for PICU (http://www.picanet.org.uk/documentation.html), congenital cardiac disease http://nicor4.nicor.org.uk and oncology. **Pg 9**

PICU SMR - The risk adjusted SMR is the ratio of the observed number of deaths in the population against the expected number of deaths predicted by PIM3. Control limits are displayed on the funnel plots; variation within these limits is termed common-cause variation; variation outside of these limits is special-cause variation. Points above the upper control limit indicate higher than normal mortality; highlighting the need for further investigation into the mortality rate. **Pg 10**

PRAiS and VLAD charts - The PRAiS model uses the risk factors including specific procedure, age, weight, diagnoses and comorbidities. The National Institute for Cardiovascular Outcomes Research (NICOR) will use this information to produce funnel charts comparing the Standardised Mortality Ratio (SMR) across centres.
The plotted line goes up for a survival and down for a death; for higher risk patients who survive the line is steeper than low risk survivals; for low risk deaths the line is steeper than deaths for high risk patients. If the outcomes are as expected the line will be close to zero. The line will rise less steeply for a run of survivals than it will decrease for a run of deaths. Re-interventions are displayed as circles on the plotted line. Monitoring of VLAD charts provides additional quality assurance. **Pg 12**

BOARD OF DIRECTORS
Thursday, 30th September 2021

Paper Title:	**Quarter 1 2021/22 Complaints, PALS and Compliments report**
Paper of:	Nathan Askew Chief Nurse
Paper Prepared by:	Val Shannon, Patient Experience Quality Lead
Paper Presented by:	Nathan Askew Chief Nurse

Purpose of Paper:	The purpose of this paper is to provide the Trust Board with an update and assurance on the performance against complaints and PALS targets in Q1 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 decrease in formal complaints received during Q1 (33) compared to Q4 2020/21 (53). The top reason for formal complaints received in Q1 continues to be treatment and procedures. Compliance with the 3 working day acknowledgement for formal complaints is 100% in Q1. Compliance with the internal Trust target of 25 working day response time is 82% in Q1; this is a major improvement on 35% compliance in the previous quarter. Two complaints from across Q1 were responded to as second stage complaints. The Trust has 0 new referrals to the PHSO in Q1. There has been an increase in the number of informal concerns received during Q1 (378) compared to Q4 2020/21 (271). The main reason for informal PALS concerns is regarding appointments and communication. Compliance with the 5day target to resolve informal concerns is 74%. 44 compliments are recorded centrally in the Ulysses system for Q1.
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: ➢ **Trust's Strategic**	**Delivery of outstanding care** **The best people doing their best work**

Direction ➢ Strategic Objectives	Sustainability through external partnerships Game-changing research and innovation Strong Foundations
Resource Impact:	Yes
Action/Decision Required:	The Board are asked to note the content of this report and support the ongoing Complaints Improvement Plan.

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 April to June 2021 (Q1). This report aims of providing 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

2.1.1 Number of formal complaints received Q1 2021/22

The Trust experienced a decrease in the number of formal complaints in Q1 2021/22, with 33 submitted compared to 53 in the previous quarter (Q4 2020/21). A comparison of Q1 with the same period last year 2020/21 is shown in Figure 1; Figure 2 shows the breakdown of complaints received by service in Q1.

Figure 1: Number of formal complaints in Q1 2021/22 compared to same period in 2020/21

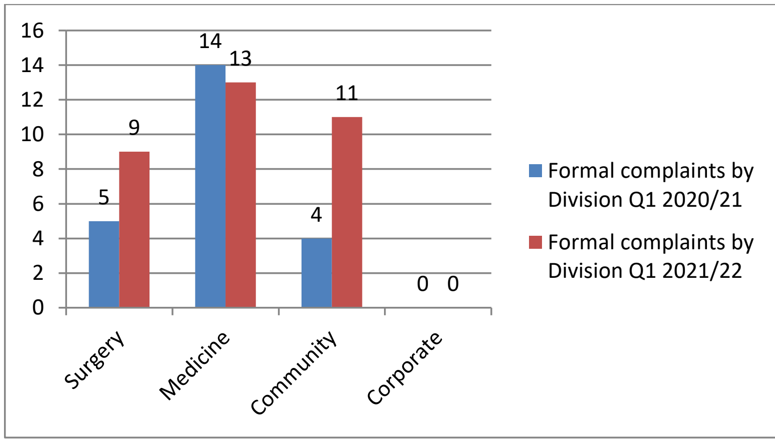
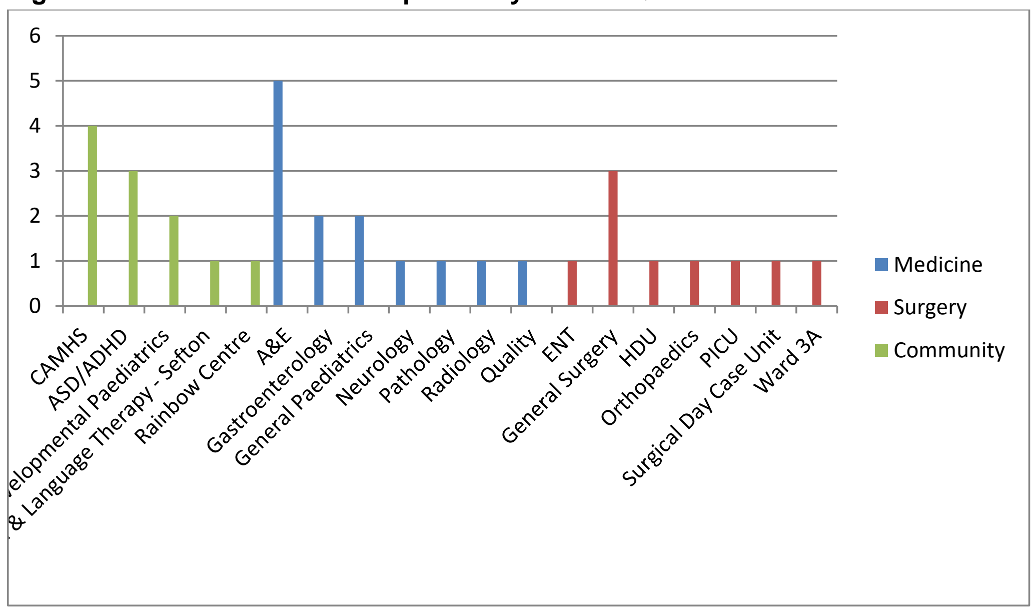


Figure 2: Number of formal complaints by service Q1 2021/22



2.1.2 Number of formal complaints received in year 2021/22

There have been 33 formal complaints received so far in 2021/22 as shown in Figure 3. Figure 4 shows the number of complaints by Division for Q1.

Figure 3: Number of formal complaints 2021/22

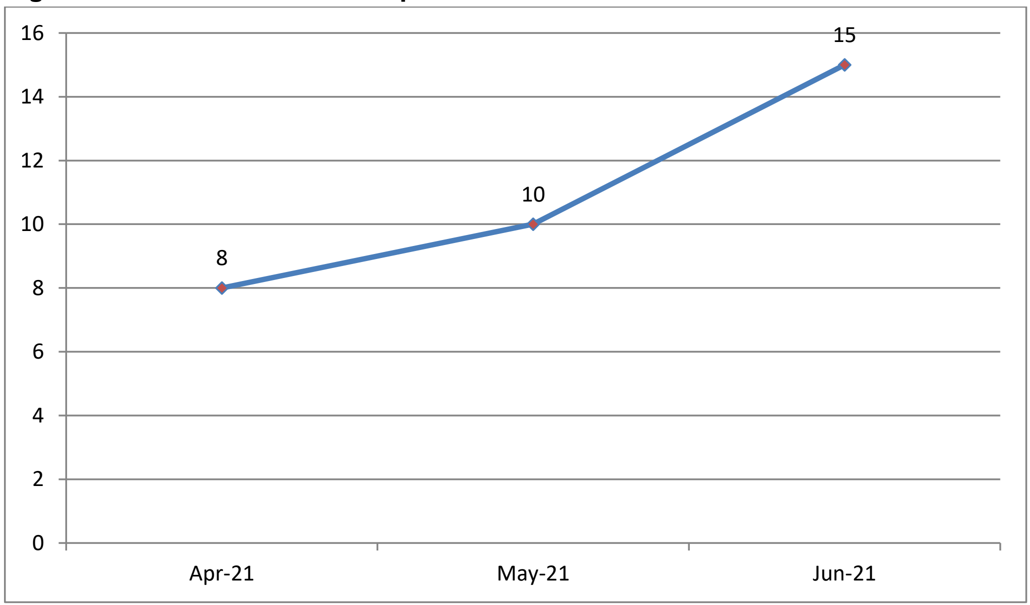


Figure 4: Number of formal complaints by Division in Q1 2021/22

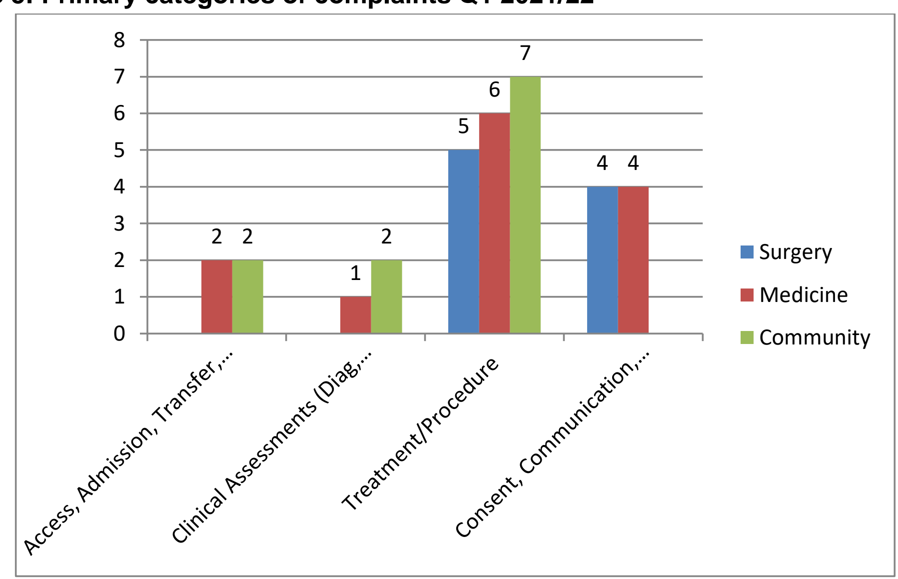
	Medicine	Surgery	Community	Corporate
Q1	13	9	11	
Q2				
Q3				
Q4				

2.2 Complaints received by category Q1 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 treatment and procedure with a total of 18 complaints (55%) in Q1.

Figure 5: Primary categories of complaints Q1 2021/22



Sub-category identification provides further detail regarding the primary issues raised by families. Figures 6 demonstrate that the main theme within the treatment and procedure category is in relation to alleged failure in medical care with 12 complaints (36%) in Q1.

Figure 6: Sub categories of complaints Q1 2021/22

7
6
5
4
3
2
1
0

Alleged Failure in Medical Care
Attitude of Staff
Coordination of Services
Diagnosis Delayed
Explanation of Treatment Inadequate
Treatement Delayed
Waiting Time for Appointment
Waiting Time General
Communication Failure
Conflicting Information
Lack of Respect
Test Results Not Available
Transition Arrangement To Adult Care
Alleged Failure in Nursing Care

Surgery
Medicine
Community

A review of the Ulysses complaints module is underway which includes a review of the categories to ensure they are in in line with the NHS Digital complaints categorisation.

2.3 Trust performance against Key Performance Indicators (KPI)

2.3.1 National context

In response to the coronavirus pandemic, in April 2020 NHSE/I supported that Trusts could suspend investigation of new complaints. However, throughout the pandemic, the Trust has continued to respond to complaints in line with RM6 Complaints and Concerns policy.

Current national guidance has set out that Trusts must continue to comply with NHS Complaints Regulations, however acknowledge 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 letter 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 letter 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 Q1, 100% of formal complaints received were acknowledged within 3 working days, with 30 (91%) being acknowledged on the same day. This is a dramatic improvement in performance exceeding the Trust target. 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 Q1 2021/22

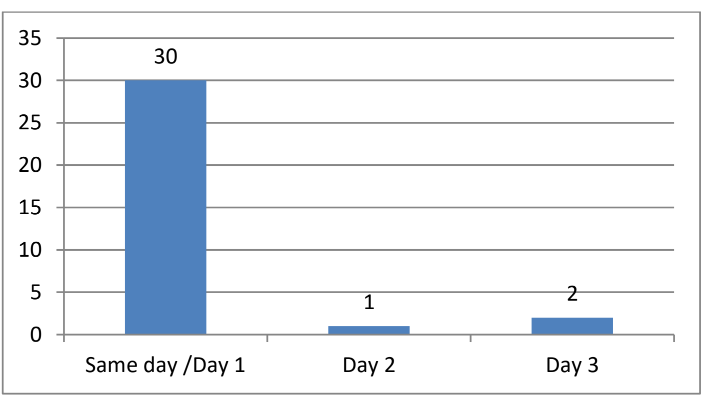


Table 1 shows the compliance by number demonstrating increased compliance with this standard.

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%

2.3.3 Complaints responded to and closed in Q1 2021/22

A total of 44 complaints were responded to and closed in Q1 of which 15 were received during Q1; 28 were received in Q4 2020/21; and 1 was received in Q3 2020/21. The complaint received in Q3 was received by the Surgical Division in relation to treatment delayed and took 109 days to close due to the complexity of the complaint.

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 is can lead to a successful resolution of the concerns raised.

15 of 33 complaints received in Q1 were responded to during the same quarter. The response times are illustrated in Table 2 below and Figure 8 demonstrates that 27 (82%) of complaints are still within 25 days compliance; this is a huge improved performance compared to Q4 2020/21. It is recognised that improvement work related to complaints performance needs to continue.

Table 2 – Response days for complaints received in Q1

	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
Q1 2021/22	33	15	27 (82%)	4 (12%)	2 (6%)				

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

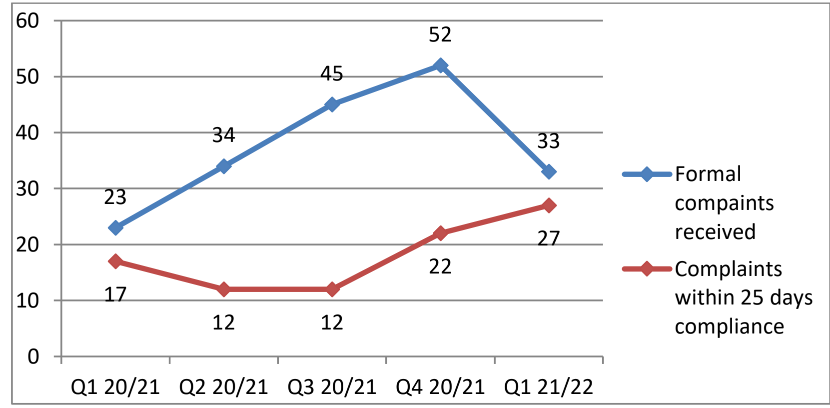
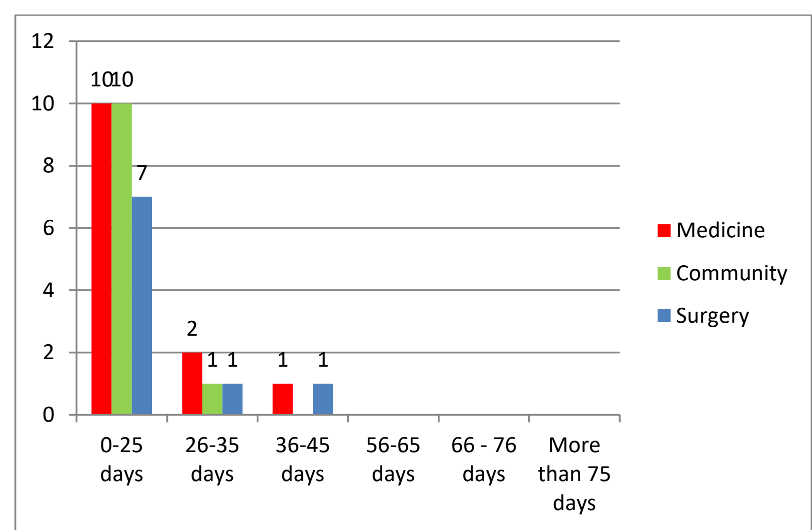


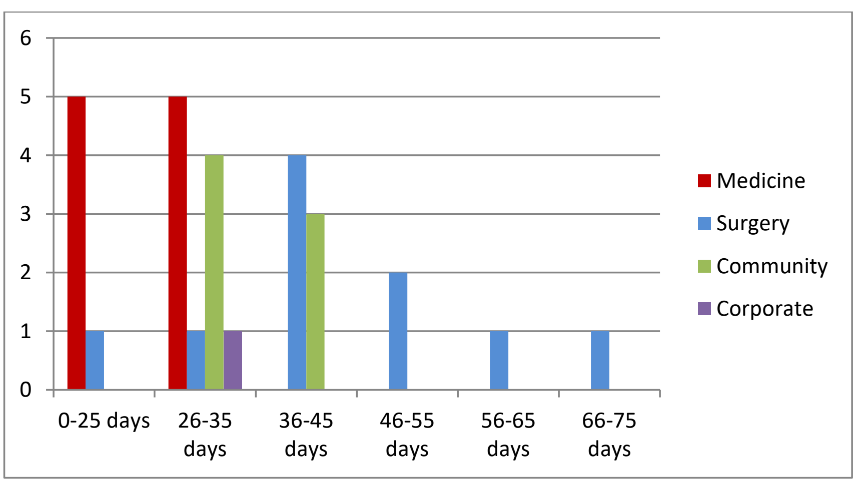
Figure 9 below demonstrates the monthly compliance with the 25 day response by Division related to complaints received and responded to within Q1.

Figure 9: Compliance with 25 day response – complaints received and responded to in Q1



Of the 33 complaints received during this period, 17 have ongoing investigations however 2 of these have exceeded the 25 working day response time (1 in Medicine; 1 in Surgery) and 1 case (Medicine) has been suspended but not yet closed.

Figure 10: Compliance with 25 day response by Division – complaints received in Q4 (2020/21) and responded to in Q1



2.3.4 Number of open and closed formal complaints by month

Table 3 shows there were 33 formal complaints opened in 2021/22 and 44 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	8	10	15										**33**
Open	18	17	24										
Closed	25	11	8										**44**

Note* 25 complaints carried over from the previous financial year 2019/20

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 decrease in the number of complaints received in Q1 has been identified as a reason for responses being administered quicker. There is an ongoing recognition by the Trust and the Divisions that it is essential that complaints are responded to in a comprehensive and timely manner.

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, Q1 data was submitted in July 2021.

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 Q1 and of the 15 closed complaints, 2 complaints were withdrawn; 9 were partially upheld, and 4 were fully upheld. A complaint will be partially upheld if any one concern raised is upheld irrespective of whether the majority of 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 15 complaints closed in Q1 received in Q1

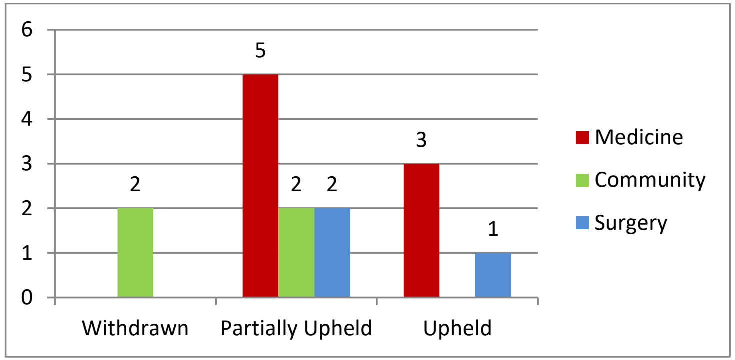


Figure 12: Outcome of 28 complaints closed in Q1 received in Q4 2020/21

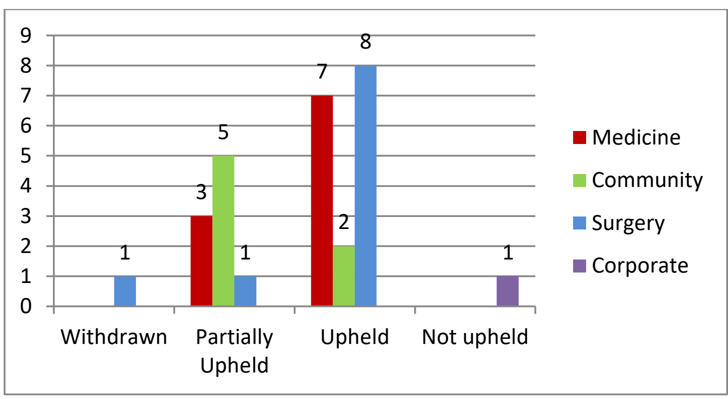
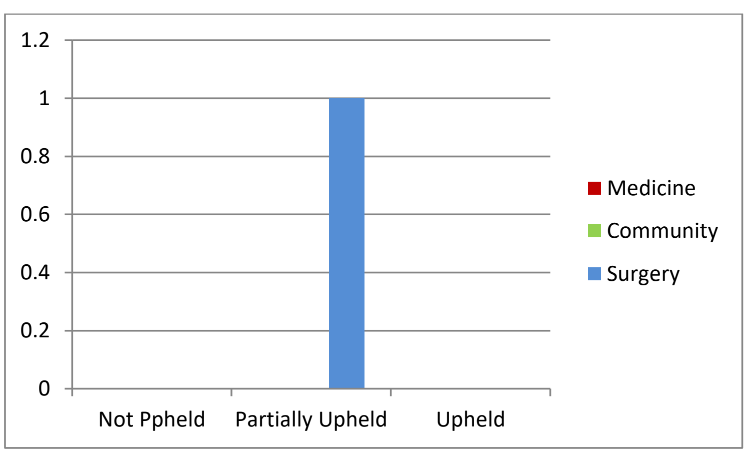


Figure 13: Outcome of 1 complaint closed in Q1 received in Q3 2020/21



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 Q1, 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 Q1 remain open and under continued investigation.

Two second stage complaints have been received in 2021/22 so far. Therefore, at the time of reporting 6% (2 out of 33) 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 4 below shows the number of second stage complaints received within 25 working days in 2021/22; both complaints (100%) were received within 25 days working days after the initial response.

Table 4: 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								
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).

3.1 Number of informal PALS concerns received Q1 2021/22

There were 378 informal concerns received during Q1, compared to 174 in Q1 2020/21 when the Trust experienced reduced service and number of appointments during the beginning of COVID-19. In Q4 2021/22, 271 informal concerns were received, therefore there has been an increase of 107 from the previous quarter, however the Trust has seen a reduction in formal complaints as a number have been managed informally to the satisfaction of the family member.

Figure 14: Number of PALS in Q1 2021/22

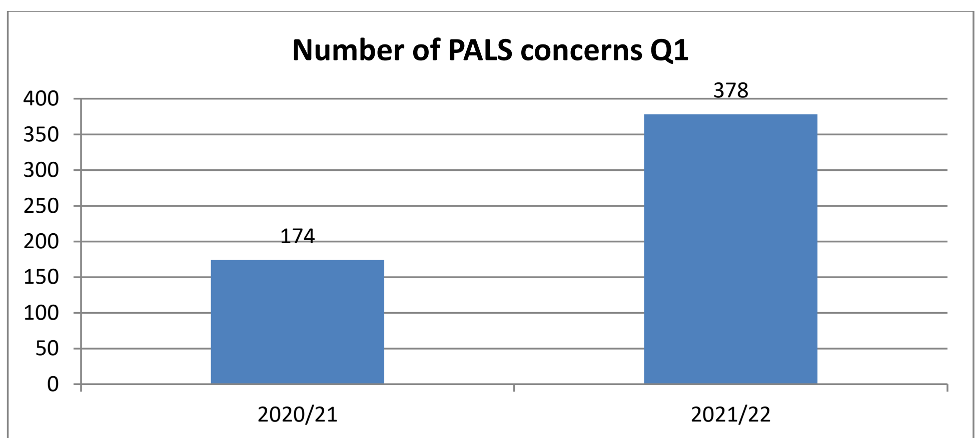
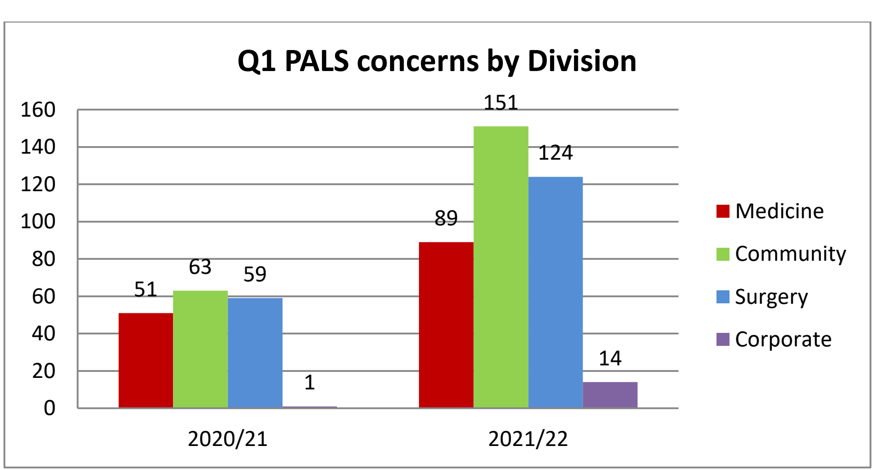


Figure 15 below shows the number of informal PALS concerns by Division in Q1 2021/22 compared with the same period in 2020/21; demonstrating an increase in all Divisions.

Figure 15: Q1 PALS concerns by Division



3.2 Informal PALS concerns received by category Q1 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 Q1 relate to communication, appointment waiting times, and attitude of staff as shown in Figure 16 and 17.

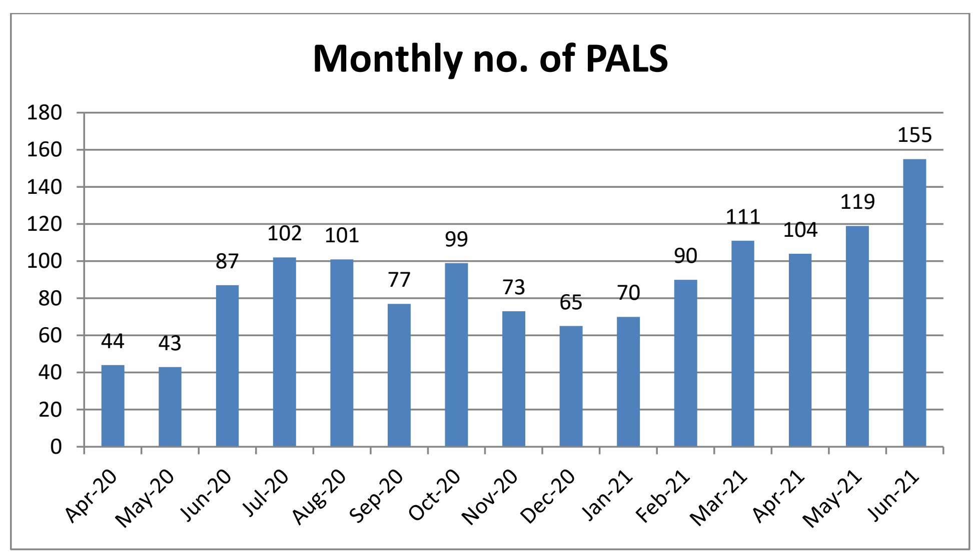


Figure 16: Categories of informal PALS concerns Q1

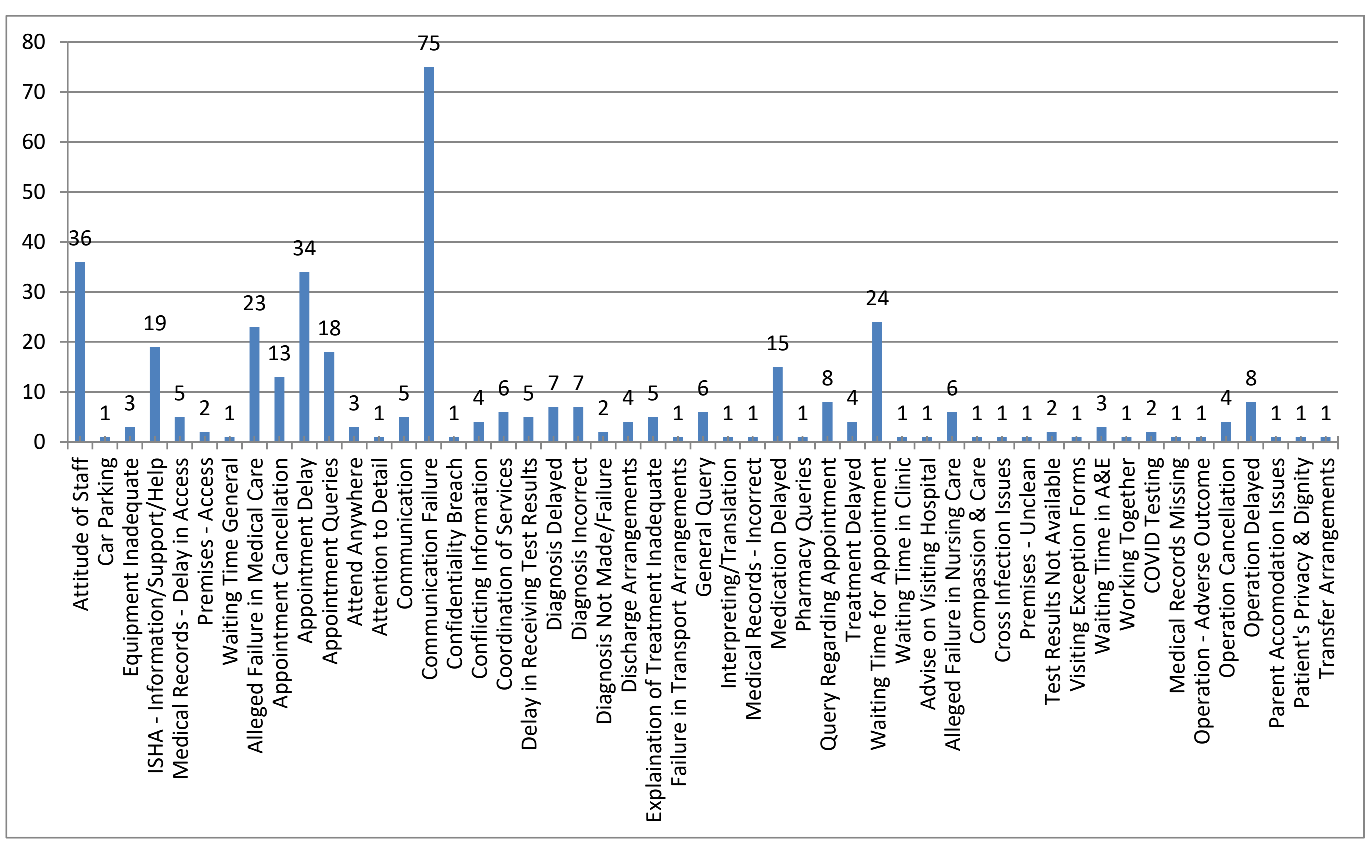


Figure 17 - Categories of informal PALS concerns Q1 by Division

40
35
30
25
20
15
10
5
0

Attitude of Staff
Equipment Inadequate
Medical Records - Delay in...
Waiting Time General
Appointment Cancellation
Appointment Queries
Attention to Detail
Communication Failure
Conflicting Information
Delay in Receiving Test...
Diagnosis Incorrect
Discharge Arrangements
Failure in Transport...
Interpreting/Translation
Medication Delayed
Query Regarding...
Waiting Time for...
Advise on Visiting Hospital
Compassion & Care
Premises - Unclean
Visiting Exception Forms
Working Together
Medical Records Missing
Operation Cancellation
Parent Accomodation Issues
Transfer Arrangements

Medicine
Community
Surgery
Corporate

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 Q1, 1696 calls were received, an increase of 22 compared to the 1674 calls received in Q4 2020/21; 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 who are shielding or the Concierge staff. 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 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.

Figure 18: Number of calls to the helpline 2021/22

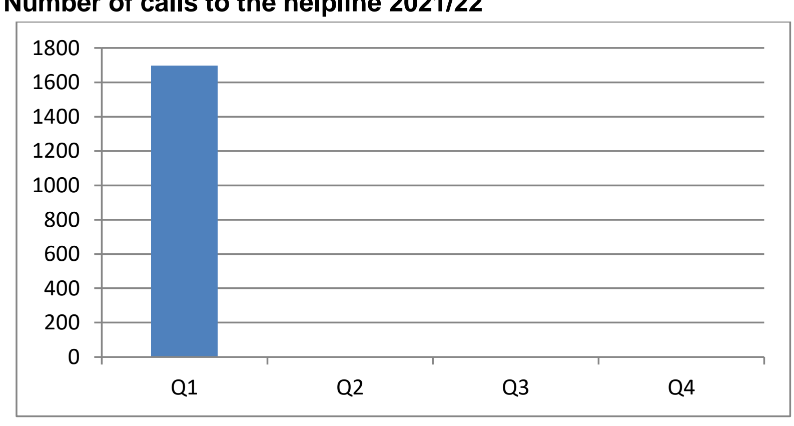
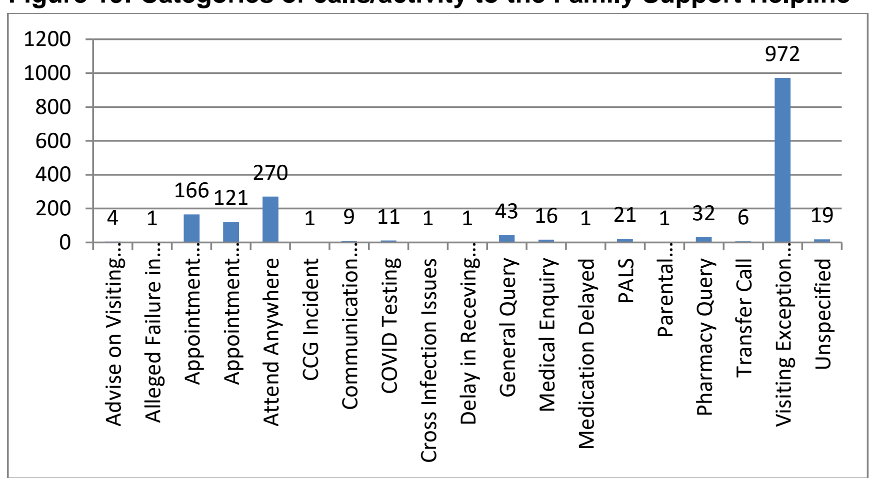


Figure 19 shows that the highest numbers of activity is due to patient experience staff processing visiting exception forms (972), which have been introduced to assist with visiting arrangements which has been restricted due to COVID regulations. The number of activity surrounding visiting exception forms has seen a massive increase from the previous quarter (531 in Q4 2020/21). The second highest reason for calls to the helpline were made in regards to help, support and advice in relation to appointments (166 appointment queries, 121 related to cancelled appointments, and 270 regarding Attend Anywhere).

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



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

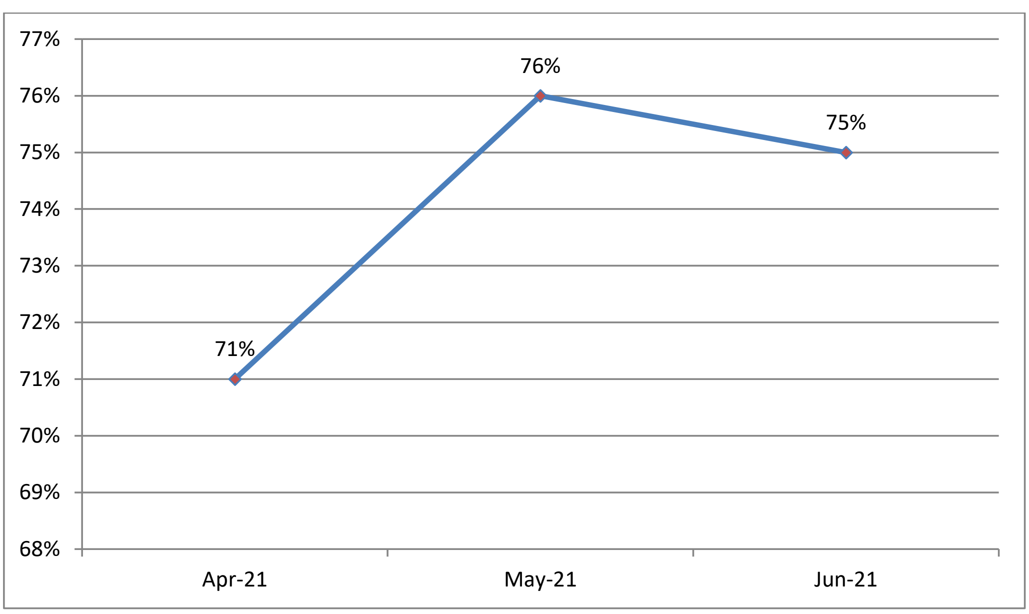
The PALS and Complaints teams endeavour to respond to concerns within the 5 day timeframe in order to try and obtain quicker resolution for children and young people. For Q1, the KPI of 90% of concerns responded to within 5 days was not met, with only 74% of PALS reported to be concluded within this time period as recorded within the Ulysses system and shown in Table 5 below. However, this is a significant improvement compared to Q4 2020/21 which only had 56% of PALS concerns responded to within 5 days.

Table 5: Compliance with 5 day response to PALS concerns

PALS	Received Q1	Q1 5 day response	Q1 overdue
Surgery	124	98 (79%)	26 (21%)
Medicine	89	69 (78%)	20 (22%)
Community	151	103 (68%)	48 (32%)
Corporate	14	11 (79%)	3 (21%)
Total	**378**	**281 (74%)**	**97 (26%)**

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



4. Compliments in Q1

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 6: Compliments recorded on Ulysses	
Division	**No. of compliments**
Community	34
Medicine	6
Surgery	4

Appendix I provides examples of compliments received during Q1.

5. Proposed developments in the management of complaints and PALS

Progress continues in line with the improvement plan which is demonstrated through the improving trend across all KPI's

Appendix I: Examples of compliments received during Q1

Complex Discharge Team

“What a difference you have made to Alder Hey getting all these complex children home. You are amazing Cathryn and I'm proud of you. It’s the case of doing your job, being professional and caring about the children you look after, what an amazing service. Everybody who knows you says how amazing you are as well and truly loved so much"

South Sefton SPOT Clinic

"I just wanted to say thank you for today. It was so nice to meet you and a relief to have someone just listen to our concerns and understand why we are having them. I know [patient] has a great team around him but now having you to support him and us I know he will get everything he needs. Thank you so much”

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”

CAMHS

“Lauren was amazing helping me understand my son’s anxieties better and talking to my son and helping him open up. I don’t think we would have got the support he needed from school if it wasn’t for Lauren phoning and emailing them. Lauren was lovely, caring, helpful, and my son said he felt safe and happy to talk with Lauren. My sons starting to get back to his happy self; still a long way to go but I am so thankful for the help. Lauren reassured me if need help in the future I can refer back, thank you”

Sefton CAMHS

“I have to say, Sefton CAMHS have been amazing with me and support I had from August till April and thank. Stay safe"

BOARD OF DIRECTORS

Thursday, 30th September 2021

Paper Title:	**EPRR Self-Assessment Assurance**
Report of:	**Nathan Askew, Chief Nursing Officer**
Paper Prepared by:	Nathan Askew, Chief Nurse Pauline Brown, Director of Nursing Phil O'Connor, Deputy Director of Nursing

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ■
Background Papers and/or supporting information:	The Trust Board are required to formally sign off EPRR self-assessment annually and publish the self-assessment. The annual self-assessment process has been graded as significant assurance with 2 standards where the Trust is partially compliant. Both standards have a relevant action plan to ensure full compliance within the next 12 months. The deep dive area of focus is on medical gases in light of the challenges faced by some organisations at the height of the COVID 19 pandemic. The trust is fully compliant with all deep dive standards. The EPRR annual report is included for information The Trust board are asked to approve and support the outcome of the self-assessment.
Action/Decision Required:	To note ☐ To approve ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ ■

	Strong Foundations
Resource Impact:	Resource will be identified through the planned review of EPRR this year
Associated risk (s)	With significant assurance there are currently minimal risks to the organisation related to EPRR. The most pressing risk is the need for the decontamination tank to be sealed, there are robust mitigation plans in place until the work has been completed.

1. Introduction

This report requests the formal approval of the Trust Board in line with its legal and statutory requirements to meet NHS England EPRR Core Standards and the Civil Contingencies Act 2004.

2. Background

The Trust are required to complete an annual self-assessment against the NHS England EPRR core standards. In addition, through local EPRR resilience groups the Trust are required to complete a deep dive into a nominated area.

The Trust have a well-developed series of EPRR plans, robust training and exercising and programme and a suitable governance framework for EPRR with the EPRR committee reporting into Audit and Risk Committee, chaired by the Non-Executive Director, Kerry Byrnes, nominated for EPRR.

The Trust Accountable Emergency Officer is Nathan Askew, Chief Nursing Officer who discharges the operational responsibility of the role through the Director of Nursing and the Emergency Planning Officer.

3. Summary

The Trust are fully compliant with 44 out of 46 relevant core standards as noted in the self-assessment, providing an overall level of significant assurance.

The two standards which are partially compliant are detailed below:

Core Standard 5

The relevant roles are described adequately within the relevant Trust policies and procedures, however there is a need to review the resource allocated to EPRR. This is in light of the significant business continuity work of the current role and the changing footprint of the acute Trust site.

There are plans in place this year to review the roles and functions of the EPRR team and this may require some additional resource to be fully compliant with this standard.

Core Standard 60

There is a current issue with the drainage tank of the decontamination room. The issue with the tank, which needs to be resealed, has left the current room unusable for the intended purpose. Whilst there are plans to re-seal the tank and an agreed programme of work to rectify this fault, currently the Trust cannot be fully compliant with this standard.

The Trust have informed NHSE and other relevant agencies and have mitigation plans to utilize IOR remove, remove, remove principles. This risk is recorded, monitored and reviewed on the EPRR risk register. Once the remedial work has been conducted on the tank the Trust will become fully compliant with this standard.

Deep Dive

The local EPRR leadership team have selected medical gases as the topic for the annual deep dive. The Trust are fully complaint with all associated standards.

EPRR Annual Report
The EPRR annual report is included in this pack for information. This includes details of the work in year and the exercise plan for the coming year.

Self-Assessment
The self-assessment statement of compliance is included which demonstrates a significant level of assurance

4. Conclusion

The Trust board are asked to formally approve the statement of compliance
The Trust will publish the statement of compliance as part of the annual accounts

Nathan Askew
Chief Nursing Officer, Accountable Emergency Officer
19.08.21

Ref	Domain	Standard	Detail	Acute Providers	Specialist Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance												
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	Y	• Name and role of appointed individual	Accountable Emergency Officer is Nathan Askew, Chief Nurse. The NED for EPRR is Kerry Byrne.		N/A	N/A	N/A	N/A
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Major Incident Policy available		N/A	N/A	N/A	N/A
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the	Y	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Bi monthly risk reports submitted to Risk Management Committee. Annual Report available to go to Audit and Risk Committee an annually to Trust Board. Audit and Risk Committee, on behalf of Trust Board, receive plans for approval		N/A	N/A	N/A	N/A
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Currently 1 EPRR Manager - additional administrative/resilience officer support required to be able to fulfil all duties and provide the training/exercising required		Review resources for Emergency Preparedness	Deputy Director of Nursing /EPRR lead	31.10.21	the service support will be reviewed and allocated resource or a business case prepared
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	Y	• Process explicitly described within the EPRR policy statement	the Trust conducts debriefs from incidents to inform learning and change in practice/plans/policy		N/A	N/A	N/A	N/A
Domain 2 - Duty to risk assess												
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	EPRR Risk Register report submitted to Risk Management Committee. Emergency Preparedness Manager also attends Risk Register revalidation meeting siwht Associate Director of Nursing & Governance on a monthly basis		Risk reviews are undertaken via the EPRR lead and documemented onto the Trusts risk register. They are reviewed and updated as	EPRR lead	30/09/2021	N/A
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	EPRR Risk are reviewed at the Emergency Preparedness Group meetings		N/A	N/A	N/A	N/A
Domain 3 - Duty to maintain plans												

11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Critical Incident Plan in place and produced with support from NHSEi Head of Emergency Preparedness		N/A	N/A	N/A	N/A
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Major Incident Command and Control Plan in place.		N/A	N/A	N/A	N/A
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Heatwave Plan in place and regularly referred to. Useful heatwave poster on how to keep cool also included		N/A	N/A	N/A	N/A
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Cold Weather Plan in place and regularly referred to during winter		N/A	N/A	N/A	N/A
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Major Incident Plan includes Mass Casualty Arrangements		N/A	N/A	N/A	N/A
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a system in ED for unidentified patients. It also has a paper system during emergency/mass casualty incidents. The Trust plans to move to this an electronic system and this is currently being progressed by the digital team		Finalise electronic system for unidentified patients	AED EPRR lead/EPRR Manager	30/09/2021	
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a whole hospital evacuation plan which was tested on 10/08/21. The exercise demonstrated that further updates to the plan would be useful and the plan will be updated accordingly.		Learning from the exercise will be incorporated into plans and a further exercise held	EPRR Manager	31/03/2022	
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a Lockdown Plan in place which has been regularly exercised during a live incident.		N/A	N/A	N/A	N/A
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Included in 'External Communications Policy, including VIP and Media Visits'. A new VIP patient policy is in place		N/A	N/A	N/A	N/A
Domain 4 - Command and control												
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	24/7 dedicated on call mechanism is in place 24/7		N/A	N/A	N/A	N/A
Domain 5 - Training and exercising												
Domain 6 - Response												
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y	Y		Incident Coordination Centre available and back up ICC available		N/A/	N/A	N/A	N/A
32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	Y	• Business Continuity Response plans	Business Continuity Plan in Place		N/A	N/A	N/A	N/A

34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	Y	• Documented processes for completing, signing off and submitting SitReps	Example situation reporting templates included in plans		N/A	N/A	N/A	N/A
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y		• Guidance is available to appropriate staff either electronically or hard copies	Document available on intranet and also in the policies section fo reference		N/A	N/A	N/A	N/A
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y		• Guidance is available to appropriate staff either electronically or hard copies	ED have access to this document in the ED Training Room with the Trust CBRNE plan		N/A	N/A	N/A	N/A
Domain 7 - Warning and informing												
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	This is referenced in policies and plans		N/A	N/A	N/A	N/A
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Communications Major Incident Action Card, plus External Communications Policy in place.		N/A	N/A	N/A	N/A
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	External Communications Policy in place		N/A	N/A	N/A	N/A
Domain 8 - Cooperation												
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Mutual aid arrangements are referenced in Trust Major Incident Policy. Process for requesting MQACA is referenced in Major Incident Command and Control Plan		N/A	N/A	N/A	N/A
43	Cooperation	Arrangements for multi-region response	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.			• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs			N/A	N/A	N/A	N/A
44	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.			• Detailed documentation on the process for managing the national health aspects of an emergency			N/A	N/A	N/A	N/A
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Reference to sharing information is included in Major Incident Policy There are also data sharing regulations relating to major incidents for reference Internal Situation Report		N/A	N/A	N/A	N/A
Domain 9 - Business Continuity												
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Y	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Policy includes statement of intent and commitment to BCMS		N/A	N/A	N/A	N/A
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles	Trust Business Continuity Plan and local ward/dept. Business Continuity Plans		N/A	N/A	N/A	N/A

50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Y	Statement of compliance	DPST toolkit compliance statement was shared with trust board following the annual review		N/A	N/A	N/A	N/A
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Reference in local business continuity plans		N/A	N/A	N/A	N/A
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	The Trust has added into the business continuity plan a process for internal audit and this will be taken forward into this year		N/A	N/A	N/A	N/A
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	Annual review of business continuity plans		N/A	N/A	N/A	N/A
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	This is referenced in local business continuity plans		N/A	N/A	N/A	N/A
Domain 10: CBRN												
56	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Referencedin CBRNE Plan		N/A	N/A	N/A	N/A
57	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes	CBRNE/HAZMAT Plan available		N/A	N/A	N/A	N/A
58	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste	Y	Y	• Impact assessment of CBRN decontamination on other key facilities	Dynamic Risk Assessment Template Available		N/A	N/A	N/A	N/A
59	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y		• Rotas of appropriately trained staff availability 24 /7	Full staff training programme in place including annual refresher updates and rotas reviewed to consider 24/7 capability		N/A	N/A	N/A	N/A
60	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	• Completed equipment inventories; including completion date	There is currently an issue with the decontamination tank in that it is not sealed, however, the Trust has a safe system in place to use IOR Remove Remove Principles.		Decontamination Tank to be sealed and fit for purpose by end of October 2021	Building services Manager	31/10/2021	NA
62	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y		• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	Monthly Checklist		N/A	N/A	N/A	N/A
63	**CBRN**	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y		• Completed PPM, including date completed, and by whom	Maintenance programme for PRPS suits, RAMGENE Monitor serviced by BME Dept, Monthly ED Checklist		N/A	N/A	N/A	N/A
64	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y		• Organisational policy	This is referenced in CBRNE/HAZMAT Plan		N/A	N/A	N/A	N/A
65	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y		• Maintenance of CPD records	There are trained HAZMAT/CBRNE trainers		N/A	N/A	N/A	N/A
67	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y		• Maintenance of CPD records	There are trained HAZMAT/CBRNE trainers		N/A	N/A	N/A	N/A

68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Y	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	This is referenced in training and in the HAZMAT/CBRNE plan		NA	NA	NA	NA	
69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y	Y		Fit testing arrangements in place		N/A	N/A	N/A	N/A	

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HART Domain: Capability										
H1	**HART**	**HART tactical capabilities**	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials • Chemical, Biological Radiological, Nuclear, Explosives (CBRNe) • Marauding Terrorist Firearms Attack • Safe Working at Height • Confined Space • Unstable Terrain • Water Operations • Support to Security Operations	Y						
H2	**HART**	**National Capability Matrices for HART**	Organisations must maintain HART tactical capabilities to the interoperable standards specified in the National Capability Matrices for HART.	Y						
H3	**HART**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
H4	**HART**	**Staff competence**	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National Training Information Sheets for HART.	Y						
H5	**HART**	**Protected training hours**	Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period i.e. training hours can be converted to live hours providing they are rescheduled as protected training hours within the seven-week period.	Y						
H6	**HART**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all HART personnel in their establishment. These records must include: • mandated training completed • date completed • any outstanding training or training due • indication of the individual's level of competence across the HART skill sets • any restrictions in practice and corresponding action plans	Y						
H7	**HART**	**Registration as Paramedics**	All operational HART personnel must be professionally registered Paramedics.	Y						
H8	**HART**	**Six operational HART staff on duty**	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.	Y						
H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must pass an initial Physical Competency Assessment (PCA) to the nationally specified standard.	Y						
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**	All operational HART staff must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						
H11	**HART**	**Returned to duty Physical Competency Assessment**	Any operational HART personnel returning to work after a period exceeding one month (where they have not been engaged in HART operational activity) must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						
H12	**HART**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident.	Y						
Domain: Administration										
H13	**HART**	**Effective deployment policy**	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y						
H14	**HART**	**Identification appropriate incidents / patients**	Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call.	Y						
H15	**HART**	**Notification of changes to capability delivery**	In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such correspondence.	Y						
H16	**HART**	**Recording resource levels**	Organisations must record HART resource levels and deployments on the nationally specified system.	Y						

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H17	HART	Record of compliance with response time standards	Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.	Y						
H18	HART	Local risk assessments	Organisations must maintain a set of local HART risk assessments which compliment the national HART risk assessments. These must cover specific local training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
H19	HART	Lessons identified reporting	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
H20	HART	Safety reporting	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
H21	HART	Receipt and confirmation of safety notifications	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.	Y						
H22	HART	Change Request Process	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y						
Domain: Response time standards										
H23	HART	Initial deployment requirement	Four HART personnel must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations.	Y						
H24	HART	Additional deployment requirement	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised.	Y						
H25	HART	Attendance at strategic sites of interest	Organisations maintain a HART service capable of placing six HART personnel on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). A delayed response is acceptable if the live HART team is already deploying HART capabilities at other incident in the region.	Y						
H26	HART	Mutual aid	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30 minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the 'on duty' HART team is already deployed at a local incident requiring HART capabilities.	Y						
Domain: Logistics										
H27	HART	Capital depreciation and revenue replacement schemes	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment.	Y						
H28	HART	Interoperable equipment	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y						
H29	HART	Equipment procurement via national buying frameworks	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable, and they subsequently receive approval from NARU for that local procurement.	Y						
H30	HART	Fleet compliance with national specification	Organisations ensure that the HART fleet and associated incident technology remain compliant with the national specification.	Y						
H31	HART	Equipment maintenance	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.	Y						
H32	HART	Equipment asset register	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						

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H33	**HART**	**Capital estate provision**	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification.	Y						
MTFA Domain: Capability										
M1	**MTFA**	**Maintenance of national specified MTFA capability**	Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas.	Y						
M2	**MTFA**	**Compliance with safe system of work**	Organisations must ensure that their MTFA capability remains compliant with the nationally specified safe system of work.	Y						
M3	**MTFA**	**Interoperability**	Organisations must ensure that their MTFA capability remains interoperable with other Ambulance MTFA teams around the country.	Y						
M4	**MTFA**	**Compliance with Standard Operating Procedures**	Organisations must ensure that their MTFA capability and responders remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
M5	**MTFA**	**Ten competent MTFA staff on duty**	Organisations must maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA Capability Matrix. Note: this ten is in addition to MTFA qualified HART staff.	Y						
M6	**MTFA**	**Completion of a Physical Competency Assessment**	Organisations must ensure that all MTFA staff have successfully completed a physical competency assessment to the national standard.	Y						
M7	**MTFA**	**Staff competency**	Organisations must ensure that all operational MTFA staff maintain their training competency to the standards articulated in the National Training Information Sheet for MTFA.	Y						
M8	**MTFA**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include: • mandated training completed • date completed • outstanding training or training due • indication of the individual's level of competence across the MTFA skill sets • any restrictions in practice and corresponding action plans.	Y						
M9	**MTFA**	**Commander competence**	Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident.	Y						
M10	**MTFA**	**Provision of clinical training**	The organisation must provide, or facilitate access to, MTFA clinical training to any Fire and Rescue Service in their geographical service area that has a declared MTFA capability and requests such training.	Y						
M11	**MTFA**	**Staff training requirements**	Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing: • 100% Strategic Commanders • 100% designated MTFA Commanders • 80% all operational frontline staff	Y						
Domain: Administration										
M12	**MTFA**	**Effective deployment policy**	Organisations must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						
M13	**MTFA**	**Identification appropriate incidents / patients**	Organisations must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						
M14	**MTFA**	**Change Management Process**	Organisations must use the NARU Change Management Process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.	Y						
M15	**MTFA**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU).	Y						
M16	**MTFA**	**Notification of changes to capability delivery**	In any event that the organisation is unable to maintain the MTFA capability to the these standards, the organisation must have a robust and timely mechanism to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the default in writing to their lead commissioners.	Y						
M17	**MTFA**	**Recording resource levels**	Organisations must record MTFA resource levels and any deployments on the nationally specified system in accordance with reporting requirements set by NARU.	Y						

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M18	MTFA	Local risk assessments	Organisations must maintain a set of local MTFA risk assessments which compliment the national MTFA risk assessments (maintained by NARU). Local assessments should cover specific training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment	Y						
M19	MTFA	Lessons identified reporting	Organisations must have a robust and timely process to report any lessons identified following a MTFA deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
M20	MTFA	Safety reporting	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
M21	MTFA	Receipt and confirmation of safety notifications	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.	Y						
Domain: Response time standards										
M22	MTFA	Readiness to deploy to Model Response Sites	Organisations must ensure their MTFA teams maintain a state of readiness to deploy the capability at a designed Model Response locations within 45 minutes of an incident being declared to the organisation.	Y						
M23	MTFA	10minute response time	Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation.	Y						
Domain: Logistics										
M24	MTFA	PPE availability	Organisations must ensure that the nationally specified personal protective equipment is available for all operational MTFA staff and that the equipment remains compliant with the relevant National Equipment Data Sheets.	Y						
M25	MTFA	Equipment procurement via national buying frameworks	Organisations must procure MTFA equipment specified in the buying frameworks maintained by NARU and in accordance with the MTFA related Equipment Data Sheets.	Y						
M26	MTFA	Equipment maintenance	All MTFA equipment must be maintained in accordance with the manufacturers recommendations and applicable national standards.	Y						
M27	MTFA	Revenue depreciation scheme	Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.	Y						
M28	MTFA	MTFA asset register	Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include: • individual asset identification • any applicable servicing or maintenance activity • any identified defects or faults • the expected replacement date • any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment)	Y						
CBRN **Domain: Capability**										
B1	CBRN	Tactical capabilities	Organisations must maintain the following CBRN tactical capabilities: • Initial Operational Response (IOR) • Step 123+ • PRPS Protective Equipment • Wet decontamination of casualties via clinical decontamination units • Specialist Operational Response (HART) for inner cordon / hot zone operations • CBRN Countermeasures	Y						
B2	CBRN	National Capability Matrices for CBRN.	Organisations must maintain these capabilities to the interoperable standards specified in the National Capability Matrices for CBRN.	Y						
B3	CBRN	Compliance with National Standard Operating Procedures	Organisations must ensure that CBRN (SORT) teams remain compliant with the National Standard Operating Procedures (SOPs) during local and national pre-hospital deployments.	Y						
B4	CBRN	Access to specialist scientific advice	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. Tactical and Operational Commanders must be able to access this advice at all times. (24/7).	Y						
Domain: Human resources										
B5	CBRN	Commander competence	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.	Y						

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B6	**CBRN**	**Arrangements to manage staff exposure and contamination**	Organisations must ensure they have robust arrangements in place to manage situations where staff become exposed or contaminated.	Y						
B7	**CBRN**	**Monitoring and recording responder deployment**	Organisations must ensure they have systems in place to monitor and record details of each individual staff responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination activities, this must include the duration of their deployment (time committed).	Y						
B8	**CBRN**	**Adequate CBRN staff establishment**	Organisations must have a sufficient establishment of CBRN trained staff to ensure a minimum of 12 staff are available on duty at all times.	Y						
B9	**CBRN**	**CBRN Lead trainer**	Organisations must have a Lead Trainer for CBRN that is appropriately qualified to manage the delivery of CBRN training within the organisation.	Y						
B10	**CBRN**	**CBRN trainers**	Organisations must ensure they have a sufficient number of trained decontamination / PRPS trainers (or access to trainers) to fully support its CBRN training programme.	Y						
B11	**CBRN**	**Training standard**	CBRN training must meet the minimum national standards set by the Training Information Sheets as part of the National Safe System of Work.	Y						
B12	**CBRN**	**FFP3 access**	Organisations must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) and that they have been appropriately fit tested.	Y						
B13	**CBRN**	**IOR training for operational staff**	Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR).	Y						
Domain: administration										
B14	**CBRN**	**HAZMAT / CBRN plan**	Organisations must have a specific HAZMAT/ CBRN plan (or dedicated annex). CBRN staff and managers must be able to access these plans.	Y						
B15	**CBRN**	**Deployment process for CBRN staff**	Organisations must maintain effective and tested processes for activating and deploying CBRN staff to relevant types of incident.	Y						
B16	**CBRN**	**Identification of locations to establish CBRN facilities**	Organisations must scope potential locations to establish CBRN facilities at key high-risk sites within their service area. Sites to be determined by the Trust through their Local Resilience Forum interfaces.	Y						
B17	**CBRN**	**CBRN arrangements alignment with guidance**	Organisations must ensure that their procedures, management and decontamination arrangements for CBRN are aligned to the latest Joint Operating Principles (JESIP) and NARU Guidance.	Y						
B18	**CBRN**	**Communication management**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage and coordinate communications with other key stakeholders and responders.	Y						
B19	**CBRN**	**Access to national reserve stocks**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to access national reserve stocks (including additional PPE from the NARU Central Stores and access to countermeasures or other stockpiles from the wider NHS supply chain).	Y						
B20	**CBRN**	**Management of hazardous waste**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage hazardous waste.	Y						
B21	**CBRN**	**Recovery arrangements**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage the transition from response to recovery and a return to normality.	Y						
B22	**CBRN**	**CBRN local risk assessments**	Organisations must maintain local risk assessments for the CBRN capability which compliment the national CBRN risk assessments under the national safe system of work.	Y						
B23	**CBRN**	**Risk assessments for high risk areas**	Organisations must maintain local risk assessments for the CBRN capability which cover key high-risk locations in their area.	Y						
Domain: Response time standards										
B24	**CBRN**	**Model response locations - deployment**	Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation.	Y						
Domain: logistics										
B25	**CBRN**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y						
B26	**CBRN**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable and that local deviation is approved by NARU.	Y						
B27	**CBRN**	**Equipment maintenance - British or EN standards**	Organisations ensure that all CBRN equipment is maintained according to applicable British or EN standards and in line with manufacturer's recommendations.	Y						
B28	**CBRN**	**Equipment maintenance - National Equipment Data Sheet**	Organisations must maintain CBRN equipment, including a preventative programme of maintenance, in accordance with the National Equipment Data Sheet for each item.	Y						

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B29	CBRN	Equipment maintenance - assets register	Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
B30	CBRN	PRPS - minimum number of suits	Organisations must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational.	Y						
B31	CBRN	PRPS - replacement plan	Organisations must ensure they have a financial replacement plan in place to ensure the minimum number of suits is maintained. Trusts must fund the replacement of PRPS suits.	Y						
B32	CBRN	Individual / role responsible fore CBRN assets	Organisations must have a named individual or role that is responsible for ensuring CBRN assets are managed appropriately.	Y						
Mass Casualty Vehicles **Domain: Administration**										
V1	MassCas	MCV accommodation	Trusts must securely accommodate the vehicle(s) undercover with appropriate shore-lining.	Y						
V2	MassCas	Maintenance and insurance	Trusts must insure, maintain and regularly run the mass casualty vehicles.	Y						
V3	MassCas	Mobilisation arrangements	Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents which may benefit from its deployment.	Y						
V4	MassCas	Mass oxygen delivery system	Trusts must maintain the mass oxygen delivery system on the vehicles.	Y						
Domain: NHS England Mass Casualties Concept of Operations										
V6	MassCas	Mass casualty response arrangements	Trusts must ensure they have clear plans and procedures for a mass casualty incident which are appropriately aligned to the *NHS England Concept of Operations for Managing Mass Casualties*.	Y						
V7	MassCas	Arrangements to work with NACC	Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) which will coordinate national Ambulance mutual aid and the national distribution of casualties.	Y						
V8	MassCas	EOC arrangements	Trusts must have arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving centres within the first hour of mass casualty incident.	Y						
V9	MassCas	Casualty management arrangements	Trusts must have a casualty management plan / patient distribution model which has been produced in conjunction with local receiving Acute Trusts.	Y						
V10	MassCas	Casualty Clearing Station arrangements	Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation.	Y						
V11	MassCas	Management of non-NHS resource	Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y						
V12	MassCas	Management of secondary patient transfers	Trusts must have arrangements in place to support some secondary patient transfers from Acute Trusts including patients with Level 2 and 3 care requirements.	Y						
Command and control **Domain: General**										
C1	C2	Consistency with NHS England EPRR Framework	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements.	Y						
C2	C2	Consistency with Standards for NHS Ambulance Service Command and Control.	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the Standards for NHS Ambulance Service Command and Control.	Y						
C3	C2	NARU notification process	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure to manage the incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS Ambulance Strategic Commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y						

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C4	C2	**AEO governance and responsibility**	The Accountable Emergency Officer in each NHS Ambulance Service provider is responsible for ensuring that the provisions of the Command and Control Standards and Guidance including these standards are appropriately maintained. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y						
Domain: Human resource										
C5	C2	**Command role availability**	NHS Ambulance Service providers must ensure that the command roles defined as part of the 'chain of command' structure in the Standards for NHS Ambulance Service Command and Control (**Schedule 2**) are maintained and available at all times within their service area.	Y						
C6	C2	**Support role availability**	NHS Ambulance Service providers must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the dedicated support roles set out in the standards at all times.	Y						
C7	C2	**Recruitment and selection criteria**	NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command). This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y						
C8	C2	**Contractual responsibilities of command functions**	Personnel expected to discharge Strategic, Tactical, and Operational command functions must have those responsibilities defined within their contract of employment.	Y						
C9	C2	**Access to PPE**	The NHS Ambulance Service provider must ensure that each Commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function.	Y						
C10	C2	**Suitable communication systems**	The NHS Ambulance Service provider must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y						
Domain: Decision making										
C11	C2	**Risk management**	NHS Ambulance Commanders must manage risk in accordance with the method prescribed in the National Ambulance Service Command and Control Guidance published by NARU.	Y						
C12	C2	**Use of JESIP JDM**	NHS Ambulance Commanders at the Operational and Tactical level must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y						
C13	C2	**Command decisions**	NHS Ambulance Command decisions at all three levels must be made within the context of the legal and professional obligations set out in the Command and Control Standards and the National Ambulance Service Command and Control Guidance published by NARU.	Y						
Domain: Record keeping										
C14	C2	**Retaining records**	C14: All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y						
C15	C2	**Decision logging**	C15: Each Commander (Strategic, Tactical and Operational) must have access to an appropriate system of logging their decisions which conforms to national best practice.	Y						
C16	C2	**Access to loggist**	C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise.	Y						
Domain: Lessons identified										
C17	C2	**Lessons identified**	The NHS Ambulance Service provider must ensure it maintains an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards.	Y						
Domain: Competence										
C18	C2	**Strategic commander competence - National Occupational Standards**	Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						

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C19	C2	**Strategic commander competence - nationally recognised course**	Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU).	Y						
C20	C2	**Tactical commander competence - National Occupational Standards**	Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C21	C2	**Tactical commander competence - nationally recognised course**	Personnel that discharge the Tactical Commander function must have successfully completed a nationally recognised Tactical Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C22	C2	**Operational commander competence - National Occupational Standards**	Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C23	C2	**Operational commander competence - nationally recognised course**	Personnel that discharge the Operational Commander function must have successfully completed a nationally recognised Operational Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C24	C2	**Commanders - maintenance of CPD**	All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.	Y						
C25	C2	**Commanders - exercise attendance**	All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc.	Y						
C26	C2	**Training and CDP - suspension of non-compliant commanders**	Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence.	Y						
C27	C2	**Assessment of commander competence and CDP evidence**	Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.	Y						
C28	C2	**NILO / Tactical Advisor - training**	Personnel that discharge the NILO /Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y						
C29	C2	**NILO / Tactical Advisor - CPD**	Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor discipline.	Y						
C30	C2	**Loggist - training**	Personnel that discharge the Loggist function must have completed a loggist training course which covers the elements set out in the National Ambulance Service Command and Control Guidance.	Y						
C31	C2	**Loggist - CPD**	Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y						
C32	C2	**Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor**	The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control).	Y						

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C33	C2	**Medical Advisor of Forward Doctor - exercise attendance**	Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.	Y						
C34	C2	**Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures**	Commanders (Strategic, Tactical and Operational) and the NILO/Tactical Advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in line with these principles.	Y						
C35	C2	**Control room familiarisation with capabilities**	Control starts with receipt of the first emergency call, therefore emergency control room supervisors must be aware of the capabilities and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the NARU command guidance sufficient to enable the initial steps to be taken (e.g. notifying the Trust command structure and alerting mechanisms, following action cards etc.)	Y						
C36	C2	**Responders awareness of NARU major incident action cards**	Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.	Y						
JESIP **Domain: Embedding doctrine**										
J1	JESIP	**Incorporation of JESIP doctrine**	The JESIP doctrine (as specified in the JESIP Joint Doctrine: The Interoperability Framework) must be incorporated into all organisational policies, plans and procedures relevant to an emergency response within NHS Ambulance Trusts.	Y						
J2	JESIP	**Operations procedures commensurate with Doctrine**	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y						
J3	JESIP	**Five JESIP principles for joint working**	All NHS Ambulance Trust operational procedures for major or complex incidents must reference the five JESIP principles for joint working.	Y						
J4	JESIP	**Use of METHANE**	All NHS Ambulance Trust operational procedures for major or complex incidents must use the agreed model for sharing incident information stated as M/ETHANE.	Y						
J5	JESIP	**Joint Decision Model - advocate use of**	All NHS Ambulance Trust operational procedures for major or complex incidents must advocate the use of the JESIP Joint Decision Model (JDM) when making command decisions.	Y						
J6	JESIP	**Review process**	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine.	Y						
J7	JESIP	**Access to JESIP products, tools and guidance**	All NHS Ambulance Trusts must ensure that Commanders and Command Support Staff have access to the latest JESIP products, tools and guidance.	Y						
Domain: Training										
J8	JESIP	**Awareness of JESIP - Responders**	All relevant front-line NHS Ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene. This must be refreshed and updated annually.	Y						
J9	JESIP	**Awareness of JESIP - control room staff**	NHS Ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets. This must be refreshed and updated annually.	Y						
J10	JESIP	**Awareness of JESIP - Commanders and Control Room managers / supervisors**	All NHS Ambulance Commanders and Control Room managers/supervisors attain and maintain competence in the use of JESIP principles relevant to the command role they perform through relevant JESIP aligned training and exercising in a joint agency setting.	Y						
J11	JESIP	**Training records - staff requiring training**	NHS Ambulance Service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y						
J12	JESIP	**Command function - interoperability command course**	All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course.	Y						

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J13	JESIP	Training records - annual refresh	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e-learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y						
J14	JESIP	Commanders - interoperability command course	Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course.	Y						
J15	JESIP	Participation in multiagency exercise	Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.	Y						
J16	JESIP	Induction training	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y						
J17	JESIP	Training - review process	All NHS Ambulance Trusts must have an effective internal process to regularly review their operational training programmes against the latest version of the JESIP Joint Doctrine.	Y						
J18	JESIP	JESIP trainers	All NHS Ambulance Trusts must maintain an appropriate number of internal JESIP trainers able to deliver JESIP related training in a multi-agency environment and an internal process for cascading knowledge to new trainers.	Y						
Domain: Assurance										
J19	JESIP	JESIP self-assessment survey	All NHS Ambulance Trusts must participate in the annual JESIP self-assessment survey aimed at establishing local levels of embedding JESIP.	Y						
J20	JESIP	Training records - 90% operational and control room staff are familiar with JESIP	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message.	Y						
J21	JESIP	Exercise programme - multiagency exercises	All NHS Ambulance Trusts must maintain a programme of planned multi-agency exercises developed in partnership with the Police and Fire Service (as a minimum) which will test the JESIP principles, use of the Joint Decision Model (JDM) and METHANE tool.	Y						
J22	JESIP	Competence assurance policy	All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required.	Y						
J23	JESIP	Use of JESIP exercise objectives and Umpire templates	All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them.	Y						

Ref	Domain	Standard	Detail	Evidence - examples listed below	Acute Providers	Mental Health Providers	Community Service Providers	Organisational Evidence	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Oxygen Supply **Domain: Oxygen Supply**													
DD1	**Oxygen Supply**	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	• Committee meets annually as a minimum • Committee has signed off terms of reference • Minutes of Committee meetings are maintained • Actions from the Committee are managed effectively • Committee reports progress and any issues to the Chief Executive • Committee develops and maintains organisational policies and procedures • Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) • Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate • The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board	Y	Paediatric Mental Health is provided by Alder Hey Children's NHS Foundation Trust CAMHS	Some Paediatric Community Services are provided by Alder Hey Children's NHS Foundation Trust	Minutes and Medical Gas Policy and Medical Gas Operation Management Plans are available		N/A	N/A	N/A	N/A
DD2	**Oxygen Supply**	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	• The organisation has reviewed and updated the plans and are they available for view • The organisation has assessed its maximum anticipated flow rate using the national toolkit • The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. • The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site • The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) • Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies • The organisation has breaching points available to support access for additional equipment as required • The organisation has a developed plan for ward level education and training on good housekeeping practices • The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases	Y	Paediatric Mental Health is provided by Alder Hey Children's NHS Foundation Trust CAMHS	Some Paediatric Community Services are provided by Alder Hey Children's NHS Foundation Trust	Alder Hey Children's NHS Foundation Trust works with BOC and Mitie our Service Provider. Alder Hey has a new PFI Hospital and has been open six years and has built in resilience. An Audit was done at the end of 2019 to ensure we continued to have adequate capacity with the added resilience of a bottle gas supply. This was all captured in the Medical Gas Operational Management Plan. The organisation continues to work with BOC for the required training for each discipline		N/A	N/A	N/A	N/A
DD3	**Oxygen Supply**	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	• The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries • The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms • The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes • Organisation has utilised the checklist retrospectively as part of an assurance or audit process	Y	Paediatric Mental Health is provided by Alder Hey Children's NHS Foundation Trust CAMHS	Some Paediatric Community Services are provided by Alder Hey Children's NHS Foundation Trust for example Speech Therapy and Physiotherapy	Pharmacy works with the medical gas porters to ensure safe and secure deliveries. BOC works with the Pharmacy on the calculations of medical gas consumption via the VIE, manifolds and cylinders. There are regular checks by Mitie regarding the icing of the VIE plant and act accordingly.		N/A	N/A	N/A	N/A
DD4	**Oxygen Supply**	**Medical gasses -workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	• Job descriptions/person specifications are available to cover each identified role • Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. • Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements • Medical gas training forms part of the induction package for all staff.	Y	Paediatric Mental Health is provided by Alder Hey Children's NHS Foundation Trust CAMHS	Some Paediatric Community Services are provided by Alder Hey Children's NHS Foundation Trust for example Speech Therapy and Physiotherapy	Job Descriptions are available and there is twenty four hour cover, in order to comply there is ongoing training and updates via BOC. The Medical Devices Services Officer provides Medical Gas Training in the induction package		N/A	N/A	N/A	N/A
DD5	**Oxygen Supply**	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	• SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds • Staff are informed and aware of the requirements for increasing de-icing of vaporisers • SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO	Y	Paediatric Mental Health is provided by Alder Hey Children's NHS Foundation Trust CAMHS	Some Paediatric Community Services are provided by Alder Hey Children's NHS Foundation Trust for example Speech Therapy and Physiotherapy	SOP's are incorporated into the Medical Gas Operational Management Plan. There has been extensive work completed around 'Good Housekeeping' during the pandemic. Staff are clear of the need to increase de-icing of vaporisers during surge in demand.		N/A	N/A	N/A	N/A
DD6	**Oxygen Supply**	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	• Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report	Y	Paediatric Mental Health is provided by Alder Hey Children's NHS Foundation Trust CAMHS	Some Paediatric Community Services are provided by Alder Hey Children's NHS Foundation Trust for example Speech Therapy and Physiotherapy	A technical file with updated Instructions for use (IFU) are included in the authorising engineers annual report		Annual verification	BOC/Medical Gasses le	20/10/2021	ensure the technical file is available for reference
DD7	**Oxygen Supply**	**Oxygen systems**	The organisation has undertaken a risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	• Organisation has a risk assessment as per section 6.6 of the HTM 02-01 • Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)	Y	Paediatric Mental Health is provided by Alder Hey Children's NHS Foundation Trust CAMHS	Some Paediatric Community Services are provided by Alder Hey Children's NHS Foundation Trust for example Speech Therapy and Physiotherapy	The Organisations annual Risk Review has been undertaken. Issues highlighted have been immediately identified and addressed and uploaded to the Trusts Risk Register via (Ulysses)		Risk register revie	Medical Gasses lead	31/10/2021	continue to monitor any residual risks

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

Alder Hey Children's NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Alder Hey Children's NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
46	0	2	44

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

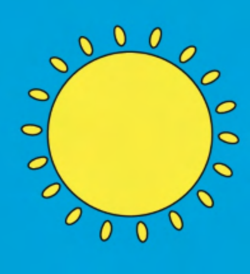
Signed by the organisation's Accountable Emergency Officer

19/08/2021
Date signed

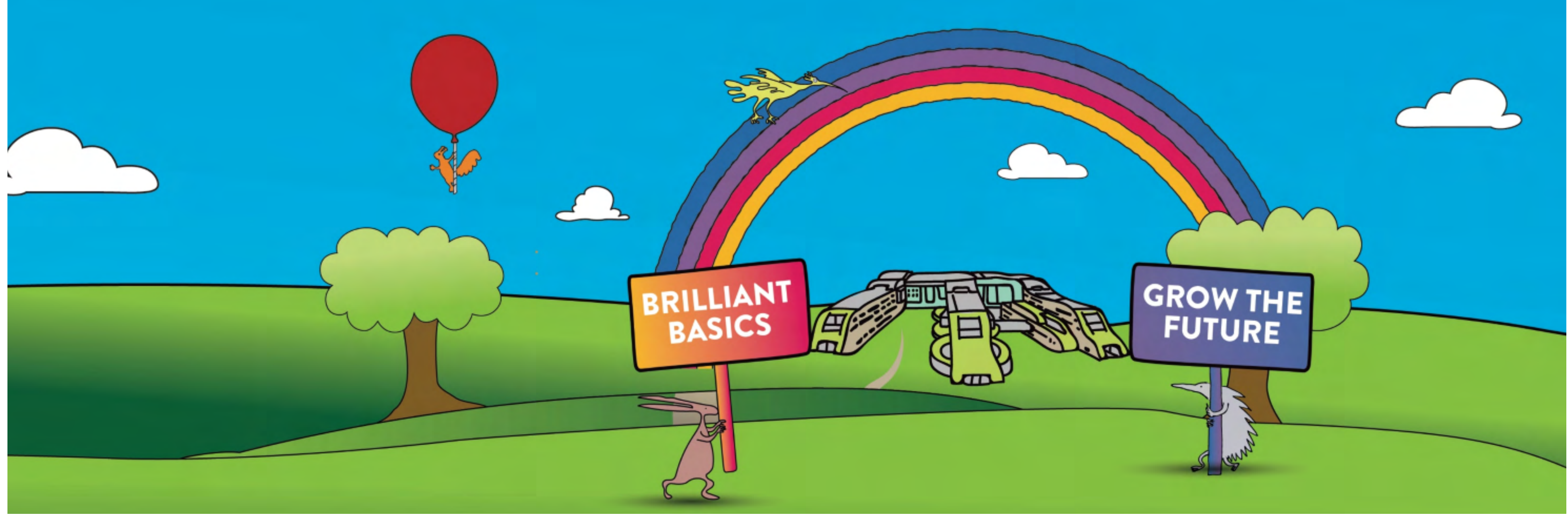
30/09/2021
Date of Board meeting

30/09/2021
Date presented at Public Board

04/04/2022
Date published in organisations Annual Report



TRUST BOARD Report August 2021



How Did We Do?

Executive Summary **Month: August** **Year: 2021**

Delivery of Outstanding Care

Safe

- Clinical incident reporting for August was reduced relating to holiday period
- 99.8% of all our clinical incidents reported are near misses or no/minor harm
- 0 incidents reported resulting in permanent harm
- Patients treated for sepsis within 60 minutes remains below the 90% threshold reflecting the continued challenge re activity both in ED and in-patient wards

Highlight

- 0 Hospital acquired infections in month
- 0 pressure ulcers category 3 and above in month

Challenges

- 6 medication errors resulting in harm, albeit 1 was not an AH incident as it related to a mum not being able to contact community pharmacy. 1 related to a patient discharged post tonsillectomy without morphine. 1 was a double dose of Phenobarbital. 1 was a dose of noradrenalin wrongly increased. 2 related to Ametop cream being left on too long. All appropriate investigation and review processes are in place to ensure lessons are learned from these incidents in order to prevent future errors and are managed through Divisional and corporate governance structures.
- 1 incident resulting in moderate harm in August relating to a child who developed urinary sepsis following some issues with antibiotic administration and follow up appointment. A level 1 RCA is underway.

The Best People Doing their Best Work

Caring

- The score of 84.9% in respect of the overall Friends and Family response to who would recommend the Trust is the lowest of the year. Work is ongoing across the Trust to address the concerns and issues raised by families in the FF survey.
- PALS referrals were significantly down in month from 123 to 90 with complaints numbers running at the yearly average

Highlight

- Significant improvement in August in relation to AED FF score although still well below the 90% threshold
- Community FF score continues to be consistently above the 90% threshold with a score of 97.3%. Equally the score for mental health is 95.8%

Challenges

- AED score reflects the continuing high level of activity and associated challenges in the department

Delivery of Outstanding Care

Effective

- The time taken for patients to be seen and treated in the Emergency Department improved significantly in August to 87.73%. Attendance levels are lower in August relative to other times of the year but were higher than attendances in August 2019. We expect that attendances will surge in September as children return to school and transmission levels increase. Gold Command has been established to review progress in enhancing urgent care capacity and improving patient flow. Pressures in the Emergency Department are expected to be high in Winter and an action plan is in place to support staff welfare, stream low acuity patients to access care away from the main Department and to improve patient flow.
- There was an increase in the number of patients waiting over 28 days for treatment following a cancelled operation, driven by less access to additional operating sessions in August. From October we expect performance to improve with additional recovery capacity in place and enhanced monitoring at Access to Care meetings.

Highlight

- Improvement in the timeliness of care in the Emergency Department
- Low number of cancelled operations

Challenges

- Treating 95% of patients who attend ED within 4 hrs
- Patients waiting over 28 days for treatment after a cancelled operation

Delivery of Outstanding Care

Responsive

195 children & young people are waiting over 52 weeks for treatment, a slight increase increased slightly. This is caused, in part, by our decision to reduce additional outpatient and theatre sessions, in order to support staff to take annual leave and rest. In September and October, the number of long wait patients is expected to rise as we conclude the safe waiting list management data assurance review. Our forward look for half-2 has a range of scenarios: in a low RSV and winter surge scenario we expect to deliver at least a 50% reduction in the number of 52 week wait patients. Other risk factors affecting recovery includes staff fatigue and workforce availability (after absence and vacancy). Our mitigation strategy includes a focus on recruitment and in-week productivity of outpatient and theatre sessions.

Highlight

- Access to cancer care

Challenges

- Patients waiting over 52 weeks for treatment
- RTT % of patients on an open pathway waiting less than 18 weeks

The Best People Doing their Best Work

Well Led

Finance

For the Month of August (Month 5), the Trust is reporting a year to date deficit of £1.8m which is £0.7m adverse to plan for the year to date (April-August).

This deficit is largely due to reduced car parking and catering income plus slippage on the Trusts efficiency programme.

The Trust has received notification of ERF funding from the C & M system which is £1m lower than original plan year to date. The Trust is also awaiting confirmation of arrangements for the H2 finance regime. Guidance is expected to be released in late September.

Cash in the bank at the end of August was £82m.

Highlight

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

Challenges

- Continue to work with NHSI re clarification of funding arrangements for 2021/22, in particular the implications of ERF funding for the remainder of H1.
- Managing sickness rates and staff returning to work.

The overall capital expenditure in month for August was £1.6m (£6.9m year to date) against a plan of £1.8m in month (£7.3m year to date). This demonstrates that spend is in now largely back on line with plan year to date. **Sickness update** The HR BP's remain aware of the priority of and impact of attendance levels on the Trust. In line with this, there is a focus on activity of both short and long term in nature. As part of this approach a range of targeted interventions are in place and are being reviewed to further enhance linked to hot spots. Key activities include: • Early invention accessing occupational health • Weekly review of OH reports by HR Officers, with follow up activities if required • Attend KPI meetings with ward managers and ensure referrals are undertaken in a timely manner • Introduction of regular surgeries for managers being considered • Monitoring on a case by case basis including progressing through the policy stages as required Organisational support through SALS, EAP and the Alder Centre continues to be highlighted as part of this approach. Turnover Continue to monitor turnover on a monthly basis, however current figures remain within the KPI threshold. Attention is required in the future to support workforce planning and succession planning as an activity. **Mandatory Training** Overall Mandatory Training at the end of August dropped by 1% to 87%, 3% below the target of 90%. As per the previous updates our key areas of low compliance are still within our annual topics that require face to face training including: Basic Life Support, PLS/APLS Annual Update and Moving and Handling Level 2.	• PDR compliance. • Delivery of CIP through remainder of 2021/22 with increasing operational pressures.

There are plans for two temporary secondment posts to be filled by the start of October 2021 to support addressing the Moving and Handling Level 2 compliance figures and the Resus team are looking at alternative delivery models including the use of some online materials for Basic Life Support. Our Estates and Ancillary Staff group continue to be our least compliance staff group and have seen a substantial drop in compliance this month after a steady period of improvement, we will continue to work with the areas of low compliance to ensure improvements. In addition to the above, all staff outstanding any training were sent an email directly informing them of their outstanding topics and how to remedy the issue in the last 2-3 weeks. **PDR** At the end of August the Appraisal rate recorded on ESR was 65% against a target of 90%, we are continuing to encourage managers and staff to have and record completed appraisals in ESR including their wellbeing conversations to ensure that as many staff as possible have an appraisal this year. In total we ran 8 workshops for Reviewees across the Trust to ensure that they were equipped to have supportive wellbeing conversations as well as meaningful appraisal discussions. Regular divisional reports are being sent out to leaders for encouraging their staff to complete their appraisals	

Game Changing Research and Innovation

Research and Development

Month 5 Research Activity:

- 163 research studies currently open
- 910 patients recruited to research studies (5113 in 21/22)

Divisional Participation:

- Division of Medicine – 136 open studies
- Division of Surgical Care – 24 open studies
- Division of Community & Mental Health – 3 open studies

Research Assurance:

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

Highlight

- Recovery plan remains on track

Challenges

- Financial performance
- Clinical capacity

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Leading Metrics

SAFE

Metric	Value	Period
Clinical Incidents resulting in catastrophic, death	0	Aug 2021
Hospital Acquired Organisms - C.difficile	0	Aug 2021
Hospital Acquired Organisms - MRSA (BSI)	0	Aug 2021
Medication errors resulting in harm	6	Aug 2021
Never Events	0	Aug 2021
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	86.36 %	Aug 2021
Sepsis: Patients treated for Sepsis within 60 Minutes - A&E	90.24 %	Aug 2021

CARING

Metric	Value	Period
Friends & Family: Overall Percentage Recommended Trust	92.33 %	Aug 2021

EFFECTIVE

Metric	Value	Period
ED: 95% Treated within 4 Hours	87.73 %	Aug 2021

RESPONSIVE

Metric	Value	Period
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	100 %	Aug 2021
All Cancers: 31 day wait until subsequent treatments	100 %	Aug 2021
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100 %	Aug 2021
Diagnostics: % Completed Within 6 Weeks	94.71 %	Aug 2021
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	100 %	Aug 2021
RTT: Open Pathway: % Waiting within 18 Weeks	71.07 %	Aug 2021
Waiting Greater than 52 weeks - Incomplete Pathways	195	Aug 2021
Waiting List Size	13286	Aug 2021

WELL LED

Metric	Value	Period
Cash in Bank (£'000s)	82121	Aug 2021
Control Total In Month Variance (£'000s)	-50.59	Aug 2021
Mandatory Training	87.44 %	Aug 2021
Safer Staffing (Shift Fill Rate)	92.16 %	Aug 2021
Sickness	6.52 %	Aug 2021

Delivery of Outstanding Care

SAFE

BRILLIANT BASICS

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

Indicator		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG			Comments Available
Proportion of Near Miss, No Harm & Minor Harm	D	99.1%	100.0%	100.0%	100.0%	99.8%	99.8%	99.8%	99.8%	99.8%	99.1%	99.6%	99.6%	99.8%		>=99 %	N/A	<99 %	✔
Clinical Incidents resulting in Near Miss	D	52	50	75	100	74	53	63	98	80	82	91	73	65		No Threshold			
Clinical Incidents resulting in No Harm	D	323	341	328	410	314	288	333	401	394	362	321	330	293		No Threshold			
Clinical Incidents resulting in minor, non permanent harm	D	83	70	67	83	75	81	76	95	91	80	71	95	90		No Threshold			
Clinical Incidents resulting in moderate, semi permanent harm	D	1	0	0	0	1	1	1	1	1	4	1	2	1		No Threshold			
Clinical Incidents resulting in severe, permanent harm	D	2	0	0	0	0	1	0	0	0	1	0	0	0		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	0	0	0	0	1	0	0		0	N/A	>0	✔
Medication errors resulting in harm	D	2	8	1	11	0	6	3	4	4	2	2	2	6		<=3	N/A	>3	✔
Pressure Ulcers (Category 3)	W	0	0	0	0	1	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	0	0	1	0	0	0	0	0		0	N/A	>0	✔
Sepsis: Patients treated for Sepsis within 60 Minutes - A&E	D P	77.3%	85.2%	74.1%	79.2%	73.7%	89.5%	80.6%	100.0%	85.0%	94.4%	87.9%	88.9%	90.2%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	85.2%	86.1%	94.3%	80.8%	70.8%	87.5%	84.0%	88.9%	83.3%	89.7%	91.7%	88.9%	86.4%		>=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	0	1	1	0	0	0	0	0	0	1	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	D	4	1	0	1	0	3	1	0	0	1	0	2	0		No Threshold			

The Best People doing their best Work

CARING

D Drive W Watch P Programme

	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust W	93.8%	90.6%	94.7%	93.7%	91.5%	95.3%	94.9%	92.9%	94.0%	90.2%	91.0%	87.6%	92.3%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust D	91.5%	84.4%	92.1%	89.2%	91.5%	93.2%	93.1%	88.0%	88.0%	76.2%	79.2%	59.8%	79.6%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust D	92.3%	89.1%	94.7%	98.8%	100.0%	92.7%	96.7%	93.0%	95.9%	92.4%	95.9%	97.1%	96.2%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust D	95.1%	92.4%	94.5%	95.5%	93.4%	94.2%	90.4%	89.8%	96.4%	95.1%	87.0%	88.8%	91.4%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust D	82.4%	92.3%	89.7%	91.3%	100.0%	96.3%	90.3%	87.9%	90.6%	85.7%	95.0%	94.7%	95.8%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust D P	95.7%	94.1%	95.5%	93.9%	90.4%	96.1%	96.0%	95.1%	95.3%	94.4%	94.8%	95.5%	95.4%		>=95 % >=90 % <90 %	✔
Complaints W	20	11	19	15	10	15	11	23	6	9	15	10	12		No Threshold	
PALS W	105	77	99	74	65	68	88	110	100	119	150	123	90		No Threshold	

Delivery of Outstanding Care

EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG			Comments Available
% Readmissions to PICU within 48 hrs	W	0.0%	0.0%	1.6%	4.2%	1.4%	0.0%	0.0%	1.6%	0.0%	2.6%	0.0%	1.4%			No Threshold			✔
ED: 95% Treated within 4 Hours	D	97.7%	95.1%	96.8%	97.1%	98.6%	98.5%	97.8%	95.3%	92.5%	81.1%	85.5%	67.9%	87.7%		>=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	18	17	19	16	10	5	7	12	13	7	13	13	12		<=20	N/A	>20	✔
28 Day Breaches	W	0	8	2	1	3	3	1	2	4	3	0	3	8		0	N/A	>0	✔

Delivery of Outstanding Care

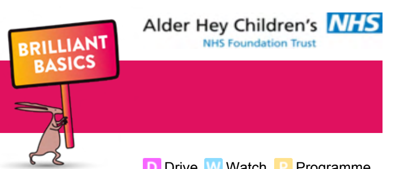
RESPONSIVE

D Drive W Watch P Programme

Indicator	Type	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG Green	RAG Amber	RAG Red	Comments Available
IP Survey: % Received information enabling choices about their care	W	95.9%	95.4%	95.4%	95.7%	97.5%	99.3%	93.6%	95.6%	96.0%	98.0%	94.3%	94.4%	96.2%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Treated with respect	W	97.9%	96.0%	98.3%	98.6%	97.5%	100.0%	98.1%	94.7%	98.5%	99.0%	94.3%	94.4%	97.8%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Know their planned date of discharge	D P	93.2%	97.1%	96.7%	97.8%	95.0%	98.5%	98.1%	94.2%	98.5%	92.2%	96.4%	93.9%	93.0%		>=90 %	>=85 %	<85 %	✔
IP Survey: % Know who is in charge of their care	W	99.3%	98.3%	100.0%	99.3%	91.7%	100.0%	94.9%	96.1%	98.5%	98.5%	98.6%	97.0%	96.2%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Patients involved in Play	D	81.5%	82.3%	83.3%	84.9%	76.7%	80.3%	85.9%	78.2%	81.1%	80.0%	79.3%	82.7%	77.4%		>=90 %	>=85 %	<85 %	✔
IP Survey: % Patients involved in Learning	D	78.1%	75.4%	88.3%	71.9%	81.6%	94.9%	92.9%	90.9%	91.0%	91.7%	89.3%	91.9%	87.6%		>=90 %	>=85 %	<85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	43.1%	47.9%	53.8%	58.7%	60.9%	61.1%	63.2%	68.1%	68.6%	71.9%	74.8%	72.7%	71.1%		>=92 %	>=90 %	<90 %	✔
Waiting List Size	W	11,369	10,939	10,838	10,755	10,443	10,648	11,453	11,892	11,110	11,564	11,414	12,096	13,286		No Threshold			
Waiting Greater than 52 weeks - Incomplete Pathways	W	127	145	145	148	184	222	307	361	283	235	204	187	195		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%	100.0%	100.0%	95.7%	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	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%		100 %	N/A	<100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	78.9%	91.8%	96.4%	97.1%	92.3%	93.7%	95.8%	97.5%	95.2%	95.2%	98.5%	95.5%	94.7%		>=99 %	N/A	<99 %	✔
PFI: PPM%		99.0%	99.0%	100.0%	98.0%	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



D Drive W Watch P Programme

		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG			Comments Available
Control Total In Month Variance (£'000s)	W	-1	-1	-359	331	686	242	590	3,824	-955	592	391	-589	-51		>=-5%	>=-20%	<-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	-483	4,518	187	-1,733	1,610	-1,979	-3,207	-5,794	-910	974	13	162	234		>=-5%	>=-10%	<-10%	✔
Cash in Bank (£'000s)	W	107,763	108,756	109,084	110,503	110,776	110,776	110,871	92,708	92,708	88,440	82,001	82,006	82,121		>=-5%	>=-20%	<-20%	✔
Income In Month Variance (£'000s)	W	1,076	2,492	-793	748	234	227	2,309	18,172	-494	715	1,597	2,980	-1,713		>=-5%	>=-20%	<-20%	✔
Pay In Month Variance (£'000s)	W	-291	-1,160	20	492	-192	-373	-387	-13,171	-308	-370	-545	553	71		>=-5%	>=-20%	<-20%	✔
Non Pay In Month Variance (£'000s)	W	-786	-1,333	414	-909	644	387	-1,333	-1,176	-153	247	-661	-4,122	1,591		>=-5%	>=-20%	<-20%	✔
AvP: IP - Non-Elective	W	817	971	961	950	929	747	731	1,066	-98	-102	1,289	-187	-141		>=0	N/A	<0	✔
AvP: IP Elective vs Plan	W	357	366	400	411	390	340	353	455	-90	-62	448	-22	-113		>=0	N/A	<0	✔
AvP: Daycase Activity vs Plan	W	1,452	1,511	1,660	1,772	1,713	1,507	1,598	2,075	184	-7	2,103	266	-128		>=0	N/A	<0	✔
AvP: Outpatient Activity vs Plan	W	17,767	22,055	22,780	23,876	20,845	22,271	22,301	26,637	1,481	3,862	26,724	4,385	-521		>=0	N/A	<0	✔
PDR	W	20.7%	29.5%	62.6%	72.4%	74.6%	74.4%	74.4%	74.4%	0.9%	6.3%	19.7%	56.3%	65.0%		No Threshold			✔
Medical Appraisal	W	95.6%	95.6%	95.6%	95.6%	95.9%	95.9%	95.9%	95.9%	21.9%	30.9%	34.8%	42.4%	70.8%		No Threshold			✔
Mandatory Training	W	90.6%	89.3%	88.6%	85.8%	85.0%	86.0%	85.8%	86.8%	88.4%	87.2%	88.1%	88.0%	87.4%		>=90 %	>=80 %	<80 %	✔
Sickness	D	5.0%	5.2%	6.0%	5.4%	5.6%	7.2%	5.7%	4.7%	4.5%	5.2%	5.6%	6.3%	6.5%		<=4 %	<=4.5 %	>4.5 %	✔
Short Term Sickness	D	1.1%	1.4%	1.9%	1.3%	1.1%	2.3%	1.2%	1.2%	1.1%	1.4%	1.5%	1.8%	1.5%		<=1 %	N/A	>1 %	✔
Long Term Sickness	D	3.9%	3.9%	4.1%	4.2%	4.5%	4.9%	4.4%	3.6%	3.4%	3.9%	4.1%	4.5%	5.0%		<=3 %	N/A	>3 %	✔
Temporary Spend ('000s)	D	946	1,015	1,061	1,365	1,392	1,373	1,279	2,272	1,071	1,040	960	1,132	1,096		No Threshold			✔
Staff Turnover	D	10.0%	9.7%	9.3%	9.2%	9.1%	9.1%	9.0%	9.0%	9.8%	10.3%	9.9%	10.3%	10.1%		<=10 %	<=11 %	>11 %	✔
Safer Staffing (Shift Fill Rate)	W	91.3%	94.2%	94.2%	94.9%	93.6%	90.5%	94.5%	94.0%	97.7%	98.8%	97.6%	89.6%	92.2%		>=90 %	N/A	<90 %	✔
Domestic Cleaning Audit Compliance	W	97.0%	93.8%	90.0%	87.5%	90.4%	94.4%	97.7%	97.7%	97.7%	88.6%	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

D Drive W Watch P Programme

		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	50	61	66	71	76	80	80	90	100	103	108	117	125		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	27	28	34	37	36	36	36	36	34	36	38	37	38		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	3	4	1	4	4	1	0	6	7	2	3	7	3		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	2	0	2	1	0	0	0	2	0	3	1	1	0		>=1	N/A	<1	✔
Number of patients recruited	W	508	413	665	832	182	504	403	105	1,055	1,039	896	439	1,060		>=100	>=86	<86	✔

Delivery of Outstanding Care

7.1 - QUALITY - SAFE

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 Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded. **Exec Lead:** Nicki Murdock **Committee:** SQAC	99.78 %	R <99 % A N/A G >=99 %		No Action Required
Incidents: Increasing Reporting	**Clinical Incidents resulting in Near Miss** D Total number of Near Miss Incidents reported **Exec Lead:** Nicki Murdock **Committee:** SQAC	65	No Threshold		
Incidents: Increasing Reporting	**Clinical Incidents resulting in No Harm** D Total number of No Harm Incidents reported. **Exec Lead:** Nicki Murdock **Committee:** SQAC	293	No Threshold		

Delivery of Outstanding Care

7.2 - QUALITY - SAFE

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 Total number of Minor Harm Incidents reported. **Exec Lead:** Nicki Murdock **Committee:** SQAC	90	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** D Incidents reported resulting in moderate harm. **Exec Lead:** Nicki Murdock **Committee:** SQAC	1	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.3 - QUALITY - SAFE

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R	>0		No Action Required
			A	N/A		
			G	0		
Reducing Medication Errors	**Medication errors resulting in harm** D 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. **Exec Lead:** Nicki Murdock **Committee:** SQAC	6	R	>3		No incidents of moderate/severe harm, 6 minor harm in August. 1 patient was discharged without Morphine post-operatively; an infusion rate was increased rather than reduced which lengthened the patient's stay; anaesthetic cream was left on 2 patients for too long causing skin reactions and a double dose of antiepileptic drug was given. 1 incident originated outside the Trust & involved medication availability in the community. All incidents have been investigated and relevant action taken.
			A	N/A		
			G	<=3		
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** W Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R	>0		No Action Required
			A	N/A		
			G	0		

Delivery of Outstanding Care

7.4 - QUALITY - SAFE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** W Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R: >0 A: N/A G: 0		No Action Required
Never Events	**Never Events** W Never Events. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R: >0 A: N/A G: 0		No Action Required
Sepsis	**Sepsis: Patients treated for Sepsis within 60 Minutes - A&E** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 21/22 aim is 90%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	90.24 %	R: <90 % A: N/A G: >=90 %		No Action Required

Delivery of Outstanding Care

7.5 - QUALITY - SAFE

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 Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 21/22 aim is 90%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	86.36 %	R A G	<90 % N/A >=90 %		Slight decrease in the number of patients identified. 3 delays , one requiring transfer to critical care for airway support IVAB time 74mins. Two other delays patinets not clinically deterioarting/septic, treated as precaution. Feedback about communication and eary/clear documenting plans for patients with complex medical history to aid in decision making when concerns around infection/sepsis. Continued awareness across nurses and clinicians as we are seeing an increase in acuity and also some early warning signs for sepsis. Ongoing communication with Divisional Leads
Mortality	**Number of children that have experienced avoidable factors causing death - Internal** W 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. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R A G	>0 N/A 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** D The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R A G	>0 N/A 0		No Action Required

Delivery of Outstanding Care

7.6 - QUALITY - SAFE

D Drive W Watch P Programme

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

The Best People doing their best Work

8.1 - QUALITY - CARING

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family: Overall Percentage Recommended Trust** W 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. **Exec Lead:** Nicki Murdock **Committee:** SQAC	92.33 %	R <90 % A >=90 % G >=95 %		In August 2021, there were a total of 1,382 responses to the Family & Friends Test. There were 1,176 very good or good responses which gave an overall Trust FFT percentage of 92.33%. This percentage is related to patients and families who found their experiences to be either good or very good. This is a 6% increase on the previous month
Friends & Family	**Friends & Family A&E - % Recommend the Trust** D 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. **Exec Lead:** Nicki Murdock **Committee:** SQAC	79.63 %	R <90 % A >=90 % G >=95 %		A&E has had 314 FFT responses compared to 232 last month. The positive responses have increased by 15% compared to last month. The trends for negative responses are waiting times not being communicated, no toys available and only one parent rule.
Friends & Family	**Friends & Family Community - % Recommend the Trust** D 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. **Exec Lead:** Nicki Murdock **Committee:** SQAC	96.20 %	R <90 % A >=90 % G >=95 %		No Action Required

The Best People doing their best Work

8.2 - QUALITY - CARING

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** D 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. **Exec Lead:** Nicki Murdock **Committee:** SQAC	91.35 %	R <90 % A >=90 % G >=95 %	Aug-20 to Aug-21 (Actual, Average, UCL, LCL, UWL, LWL, Green)	Increase of 2.58% recommend the Trust this month. 169 rated good or very good. 6 responses very poor. Analysis of comments identifies visiting restrictions and lack of communication as the common negatives.
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** D 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. **Exec Lead:** Nicki Murdock **Committee:** SQAC	95.83 %	R <90 % A >=90 % G >=95 %	Aug-20 to Aug-21 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** D P 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. **Exec Lead:** Nicki Murdock **Committee:** SQAC	95.39 %	R <90 % A >=90 % G >=95 %	Aug-20 to Aug-21 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required

The Best People doing their best Work

8.3 - QUALITY - CARING

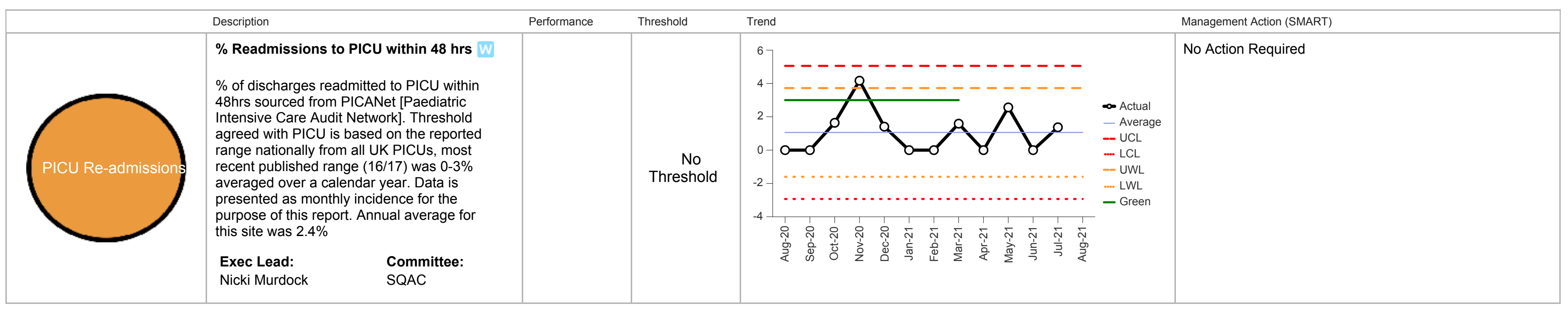
D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Nicki Murdock **Committee:** SQAC	12	No Threshold		
PALS	**PALS** W Total number of PALS contacts. **Exec Lead:** Nicki Murdock **Committee:** SQAC	90	No Threshold		

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

D Drive W Watch P Programme



	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** W % 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% **Exec Lead:** Nicki Murdock **Committee:** SQAC		No Threshold		No Action Required

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

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 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. **Exec Lead:** Nicki Murdock **Committee:** SQAC	96.24 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Respect	**IP Survey: % Treated with respect** W Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 21/22 is 100%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	97.85 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** D P 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. **Exec Lead:** Nicki Murdock **Committee:** SQAC	93.01 %	R <85 % A >=85 % G >=90 %		No Action Required

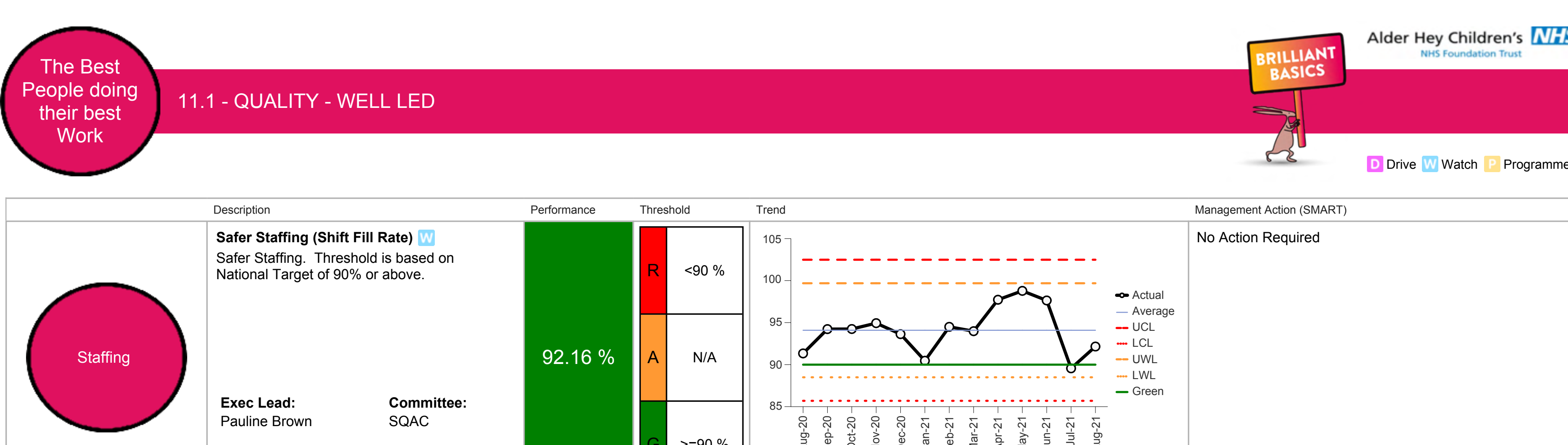
Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

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 % 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. **Exec Lead:** Nicki Murdock **Committee:** SQAC	96.24 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Play	**IP Survey: % Patients involved in Play** D % of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	77.42 %	R <85 % A >=85 % G >=90 %		The percentage of patients that reported engagement with play this month was 77.42%, a decrease of 5.33% from July 2021. Surgery % = 79.14 and Medicine % = 72.34 There were 186 responses during Aug 2021- 42 of those responses said they they did not have access to play/activities. Actions are taking place to improve Play performance with discussions regarding additional volunteer support and the recruitment of Play support currently ongoing.
Inpatient Survey: Learning	**IP Survey: % Patients involved in Learning** D % of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	87.63 %	R <85 % A >=85 % G >=90 %		Data this months presents 4.24% decrease in access to learning. This decrease reflects the reduction of delivery due to summer break.

Trend charts (each): Aug-20, Sep-20, Oct-20, Nov-20, Dec-20, Jan-21, Feb-21, Mar-21, Apr-21, May-21, Jun-21, Jul-21, Aug-21; legend: Actual, Average, UCL, LCL, UWL, LWL, Green. Y axes: 90–105; 70–95; 60–110.



	Description	Performance	Threshold		Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** W Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** SQAC	92.16 %	R	<90 %		No Action Required
			A	N/A		
			G	>=90 %		

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	87.73 %	R A G	<95 % N/A >=95 %		Continued pressure on the department. Attributing this to easing of lockdown restrictions, limited patient access to P/C, other healthcare providers and a lack of F2F appts. We are placing high priority on ensuring the dept is well staffed and staff's well-being. High-med acuity patients continue to be priority, however we are looking at deflection of certain patients were appropriate to access providers/treatments most suitable. Comms about ED have also been stepped up with the aim relieve pressure within ED.
ED 12 Hr Waits	**ED: Number of patients spending >12 hours from decision to admit to admission** W 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. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R A G	>0 N/A 0		No Action Required
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** D Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	12	R A G	>20 N/A <=20		No Action Required

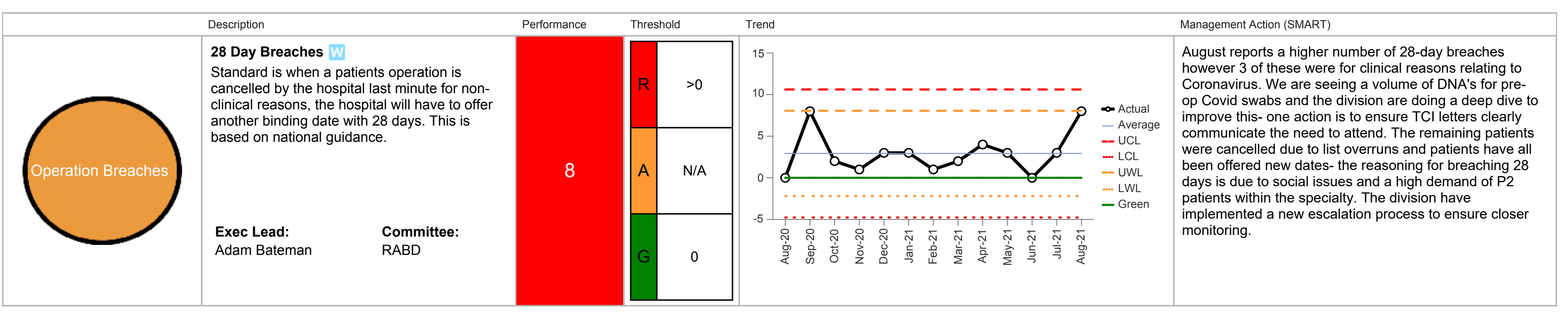
Delivery of Outstanding Care

12.2 - 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)
Operation Breaches	**28 Day Breaches** W 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. **Exec Lead:** Adam Bateman **Committee:** RABD	8	R	>0		August reports a higher number of 28-day breaches however 3 of these were for clinical reasons relating to Coronavirus. We are seeing a volume of DNA's for pre-op Covid swabs and the division are doing a deep dive to improve this- one action is to ensure TCI letters clearly communicate the need to attend. The remaining patients were cancelled due to list overruns and patients have all been offered new dates- the reasoning for breaching 28 days is due to social issues and a high demand of P2 patients within the specialty. The division have implemented a new escalation process to ensure closer monitoring.
			A	N/A		
			G	0		

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W 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. **Exec Lead:** Adam Bateman **Committee:** RABD	71.07 %	R A G	<90 % >=90 % >=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 Total waiting list size of Inpatient and Outpatient RTT incomplete pathways **Exec Lead:** Adam Bateman **Committee:** RABD	13286	No Threshold			
Waiting Times	**Waiting Greater than 52 weeks - Incomplete Pathways** W 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. **Exec Lead:** Adam Bateman **Committee:** RABD	195	R A G	>0 N/A 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

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 Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R	<100 %		No Action Required
			A	N/A		
			G	100 %		
Cancer RTT	**Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R	<100 %		No Action Required
			A	N/A		
			G	100 %		
Cancer RTT	**All Cancers: 31 day wait until subsequent treatments** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R	<100 %		No Action Required
			A	N/A		
			G	100 %		

Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

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 Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R A G	<100 % N/A 100 %		No Action Required
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** W Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	94.71 %	R A G	<99 % N/A >=99 %		We are in the similar position with regards to urgent requests for MRI. Dip in performance has been due to patient slots being lost at short notice due to Covid and holiday season. The teams are working hard with additional weekend lists to bring the performance back up and the diagnostics teams overall in medicine are working on an action plan to forecast what steps are needed to bring us up to 99% target.

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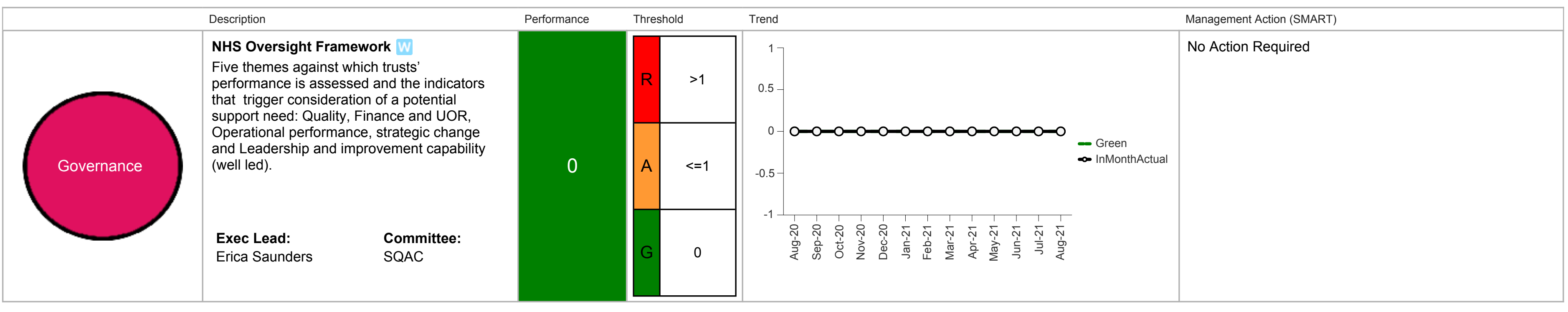
14.1 - PERFORMANCE - WELL LED

D Drive W Watch P Programme



	Description	Performance	Threshold		Trend	Management Action (SMART)
Governance	**NHS Oversight Framework** W 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). **Exec Lead:** Erica Saunders **Committee:** SQAC	0	R	>1		No Action Required
			A	<=1		
			G	0		

The Best People doing their best Work

15.1 - PEOPLE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** W 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). **Exec Lead:** Melissa Swindell **Committee:** PAWC	65.00 %	No Threshold		At the end of August the Appraisal rate recorded on ESR was 65% against a target of 90%, we are continuing to encourage managers and staff to have and record completed appraisals in ESR including their wellbeing conversations to ensure that as many staff as possible have an appraisal this year. In total we ran 8 workshops for Reviewees across the Trust to ensure that they were equipped to have supportive wellbeing conversations as well as meaningful appraisal discussions. Regular divisional reports are being sent out to leaders for encouraging their staff to complete their appraisals.
Appraisal	**Medical Appraisal** W Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** PAWC	70.82 %	No Threshold		
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** PAWC	87.44 %	R <80 % A >=80 % G >=90 %		Overall Mandatory Training at the end of August dropped by 1% to 87%, 3% below the target of 90%. As per the previous updates our key areas of low compliance are still within our annual topics that require face to face training including: Basic Life Support, PLS/APLS Annual Update and Moving and Handling Level 2, There are plans for two temporary secondment posts to be filled by the start of October 21 to support addressing the Moving and Handling Level 2 compliance figures and the Resus team are looking at alternative delivery models including the use of some online materials for BLS.

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15.2 - PEOPLE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Sickness	**Sickness** D % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** PAWC	6.52 %	R A G	>4.5 % <=4.5 % <=4 %		The HRBP's remain aware of the priority of and impact of attendance levels on the Trust. In line with this, there is a focus on activity of both short and long term in nature. As part of this approach a range of targeted interventions are in place and are being reviewed to further enhance linked to hot spots. Key activities include: Early invention accessing occupational health, Weekly review of OH reports by HR Officers, with follow up activities if required, Attend KPI meetings with ward managers and ensure referrals are undertaken in a timely manner and Introduction of regular surgeries.
Sickness	**Short Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** PAWC	1.52 %	R A G	>1 % N/A <=1 %		as above
Sickness	**Long Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** PAWC	5.00 %	R A G	>3 % N/A <=3 %		as above

Trend chart legend: Actual, Average, UCL, LCL, UWL, LWL, Green. X-axis: Aug-20, Sep-20, Oct-20, Nov-20, Dec-20, Jan-21, Feb-21, Mar-21, Apr-21, May-21, Jun-21, Jul-21, Aug-21.

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15.3 - PEOPLE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Temporary Spend	**Temporary Spend ('000s)** D Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** PAWC	1096.27	No Threshold	Chart: y-axis 0–2,500; Aug-20 to Aug-21; Actual, Average, UCL, LCL, UWL, LWL, Green	
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** PAWC	10.13 %	R >11 % A <=11 % G <=10 %	Chart: y-axis 8–12; Aug-20 to Aug-21; Actual, Average, UCL, LCL, UWL, LWL, Green	Continue to monitor turnover on a monthly basis, however current figures remain within the KPI threshold. Attention is required in the future to support workforce planning and succession planning as an activity.

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16.1 - FINANCE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**Control Total In Month Variance (£'000s)** W 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 **Exec Lead:** John Grinnell **Committee:** RABD	-51	R A G	<-20% >=-20% >=-5%		
Finance	**Capital Expenditure In Month Variance (£'000s)** W 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 **Exec Lead:** John Grinnell **Committee:** RABD	234	R A G	<-10% >=-10% >=-5%		No Action Required
Finance	**Cash in Bank (£'000s)** W 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 **Exec Lead:** John Grinnell **Committee:** RABD	82,121	R A G	<-20% >=-20% >=-5%		No Action Required

Chart 1: y-axis 4,000; 2,000; 0; -2,000; -4,000. x-axis Aug-20, Sep-20, Oct-20, Nov-20, Dec-20, Jan-21, Feb-21, Mar-21, Apr-21, May-21, Jun-21, Jul-21, Aug-21. Legend: Actual, Average, UCL, LCL, UWL, LWL, Green

Chart 2: y-axis 10,000; 5,000; 0; -5,000; -10,000. x-axis Aug-20, Sep-20, Oct-20, Nov-20, Dec-20, Jan-21, Feb-21, Mar-21, Apr-21, May-21, Jun-21, Jul-21, Aug-21. Legend: Actual, Average, UCL, LCL, UWL, LWL, Green

Chart 3: y-axis 140,000; 120,000; 100,000; 80,000; 60,000; 40,000; 20,000; 0; -20,000. x-axis Aug-20, Sep-20, Oct-20, Nov-20, Dec-20, Jan-21, Feb-21, Mar-21, Apr-21, May-21, Jun-21, Jul-21, Aug-21. Legend: Actual, Average, UCL, LCL, UWL, LWL, Green

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16.2 - FINANCE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**Income In Month Variance (£'000s)** W 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 **Exec Lead:** John Grinnell **Committee:** RABD	-1,713	R A G	<-20% >=-20% >=-5%	Chart: 20,000 / 10,000 / 0 / -10,000 / -20,000; Aug-20 … Aug-21; Actual, Average, UCL, LCL, UWL, LWL, Green	
Finance	**Pay In Month Variance (£'000s)** W 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 **Exec Lead:** John Grinnell **Committee:** RABD	71	R A G	<-20% >=-20% >=-5%	Chart: 10,000 / 5,000 / 0 / -5,000 / -10,000 / -15,000; Aug-20 … Aug-21; Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
Finance	**Non Pay In Month Variance (£'000s)** W 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 **Exec Lead:** John Grinnell **Committee:** RABD	1,591	R A G	<-20% >=-20% >=-5%	Chart: 4,000 / 2,000 / 0 / -2,000 / -4,000 / -6,000; Aug-20 … Aug-21; Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required

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16.3 - FINANCE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: IP - Non-Elective** W Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-141.07	R <0 A N/A G >=0		Non-electives volumes have not yet recovered to pre-pandemic levels
Finance	**AvP: IP Elective vs Plan** W Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-112.52	R <0 A N/A G >=0		Most significant under performances were in orthopaedics and ENT
Finance	**AvP: Daycase Activity vs Plan** W Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-128.40	R <0 A N/A G >=0		Most significant under performing specialties were urology and paed surgery

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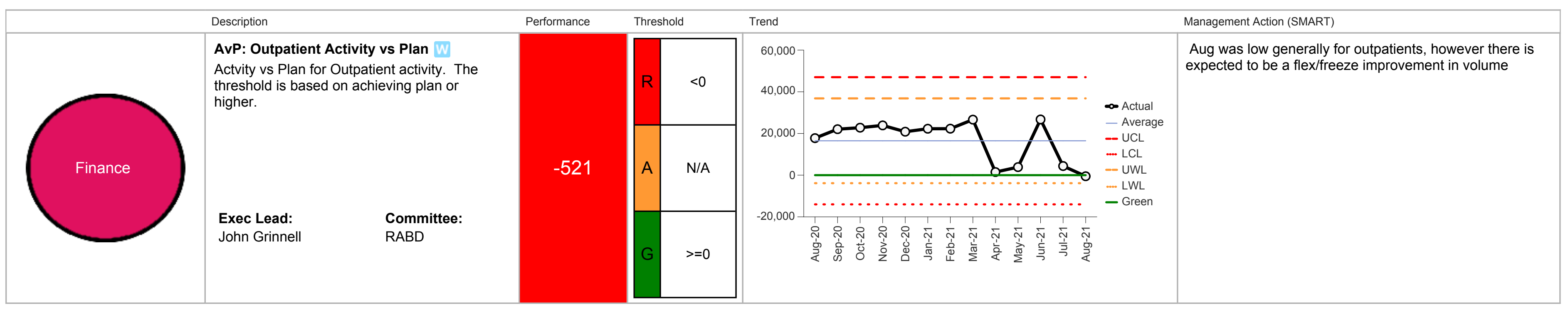
16.4 - FINANCE - WELL LED

D Drive W Watch P Programme



	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**AvP: Outpatient Activity vs Plan** W Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-521	R	<0		Aug was low generally for outpatients, however there is expected to be a flex/freeze improvement in volume
			A	N/A		
			G	>=0		

Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Academic** W Number of academic studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	125	R	<111		On track with the planned increase in the number of open academic studies.
			A	>=111		
			G	>=130		
Clinical Research	**Number of Open Studies - Commercial** W Number of commercial studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	38	R	<21		No Action Required
			A	>=21		
			G	>=30		
Clinical Research	**Number of New Studies Opened - Academic** W Number of new academic studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	3	R	<2		No Action Required
			A	>=2		
			G	>=3		

Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

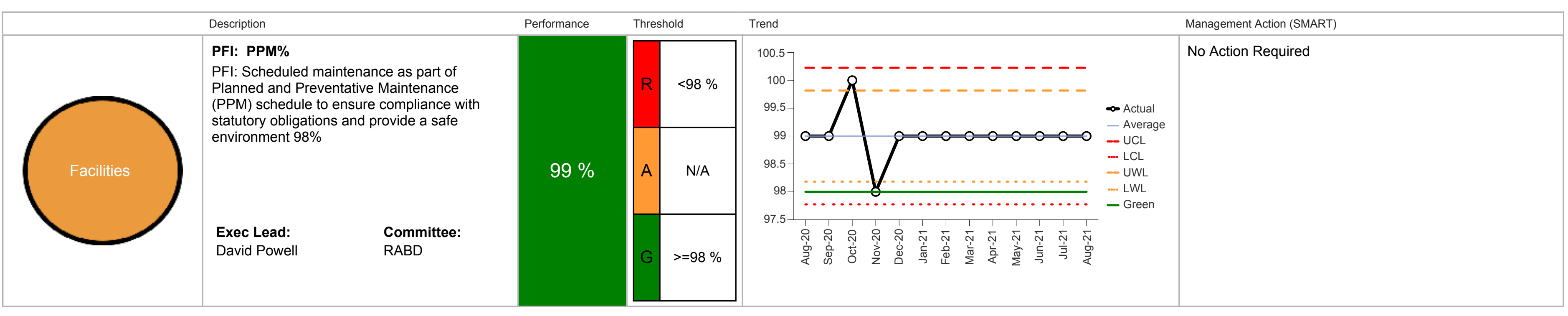
D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	0	R A G	<1 N/A >=1		Opening of new studies limited due to reduced capacity.
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Jo Blair **Committee:** RMB	1060	R A G	<86 >=86 >=100		No Action Required

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

D Drive W Watch P Programme



	Description	Performance	Threshold		Trend	Management Action (SMART)
Facilities	**PFI: PPM%** PFI: Scheduled maintenance as part of Planned and Preventative Maintenance (PPM) schedule to ensure compliance with statutory obligations and provide a safe environment 98% **Exec Lead:** David Powell **Committee:** RABD	99 %	R	<98 %		No Action Required
			A	N/A		
			G	>=98 %		

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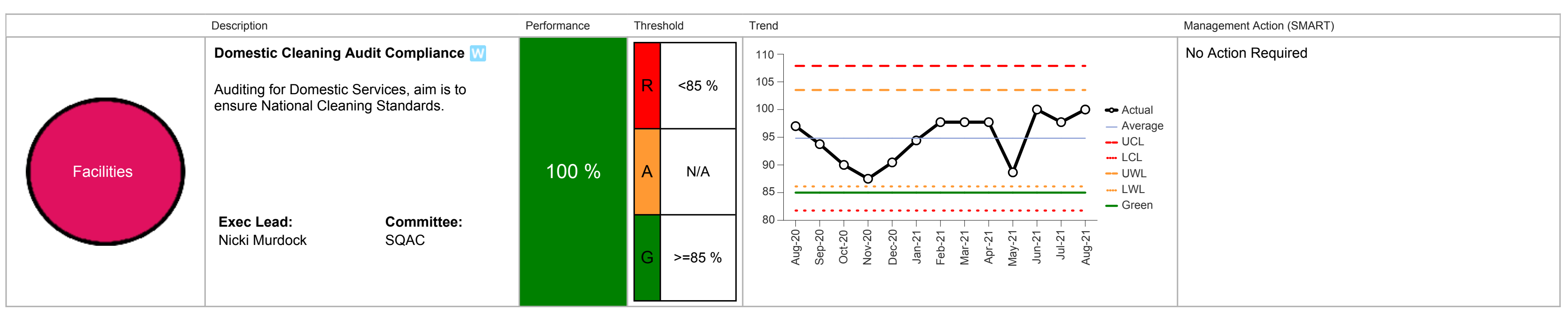
19.1 - FACILITIES - WELL LED

D Drive W Watch P Programme



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

All Divisions

D Drive W Watch P Programme

SAFE

		COMMUNITY	MEDICINE	SURGERY	RAG
Clinical Incidents resulting in Near Miss	D	5	31	25	No Threshold
Clinical Incidents resulting in No Harm	D	64	97	114	No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	10	18	49	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	0	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	2	3	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		75.0%	100.0%	>=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	0	0	No Threshold

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	3	4	4	No Threshold
PALS	W	34	27	25	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG
% Readmissions to PICU within 48 hrs	W			1.4%	No Threshold
ED: 95% Treated within 4 Hours	D		87.7%		>=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	9	No Threshold		
28 Day Breaches	W	0	0	8	0	N/A	>0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		100.0%	95.0%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		97.9%	97.8%	>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P		91.5%	93.5%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		87.2%	99.3%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		72.3%	79.1%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		74.5%	92.1%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	61.2%	83.3%	67.4%	>=92 %	>=90 %	<90 %
Waiting List Size	W	1,147	3,507	8,632	No Threshold		
Waiting Greater than 52 weeks - Incomplete Pathways	W	2	7	186	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		94.4%	100.0%	>=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	250	-58	-5	No Threshold
Income In Month Variance (£'000s)	W	75	-490	28	No Threshold
Pay In Month Variance (£'000s)	W	167	47	-64	No Threshold
Non Pay In Month Variance (£'000s)	W	8	385	31	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective	W	-1	-19	-121	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	-58	-55	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		79	-208	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	368	-965	-1,822	>=0	N/A	<0
PDR	W	78.8%	61.7%	52.8%	No Threshold		
Medical Appraisal	W	68.0%	75.9%	66.7%	No Threshold		
Mandatory Training	W	91.9%	86.9%	88.4%	>=90 %	>=80 %	<80 %
Sickness	D	6.3%	7.1%	0.0%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.4%	1.8%	0.0%	<=1 %	N/A	>1 %
Long Term Sickness	D	4.9%	5.4%	0.0%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	127	263	469	No Threshold		
Staff Turnover	D	9.9%	8.4%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	98.9%	90.6%	92.5%	>=90 %	>=80 %	<90 %

Medicine Division

SAFE	Sepsis Lead Nurse to facilitate 'Survey Monkey' regarding staff understanding of 'parental/nurse' concern. Gen Paeds to ensure all new patients are handed over to COW/PTWR Consultant for clinical review	**Highlight** • Multidisciplinary attendance at weekly divisional incident review meeting for rapid learning and sharing • Incident themes identified – • 1) allocation of emergency admissions under incorrect Consultant/Specialty • 2) Recognition of clinical deterioration/ use of 'parent/nurse' concern **Challenges** • ~400 open incidents for the Division for 2021 (0 open incidents for 2018-2020)
CARING	Concerns re PALS compliance escalated to Patient Experience Manager to provide additional resources to release Divisional PALS Officer to follow-up PALS to completion	**Highlight** • 100% acknowledgement of formal complaints within 3 working days • Number of complaints remain down compared to 2020 however Neurology remains the specialty with the highest number of complaints **Challenges** • PALS compliance with the 5 working day timeframe for responses has been variable – 75%-100% due to staffing gaps within the wider PALS team requiring cover
EFFECTIVE	Restart of support streaming for ED in September to mitigate expected increases in attendances Monitor cancellations closer through Access to Care	**Highlight** • Improvement in ED performance over summer • Overall WNB remains green **Challenges** • Cancellations < 6 weeks increased • WNB for 1st OPD increased
RESPONSIVE	Additional sleep bed now in use so waits will start to slowly reduce. Trajectory for improvement to be submitted to safe waiting list group for oversight. Medica to undertake additional reporting to catch up backlog. Team exploring locally commissioned service to have multiple options.	**Highlight** ▪ Patients waiting over 40 weeks from referral continues to reduce on PTL ▪ Cancer performance standards met including new Faster Diagnosis standard **Challenges** ▪ Diagnostic wait time standard not being met and likely to deteriorate further due to the inclusion of sleep studies in reporting ▪ Radiology reporting turnaround delayed due to technical issues with pipeline to Medica. Now resolved but 2 week delay for MRI routine scans to be reported.

WELL LED	Sickness Absence remains a high priority and Division has seen an increase in LTS. The HR Business Partner team are supporting Managers and ensuring all staff have an action plan and appropriate support to RTW Continued utilisation of wellbeing support services including SALs, Alder Centre, Occupational Health, First Care and HR Wellbeing Officers Hybrid working conversations to continue with staff, to support Flexible Working. HR Advisor to receive feedback from Services regarding the HW guidance Review of some key mandatory training content completed, SEPSIS training amended as an outcome	**Highlight** • Good progress made with out of date policies, guidelines and patient information leaflets • Formal employment relations cases continue to be low; the HR team continue to focus on informal resolution • Staff turnover remains green at 8% • Wellbeing discussions continue to take place as part of PDR's. Although the corporate report highlights a return of 50.2%, as at 9th September, PDR is currently running at 70.89%. The HR Advisor continues to support Managers with data input. **Challenges** • Small number of ER cases are very complex and ongoing with support from HR • Overall sickness absence has increased by 0.3% between July and August, 21 and by 1.3% over the last quarter. Between July and August, short term absence reduced by 0.8%, however long term increased by 1.1% during the same period. • Recruitment service pressures continue - New starters within the team have commenced and are currently undergoing training • Mandatory Training currently sitting at 87.3%. Currently 23 teams are above 90%, a further 11 are above 85%, the remaining 18 are below 80%

Alder Hey Children's NHS Foundation Trust

Medicine

D Drive W Watch P Programme

SAFE

Indicator		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	19	17	28	34	22	18	23	33	43	33	37	29	31		No Threshold
Clinical Incidents resulting in No Harm	D	76	94	70	126	99	90	97	125	121	122	88	101	97		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	20	16	11	18	19	21	17	19	23	23	16	17	18		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	0	0	0	1	1	0	2	1	2	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	D	1	0	0	0	0	1	0	0	0	1	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	4	0	0	0	4	1	2	0	0	1	0	2		No Threshold
Medication Errors (Incidents)		23	19	24	32	36	34	28	39	28	41	25	14	19		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		2	2	0	0	1	0	2	4	1	3	1	0	2		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	84.6%	91.7%	100.0%	75.0%	90.9%	83.3%	84.6%	87.5%	90.9%	88.2%	93.3%	96.2%	75.0%		>=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	0	0	1	0	0	0	0	0	0	1	0	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI		2	0	0	0	2	2	2	1	5	0	0	2	3		No Threshold
Hospital Acquired Organisms - MSSA	D	0	0	0	0	0	1	1	0	0	0	0	0	0		No Threshold
Cleanliness Scores		97.8%	98.0%	98.0%	96.0%	95.1%	98.4%	97.2%	98.6%	98.7%	98.2%	98.6%	98.6%	98.7%		No Threshold
Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region.		99.8%	99.8%	99.8%	99.7%											>=95 % N/A <95 %
Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed.		63.8%	63.8%	49.3%	64.6%	71.3%	53.9%	68.2%								>=50 % N/A <50 %
Pharmacy - Dispensing for Out Patients - Routine within 30 minutes		84.0%	77.3%	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%	100.0%	100.0%	77.0%		100.0%	100.0%								>=90 % N/A <90 %

CARING

Indicator		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG
Complaints	W	11	7	8	7	6	8	3	12	5	5	2	4	4		No Threshold
PALS	W	49	27	24	28	27	25	20	37	24	23	41	41	27		No Threshold

EFFECTIVE

Indicator		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG
Referrals Received (Total)		1,574	2,286	2,023	2,099	1,703	2,080	1,681	2,223	2,130	2,233	2,398	2,229	1,891		No Threshold
ED: 95% Treated within 4 Hours	D	97.7%	95.1%	96.8%	97.1%	98.6%	98.5%	97.8%	95.3%	92.5%	81.1%	85.5%	67.9%	87.7%		>=95 % N/A <95 %
ED: Percentage Left without being seen	W	0.8%	2.0%	0.8%	1.0%	0.6%	0.5%	0.7%	2.2%	3.8%	7.4%	4.9%	12.5%	4.3%		<=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	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	0			0 N/A >0
ED: Re-attendance within 7 days of original attendance (%)	W	8.3%	7.0%	7.9%	7.8%	7.9%	9.0%	7.9%	7.5%	8.3%	9.5%	8.6%	9.8%	9.7%		No Threshold

Medicine

D Drive W Watch P Programme

Metric	Flag	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-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	82.1%	81.3%	83.6%	82.2%	84.7%	84.0%	87.0%	82.6%	84.6%	80.3%	77.8%	79.9%	77.3%		>=90 % / >=80 % / <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons	D	3	2	1	1	2	0	0	1	2	0	1	0	3		No Threshold
28 Day Breaches	W	0	3	2	0	0	1	0	0	0	0	0	0	0		0 / N/A / >0
Hospital Initiated Clinic Cancellations < 6 weeks notice		55	20	33	20	47	16	14	18	21	19	21	37	42		No Threshold
OP Appointments Cancelled by Hospital %		11.4%	12.3%	11.2%	12.4%	13.8%	12.2%	12.2%	11.8%	9.8%	10.2%	11.2%	14.4%	14.2%		<=5 % / N/A / >10 %
Was Not Brought Rate	W P	12.3%	11.9%	11.2%	9.5%	10.4%	9.8%	9.5%	8.8%	9.2%	9.0%	10.1%	10.9%	11.1%		<=12 % / <=14 % / >14 %
Was Not Brought Rate (New Appts)	W	13.5%	15.8%	12.4%	11.3%	11.5%	12.0%	10.9%	9.3%	12.5%	10.5%	11.3%	10.7%	11.9%		<=10 % / <=12 % / >12 %
Was Not Brought Rate (Followup Appts)	W	12.1%	11.1%	10.9%	9.1%	10.2%	9.3%	9.1%	8.7%	8.4%	8.7%	9.9%	10.9%	11.0%		<=14 % / <=16 % / >16 %
Coding average comorbidities		5.28	5.17	5.31	5.45	5.50	5.45	5.54	5.41	5.14	5.17	5.59	5.47	5.56		No Threshold

RESPONSIVE

Metric	Flag	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	W	95.6%	92.9%	92.9%	96.9%	95.8%	100.0%	96.4%	95.2%	96.2%	98.3%	93.5%	87.9%	100.0%		>=95 % / >=90 % / <90 %
IP Survey: % Treated with respect	W	97.8%	100.0%	97.2%	100.0%	95.8%	100.0%	100.0%	95.2%	98.1%	100.0%	89.1%	87.9%	97.9%		>=95 % / >=90 % / <90 %
IP Survey: % Know their planned date of discharge	D P	93.3%	95.2%	88.9%	100.0%	91.7%	96.9%	98.2%	91.9%	96.2%	91.5%	95.7%	86.2%	91.5%		>=90 % / >=85 % / <85 %
IP Survey: % Know who is in charge of their care	W	100.0%	97.6%	100.0%	100.0%	87.5%	100.0%	92.9%	95.2%	94.3%	100.0%	97.8%	93.1%	87.2%		>=95 % / >=90 % / <90 %
IP Survey: % Patients involved in Play	D	80.0%	88.1%	77.8%	84.4%	81.2%	75.0%	89.3%	85.5%	84.9%	88.1%	71.7%	81.0%	72.3%		>=90 % / >=85 % / <85 %
IP Survey: % Patients involved in Learning	D	82.2%	76.2%	63.9%	62.5%	81.2%	93.8%	94.6%	80.0%	90.6%	89.8%	80.4%	87.9%	74.5%		>=90 % / >=85 % / <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	45.0%	55.5%	68.0%	81.0%	88.1%	89.5%	90.8%	92.9%	92.0%	93.1%	92.5%	86.8%	83.3%		>=92 % / >=90 % / <90 %
Waiting List Size	W	2,420	2,151	1,916	1,778	1,785	1,731	2,110	2,280	2,509	2,819	3,122	3,338	3,507		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	W	0	0	0	0	0	1	16	4	4	3	6	11	7		0 / N/A / >0
Waiting Times - 40 weeks and above		181	137	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%	100.0%	100.0%	95.7%	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	77.9%	91.4%	96.2%	97.7%	91.7%	94.6%	96.0%	97.7%	95.5%	95.1%	98.4%	95.6%	94.4%		>=99 % / N/A / <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%		100 % / N/A / <100 %
Pathology - % Turnaround times for urgent requests < 1 hr		92.7%	89.7%	90.0%	90.6%	90.4%	90.4%	90.4%	91.9%	91.1%	92.6%	91.1%	91.6%	91.9%		>=90 % / >=85 % / <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs		100.0%	100.0%	100.0%	99.8%	100.0%	99.9%	100.0%	100.0%	100.0%	99.5%	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		98.0%	100.0%	100.0%	97.0%	95.0%	99.0%	99.0%	100.0%	89.0%	96.0%	100.0%	99.0%	100.0%		>=90 % / >=85 % / <90 %
Imaging - % Reporting Turnaround Times - Inpatients		97.0%	98.0%	93.0%	98.0%	92.0%	99.0%	98.0%	99.0%	89.0%	96.0%	95.0%	92.0%	93.0%		>=90 % / >=85 % / <90 %
Imaging - % Reporting Turnaround Times - Outpatients		69.0%	71.0%	74.0%	72.0%	51.0%	75.0%	77.0%	58.0%	65.0%	57.0%	52.9%	54.0%	61.0%		>=85 % / N/A / <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks		59.1%	98.0%	98.8%	100.0%	94.2%	100.0%	95.0%	98.0%	98.7%	100.0%	91.9%	89.4%	83.1%		>=99 % / N/A / <99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks		77.8%	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.5%	91.7%		>=99 % / N/A / <99 %
Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks		95.0%	92.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	99.3%	100.0%		>=99 % / N/A / <99 %

Medicine

D Drive W Watch P Programme

WELL LED

		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-1,111	-1,201	-264	153	41	189	160	-586	263	200	-1,036	-347	-58		No Threshold
Income In Month Variance (£'000s)	W	-1,170	-622	-647	561	142	10	36	170	37	-26	-1	209	-490		No Threshold
Pay In Month Variance (£'000s)	W	62	-211	-143	338	30	-61	-52	-148	-64	60	-150	48	47		No Threshold
AvP: IP - Non-Elective	W	484	640	595	595	586	405	416	676	-153	-78	807	-82	-19		>=0 N/A <0
AvP: IP Elective vs Plan	W	99	119	121	147	136	123	138	154	-16	-10	157	-25	-58		>=0 N/A <0
AvP: OP New		842.00	1,000.00	1,330.00	1,392.00	1,030.00	1,119.00	1,080.00	1,222.00	-389.97	-409.28	1,282.00	-523.93	-600.20		>=0 N/A <0
AvP: OP FollowUp		3,853.00	5,043.00	4,859.00	4,921.00	4,440.00	4,948.00	4,588.00	5,408.00	959.17	564.80	5,578.00	294.46	290.03		>=0 N/A <0
AvP: Daycase Activity vs Plan	W	897	915	1,051	1,092	1,071	1,003	1,030	1,264	245	187	1,313	229	79		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W	5,439	6,930	7,170	7,386	6,440	6,911	6,766	7,786	123	-144	7,861	-815	-965		>=0 N/A <0
PDR	W	23.0%	21.8%	60.2%	69.1%	74.6%	74.2%	74.2%	74.2%	2.6%	6.8%	18.5%	50.2%	61.7%		No Threshold
Medical Appraisal	W	96.0%	96.0%	96.0%	96.0%	94.1%	94.1%	94.1%	94.1%	23.4%	28.6%	33.9%	42.0%	75.9%		No Threshold
Mandatory Training	W	91.3%	89.9%	90.2%	88.9%	86.7%	88.1%	87.1%	88.5%	89.1%	87.6%	87.9%	87.2%	86.9%		>=90 % >=80 % <80 %
Sickness	D	5.1%	5.0%	5.8%	4.7%	4.9%	6.3%	5.1%	4.1%	4.4%	5.4%	5.2%	6.3%	7.1%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.1%	1.4%	2.2%	1.5%	1.3%	2.0%	1.4%	1.1%	1.2%	1.5%	1.5%	2.0%	1.8%		<=1 % N/A >1 %
Long Term Sickness	D	4.1%	3.6%	3.6%	3.3%	3.7%	4.3%	3.7%	3.0%	3.2%	3.9%	3.7%	4.3%	5.4%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	217	266	235	239	213	247	267	261	210	262	230	265	263		No Threshold
Staff Turnover	D	7.4%	6.5%	6.5%	6.9%	7.2%	6.7%	6.6%	6.1%	6.6%	7.3%	7.8%	7.9%	8.4%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	94.9%	94.9%	93.2%	93.6%	93.2%	91.2%	97.8%	93.9%	101.7%	97.9%	96.0%	87.2%	90.6%		>=90 % >=80 % <90 %

Alder Hey Children's NHS Foundation Trust

Surgery

D Drive W Watch P Programme

SAFE

		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	23	21	27	46	31	24	25	46	26	32	43	27	25		No Threshold
Clinical Incidents resulting in No Harm	D	151	138	154	190	143	108	140	175	169	167	165	119	114		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	52	38	37	45	42	38	27	33	35	29	38	32	49		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	1	0	0	0	1	1	0	0	1	2	0	0	1		No Threshold
Clinical Incidents resulting in severe, permanent harm	D	1	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	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm	D	1	4	1	11	0	1	2	2	4	2	1	2	3		No Threshold
Medication Errors (Incidents)		36	37	38	68	44	23	40	45	44	36	30	24	27		No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0	1	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	0	0	1	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	85.7%	75.0%	86.7%	90.0%	53.8%	91.7%	83.3%	90.9%	76.9%	91.7%	88.9%	66.7%	100.0%		>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)		0	0	0	0	1	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	1	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA	D	4	1	0	1	0	2	0	0	0	1	0	2	0		No Threshold
Cleanliness Scores		96.0%	98.2%	98.0%	96.0%	97.9%	98.9%	97.0%	97.9%	98.9%	98.4%	98.2%	98.7%	98.2%		No Threshold

CARING

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

EFFECTIVE

		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG
Readmissions to PICU within 48 hrs	D	0	0	1	2	1	0	0	1	0	2	0	1	0		No Threshold
% Readmissions to PICU within 48 hrs	W	0.0%	0.0%	1.6%	4.2%	1.4%	0.0%	0.0%	1.6%	0.0%	2.6%	0.0%	1.4%			No Threshold
Referrals Received (Total)		2,611	3,206	3,039	2,978	2,809	2,684	2,891	4,022	3,928	4,066	4,319	3,680	3,168		No Threshold
Theatre Utilisation - % of Session Utilised	W	89.1%	88.9%	89.2%	88.6%	85.0%	87.6%	90.3%	89.5%	84.1%	88.8%	85.2%	85.1%	86.8%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons	D	15	15	18	15	8	5	7	11	11	7	12	13	9		No Threshold
28 Day Breaches	W	0	5	0	1	3	2	1	2	4	3	0	3	8		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice		70	52	58	38	45	38	50	37	47	46	59	63	74		No Threshold
OP Appointments Cancelled by Hospital %		12.0%	11.4%	11.1%	11.9%	10.6%	10.6%	10.8%	11.8%	10.0%	10.1%	11.3%	9.8%	11.8%		<=5 % <=10 % >10 %
Was Not Brought Rate	W P	10.0%	9.9%	9.0%	8.7%	10.1%	10.4%	8.0%	7.2%	6.7%	8.0%	7.6%	9.6%	10.6%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts)	W	10.8%	11.8%	9.5%	9.5%	11.7%	11.6%	10.5%	8.5%	7.3%	9.7%	8.6%	11.8%	12.1%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	W	9.7%	9.2%	8.8%	8.5%	9.5%	10.0%	7.0%	6.8%	6.4%	7.3%	7.2%	8.7%	10.0%		<=14 % <=16 % >16 %
Coding average comorbidities		4.50	4.46	4.39	4.40	4.48	4.40	4.43	4.54	4.63	4.40	4.49	4.61	4.49		No Threshold
CCAD Cases		32	31	31	27	28	25	29	34	34	31	39	28	19		No Threshold

Alder Hey Children's NHS Foundation Trust

Surgery

D Drive W Watch P Programme

RESPONSIVE

Measure		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG		
IP Survey: % Received information enabling choices about their care	W	96.0%	96.2%	96.2%	95.3%	99.2%	99.0%	92.0%	95.8%	95.9%	97.9%	94.7%	97.1%	95.0%		>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W	98.0%	94.7%	98.8%	98.1%	99.2%	100.0%	97.0%	94.4%	98.6%	98.6%	96.8%	97.1%	97.8%		>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P	93.1%	97.7%	100.0%	97.2%	98.4%	99.0%	98.0%	95.1%	99.3%	92.5%	96.8%	97.1%	93.5%		>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W	99.0%	98.5%	100.0%	99.1%	95.9%	100.0%	96.0%	96.5%	100.0%	97.9%	98.9%	98.6%	99.3%		>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D	82.2%	80.5%	85.7%	85.0%	72.1%	81.9%	84.0%	75.0%	79.7%	76.7%	83.0%	83.5%	79.1%		>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D	76.2%	75.2%	98.8%	74.8%	82.0%	95.2%	92.0%	95.8%	91.2%	92.5%	93.6%	93.5%	92.1%		>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	43.2%	46.8%	50.9%	53.4%	54.3%	54.5%	56.2%	61.8%	61.6%	64.2%	67.9%	68.5%	67.4%		>=92 %	>=90 %	<90 %
Waiting List Size	W	7,840	7,737	8,127	8,221	7,858	8,132	8,432	8,701	7,773	7,980	7,484	7,787	8,632		No Threshold		
Waiting Greater than 52 weeks - Incomplete Pathways	W	121	135	143	147	183	221	291	357	276	232	197	174	186		0	N/A	>0
Diagnostics: % Completed Within 6 Weeks	W	100.0%	100.0%	100.0%	87.5%	100.0%	50.0%	90.0%	94.1%	91.3%	100.0%	100.0%	93.8%	100.0%		>=99 %	N/A	<99 %

WELL LED

Measure		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG		
Control Total In Month Variance (£'000s)	W	-1,540	-1,990	-487	54	-502	-245	11	-857	-734	199	90	636	-5		No Threshold		
Income In Month Variance (£'000s)	W	-1,428	-1,460	15	1	34	0	83	152	47	49	209	223	28		No Threshold		
Pay In Month Variance (£'000s)	W	35	-457	-68	-67	-398	-364	-169	-549	-608	21	-124	565	-64		No Threshold		
AvP: IP - Non-Elective	W	333	331	366	355	343	341	308	390	56	-22	482	-104	-121		>=0	N/A	<0
AvP: IP Elective vs Plan	W	258	247	279	262	254	217	215	300	-75	-51	290	2	-55		>=0	N/A	<0
AvP: OP New		1,714.00	1,951.00	1,807.00	2,085.00	1,911.00	1,952.00	2,059.00	2,591.00	355.54	-92.15	2,817.00	693.90	-112.72		>=0	N/A	<0
AvP: OP FollowUp		5,113.00	6,633.00	6,803.00	6,817.00	5,813.00	6,158.00	6,386.00	7,840.00	-2,492.10	461.79	7,912.00	1,530.00	-1,520.90		>=0	N/A	<0
AvP: Daycase Activity vs Plan	W	555	595	609	680	642	502	568	808	-62	-193	789	35	-208		>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	7,794	9,657	9,808	10,137	8,974	9,305	9,714	12,005	-2,089	389	12,270	2,528	-1,822		>=0	N/A	<0
PDR	W	24.7%	35.5%	57.8%	67.5%	67.6%	66.1%	66.1%	66.1%	0.1%	9.0%	20.3%	47.2%	52.8%		No Threshold		
Medical Appraisal	W	94.1%	94.1%	94.1%	94.1%	96.8%	96.8%	96.8%	96.8%	24.0%	34.8%	37.8%	44.2%	66.7%		No Threshold		
Mandatory Training	W	89.3%	88.0%	87.1%	84.8%	85.6%	86.7%	86.9%	87.8%	89.0%	87.1%	87.8%	88.2%	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	332	286	446	505	415	434	382	560	518	459	334	447	469		No Threshold		
Safer Staffing (Shift Fill Rate)	W	89.1%	93.6%	94.4%	95.3%	93.5%	89.6%	92.7%	93.7%	95.8%	99.2%	98.4%	90.0%	92.5%		>=90 %	>=80 %	<90 %

Community & Mental Health Division

SAFE	**Lessons learnt from incidents include:** • Out of hours retained estates on call escalation process shared with relevant on call and ACT colleagues to ensure safety of staff working in Catkin building overnight • Improvement made to SALT booking processes to ensure when booking an interpreter that the dialect spoken by the family is also requested	**Highlight** • Zero clinical incidents resulting in moderate harm, severe harm or death. • Zero grade 3 or 4 pressure ulcers • 110 incidents recorded in August, 77 clinical and 33 non-clinical • Reduction in incidents reported after 24 hours (19 in August) **Challenges** • Gaps in domestic provision from OCS at Tier 4 Children's Inpatient Unit – escalation to contracting • Lack of dedicated Infection Control support to Division
CARING	Two successful partnership bids for ASD approved: • Delivery of autism training in schools • Provision of post diagnostic support for children and young people receiving an ASD diagnosis	**Highlight** • Reduction in PALS for third consecutive month • 11 Excellence Reports recorded in August • 21 Compliments receiving in August • Continued 95% FFT scores for Community & Mental Health Services **Challenges** • 3 formal complaints received in August. These relate to ASD/ADHD waiting times for ASD and communication with the service.
EFFECTIVE	CYP as One referral platform nominated for HSJ award "Mental Health Innovation of the Year"	**Highlight** • Referral logging turnaround reduced to within Trust target of 2 working days **Challenges** • Increased in OPD appts cancelled by the hospital (13.2% in August) due to absence. • Increase in referrals to mental health services in August 2021 by 60% compared to August 2019
RESPONSIVE	Successful award from NHS England for a three year programme supporting delivery of an integrated care framework for most vulnerable young people accessing mental health services within the youth justice services	**Highlight** • 100% of all urgent Eating Disorder patients seen within 7 days of referral **Challenges** • Continued challenges in meeting the Eating Disorder waiting time targets for routine patients (21.4% in August). Recruitment is ongoing to fill positions funded by new investment.

		• Reduction in RTT compliance for community paediatrics in month to 61.2% RTT
WELL LED	In August 2021 the Division are £250k better than budget in month and £751k better than Budget year to date. The division have also met their recurrent CIP target of £364k	**Highlight** • Staff turnover remains within Trust target at 9.9% • Mandatory training is above Trust target at 92% • Successfully recruited to Consultant Community Paediatrician post • COVID related absence for the Division is at 0.14% **Challenges** • Recruitment team shortages continues to result in significant recruitment delays and risk to new investment. • Increase in divisional sickness to 6.2%. Ongoing support provided to line managers from HR advisor and business partner

Community

D Drive W Watch P Programme

SAFE

		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	5	8	16	10	16	5	5	9	7	12	7	12	5		No Threshold
Clinical Incidents resulting in No Harm	D	73	88	84	76	53	63	75	84	74	54	51	94	64		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	5	9	11	12	9	11	21	35	28	19	11	20	10		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	0	0	1	0	0		0 N/A >0
Medication Errors (Incidents)		10	20	33	26	16	19	17	23	17	9	9	10	8		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%	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

		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG
Complaints	W	2	2	1	4	2	5	4	3	1	0	8	0	3		No Threshold
PALS	W	22	26	32	17	15	14	39	41	40	50	55	40	34		No Threshold

EFFECTIVE

		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG
Referrals Received (Total)		637	857	978	1,048	847	775	879	1,105	911	1,311	1,320	1,047	697		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice		25	25	18	2	5	7	10	7	11	5	9	21	22		No Threshold
OP Appointments Cancelled by Hospital %		10.3%	10.0%	10.0%	11.5%	8.2%	12.7%	9.8%	12.4%	11.6%	8.8%	9.9%	11.9%	13.2%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts)	W	11.2%	8.1%	11.6%	8.2%	7.5%	9.3%	10.5%	13.8%	13.0%	19.7%	20.0%	25.4%	22.2%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	W	14.1%	14.4%	13.3%	11.0%	12.9%	12.4%	11.4%	13.4%	14.5%	14.3%	16.0%	18.0%	21.2%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics		13.2%	12.4%	16.6%	10.6%	9.4%	10.9%	15.1%	17.2%	16.7%	17.7%	13.5%	18.6%	15.5%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics		16.2%	19.1%	16.1%	12.3%	16.2%	17.6%	14.7%	17.7%	17.4%	17.0%	18.6%	22.4%	24.6%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS		23.6%	9.7%	12.8%	13.3%	13.6%	20.3%	11.5%	15.1%	6.9%	15.8%	11.7%	22.8%	19.7%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS		14.1%	13.2%	13.3%	11.6%	13.2%	12.0%	10.9%	12.9%	14.0%	13.3%	12.2%	15.6%	17.3%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday		75.6%	91.4%	107.8%	91.0%	109.7%	110.1%	106.6%	114.3%	113.3%	114.3%	112.9%	100.0%	99.5%		No Threshold
CAMHS: Tier 4 DJU Bed Days		164	192	235	191	239	238	210	248	239	248	237	217	216		No Threshold
Coding average comorbidities		6.00		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

	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU	1	1		2	2		1		1						No Threshold
CAMHS: Referrals Received	257	357	348	417	340	268	351	470	396	536	638	373	297		No Threshold
CAMHS: Referrals Accepted By The Service	146	269	193	232	198	158	182	252	198	254	316	172	141		No Threshold

Alder Hey Children's NHS
NHS Foundation Trust

Community

D Drive W Watch P Programme

		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG
CAMHS: % Referrals Accepted By The Service		56.8%	75.4%	55.5%	55.6%	58.2%	59.0%	51.9%	53.6%	50.0%	47.4%	49.5%	46.1%	47.5%		No Threshold
RTT: Open Pathway: % Waiting within 18 Weeks	W	38.1%	40.2%	49.2%	64.3%	64.4%	66.2%	64.5%	66.0%	63.3%	74.0%	69.6%	57.1%	61.2%		>=92 % >=90 % <90 %
Waiting List Size	W	1,109	1,051	795	756	800	785	911	911	828	765	808	971	1,147		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	W	6	10	2	1	1	0	0	0	3	0	1	2	2		0 N/A >0
CAMHS: Crisis / Duty Call Activity		494	517	598	720	698	650	804	807	744	756	717	573	367		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks	W	53.2%	59.1%	68.8%	70.0%	69.9%	65.9%	67.9%	67.3%	65.6%	68.0%	70.1%	69.3%	68.3%		>=92 % >=90 % <88 %
ASD: Completed Pathways		146	132	129	110	55	74	74	100	97	122	109	59	188		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)		76.0%	79.5%	94.6%	89.1%	83.6%	62.2%	81.1%	69.0%	24.7%	20.5%	15.6%	5.1%	2.7%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%)	P			100.0%	100.0%	100.0%	91.7%	100.0%	46.2%	16.7%	23.5%	28.6%	6.7%	21.4%		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%	100.0%	25.0%	100.0%	50.0%	100.0%		>=95 % >=92 % <92 %
CCNS: Number of Referrals	W	122	144	146	151	127	119	139	169	120	135	150	582	144		No Threshold
CCNS: Number of Contacts	D	803	1,035	1,038	877	844	783	826	896	791	821	835	959	809		No Threshold

WELL LED

		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	0	-70	369	270	45	321	221	-41	14	212	-11	287	250		No Threshold
Income In Month Variance (£'000s)	W	-44	96	397	155	75	148	996	150	94	88	50	154	75		No Threshold
Pay In Month Variance (£'000s)	W	-98	-31	-81	30	12	65	-81	137	5	-49	-87	260	167		No Threshold
AvP: OP New		457.00	690.00	753.00	777.00	585.00	639.00	519.00	615.00	108.50	294.95	568.00	-181.00	-86.30		>=0 N/A <0
AvP: OP FollowUp		2,806.00	3,293.00	3,543.00	3,782.00	3,359.00	3,778.00	3,735.00	4,052.00	1,374.90	1,317.84	3,968.00	835.00	453.30		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W	3,265	3,983	4,296	4,559	3,944	4,419	4,254	4,667	1,484	1,613	4,536	654	368		>=0 N/A <0
PDR	W	23.1%	41.3%	73.4%	81.9%	81.9%	83.1%	83.1%	83.1%	0.0%	1.5%	21.5%	71.5%	78.8%		No Threshold
Medical Appraisal	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	6.2%	24.0%	24.0%	36.0%	68.0%		No Threshold
Mandatory Training	W	92.0%	91.4%	91.7%	89.2%	88.4%	89.2%	88.6%	89.3%	91.8%	91.0%	92.3%	92.1%	91.9%		>=90 % >=80 % <80 %
Sickness	D	2.7%	3.8%	4.0%	4.3%	4.5%	5.7%	4.7%	3.9%	3.1%	3.9%	4.9%	5.5%	6.3%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	0.9%	1.3%	1.6%	1.2%	0.9%	1.9%	1.0%	1.0%	0.9%	1.2%	1.5%	1.4%	1.4%		<=1 % N/A >1 %
Long Term Sickness	D	1.9%	2.5%	2.5%	3.2%	3.6%	3.8%	3.7%	2.9%	2.2%	2.7%	3.5%	4.2%	4.9%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	194	169	173	212	355	226	169	141	183	192	229	171	127		No Threshold
Staff Turnover	D	10.6%	10.4%	9.7%	9.0%	8.7%	9.3%	9.5%	9.8%	10.7%	9.6%	9.8%	10.0%	9.9%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	99.8%	99.8%	100.1%	98.5%	98.6%	99.9%	99.4%	100.2%	97.2%	99.1%		99.2%	98.9%		>=90 % >=80 % <90 %

Research Division

SAFE	• Divisional Mandatory training demonstrates good compliance • All current risks compliant with review dates • CRF achieved 100% for perfect ward audit • All patients continue to be screened for potential COVID 19 prior to hospital visit using telephone triage • All Areas have been certified Covid Secure (all actions completed)	**Highlight** • PDR Target of >90% met • Mandatory Training > 94% • GCP training 97% • SOP compliance 98% • ANTT compliance 100%-CRF Ward • CRD ICP compliant • CRD involved in Trust Quality Rounds **Challenges** • Limited storage space on CRF causing H&S risk • Research blood samples for multiple trials • x1 incidents reported re IPC breach • CRD report for SQUAC needs review
CARING	• 0 complaints received • Patient centred follow up care for patients on clinical trials • Patient feedback used to improve quality of patient care and experience • Plans underway to capture experience patient experience data • Patient compliments received for CRF	**Highlight** • X 0 Complaints or PALS concerns • New Children's PRES developed for 21/22 ongoing • Research invited to Trust PEG **Challenges** • More work to do on local patient internal audits • 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. • Current portfolio regularly reviewed with monthly performance meetings • No housekeeping allocated to CRF ward. Nursing staff arranging and collection meals for patients. • Clinicians encourage children and young people to make informed decisions about participating in studies. • CRD performance reports and meetings restarted to review portfolio • Essential skills training approved for Division	**Highlight** • Important Covid 19 studies remain open within Trust • Site selected for LAVA 2 study and recruited 10% of RTT despite IT challenges (Crit Care) • Portfolio growth in line with plan **Challenges** • CRF housekeeping • PHE has significantly reduced LAVA 2 study RT • Trust space for extension of Siren study • 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 • 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. • H&S Covid RA's completed for all areas of research • Coordinated and partnership working with local providers to offer joint training programmes.	**Highlight** • Agile working implemented to reduce footfall • Collaborative working with external partners • TNA requests for CPD training approved for all applicants **Challenges** • Storage for site files and equipment is insufficient for research department • Research team supporting Trust seasonal vaccine programme

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

BOARD OF DIRECTORS

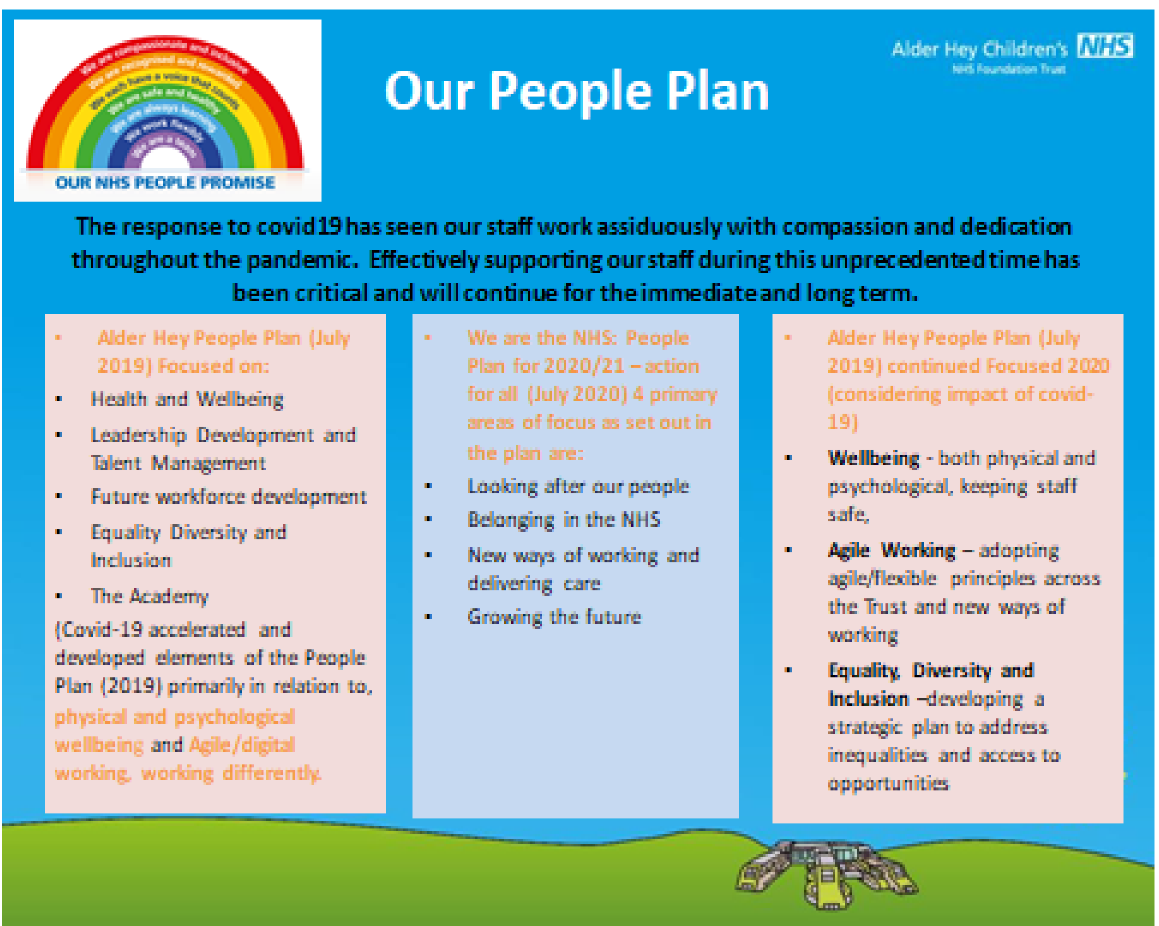
Thursday, 30th September 2021

Paper Title:	**People and Wellbeing update**
Report of:	**HR and OD Department**
Paper Prepared by:	Deputy Director of HR & OD

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ☐
Background Papers and/or supporting information:	None
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	
Associated risk (s)	1739; 2100; 2157; 2160; 2161; 2181, 2415

1. Purpose

The purpose of this paper is to provide the Board with a strategic update on the Alder Hey People Plan and our response to the requirements of the national NHS People Promise.



1. Wellbeing

1.1 Staff Advice and Liaison Service

Staff Advice and Liaison Service Updates

The Staff Advice and Liaison service has continued to remain busy and we have had over 1,950 contacts to the service. The team have seen an increase in new referrals and drop ins to the service particularly during August and September (from the beginning of August to the 16th September the service has had 197 contacts) Whilst really busy the team are still able to respond quickly (within 24-48 hours) to any new referral which comes via e mail, phone call or drop in. For information purposes the main themes that staff are experiencing are:

- Burnout
- Staff in Crisis (Presenting with suicidal ideation)
- Development or management of OCD
- Trauma
- Workplace Issues
- Relationship issues within workplace
- Bereavement

- Supporting staff on Long Term sick and facilitating a return to work and often undertaking Stress Risk Assessments. The requests for stress risk assessments via SALS has increased significantly in the last three months.
- Supporting staff through formal employment processes
- Domestic Abuse
- Physical illness support (cancer)
- Issues with housing/homelessness
- Generalised stress and anxiety
- Relationship issues outside of work.

Staff presenting in crisis has been particularly prevalent in the last two months. The team work with outside agencies to be able to get the right support for staff in crisis, whilst still offering support to those staff on an ongoing basis.

As reported in our last paper the team has also continue to help and to offer support in ED in line with the additional pressures on the ED team. This has included SALS drop ins in ED, virtual support sessions for consultants and senior leads, facilitating Wingman on Wheels and a massage van for staff. The team are also supporting the development of a Pastoral Care Volunteer team who will be offering additional support to staff via additional drop ins to facilitate the use of the Ground TRUTH tool (as per the model developed during the third wave in ICU. The SALS team are currently exploring whether SALS Pals can be implemented within ED to support staff locally. Trends and themes of staff attending SALS specifically from AED is shared with the Senior Leadership Team in AED which helps think about what other solutions can be identified to support our staff.

The SALS team have been shortlisted for an HPMA Brown Jacobson staff engagement award with the awards ceremony taking place on the 7th October 2021.

1.2 Health Wellbeing Steering Group

The Health and Wellbeing Steering group continues to be well attended and focussed on the following.

- Financial wellbeing
- Staff Survey and the Big Conversations
- Health and Wellbeing conversations
- Menopause support – next steps
- Wellbeing Guardian role and the Nine Principals of the Wellbeing Guardian.
- Health & Wellbeing Champions/SALS Pals
- Schwartz Rounds and Team Time
- Outside Space for Staff
- Health and Wellbeing Induction & Reviewing Induction in line with ‘First 100 days’
- Carers Passport
- Physical Health

Focus was on the implementation of Health and Wellbeing Conversations as part of the PDR process earlier on this year and informal feedback tells us that staff found this a rewarding process.Taking this principle forward the Health and Wellbeing Group will also look to support all new starters being offered a Health and Wellbeing Induction as part of the NHS People Plan, and how we can further improve Trust Induction for all our new starters.

1.3 Staff Survey 2021

The annual NHS Staff Survey 2021 goes live 21st September 2021. For the first time, in 2021 the questions will be aligned with the NHS People Promise to track progress against its ambition to make the NHS the workplace we all want it to be by 2024.

1.4 Equality, Diversity & Inclusion

The Trust Black, Asian and Minority Inclusion Taskforce led by Claire Dove OBE, continues to meet monthly to focus on improving and championing positive people practises within the organisation.

Amongst other activities, three key workstreams have been identified to date focusing on recruitment, apprenticeships and zero tolerance with task and finish groups established with representatives from across the Trust working collaboratively. A full and comprehensive action plan is in place

and progress monitored against plan is reported monthly to the Taskforce.

2. Flexible Working

Earlier this year, the NHS Staff Council reached agreement on amendments to the flexible working provisions in the NHS Terms and Conditions of Service (NHS TCS) handbook. These took effect from 13 September 2021. The key changes are as follows;

- All NHS employees covered by this section and who are employed by an NHS organisation, have the contractual right to request flexible working from day one of employment.
- Employees can make more than one flexible working request per year and can do so regardless of the reasons for them. This does not preclude other statutory or handbook entitlements where flexible working may be relevant.
- Revised process to request flexible working and new structure to support managers to be more explorative in reaching mutually workable outcomes
- A re-emphasis on the importance of monitoring flexible working requests at an organisational level, to ensure greater consistency of access to flexible working.

The HR department is working with key stakeholders across the Trust to implement and communicate these changes.

3. Staff Availability

Table 3.1- Sickness position as of 17th September 2021

	Trust		Community		Corporate		Medicine		Research		Surgery	
Reason	%	No of Staff	%	No of Staff	%	No of Staff	%	No of Staff	%	No of Staff	%	No of Staff
Non Covid Related Sickness	6.42%	256	5.55%	39	6.65%	48	5.77%	69	7.81%	5	7.30%	95
Covid Related Sickness	0.48%	19	0.14%	1	0.42%	3	0.75%	9	0.00%	0	0.46%	6
Absence Related to Covid - not inc sickness	0.23%	9	0.14%	1	0.00%	0	0.42%	5	0.00%	0	0.23%	3
Absence Related to Covid Inc Sickness	0.70%	28	0.28%	2	0.42%	3	1.17%	14	0.00%	0	0.69%	9
All Absence (total of above)	7.13%	284	5.83%	41	7.06%	51	6.95%	83	7.81%	5	7.99%	104

Compared to this time last month, overall sickness has seen an increase and total sickness absence as of 17th September 2021, at just over 7%. The numbers of staff absent with COVID related absence only accounting for 0.24% increase. The contributing factor to increases in absence rates have been observed as non-Covid related and long-term absences, as opposed to short term absence. The number one reason for absence remains mental health related across the whole Trust. All mental health related absences are referred to Occupational Health

and the SALS team, as part of our suite of support to staff. Staff continue to be reminded to be vigilant and we will continue to follow all safety measures across the organisation. Absence will be monitored closely for any emerging trends/hotspots.

A trend has become apparent which indicates increased level of recording compliance in areas that have introduced Erostering across areas, this is having an impact of elevated sickness figures (when compared to last year's statistics).

4. Governance and Ongoing Business

4.1 Case Management

In line with the national Social Partnership Forum (SPF) all cases continue to be managed on a case-by-case basis in partnership with staff side colleagues from all of our recognised Unions with appropriate measures and risk assessments put in place to ensure staff health and wellbeing continue to be prioritised.

There has been a decrease in the number of Employee Relations case since the July reporting period, namely a reduction/closure of 2 grievances, 1 Bullying and Harassment case and 1 appeal. There has however been an increase in numbers of staff at the 3rd stage of the Trust Sickness absence process with 10 staff at this stage.

Table 4.11- Employee Relations Activity Per Division as of 17th September 2021

Division	MHPS	Disciplinary	Grievance	B&H	Appeal	ET	Stage 3	Total
Surgery H/C 1326	2	2	3	0	1	0	2	**10**
Medicine H/C 1223	0	1	1	0	0	0	3	**5**
Community H/C 687	1	1	0	0	0	0	1	**3**
Corporate & Research H/C 695/65	0	1	0	0	0	0	4	**5**
Grand Total	**3**	**5**	**4**	**0**	**1**	**0**	**10**	**23**

4.2 Completion of the DBS renewal programme

In 2019 the Trust agreed a DBS renewal process subsequent to the Lampard review and NHSI/E recommendations. The DBS renewals programme commenced in June 2019 and was an agreed two year programme with anticipated completion scheduled for June 2021. During 2020, the renewal programme experienced delays due to significant pressures relating to Covid-19.

The programme placed groups of staff in priority categories for processing as follows;

- **Priority Group 1** – Those staff who have never completed a DBS or CRB, due to being in post prior to the introduction of DBS or CRB and have not moved roles or departments since commencement (1055 staff were identified in this category).

- **Priority Group 2** - staff with an enhanced (with barred) DBS check dated prior to August 2015. (1695 staff in this priority group)

- **Priority Group 3** – Staff with a current valid DBS (with barred) in place which would expire during the roll out period (1013 staff were identified in this category). Focus on this group started in May 2021.

All those in priority groups one and two have fully engaged in the renewal process with the exception of those staff on long term sickness, or maternity leave, who will be contacted on their return to work. The programme for those without a valid DBS has now been completed. The process of 3 yearly DBS renewals is now part of business as usual reporting and this practise will continue throughout the organisation. Monthly reports will be generated for those who will be required to renew their DBS every three years.

The DBS renewal position was identified as a Trust risk on 19/02/2019 monitored, managed and mitigated through the Trust's risk management process (risk ref: 2090, score 9). This risk has now been addressed, de-escalated and the risk closed down

There is assurance that processes are in place for both new DBS processes and for renewals and the position against the renewal programme is updated through the Trust Risk management processes. New recruits into the organisation or those internal applicants recruited into new posts are all subject to satisfactory pre-employment checks and appointments are only made based on completion of satisfactory checks, which is inclusive of DBS.

4.3 Training

As of the 9th of September 2021, Mandatory Training was at 87% overall, 3% below the Trust target of 90% and down 1% from the previous month. We continue to work with staff, managers and SMEs to encourage improvements in compliance.

Our key areas of lowest compliance continue be any face to face topic that requires an annual refresher, namely Basic Life Support, PLS/APLS annual updates and Practical Moving & Handling Training. The other area of low compliance is within our facilities department and specifically our Estates and Ancillary staff.

In particular this month we have also seen a large drop in compliance within IM&T (-12%) this is largely caused by a large TUPE recently with the majority of these staff still awaiting their mandatory training coming across from LHCH.

In terms of Resuscitation training the Resus team are looking to develop an online Basic Life Support course that can be rolled out to staff in order to improve BLS compliance and free up resources to deliver more PLS / APLS courses.

In terms of Moving & Handling, the Health & Safety team are in the process of appointing two staff on secondment to improve compliance across the Trust.

We continue to utilise remote/e-learning for training delivery where possible for mandatory training to encourage social distancing and ensure the safety of staff whilst regularly reviewing current Trust guidance around face to face delivery so we can begin to offer some socially distanced face to face training in the future as required.

Table 4.31- Mandatory Training compliance - 8th September 2021

Trust	Overall Mandatory Training	Change (Since Last Report)
Trust	87.37%	-0.65%
Division	**Overall Mandatory Training**	**Change (Since Last Report)**
411 Alder Hey in the Park	85.20%	-1.29%
411 Community	91.03%	-1.34%
411 Corporate Other Department	85.05%	-2.28%
411 Executive	90.00%	-
411 Facilities	65.54%	-2.42%
411 Finance	89.59%	0.01%
411 Human Resources	88.25%	-0.88%
411 IM&T	81.69%	-12.01%
411 Innovation	97.22%	0.48%
411 Medicine	87.02%	-0.72%
411 Nursing & Quality	92.31%	1.12%
411 Research & Development	93.99%	-0.15%
411 Surgery	88.64%	0.95%

Table 4.32 – PDR Compliance as of 14th September 2021

As of the 14th of September, our Trust appraisal rate was 70.48%, just under 20% lower than our target of 90%. We will continue to actively encourage staff and managers to complete an appraisal until the end of September to ensure as many staff as possible are offered an appraisal this year.

Org L2	Assignment Count	Reviews Completed	Reviews Completed %
411 Innovation L2	9	9	100.00%
411 IM&T L2	113	104	91.30%
411 Research & Development L2	62	56	90.16%

411 Finance L2	76	65	**86.11%**
411 Nursing & Quality L2	84	62	**82.93%**
411 Community L2	615	462	**77.21%**
411 Human Resources L2	71	55	**75.36%**
411 Facilities L2	197	144	**74.62%**
411 Medicine L2	991	626	**69.88%**
411 Alder Hey in the Park L2	22	14	**63.64%**
411 Surgical Care L2	1,029	622	**61.44%**
411 Corporate Other Department L2	53	22	**48.08%**
Grand Total	**3,279**	**2,311**	**70.48%**

BOARD OF DIRECTORS

Thursday, 30th September 2021

Paper Title:	**Freedom to Speak Up Review Tool for NHS Trusts and Foundation Trusts**
Report of:	**Director of Corporate Affairs**
Paper Prepared by:	Director of Corporate Affairs

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	National Guardian's Office Strategic Framework 2021
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	

Freedom to Speak Up review tool for NHS trusts and foundation trusts

September 2021

NHS England and NHS Improvement

How to use this tool

This is a tool for the boards of NHS trusts and foundation trusts to accompany the *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with page numbers in the tool) *and the Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with section numbers).

We expect the executive lead for Freedom to Speak Up (FTSU) to use the guidance and this tool to help the board reflect on its current position and the improvement needed to meet the expectations of NHS England and NHS Improvement and the National Guardian's Office.

We hope boards will use this tool thoughtfully and not just as a tick box exercise. We also hope that it is done collaboratively among the board and also with key staff groups – why not ask people you know have spoken up in your organisation to share their thoughts on your assessment? Or your support staff who move around the trust most but can often be overlooked?

Ideally, the board should repeat this self-reflection exercise at regular intervals and in the spirit of transparency the review and any accompanying action plan should be discussed in the public part of the board meeting. The executive lead should take updates to the board at least every six months.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But getting the FTSU Guardian's views would be a useful way of testing the board's perception of itself. The board may also want to share the review and its accompanying action plan with wider interested stakeholders like its FTSU focus group (if it has one) or its various staff network groups.

We would love to see examples of FTSU strategies, communication plans, executive engagement plans, leadership programme content, innovative publicity ideas, board papers to add them to our Improvement Hub so that others can learn from them. Please send anything you would specifically like to flag to nhsi.ftsulearning@nhs.net

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
Behave in a way that encourages workers to speak up					
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Section 1 p5	**In 6 months** Partial	**In 6 months** Partial	1. Appraisals and 360 feedback: Executive PDR documentation has included an assessment against Trust Values for the last five years. 2. The Trust Chair's appraisal is based on an MSF approach Staff survey includes questions inviting views on senior leaders. 2. Concerns raised: The board receives a thematic report on a quarterly basis from the FTSU Guardian 3. Senior visibility: Senior visibility is a priority across corporate communications. This has been continued virtually and innovatively throughout COVID, using methods such as Alder Hey all Staff Broadcast each Wednesday with live virtual Q&As, to maintain effective visibility of the Executive. 4. Corporate Induction: CEO or nominated Executive Director, presents at Corporate Induction, highlighting the importance of the	Complete the triangulation of data exercise agreed by NED and Exec leads with Guardian and incorporate into report. The pandemic halted the existing visibility programme; this is about to be reinstated, led directly by the Acting CEO. A range of interaction opportunities has been agreed

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				Trust's values, behaviours, and speaking up 5. Values and behaviours: Executives and Non-Executives support the use of the Behavioural Framework, to underpin the Trust's values and the use of them in staff PDR's. The Trust Chair periodically challenges all Board members to reflect on a particular Value at the end of a board meeting. 6. People Plan: the Trust's People Plan includes an objective that 'We will develop a working environment that encourages all staff to 'speak up' and 'listen up' and continue to support the work of our Freedom to Speak Up Guardian and Champions 7. NHS Staff Survey: The annual NHS Staff Survey results of questions related to FTSU, FTSU Index and the Trust's speaking up culture, are utilised to measure progress,	

<table>
<tr><th rowspan="2">Summary of the expectation</th><th rowspan="2">Reference for complete detail
Pages refer to the guidance and sections to supplementary information</th><th colspan="2">How fully do we meet this now?</th><th rowspan="2">Evidence to support a ‘full’ rating</th><th rowspan="2">Principal actions needed in relation to a ‘not’ or ‘partial’ rating</th></tr>
<tr><th>Insert review date</th><th>Insert review date</th></tr>
<tr><td colspan="6">Demonstrate commitment to FTSU</td></tr>
<tr><td>The board can evidence their commitment to creating an open and honest culture by demonstrating:
• there are a named executive and non-executive leads responsible for speaking up
• speaking up and other cultural issues are included in the board development programme
• they welcome workers to speak about their experiences in person at board meetings
• the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility
• there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made
• the trust continually invests in leadership development
• the trust regularly evaluates how effective its FTSU Guardian and champion model is
• the trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.</td><td>p6
Section 1
Section 2
Section 3</td><td>Full</td><td>Full</td><td>1. Executive and Non-Executive Leads: appointments have been made to both positions.

2. Regular 1:1 meetings: these take place between the Guardian, Executive and Non-Executive Director

3. Reports to Board: Quarterly reports are required to the Board to ensure clear sighting and accountability is upheld, as well as contributing to the Board’s own development. The suite of reports includes monitoring of IR cases, each of which has an Executive lead assigned in accordance with Baroness Harding’s guidance.

4.Staff Stories: Staff stories have been introduced to Board meetings, inviting a member of staff to share an experience of working for Alder Hey - both positive and negative stories are welcomed.

5. Leadership development: Leaders are supported and encouraged to continually develop. The Trust’s Strong Foundations programme has evaluated very positively among staff at</td><td></td></tr>
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Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				all levels and is the cornerstone of the Trust's leadership development strategy. **6.**Bullying and Harassment**:** The NHS Staff Survey results are used to monitor and measure progress. 7. FTSU is widely promoted across the Trust via various methods, with regular sessions on the Trust's Induction programmes. The Trust has an annual Speak Up Safely week each October.	
Have a strategy to improve your FTSU culture					
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies	P7 Section 4	Partial	Partial	The Trust's People Strategy currently incorporates the speaking up strand. It has previously been agreed that keeping messages simple and minimising the number of overlapping strategies is more accessible for staff.	Board to discuss the need for a separate FTSU strategy.

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.					
Support your FTSU Guardian					
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively • the Guardian has been given time and resource to complete training and development • there is support available to enable the Guardian to reflect on the emotional aspects of their role • there are regular meetings between the Guardian and key executives as well as the non executive lead. • individual executives have enabled the Guardian to escalate patient	p7 Section 1 Section 2 Section 5	Full	Full	1. The Executive team supported the increasing of the FTSU Guardian's dedicated hours. 2. The Guardian attends Regional and National training events and conferences. 3. The Board supported FTSU Leads to receive refresher training, and to train champions, with continuous plans to train more. 4. Regular Coaching and Psychological Support sessions are provided to the Guardian. 5. meetings take place between the Guardian, Exec Director and NED.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
safety matters and to ensure that speaking up cases are progressed in a timely manner • they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes • the Guardian is enabled to develop external relationships and attend National Guardian related events				6. Open access is provided to relevant Directors when dealing with individual concerns. 7. The Guardian has regular access to Regional and National training events. 8. The Guardian has open access to anonymised patient safety and employee relations data for triangulation purposes. 9. The Guardian has recently stood down as the Chair of the NW Regional Guardian Network. 10. The Guardian is able to raise issues directly with the relevant HR Business Partner, the Medical Director, Chief Nurse, the HR Director/FTSU Executive Lead and any other relevant Executives.	
Be assured your FTSU culture is healthy and effective					
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • that the policy is up to date and has been reviewed at least every two years	P8 Section 8 National policy	Full	Full	The Trust policy is modelled on the NGO policy and aligned with Alder Hey's Policy review cycle. 2. All policies are reviewed by Staff Side. The FTSUG is also an RCN union rep and therefore attends the Policy Review Group	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.					
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance • assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances • you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inpsection • you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.	P8 Section 6	Partial	Partial	The NED lead for FTSU has commissioned further work on triangulation of information, specifically a direct link with the work of the Wellbeing Guardian which is now underway. The Trust has commissioned the creation of modules in Ulysses to enable staff to input concerns in once place.	NED and Executive leads to meet with FTSU Guardian and Champions to map and assess assurances during Q3.

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	P8 Section 7	Full	Full	Comprehensive reports are presented at Board, with attendance from the Guardian on a quarterly basis, which can be evidenced by meeting minutes and papers.	
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	Section 1 NGO JD	Partial	Partial	Initial appointments predated guidance/JDs from National Guardians Office, however followed the Trust's fair recruitment process. Future appointments will follow the established process using the published FTSU guidance and example job description.	
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	Section 7	Full	Full	Review of data reports and themes are completed quarterly.	Case Reviews, published by NGO, to be included in 1:1s with Executives and NED. Lead: JC
Be open and transparent					
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion with relevant oversight organisation	P9	Full	Full	1. Regular reports are submitted to Board, and information shared with CQC and the CCG. 2. Discussions take place with relevant oversight organisation- the National Guardians Office and CQC upon their	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• discussion within relevant peer networks • content in the trust's annual report • content on the trust's website • discussion at the public board • welcoming engagement with the National Guardian and her staff				visits, with attendance at national meetings by Guardian. 3. Discussion within relevant peer networks take place as described above. 4. FTSU content is present within the Trust's annual report. 5. FTSU discussion takes place at the Public Board. 6. the FTSU Guardian is a member of the BAME taskforce which was established by the Board in 2020.	
Individual responsibilities					
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	Section 1	Partial	Partial	NED lead has a specific objective in relation to FTSU, other roles have this evaluated via Values assessment currently.	Ensure each of the key individuals has a specific focus on speaking up within their PDR.

BOARD OF DIRECTORS

Thursday, 30th September 2021

Paper Title:	Changes to Enhanced Monitoring Status
Report of:	Medical Education (Postgraduate)
Paper Prepared by:	Dr Katherine Birch, Director Alder Hey Academy

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

1. Introduction

Alder Hey NHS Foundation Trust's Paediatric Programme has been under enhanced monitoring by the GMC due to concerns that the required standards for education were not being met. This has resulted in a major programme of enhancement work over the past couple of years, led by both the Medical Director and Director of Medical Education. A range of actions have been implemented during this time and the good working relationship which we have with Health Education England (HEE) has provided further support and scrutiny to our improvement activities.

2. Update

In the last quarter of 2020, the GMC attended the Quality Review Panel with Health Education England North West (HEE NW). They received a comprehensive update on progress following their review from our Director of Medical Education in June 2021 and were 'pleased to learn of the positive work that had taken place to improve the training environment in paediatrics' (extract from their letter of 9th August 2021). Colleagues at HEE have also been appraising the GMC of our progress during this time.

In the summer, the results of the 2021 National Training Survey (NTS) were released. The NTS is an annual survey of more than 63,000 trainees and trainers across the UK and provides a vital and unique insight into the experiences of trainees across the country. The NTS results for 2021 supported the GMCs view that our organisation 'has satisfactorily and sustainably resolved the concerns in connection with the paediatrics programme' (op cit.).

Accordingly, the GMC have taken the decision that **we will no longer be part of their enhanced monitoring process**. The HEE Intensive Support Framework rating has been decreased to level 1 ("there are one of more areas where the provider does not meet HEE standards. However, there are active plans in place to meet these standards, which are consistently delivered against"). HEE NW will continue to monitor any concerns through their local monitoring processes.

This is a significant achievement and the efforts taken to reach this point were recognised by the GMC in their formal notification to us of this decision (GMC Letter to the Chief Executive 9th August 2021, GMC Reference QA4760).

3. Conclusion

This is a very positive outcome, reflecting the efforts of a large team across the organisation and driven by our commitment to delivering high quality education.

Our work to further enhance the learning experience for all students and trainees is ongoing and is monitored by both Education Governance Committee and PAWC.

BOARD OF DIRECTORS

Thursday, 30th September 2021

Paper Title:	**Future Directions for Research and Innovation**
Report of:	**Director of Research and Innovation**
Paper Prepared by:	John Chester, Director of R&I

Purpose of Paper:	Decision Assurance ☑ Information ☑ Regulation
Background Papers and/or supporting information:	Please see attached Powerpoint presentation
Action/Decision Required:	To note ☑ To approve
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** **The best people** doing their best work Sustainability through **external partnerships** Game-changing **research and innovation** ☑ **Strong Foundations**
Resource Impact:	No impact, at present

1. Introduction

Research and innovation are acknowledged strengths of Alder Hey, but there is untapped potential. R&I are important components of improvement in NHS organisations ("Today's research; tomorrow's care") and there is well-established evidence that patient outcomes are better in research-active NHS organisations. Furthermore, the Trust has designated R&I as a distinctive element in achieving its ambition to be recognised as a world-leading organisation in improving the health and well-being of children and young people (CYP). It is therefore essential that the Board is kept informed of developments in R&I. There is an intention to strengthen the awareness and involvement of the Executive team and Board in R&I, through regular updates in Board meetings, in order to ensure appropriate prioritization and oversight.

In this context, the Director of Research and Innovation presents to the Board some initial thoughts on the future direction for R&I, including plans for a joined-up strategy which better integrates each of the dimensions of R&I and which will be congruent with the Alder Hey Academy. In addition, the Managing Director of Innovation presents a briefing on the Innovation Centre's new branding strategy.

2. Background

The newly-appointed Director of Research and Innovation (John Chester) has been tasked with taking R&I 'to the next level'. An essential element in achieving the ambition of delivering game-changing research innovation will be a strategic review, culminating in a new, integrated strategy for both Research and Innovation which clearly conveys to internal and external stake-holders Alder Hey's key assets and priorities in R&I.

The Trust's Innovation Centre has been leading the way in multiple aspects of R&I activity. These include the realisation of a need to establish a distinct brand, which is appropriate for interactions with investors and business partners. A brand strategy has been developed, in collaboration with a specialist commercial partner. The proposed new brand is an important component of the Innovation Centre's 10-year strategy, which will itself be a key constituent of the integrated strategy for R&I.

3. Conclusion

A new, integrated strategy for R&I is essential if Alder Hey is to fulfil its potential and achieve its ambition of game-changing R&I. A review of R&I activity, bench-marking against current world leaders, and development of a new strategy document should be undertaken, as an immediate priority. These processes should involve consultations with a broad range of internal and external stake-holders, and particularly PPI&E representatives.

The success of the Innovation dimension of R&I depends on maximising benefits from a range of interactions with commercial partners. A distinctive and professional brand which speaks in a 'Business to Business' fashion to the Innovation Centre's target audience of potential investors and business partners is essential for appropriate visibility and for conveying an appropriate ambition as a global leader in health care innovation.

4. Recommendations

- A formal strategic review should be initiated, during the coming quarter.
- A new strategy should be developed, which closely integrates research and innovation.
- This should align closely with that of the Alder Hey Academy and of key NHS and academic partners
- It should be informed by close involvement of PPI&E representatives.
- It should have an emphasis on sustainability, including a business-like approach, in relevant areas of both research and innovation.
- An outline of the new strategy, including recently developed aspects of Innovation strategy, should come back to Board in early 2022 for input and refinement.
- That the Board should note and approve the proposed new branding strategy for Innovation.

BOARD OF DIRECTORS

Thursday 30th September 2021

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

Purpose of Paper:	Decision Assurance Information Regulation	☐ ■ ☐ ☐
Background Papers and/or supporting information:	Monthly BAF Reports	
Action/Decision Required:	To note To approve	■ ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** **The best people** doing their best work Sustainability through **external partnerships** Game-changing **research and innovation** **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 Care Delivery Board (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 the adverse impact of COVID-19, a surge in urgent care and an RSV epidemic	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	Risk of 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	New 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 15th September 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.

1.2: Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVI (S)

1.6: CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental heath crisi (S)

2.1: Workforce Sustainability and Development (W) 3.4: Financial Environment (S)

3.2: Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of (S)

3.5: New NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory (S)

2.3: Workforce Equality, Diversity & Inclusion (S) 1.1: Inability to deliver safe and high quality services (S)

4.1: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact (S)

3.1: Failure to fully realise the Trust's Vision for the Park (S)

3.6: Risk of partnership failures due to robustness of partnership governance (S) 2.2: Employee Wellbeing (S)

4.2: Digital Strategic Development & Delivery (S)

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 15th September 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 the adverse impact of COVID-19, a surge in urgent care and an RSV epidemic.**	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	**INCREASED**
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	**Risk of 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	**New NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.**	RABD		4 x3	3 x3	STATIC	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.**	Innov.		3x3	3x2	STATIC	STATIC
4.2 KW	**Digital Strategic Development and Delivery.**	RABD		4x1	4x1	STATIC	STATIC

5. Summary of August 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; actions updated.

- ***New 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. Continued commitment to key ICS development working groups. Ongoing engagement with Trust Board & Council of Governors.

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk reviewed; no change to score in month. Partnership framework under development during Q3

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

Internal risks:

- ***Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19 on waiting times for elective care (AB).***
  In August we consciously reduced additional outpatient and theatre sessions to support staff to take annual leave and to rest. The number of 52 week patients is currently stable. However, in September this could rise as we conclude our safe waiting list management work. In half 2 we expect to work through this and end the year with less than 100 patients waiting over 52 weeks for treatment. There are three significant threats to the progress in recovering services. As we look forward we can see some likely 1. vacancy levels and staff availability in key teams such as ODAs and radiography 2. increase in infection (such as norovirus) affecting access to ward capacity 3. Staff absence and fatigue affecting levels of outpatient and elective work Our mitigation strategy includes 1. maximising in-week theatre sessions with a new theatre policy to support this 2. recruitment activities in anaesthesia and radiography 3. innovation through the accelerator programme, include artificial intelligence to reduce the rate of WNB 4. focus on outpatient adoption of virtual consultations and delivery of pre-Covid clinic templates.

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

- ***Inability to deliver safe and high quality services (NA).***
  This risk has been reviewed and completed actions updated. The remaining gaps in assurance and control continue.

- ***Financial Environment (JG).***
  Risk reviewed and actions updated.

- ***Failure to fully realise the Trust's Vision for the Park (DP).***
  BAF reviewed prior to September's Trust Board.

- ***Digital Strategic Development and Delivery (KW).***
  Risk reviewed, good progress against actions. New strategy work to commence in Q3.

- ***Workforce Sustainability and Development (MS).***
  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.

- ***Employee Wellbeing (MS).***
  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.

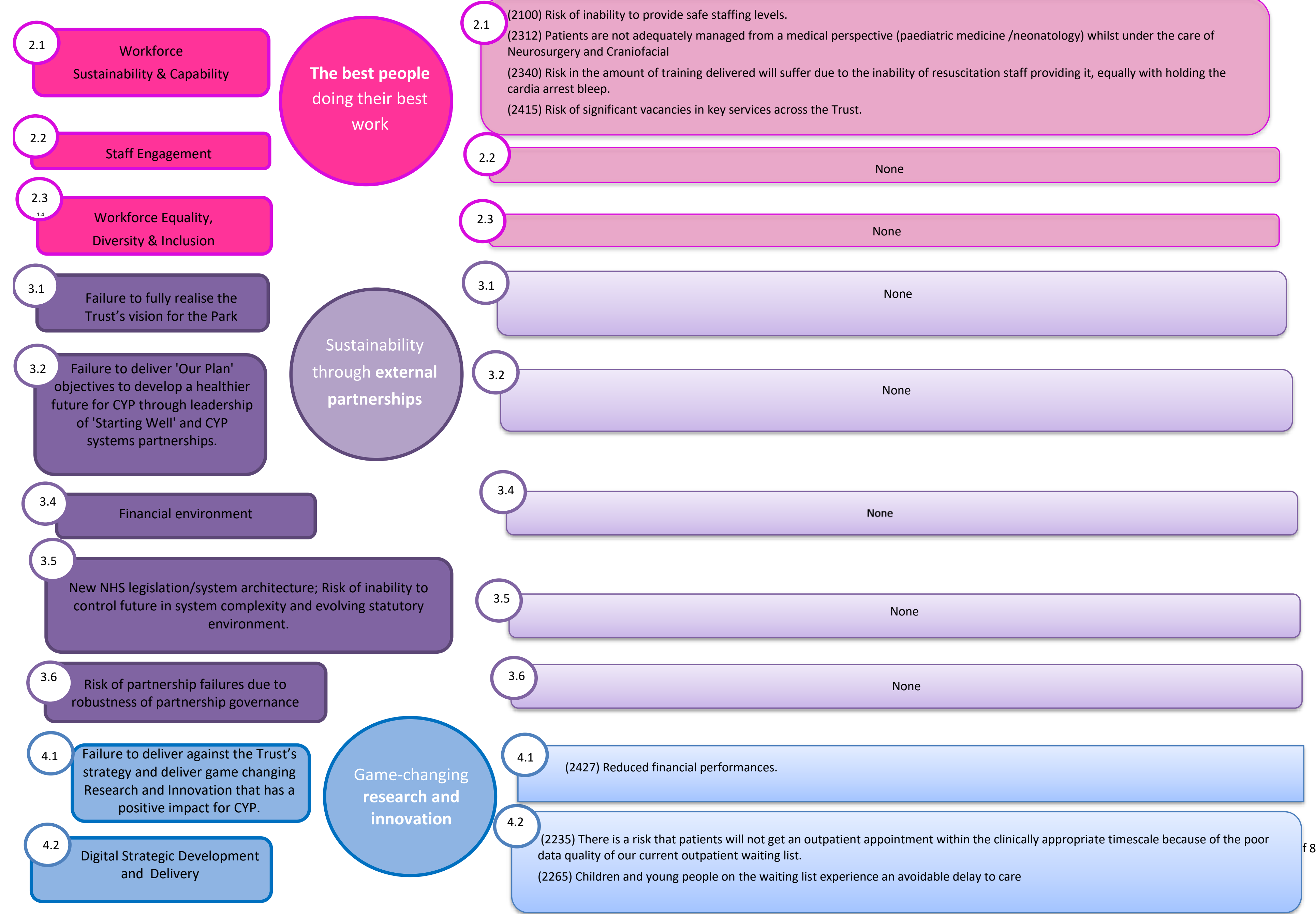
- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People (CL).***
  Risk was reviewed in September – There has been no change.

Erica Saunders
Director of Corporate Affairs

Appendix A

Links between BAF and high scored risks – as at 15th September 2021

BAF Risk	Strategic Aim	Related Corporate Risk
1.1 Inability to deliver safe and high quality services	Delivery of **outstanding care**	1.1 (1560) New patients referred to CAMHS Liverpool may breach 18 week referral to treatment target. (2229) Risk of being unable to fully coordinate care of major trauma patients which could lead to delays in providing care and treatment, standard care and prolonged stay/inappropriate discharge. (2230) Ten-fold medication errors resulting in serious harm to patients. (2233) Failure to meet QST Major Trauma peer review standards. (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 (2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial (2326) Delayed diagnosis and treatment for children and young people. (2332) Inadequate provision of service delivery if agreement cannot be reached by two main providers of paediatric cardiology care over how best to provide a 'joint approach' to service provision. (2383) Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Risk of negative impact on the mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation. (2384) Infection Control Risk – Risk of infection from spores to the children post op cardiac surgery. (2414) New referrals not being triaged timely, non-complaint with RTT pathway. Follow up patients not receiving appointments in detailed time frame, cohorts being lost to follow up due to lack of oversite. Patients not able to receive Laser treatment due to lack of training and knowledge of current team. Patients not able to receive Laser treatment timely due to availability and capacity of current team. Changed from Divisional level on the 19.5.21. (2434) Failure to meet the 90% target compliance for Trust wide Resuscitation Training in line with Mandatory Training Policy - E21. (2436) Significant reduction in the service provision. No 3D photography service, limited on-call service, limited appointments available Monday to Friday. Patients may not receive the treatment they require or may experience a significant delay based on service availability. (2441) Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval. (2463) Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard). (2475) Key vacancies in the Pharmacy Department are not being filled promptly which is affecting the way in which key Pharmacy services can be delivered.
1.2 Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19, a surge in urgent care and an RSV epidemic.		1.2 (2233) Failure to meet QST Major Trauma peer review standards.
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.		1.6 None


2.1
Workforce Sustainability & Capability
2.2
Staff Engagement
2.3
Workforce Equality, Diversity & Inclusion
The best people doing their best work
2.1
(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.
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
New 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
f 8

Board Assurance Framework 2021-22

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: 2233, 2332, 2312, 2265, 2414, 2383, 1560, 2434, 2436, 2441, 2427, 2067, 2326, 2235, 2229, 2384, 2410, 2230, 2461, 2463, 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 Care Delivery Board. 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 Committee, Trust Board and Care Delivery Board
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 and Audit and Risk 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, Integrated Governance 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.
Trust policies and Guidelines will be regularly reviewed, up-to-date and developed in line with best practice evidence	Trust audit committee reports and minutes
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
Alignment of workforce plans across the system	31/03/2021	Action captured within BAF risk 2.1
The 72hr review process will be followed for all patients who do not receive their antibiotics within the timeframe to identify themes, trends and any trust wide learning which will lead to improvement in compliance with this standard	01/07/2021	
The Trust will form a complex children programme board to improve the safety and experience of mental health patients within the Trust. Workstreams will be directed by service need and monitored through CQSG	02/08/2021	group now in place with dedicated work plan, reported through CQSG and to SQAC
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	01/10/2021	

of medication		
A new document management system to be launched All current policies and guidelines to be migrated The review and approval process to be updated Monitoring reports to be sent to CQSG monthly Number of out of date documents to be monitored through CQSG Board subcommittees to receive a quarterly report in relation tot he policies and guidelines which they are responsible for	31/05/2021	Task and finish group is in place and compliance has improved. Further meetings in May to ensure full compliance with all policy and guidelines
Review of the pre operative check list Development of a SOP "preparing the CYP for theatre" Review current checking requirements in line with NPSA guidance Ensure the process is in place across all areas of Trust	04/05/2021	

Executive Leads Assessment
August 2021 - Nathan Askew This risk as been reviewed and completed actions updated. The remaining gaps in assurance and control continue.
July 2021 - Nathan Askew This risk has been reviewed. There has been progress with the gaps in assurance as indicated by the reviews. The control remain in place and effective.
June 2021 - Nathan Askew This risk has been reviewed and completed actions updated. The quality hub has developed robust plans for each of the projects associated with gaps in assurance, the work on these will commence from July and the BAF will be updated accordingly to reflect progress

Board Assurance Framework 2021-22

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 the adverse impact of COVID-19, a surge in urgent care and an RSV epidemic		
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): - Winter Plan with additional staffing and bed capacity - ED Escalation & Surge Procedure - Additional shifts to increase staffing levels to deal with higher demand - Trust-wide support to ED, including new in-reach services (physiotherapy, Gen Paeds & CAMHS)	- Daily reports to NHS England - Daily performance summary - Monthly performance report to Operational Delivery Group - Performance reports to RABD Board Sub-Committee - Bed occupancy is good
Controls for referral-to-treatment times for planned care: - Weekly oversight and management of waiting times by specialty - Weekly oversight and management of long wait patients - Use of electronic system, Pathway Manager, to track patient pathways - Additional capacity in challenged specialties - Access to follow-up is prioritised using clinical urgent signified by tolerance for delay	- Corporate report and Divisional Dashboards - Performance reports to RABD Board Sub-Committee - Use of electronic patient pathway forms to signify follow-up clinical urgency and time-frame
Controls for access to care in Community Paediatrics: - Use of external partner to increase capacity and reduce waiting times for ASD assessments - Investment in additional workforce for Speech & Language service in Sefton - Weekly oversight and management of long wait patients	- Significant decrease in waiting times for Sefton SALT - Corporate report and Divisional Dashboards - Performance reports to RABD Board Sub-Committee
Controls for access to care in Specialist Mental Health Services: - Investment in additional workforce in Specialist Mental Health Services - Extension of crisis service to 7 days - Weekly oversight and management of long wait patients	- Monthly performance report to Operational Delivery Group - 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: - SAFER - Best in Acute Care - Best in Outpatient Care - Best in Mental Health care	- Monthly oversight of project delivery at Programme Board - Bi-monthly transformation project update to CQAC
Performance management system with strong joint working between Divisional management and Executives	- Bi-monthly Divisional Performance Review meetings with Executives - Weekly 'Executive Comm Cell' meeting held - Operational Delivery Board as a forum to collectively address challenged areas and to submit 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

Board Assurance Framework 2021-22

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.	30/09/2021	The Trust completed and submitted a data collection template detailing its accelerator schemes and costings and included activity projections/trajectories. The central accelerator team have submitted the full business case to NHS England using the trusts' completed data collection templates as a basis, which is currently awaiting final approval. The Trust prepared a position paper outlining the financial and activity impact of the elective recovery fund (ERF) and accelerator. The paper included details of the proposed accelerator schemes and their costs. Approval was given to proceed with the schemes with immediate effect.
Safe Waiting List Management programme plan to deliver good data quality, clinical reviews, clinical harm review, accurate waiting list reporting and additional RTT training.	09/07/2021	The IP RTT, planned, watchful wait and non-RTT waiting lists have been successfully implemented under release 2.1 and provides full visibility of patients waiting for treatment. The feedback from the operational teams has been very positive regarding the new waiting list, which is deemed to have a very high degree of integrity. The new OP waiting lists (RTT, follow-up, non-RTT) are in development and are due to be tested the last week in June with a view to implementation at the end of June or early July 2021. A clinical harm SOP has been signed off and is currently being used to ensure that all long waiters have a clinical review undertaken (and a full harm review where indicated). The national outcome codes have been implemented on Meditech and the ePPF updated with the new codes. Training has been rolled out to all staff and compliance is currently being monitored. A data quality dashboard has been developed and the high priority indicators have been populated on the dashboard and are currently undergoing testing.
Weekly specialty meetings to focus on booking IP TCI dates. Provision of additional capacity - including Accelerator Bid. Chronological booking. Theatre transformation to focus on Day Case and start times with expectation to increase number of patients per list.	30/09/2021	
RSV preparedness plan to be finalised with comprehensive arrangements and analysis that covers demand, escalation, staffing and resources	30/06/2021	

Executive Leads Assessment

0 - No Reviewer Entered

September 2021 - Adam Bateman
In August we consciously reduced additional outpatient and theatre sessions to support staff to take annual leave and to rest. The number of 52 week patients is currently stable. However, in September this could rise as we conclude our safe waiting list management work. In half 2 we expect to work through this and end the year with less than 100 patients waiting over 52 weeks for treatment.

There are three significant threats to the progress in recovering services. As we look forward we can see some likely 1. vacancy levels and staff availability in key teams such as ODAs and radiography 2. increase in infection (such as norovirus) affecting access to ward capacity 3. Staff absence and fatigue affecting levels of outpatient and elective work

Our mitigation strategy includes 1. maximising in-week theatre sessions with a new theatre policy to support this 2. recruitment activities in anaesthesia and radiography 3. innovation through the accelerator programme, include artificial intelligence to reduce the rate of WNB 4. focus on outpatient adoption of virtual consultations and delivery of pre-covid clinic templates.

August 2021 - Andrew Mccoll
Restoration percentage remains high compared to 2019, however additional weekend working has been paused during July and August to support staff wellbeing. This means that the total number of patients waiting more than 52 weeks remains static. RSV numbers are being monitored on a daily basis enabling escalation in line with the Surge Plan as and when required.

Board Assurance Framework 2021-22

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: John Grinnell		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
Revised Communication Strategy.	21/10/2021	
Develop Mitigation Strategy for areas of workforce fragility.	15/10/2021	

Executive Leads Assessment

September 2021 - John Grinnell
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
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
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

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		
Exec Lead: Melissa Swindell		Type: Internal, Known	Current IxL: 4x4	Target IxL: 3x2	Trend: INCREASED
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 WOD
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 -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 WOD and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Bi-monthly reports to WOD 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 WOD OFSTEAD Inspection
Leadership Strategy Implementation	Bi-monthly reports to WOD
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)

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	30/09/2021	Mandatory training continues to increase - focused recovery plans in place
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	30/09/2021	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	01/10/2021	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
September 2021 - Sharon Owen 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.
August 2021 - Sharon Owen Some actions continue to be progressed in respect of strategy and development, but the priority of imminently addressing the transactional Recruitment Service are of priority, ensuring ongoing recruitment to essential roles. Transactional recruitment are experiencing unprecedented volumes of activity. Once the actions are complete to address the unpresented volume of recruitment activity, will enable a refocus on the strategy and development work.
July 2021 - Melissa Swindell Action plans progressing. Some actions amended in light of the need to respond to current pressures (COVID, accelerator, RSV)

Board Assurance Framework 2021-22

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	30/09/2021	Ongoing proposal development with Alder Centre and in discussion with Director of HR. SALS Manager liaising with Alder

determine future service development and delivery that meets demand and is integrated with internal and external counselling provision.		Centre manager to gain more information re capacity and demand and to identify counselling resource needed going forward.
Recruit to SALS/OD fixed term psychology post and permanent admin post.	08/10/2021	Admin post out to advert internally on 7.9.21. Psychology post to be advertised.

Executive Leads Assessment
September 2021 - Jo Potier 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
August 2021 - Melissa Swindell risk reviewed, actions on track
July 2021 - Jo Potier Risk reviewed and updated to reflect updated ED support plan, Ground TRUTH sessions @execs and establishment of Wellbeing Action group. No change in risk rating due to ongoing impact of Covid, increased risk of burnout and ongoing uncertainty around likely future impacts of this pandemic.

Board Assurance Framework 2021-22

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)
WOD Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.	- Bi-monthly reporting to Board via WOD on diversity and inclusion issues - Monthly Corporate Report (including workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs, monitored through WOD
Staff Survey results analysed by protected characteristics and actions taken by EDI Manager	monitored through WOD
HR Workforce Policies	HR Workforce Policies (held on intranet for staff to access)
Equality Analysis Policy	- Equality Impact Assessments undertaken for every policy & project - EDS Publication
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - 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 -Workforce Race Equality Standards - Bi-monthly report to WOD
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 - Workforce Disability Equality Standards - Bi-monthly report to WOD
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
Taskforce to develop action plan	01/05/2021	
need to recruit	14/09/2021	

Executive Leads Assessment

September 2021 - Melissa Swindell
Risk reviewed, actions updated

August 2021 - Melissa Swindell
Risk reviewed. Temporary EDI resource secured and commencing September 2021.
BAME Taskforce Plan in place and actions agreed

July 2021 - Melissa Swindell
Actions progressing against plans. EDI Lead appointed

Board Assurance Framework 2021-22

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 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 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. Fully reconciled budget with Plan. 2. Risk quantification around the development projects. 3. Absence of final Stakeholder plan 4. COVID 19 is impacting on the project milestones

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Sign off cost plan for Park Trust Board signed off increased budget to incorporate the works	31/08/2021	Trust Board signed off revised budget to fund the completion of the park works.
Review and update Space Strategy	30/09/2021	Space strategy in draft with a further iteration required over the next month to end September
Prepare Action Plan for NE plot development	31/10/2021	Workshop with PWC occurred on the 25th June, outputs to be formulated and fed back to the Trust
Create opportunities analysis for Park/campus	31/10/2021	

Executive Leads Assessment
September 2021 - David Powell Prior to Sept Board
August 2021 - David Powell Prior to August Board
July 2021 - Russell Gates Cost estimates are under review ahead of the RABD meeting which takes place on the 26.7.21.

Board Assurance Framework 2021-22

NHS
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

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 establishment	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)
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	30/09/2021	Plan for Private Patients & International reviewed at Exec strategy away day 23.4.21. Continued commitment to developing the

		business model, define the plan & include in the proposal to Clinicians as part of future planning assurance of Trust commitment to achieve this long-term goal.
1. Strengthening the paediatric workforce	30/09/2021	Strengthened work across paediatric network continues; current focus on developing C&M RSV surge plan with embedded mutual aid arrangements, connected into NW RSV surge plan (submitted June 2021)
Full programme proposal implementation; Funding flows into AH from C&M/NHSE Recruit to all key programme roles - beginning with Programme Director Establish C&M CYP Transformation Board	29/10/2021	Programme Director in Post Programme Manager recruited Project Management & Admin under recruitment Full programme budget received and under allocation

Executive Leads Assessment
September 2021 - Dani Jones Risk reviewed; no change to score in month; actions updated.
August 2021 - Dani Jones Risk reviewed; no change to score in month
June 2021 - Dani Jones Risk reviewed; no change to score in month. Progressing implementation of C&M CYP programme. System-wide RSV surge plan under finalisation.

Board Assurance Framework 2021-22

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 - Full electronic access to budgets & specialty performance results - Financial in-month and forecast position reported through SDG, Exec Team, RABD Ops Board and Trust Board - Financial recovery plans reported through SDG and RABD - 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	31/10/2021	Space T&F group established with focus on estates programme and future requirements. Capital management group to be reestablished to monitor capital schemes and financial plans. Anticipate future capital spending restraint across C&M in 22/23 and beyond and AH have a senior finance rep on the C&M working group. Update on capital 5 year financial strategy to be provided at Sept RABD and TB.
1. Uncertainty of H2 21/22 framework and beyond	30/09/2021	Latest system forecast support a breakeven achievement across all providers for H1. Alder Hey have raised risks to this delivery however the 4 specialist trusts collectively have committed in achieving breakeven position for H1 across all 4 trusts. Planning guidance due mid September for H2, however system breakeven plan will still remain for H2.
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

September 2021 - Rachel Lea Risk reviewed and actions updated
August 2021 - Rachel Lea Risk reviewed and actions updated with latest progress
July 2021 - Rachel Lea Risk reviewed and actions updated

Board Assurance Framework 2021-22

BAF 3.5	Strategic Objective: Sustainability Through External Partnerships		Risk Title: New 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: 4x3	Target IxL: 3x3	Trend: STATIC
Assurance Committee: Trust Board					

Risk Description
NHS White Paper Innovation and Integration creating Integrated Care Systems and new statutory NHS body, including transformed system governance, finance, quality etc - under definition & rapidly evolving

Existing Control Measures	Assurance Evidence (attach on system)
Membership of C&M Provider Collaboratives x 2 - to ensure CYP voice high on agenda	
Specialist Trust Alliance membership of C&M ICS (HCP) Board	
C&M CYP Transformation Programme hosted at Alder Hey	ICS Programme Highlight Report
System Finance planning (links to BAF 3.4)	
Trust Board & CoG - continued engagement and action planning	Presentations to Trust Board & CoG

Gaps in Controls / Assurance
NHS Bill not yet read in Parliament; final statutory arrangements cannot take place until this is completed (clarity will follow)

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	28/04/2022	

Executive Leads Assessment
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.
August 2021 - Dani Jones Risk reviewed; no change to score in month. Updated control & assurance evidence

Board Assurance Framework 2021-22

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	

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 Framework - for approvals in Alder Hey. Assess core pre-existing and new partnerships against the framework and address any gaps through individual partnership governance groups.	29/10/2021	

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

Board Assurance Framework 2021-22

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: No Risks Linked		
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 Care Delivery Board to support strategy deliver.	Care Delivery 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 Commitee 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
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	
LCR/BOOM engagement and collaboration for public funding and investment.	31/08/2021	

Executive Leads Assessment

September 2021 - Claire Liddy
risk review SEPT. no change

August 2021 - Claire Liddy
AUG Review: static

July 2021 - Claire Liddy
JULY 21 - Risk review static

Board Assurance Framework 2021-22

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 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
Implementation of Alder Care Programme	01/05/2022	Programme progressing, a number of work streams with challenges being progressed.
Development of new strategy from 22/23	01/04/2022	

Executive Leads Assessment
September 2021 - Kate Warriner Risk reviewed, good progress against actions. New strategy work to commence in Q3.
August 2021 - Kate Warriner BAF reviewed, good progress, plans in place to refresh digital strategy from 22/23
July 2021 - Kate Warriner BAF reviewed, good progress

BOARD OF DIRECTORS

Thursday, 30th September 2021

Paper Title:	**Audit and Risk Committee – Chair's Highlight Report**
Date of meeting:	23rd September, 2021
Report of:	Kerry Byrne, Committee Chair
Paper Prepared by:	Kerry Byrne, Committee Chair

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the Audit and Risk Committee meeting that was held on the 23rd September 2021, along with the approved minutes from the Audit Committee meeting that was held on the 22nd July 2021.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ☐ **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
- Risk Management Forum update including the Corporate Risk Register
- Analysis of the Trust Risk Register
- Presentation on the Data Quality Team and future plans
- CQC Action Plan (for the remaining action overseen by ARC)
- Presentation on risk management within the Medicine Division
- Update on implementation of the new Consultant Job Planning Portal
- Internal Audit Progress Report
- Internal Audit Follow Up Report
- Proposed revised Client Satisfaction Questionnaire following internal audits
- Anti-Fraud Progress Report
- Update on the actions from the ARC Self-Assessment
- Clinical Claims Report
- Update on implementation of recommendations from the ACORN report (relating to governance of innovation activities)
- Management review of purchasing of PPE
- Management review of Nil Net Book Value Assets
- Ratification of the following policies:
  - Bomb Threat and Suspicious Packages / Persons Incident Plan
  - ICT Network Security Policy
  - Overarching Information Security Policy
  - Records Management Policy
  - Bring Your Own Device Policy

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

None

4. Positive highlights of note

The Committee recognised the ongoing improvements in the risk management process and the engagement of senior individuals in its oversight.

The Committee received an update from Urmi Das on how risk management is implemented within the Medicine Division noting some novel practices such as

the “Governance Hour” but also challenges arising from the regular turnover of Risk & Governance Leads (across all Divisions).

The Committee was pleased to receive an update on implementation of L2P to record Consultant Job Plans. A number of high risk recommendations were raised by internal audit in 2018 in this area. Significant work has been led by Urmi in the last 12 months to address the issues raised.

Following the separate self-assessments of IGC and Audit Committee in 2019 the Committee agreed to take a further self-assessment of the (combined) Audit & Risk Committee this year.

5. Issues for other committees

None

6. Recommendations

The Board is asked to note the Committee’s regular report.

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 22nd July 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. A. Bateman	Chief Operating Officer	(AB)
	Mr. A. Bass	Director of Surgery	(ABASS)
	Dr. U. Das	Director of Medicine	(UD)
	Ms. R. Greer	Assoc. COO	(RG)
	Mr J Grinnell	Director of Finance	(JG)
	Mr. K. Jones	Associate Finance Director	(KJ)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Mr H Rohimun	Executive Director, Ernst and Young	(HR)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Ms. C. Umbers	Assoc. Director of Nursing and Governance	(CU)
Apologies:	Ms. L. Cooper	Director of Community Services	(LC)
Item 21/22/48	Ms. L. Edwards	Head of Clinical Audit	(LE)
	Mr. S. Riley	Clinical Auditor for the DoM	(SR)
Item 21/22/48	Mr. P. Morris	Assoc. Chief Information Officer	(PM)

21/22/39 Introductions and Apologies

The Chair welcomed everyone to the meeting and noted the apologies that were received. The Committee was advised that Rachel Greer was attending the meeting on behalf of Lisa Cooper.

21/22/40 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.

21/22/41 Minutes from the Meeting held on the 17th June 2021

Resolved:

The minutes from the meeting that took place on the 17.6.21 were agreed as an accurate record of the meeting.

21/22/42 Matters Arising and Action Log

Action 20/21/49.1: *Fraud Risk Matrix* (*Provide an update to the Committee following Deloitte's review of VFM in purchasing PPE).* – An update will be provided on the 23.9.21 in terms of the internal piece of work that is being conducted to review a small number of cases using a conflicts of interest lens.

Action 20/21/51.2: Brilliant Basics Programme *(KPMG to liaise with Cathy Umbers to ensure that the Brilliant Basics Programme links in with the Trust's risk management processes)* – A meeting has taken place with KPMG to discuss how risk management can be central to the Brilliant Basics Programme. It was agreed to share the presentation from the meeting with members, as it includes the ideas that were discussed. KPMG will also be involved in the risk management training for staff that Cathy Umbers is going to conduct. Cathy Umbers agreed to monitor the progress of the elements that are to be incorporated in the Brilliant Basic Programme**. ACTION CLOSED**

21/22/42.1 **Action: CU**

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)* – A meeting took place between ES and JG and it was agreed that Ken Jones would review this area of work. A meeting will be scheduled with Kerry Byrne once a review has taken place. **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)* – Work is on-going therefore it was agreed to submit a presentation/report on the new job planning portal in September. **ACTION TO REMAIN OPEN**

Action 20/21/63.1: *Development of a Robust Process for Gifts and Hospitality (Submit a report on gifts and hospitality declarations using the data from the new electronic system)* – This item has been included on July's agenda. **ACTION CLOSED**

Action 20/21/72.2: *Board Assurance Framework Report (Refer BAF Risk 2.1 to the People and Wellbeing Committee. Audit and Risk Committee to receive an update on the mitigations in place for this risk in the next six months)* - An update will be provided in September. **ACTION TO REMAIN OPEN**

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***)** – It was confirmed that a presentation would be submitted to the Committee on the 23.9.21. **ACTION TO REMAIN OPEN**

Action 21/22/03.1: *Update on the Recommendations within the Acorn report (agree a process to enable the Innovation Committee to provide assurance to ARC on innovation operations)* – It was agreed that assurance on innovation operations will be provided Via the annual report of the Innovation Committee. **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 has been suggested that a small Exec to Exec meeting, including two NEDs, should take place in September between the Trust and Laing O'Rourke. John Grinnell has requested a formal position statement on each of the defects to enable this matter to be discussed during the meeting. A formal position update will be provided to the Trust Board on the 30.9.21, and the Audit and Risk Committee on the 18.11.21. **ACTION TO REMAIN OPEN**

Action 21/22/09.1: *Trust Risk Management Report (Liaise with the Health and Safety department re their risks that haven't been risk ranked)* – It was confirmed that the Health and Safety Department now has one outstanding risk that requires risk ranking. **ACTION CLOSED**

Action 21/22/34.1: *Anti-Fraud, Bribery and Corruption Policy and Response Plan (Transfer the new Anti-Fraud, Bribery and Corruption Policy and Response Plan into the Trust's policy format and arrange for it to be uploaded onto the intranet)* - The Anti-Fraud, Bribery and Corruption Policy and Response Plan has been transferred into the Trust's policy format and has been uploaded onto the intranet. **ACTION CLOSED**

21/22/43 Board Assurance Framework Report

The Audit and Risk Committee received an overview of the BAF as at the 30th of June 2021. The following points were highlighted:

- The Committee was advised that BAF risk 1.3 has been superseded by risk 1.6 and provides greater detail of the risks relating to the extreme pressures being experienced by the Trust at the present time due to a combination of reasons. It was confirmed that this risk will evolve during the next couple of weeks.
- Work has taken place to strengthen the risks relating to partnerships and the environment in terms of the system.
- It was pointed out that there have been a number of proposed changes to the H1 funding mechanism which will add further risk into the system. Intelligence is being acquired in terms of H2, which is still flagged as a high risk on the BAF.
- From a risk perspective, Fiona Marston queried the level of influence that the Trust has in terms of the ICS and Cheshire and Merseyside. It was reported that the Trust has created a space for children and young people as a result of the work that Louise Shepherd and Dani Jones have been conducting which has provided the organisation with a ring fence to some extent. The Trust is also working in collaboration with a number of specialist trusts and the Alliance, from a financial perspective, and is looking at how this group can speak as one to provide it with more influence. The Committee was advised that Alder Hey spans a much wider footprint than Cheshire and Merseyside and as a result of this works with colleagues in the North West region and Manchester, which is another important aspect in terms of influence.

  Anita Marsland drew attention to the importance of being mindful from a risk perspective once discussions commence about delegation to place/decision making and the impact that this could have on resources.

- *BAF Risk 2.3* - The Chair drew attention to the large amount of work that has taken place following the establishment of the BAME Taskforce and felt that greater detail needs to be included in risk 2.3 to reflect the progress that's been made. Erica Saunders agreed to look into this matter.

21/22/43.1 **Action: ES**

- *BAF Risk 4.1* – It was pointed out that the section relating to 'Actions to reduce the Risk to the Target Rating' have been deleted from the report. It was agreed to highlight this matter to the owner of this risk, Claire Liddy.

21/22/43.2 **Action: ES**

Resolved:
The Audit and Risk Committee received and noted the BAF update as at the 30.6.21.

21/22/44 **Report from the Risk Management Forum**

The Committee received an overview of the Risk Management Forum that took place on the 28.6.21. It was pointed out that this is the continuation of what was the Care Delivery Board's dedicated session on risk.

It was reported that the forum discussed the organisation's top 15+ risks whilst reviewing individual areas to ensure the Trust's risk management system is working effectively. The Committee was advised that access to service remains a common theme for a number of services across the Trust, which has been exacerbated by the challenges of the third wave of Covid-19, RSV, etc. Particularly relevant is the growing waiting times for mental health and community paediatric services. During the next Risk Management Forum, a deep dive will take place around workforce fragility, and building services risks in terms of ensuring that the organisation's buildings are being managed effectively and in a responsive manner.

For noting
Going forward, the Audit and Risk Committee will receive the minutes from the Risk Management Forum.

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

21/22/45 **Corporate Risk Register**

The Committee received an update on the Corporate Risk Register (CRR) activity from the 1.4.21 to the 14.7.21. The following points were highlighted:

- The Chair pointed out that there a very few long standing risks on the CRR which indicates that the document is live and continuous progress is being made.
- *Risk 2410 - Risk of long waits in the Emergency Department (ED) and compromised patient safety* - Adam Bateman drew attention to the risk relating to the Emergency Department and acknowledged how challenging it has been for staff, patients and families. The Committee was advised that the internal response to this risk has been strong with the organisation looking at alternative pathways of care for minor injuries and illness. In terms of the risk relating to long waits due to increased levels of attendance, it was reported that the Trust has been testing some of the changes for clinical pathways, has arranged for additional services to be implemented outside of the Emergency Department and requested support from Mersey Care and the CCG. Mutual aid has also been offered to the Trust to address this risk in partnership.
- *Risk 2310* – The Chair queried as to why there is a backlog of outstanding records that require scanning as it was felt that this issue had been dealt with. It was reported that this matter related to specifically to ED and has been addressed since the completion of the CRR.

- *Risk 2229* – The Chair queried the reduced risk rating for the risk appertaining to the Major Trauma service. It was confirmed that this risk has been reduced as a result of the robust safety processes that have been implemented rather than additional resources.

Resolved:
The received the Corporate Risk Register and noted the activity from the 1.4.21 to the 14.7.21.

21/22/46 Trust's Risk Register Analysis

The Audit and Risk Committee received the Risk Register Analysis 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 at the time of reporting. The following points were highlighted:

- The Committee was advised that work is taking place with the Divisions and Corporate Functions to address the risks (40%) that have remained static over the last twelve months.
- At the time of reporting there were 45 risks overdue, with 27 having no agreed action plan and 10 risks without a risk rating. It was confirmed that work is taking place with the respective groups to ensure this position is improved.

The Chair pointed out that the Audit and Risk Committee is tasked with providing assurances on the management of all risks across the Trust and queried as to whether a graph should be included in the report to show the percentages of risks that are overdue/without an action plan in order to enable the Committee to identify improvements and receive an overview of whether staff are engaging with the organisation's risks. Following discussion, it was felt that it would be more beneficial to have a deep dive into problem areas rather than producing a graph/chart. It was agreed to look into this matter to see how it can be addressed and tracked.

21/22/46.1 Action: CU

Resolved:
The Audit and Risk Committee received and noted the Trust's Risk Register Analysis report.

21/22/47 CQC Action Plan

The Audit and Risk Committee received version 12 of the CQC Action Plan for 2020 which contained the action for which the Committee is responsible for oversight. The following point was highlighted:

Recommendation 8 *(The Trust should review their internal risk identification methods to ensure that they identify and mitigate risks in a timely manner – Regulation 17)* - The

Committee was advised that the 'must do's' relating to recommendation 8 have been completed. It was pointed out that the organisation has committed to rolling out the e-Learning package for risk management across the Trust and it was felt that a further review of the departmental recommendations should take place to see if anything further can be done in terms of emphasis. Erica Saunders and Cathy Umbers agreed to meet to discuss this matter.

21/22/47.1 **Action: ES/CU**

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

21/22/48 **Clinical Audit Presentation**

A number of slides were submitted to the Audit and Risk Committee to provide an introduction to clinical audit. The following information was shared with the Committee:

- The remit of clinical audit.
- How clinical audits are identified and prioritised.
- How clinical audits are staffed.
- How the results from clinical audits are reported.
- The dissemination of findings.
- How the results are prioritised and followed up.
- Future plans for clinical audit.

The Committee felt that the presentation was very helpful and provided clarity.

It was pointed out that clinical audit has a massive remit therefore the team are reviewing resource/capacity and strengthening collaboration with the Divisions. The Chair asked Liz Edwards and Steve Riley if there was anything that they wished to draw out of the reports. Liz Edwards highlighted the importance of bringing action planning/monitoring to the forefront, specifically looking at the required actions and the proposal that the team have put forward. Attention was also drawn to the importance of learning from clinical audit findings to improve patient safety.

The Chair advised that SQAC will approve the Clinical Audit Plan and receive regular updates throughout the year. From an Audit and Risk Committee perspective, informed updates will be provided at various points to enable the Committee to raise any concerns that it may have. It was agreed that a meeting should take place to discuss the timings for updates during the Committee's cycle.

21/22/48.1 **Action: ES/SR**

The Chair also agreed to meet with Steve Riley in September to discuss the progress of the Clinical Audit Plan.

21/22/48.2 **Action: KB/SR**

Resolved:
The Audit and Risk Committee received and noted the contents of the clinical audit presentation.

21/22/49 **Declarations of Interest, Gifts and Hospitality 2020/21**

The Declarations of Interest (DoI) and Gifts & Hospitality 2020/21 report was submitted to the Committee to provide an update on the current position. The following points were raised:

- It was reported that DoI compliance levels are improving and progress is being made as a result of the various measures that have been implemented, as identified in the report, and the investment in the Civica system.
- Attention was drawn to the decline in Gifts and Hospitality declarations during 2020/21 which is as a result of the pandemic due to travel restrictions and conferences taking place via Microsoft Teams. The Committee was advised that the Innovation Team are active in the commercial space and a meeting has taken place with Clair Liddy and Emma Hughes to discuss the tracking of this.

The Chair referred to the implications of the outstanding DoI and highlighted the importance of getting under this. It was reported that this area of work has been centralised via a devolved management model which has been effective, with constant awareness raising via Divisional governance meetings. It was felt that the majority of the outstanding DoI relate to staff members who don't have anything to declare. A discussion took place around the possibility of applying sanctions or a mandatory tag in terms of DoI to ensure that staff members complete declarations. It was pointed out that the organisation has an obligation to bring DoI to the attention of its staff members but it's not mandatory. It was agreed that this matter would be discussed further outside of the meeting to look at what else can be done to promote DoI compliance across the Trust.

21/22/49.1 **Action: KB/ES**

Resolved
The Audit and Risk Committee received the Declarations of Interest, Gifts and Hospitality report for 2020/21 and noted the actions that have been taken to improve compliance.

21/22/50 **Conflicts of Interest Policy**
Resolved:
The Audit and Risk Committee received and approved the Conflicts of Interest Policy.

21/22/51 **Data Quality Policy.**

The Audit and Risk Committee received version 5 of the Data Quality Policy. The following points were highlighted:

- The policy has been updated to reflect revised data governance within the Trust, with accountability into the Chief Digital and Information Officer, and the Resources and Business Development Committee with assurance to the Audit and Risk Committee.
- The policy now links to new national standards, for example, the Data Security and Protection Toolkit; as well as to corporate priorities such as, transformation and innovation.
- Team and service responsibilities now reflect the Trust's current structure, with the Data Assurance team taking an active role in data quality checks, particularly Safe Waiting List measures.

- It was reported that the policy has been approved by the Information Governance Steering Group.

The Chair advised that the policy needs to reflect that the Information Governance Committee (IGC) was disbanded and that the Audit and Risk Committee and Risk Management Forum took over some of its responsibilities.

In terms of the record of changes from the previous version, the Chair queried the value of the additional tables in the document and suggested removing them as they didn't seem relevant and it would condense the document by 2.5 pages.

Resolved:
The Audit and Risk Committee ratified the Data Quality Policy pending the Chair's comments.

21/22/51.1 **Action: PM**

21/22/52 **Progress against actions from the Audit and Risk Committee Self-Assessment**

The Committee was provided with an update on the progress against the actions from the Audit and Risk Committee self-assessment. It was reported that there are two items outstanding; 1. How the Risk Management Forum/Audit and Risk Committee operate. 2. Sources of Assurance.

It was confirmed that work will take place to review how the Risk Management Forum and the Audit and Risk Committee operate to ensure there is no duplication. An update on this matter will provided on the 23.9.21.

Resolved:
The Audit and Risk Committee noted the progress against the actions to date.

21/22/53 **EPPR Plans**
Resolved:
The Audit and Risk Committee ratified the following EPPR Plans:

- Whole Hospital Evacuation Plan.
- Clinical Incident Plan.
- Business Continuity Policy and Plan.

For noting
It was suggested that when future documentation/policies are submitted to the Audit and Risk Committee for ratification that a summary be incorporated identifying the documentation that requires ratifying, the approving committee and the changes that have been made.

The Committee was advised that Kerry Byrne is the NED lead for Emergency Planning.

21/22/54 **Any Other Business**

There was none to discuss.

21/22/55 Meeting Review

It was felt that the Trust is making continued progress in terms of risk management and the BAF/CRR are live documents and are being used appropriately. It was confirmed that the Committee does not need to escalate any issues to the Trust Board or the Assurance Committees.

Date and Time of the Next Meeting: Thursday 23rd September 2021, 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 June at 10:00am, via Teams**

Present:	Ian Quinlan (Chair)	Non-Executive Director	(IQ)
	Shalni Arora	Non-Executive Director	(SA)
	Claire Dove	Non-Executive Director	(CD)
	Dani Jones	Director of Strategy & Partnerships	(DJ)
	John Grinnell	Director of Finance	(JG)
	Melissa Swindell	Director of HR & OD	(MS)
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance:			
	Graeme Dixon (part)		
	Mark Flannagan	Director of Communications	(MF)
	Russell Gates	Associate Commercial Director Development	(RG)
	Rachel Lea	Deputy Director of Finance	(RL)
	Nicki Murdock	Medical Director	(NM)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Clare Shelley	Associate Director Operational Finance	(CS)
	Ronnie Viner(part)	Safe Waiting List Management Adviser / Accelerator Programme Manager	(RV)
	Amanda Graham	Committee Administrator (*minutes*)	(AG)

20/21/238 Apologies:

Apologies were received from Adam Bateman and Claire Liddy.

20/21/239 Minutes from the meeting held on 24th May 2021.

Resolved:
Subject to an amendment being made to correct the date, the minutes of the last meeting were approved as an accurate record.

20/21/240 Matters Arising and Action log

Capacity Lab – confirmed to attend July meeting

20/21/241 Declarations of Interest

There were no declarations of interest.

20/21/242 Finance Report – Month 2

CS gave an update on the position at the end of Month 2. The Financial Plan for H1 has now been finalised and included a £3.6m deficit. However, since that submission we have been required to submit a further iteration which shows a break-even position due to an assumed contribution of £4m from the accelerator programme and further efficiency savings of requested by C&M ICS and was a requirement across the board for all organisations.

YTD is £0.6m which is currently £0.4m behind plan. Drivers include further historical pressures for Surgery, Research infrastructure costs and commercial income being below plan for Facilities. Community and Medicine are slightly ahead of plan and Finance, HR and Innovation are all broadly in line.

Elective Recovery Fund (ERF) is now included within the Plan, but the figure is yet to be validated by NHSE/I. For visibility of this, sections have been added to the paper for restoration to demonstrate the impact of ERF. Also included is a breakdown of the variance within Surgery as requested last month to illustrate how

the overspend has been made up; to highlight, this variance does not include restoration as that has been identified and funded year to date. Finally, there is a section giving an update on the CIP target achievement for the year of 55% which equates to £2.2m identified and a further opportunity of £1.1m which is reported to SDG fortnightly. The H1 control total break-even requirement has been added as a strategic risk in light of the availability of ERF funding and the efficiency savings required.

IQ queried the variance in CMV drugs income; RL responded that these are specialist drugs for children with cystic fibrosis and are passed through to Commissioners so the income only relates to any expenditure and can be sporadic.

IQ asked for clarification around the Surgery position; CS advised that due to funding guidelines, in a situation where cost pressures are being funded there cannot be back-funding so restoration costs for M1 and M2 have been given in the same month, which suggests that the division has improved and it is best to look at the YTD position. CS further advised that a deep dive into the surgical division will be undertaken to understand historical reasons behind the position, what is driving the cost pressures and what can be done about that.

SA asked in relation to the CIP savings expected to be identified in H2, what was the delay in identifying savings and what the risks might be. RL responded that this is expected to be achieved through the Brilliant Basics programme, transformational schemes and as cash-releasing benefits are mapped out they are being monitored through SDG.

Action: CS to report back to next RABD on Surgical division deep-dive (CS)

Resolved:
RABD received and noted the M2 Finance report.

20/21/243 **2021/22 Annual Plan - Finance & Activity Plan**

RL presented a brief update on the Annual Plan for 2021/22 for H1 which has been submitted as a break-even plan as requested by the C&M ICS. As previously advised, there are some challenges around the forecast ERF recovery activity which has been expected at £10m with related costs of £6m. For YTD we are on plan with costs below expected but those will not be equal in every month. It is hoped that there may be some opportunity for ERF income to offset some of the CIP.

Attention is now moving to H2 for October to March which is more uncertain and will be more challenging with higher targets set for Trusts. As yet there has been no clarity from NHSE around funding flow & reimbursement. Monitoring will continue through SDG with planning, CIP and cost control along with Commissioner agreements.

JG added that It is expected that H2 will be a form of the current model, but there is some work going on the determine future funding models. Systems that were in recurrent deficit will be asked to improve efficiency in the future and there is a system risk attached to that due to the long-standing C&M deficit position pre-Covid. It is hoped there will be more information on the H2 requirements by the next RABD meeting.

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

20/21/244 Commercial Governance SOP

RL gave a brief update to advise on the running of nonclinical income commercial areas. Updates will be made to the Corporate Governance manual and a Commercial SOP will be put in place to define and control management of the commercial areas. The new Associate Director of Commercial Finance will be in post shortly and will be tasked with pulling together a commercial paper for Innovation and also to pull something across all the commercial areas. When this is complete it will be brought to both RABD and the Innovation Committee.

Resolved:
RABD received and noted an update on the Commercial Governance SOP.

20/21/245 Capital & Cash Updates

CS gave a brief update on the current cash and capital position. Capital spend is currently £68k ahead of plan, advanced costs ahead of plan for the Dewi Jones / Community Cluster buildings have now fallen more in line with plan and cash stands favourably at £88.4m.

RL added that the key message is that close work is being done on Capital, with a sub-capital working group being established and meeting on a monthly basis to receive presentations of current capital projects. Another focus will be to forward look over the next five years and build a robust plan for future capital projects, including a significant CIP programme enabling the break-even position.

There has been a requirement as part of our audit programme to update our 'Going Concern' which looks at the cash balance and how sustainable we are as an organisation. This demonstrated that we are secure until September 2022 which is how long we project for audit and that has been satisfied by audit.

Payment is still awaited from NHSE/I which is expected by end July; the figure has been validated but not yet paid and it is expected that submission of our accounts is being awaited before payment.

Finally, the rolling cash forecast shows that subject to all assumptions made last month that over the next five years there would still be a cash balance over and above the minimum cash headroom. This will be regularly updated.

IQ asked whether mitigations are being listed in the event of that schedule not coming to fruition; RL responded that KJ has been tasked with undertaking scenario forecasting on both cash and capital in terms of what has been committed, where there are choices and what alternatives there may be so scenarios are being built that will contain the mitigations. IQ noted concern around achieving CIP; RL added there is also uncertainty around how system funding will operate in terms of whether Commissioner funding is brought back in. JG added that currently there is a high level of funding directed through central initiatives and one mitigation should be how Alder Hey place themselves in the best position to respond quickly in an agile way to these targeted initiatives.

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

20/21/246 Campus & Park Updates

RG gave an update on the progress of the campus development and park reinstatement, noting that continued demolition is on plan. Discussions are ongoing

around the future of Ronald McDonald House. The lease for new offices on Innovation Park has now been signed and it is expected that occupation will be end of August. The neonatal unit is now out to tender with cladding still to be agreed and no formal approval of including the PAU on the ground floor which could both bring delays to completion. The Cluster building in progressing well; however there are budget problems following the insurers requirement to change the roofing specification, and these are being closely monitored. A decision on the revised remediation programme is awaited from Liverpool City Council for the Park phase two, which also includes some changes to materials.

IQ asked what the situation was regarding the Knotty Ash Nursing Home following the fire; RG advised that information has been collated by the claims consultant, structural engineer and broker for the loss adjusters and whilst there is part of the building which could be retained, it would be more cost effective to demolish and rebuild.

IQ asked why deciding the colour of cladding can delay planning; RG replied that the original design was a timber effect but the architectural advised decided against it as it is not real wood; however the cladding cannot be real wood as it will sit adjacent to the hospital building, and the Planning Committee have indicated that they quite like the timber effect cladding. As a result, drawings will need to be amended for planning and will likely not be in time for the July Planning Committee as papers must be submitted 10 days prior. NM pointed out that the families were consulted, and this is what they wanted and was agreed, but now they are likely to be told it won't happen. JG asked for discussions to take place outside the meeting.

KW asked whether there should be concerns around the Cluster Building budget being over budget; RG responded that changes to meet the insurer's specifications have cost £347k which has absorbed the majority of contingency. It is unlikely that the building will be delivered within budget but the increased costs have arisen outside of our control and it was in some ways fortunate that this complete redesign and change of insulation was required at this stage and not nearing completion as other projects across the country have been. RL suggested conversations be held outside the meeting to go through the budget with RG.

Action: Conversation to be held outside the meeting on cladding & family consultation (JG/NM/RG)
Action: Conversation to be held outside the meeting on budget (RL/RG)

Resolved:
RABD received and noted the Campus & Park updates.

.20/21/247 Marketing and Communications Update

MF gave a verbal Marketing & Communications update, noting that the Volunteer Team have been awarded The Queen's Award for Voluntary Service, for which a celebration is planned. Future papers will include the Green Agenda update, an update on Marketing with Strathouse and Staff Engagement.

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

20/21/248 Accelerator Bid Update

RV presented an update on the Paediatric Accelerator programme, noting the increased activity requirements and the financial impact of this upon expected Elective Recovery Funding. The bid has been predicated upon transformational

change within five key areas and information was share on the next steps for the programme including putting changes into place within Theatres, setting up governance arrangements, plans & monitoring processes and ongoing coordination through workstreams and the central PMO.

IQ asked are we being realistic by asking staff who have worked incredibly hard for the last fifteen months to now increase their output by up to 20%; RV responded that this is voluntary and initially there has been a good take-up with a lot of the things being put in place being around longer-term sustainability of delivery.

RL commented that one of the areas looked at is Surgery and switching off some of the temporary & premium spend by recruiting into some of the posts over the next 12-18 months, so some of this may go beyond the initial 3 months. Also, we are the host for this bid on behalf of the Paediatric Trusts and will receive the funding for distribution to the other organisations.

NM noted serious concerns about the workforce and that as a Board there is a responsibility is to ensure that staff are not undertaking work which puts them at risk; it has been shown that when extra work is taken on like this there are more likely to be patient safety issues. It is very difficult because the extra money means we can do more for children, but that means pushing staff hard - the NHS message is to look after the staff and do more work but that doesn't add up. IQ added that there is a disconnect between look after your staff to get them to work harder.

SA asked whether each organisation is working in silo or whether techniques and ideas around efficiencies and technology are being shared across the paediatric trusts as this is a real opportunity to build transformative change together; RV responded that there is a lot of collaborative working with a number of groups and lessons being shared to develop the themes of becoming more effective and productive but without putting more pressure on staff to get more patients treated. RL added that as part of the bid a cross-cutting theme was created which has been funded so each organisation has put funding in to create a digital platform to share ideas and work together. This will help to maximise the funding so it is not just a short-term opportunity. There are various sub-groups which meet very regularly and are all starting to think about the legacy that can be developed from this. JG noted that this has brought everyone together and has re-energised the Children's Hospital Alliance; it's a brilliant opportunity and that bringing together could be the best thing to come out of this work.

JG noted that the Trust is entering a critical phase of acceleration with the potential RSV surge and winter ahead of us and there may be an opportunity at Trust Board to explore any worries or concerns and reflect upon today's discussion.

Resolved:
RABD received and noted the Accelerator Bid update.

20/21/249 **Month 2 Corporate Report**
JG presented a brief update on the M2 Corporate Report, noting the demand on ED with levels at 130% of pre-Covid levels. Demand is still high with performance levelling off and internal work ongoing to ensure the right resources and response and also externally with other partners around urgent care demands. Elective activity recovery has been strong with the improved position of long waiters a result of that.

Resolved:

RABD received and noted the M2 Corporate report.

20/21/250 **Safe Waiting List Management Update**

RV gave a brief presentation on the Safe Waiting List Management program and updated the meeting that Regular monitoring meetings with the CCG continue to be held. It was noted that there are 3 patients who have so far refused inpatient treatment due to Covid.

The validation process for inpatient and outpatient records is coming to a close and senior reviews will be undertaken on any records which require it. Validation of elective records is ongoing and the new Inpatient RTT waiting list has gone live successfully with full visibility of the full inpatient waiting list. Work is ongoing to define and develop the Outpatient waiting list and it is hoped that this will be live before he next RABD meeting.

Finally a business case for a substantive data assurance team has been completed and will be submitted to the next SDG and IRG meetings for approval. In terms of governance and reporting, this is managed through the Corporate Risk Register and is reviewed and updated regularly.

IQ noted that it would be helpful to record the learnings from this work so it does not happen again; RV responded that an RCA has been submitted and the full report is being finalised with full details of the root causes and lessons learned.

Resolved:

RABD received an update on Safe Waiting List Management.

20/21/251 **PFI Report**

RG noted that performance remains satisfactory with the team managing any ongoing issues, the greatest of which is the green roof, however work is ongoing with JG to escalate this with both Project Co and the shareholder boards to try to bring some conclusion to this. Something is being done but very slowly and endeavours to speed that up are not working. Corroded pipe work is still ongoing with a plan in place and risk assessments for that are currently being reviewed to ensure everything has been captures – the Digital team will then be involved to assess impact on server rooms etc.

GD joined the meeting and gave an update on energy and advised that currently ventilation systems are running 25% higher than they need to which increases energy usage. It is likely that this will continue as long as long as air changes remain, although as patient numbers increase that high usage will decrease. The ED extension has been completed and opened on 19th May and the medical gas hose replacement programme is underway.

KW asked for information around the fire risk around failing UPS and the programme for replacing the old UPS's. GD advised that the order for replacements was placed before the first incident, and this is on the radar but does need to be expedited.

NM asked when a decision will be made to remove the green roof; GD responded that this is probably the last opportunity to fully reinstate the roof and if it does not come back to how we would expect then we do need to revisit this but also agree what will replace it. MF noted that there is a lot of time spent going over building-related issues which keep coming around, and does there now need to be a more systematic review of responsiveness to concerns and issues, to undertake an

external review on whether they are actually taking the right approach or being mechanistic – other organisations have successful green roofs but ours doesn't seem to be; GD noted that an expert will be reviewing the roof situation shortly with a report to come back to a future RABD.

JG noted that following meetings with the PFI, there are things being changed over coming months and it is hoped that after the summer there will be a board-to-board meeting to include their new board and investors. There has also been a change in managing company with Mitie having taken over and a number of different directors within Project Co. It is also hoped to have a workshop with Bevan Britten to develop using the contract levers available to the Trust.

RL noted that there are now contract levers available within the updated contract for the green roof to enact and seek financial reimbursement.

Action: Board-to-Board meeting to be arranged in September to give clarity on resolution to ongoing issues (JG)

Resolved:
RABD received and noted the M2 PFI report.

20/21/252 Board Assurance Framework
ES gave an update on the Board Assurance Framework, highlighting that work needs to be undertaken with RG to update the Campus risk and associated actions.

Action: Campus risk & actions to be reviewed (ES/RG)

Resolved:
RABD received and noted the BAF update for May 2021.

20/21/253 Any Other Business
There was no other business.

20/21/254 Review of Meeting
Key points: key decisions to be taken over next few months.

Date and Time of Next Meeting: Monday 26th July 2021, 10am – 12.30pm, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 26th July 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)
	Claire Dove	Non-Executive Director	(CD)
	Dani Jones	Director of Strategy & Partnerships	(DJ)
	Melissa Swindell	Director of HR & OD	(MS)
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance:			
	Mark Flannagan	Director of Communications	(MF)
	Russell Gates	Associate Commercial Director Development	(RG)
	Ken Jones	Associate Director Financial Control & Assurance	(KJ)
	Cath Kilcoyne	Deputy Director Business Development	
	Emily Kirkpatrick	Associate Director Commercial Finance	(EK)
	Rachel Lea	Deputy Director of Finance	(RL)
	Nicki Murdock	Medical Director	(NM)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Clare Shelley	Associate Director Operational Finance	(CS)
	Ronnie Viner(part)	Safe Waiting List Management Adviser / Accelerator Programme Manager	(RV)
	Amanda Graham	Committee Administrator (*minutes*)	(AG)
	Chris Catterall	Capacity Lab (part)	(CC)

20/21/255 Apologies:

Apologies were received from John Grinnell and Claire Liddy.

20/21/256 Minutes from the meeting held on 21st June 2021.

Resolved:
Subject to an amendment being made to correct initials, the minutes of the last meeting were approved as an accurate record.

20/21/257 Matters Arising and Action log

The cladding for the new Neonatal Unit has now been agreed as being shades of green and the project has now been submitted to the Council's Planning Committee.
Action – RG to share logic behind decision
Green Plan recruitment is progressing.
The Social Value webinar has taken place and follow up will be done to integrate this into procurement processes.

20/21/258 Declarations of Interest

There were no declarations of interest.

20/21/259 Finance Report

Month 3 Financial Position

CS gave an update on the position at the end of Month 3.The current forecast is for a break-even position at the end of H1. Revised ERF guidance has now been issued, which has a potential negative impact of £2.7m income. Current YTD position is a deficit of £625k, largely in line with the planned Q1 position. Main variances are £400k for Surgery's historic pressure and pressures in Facilities around non-clinical income in particular catering and parking.

There has been a request for the Trust to submit forecast scenarios to the ICS which range from a surplus of £0.5m to deficit of £3m, made up of the lost ERF, RSV costs and non-delivery of CIP.

Write-offs
CS gave an update on the write-off's requested at the end of Month 3 totalling £29k, including one for £27k for a research study running from 2009 to 2014. Following a delay in the invoice being raised, the fund had closed with no monies available to pay it.

IQ asked why there had been such a long delay; KJ advised that attempts had been made to recovery from various sources before write off however learning from this has highlighted a need to ensure that the Research Division has robust systems & processes to manage financial activity and connect that to the Finance team. RL to take an action from this.

KW asked that the IM&T status is displayed to acknowledge the income from LHCH which will offset the suggested overspend figure.

KW asked whether this month's pressure on the Division of Medicine is expected to continue and what needs to be done to manage this from a financial perspective; CS noted that there are some significant drug costs which will be reimbursed by Commissioners but that can be clarified going forward.

Action: RL to work with Research Division to ensure appropriate financial processes & systems are in place and being utilised effectively.

Division of Surgery Deep-dive Update
CS gave a brief presentation detailing the deep dive in the Division of Surgery over the past five years from a financial perspective, highlighting key areas of historic overspend and current position to date & forecast position for 2021/22.

As an overview, the Division held 29% of overall spend for the Trust in 2019/20, with Medicine holding 31%, Community holding 11% and 29% on non-clinical spend. Currently there is a £400k deficit, with only 76% of CIP identified.

In terms of forecast, the division is set to be £6m away from plan by the end of 2021/22 if all pressures remain; however, ERF pressures could be removed as Months 1-3 will be funded as potentially will Months 7-12. Cost pressures submitted of £3m are all pay-related and predominantly recurrent historic costs. Further analysis is needed on the specialities within the Division, along with further work to understand the underlying financial position, There needs to be a focus on areas which can be controlled or undergo transformation to give recurrent CIP savings and also give consideration to current Trust priorities such as Elective Recovery.

IQ commented that whilst that was a good summation, there were no fixes; CS advised both the business accountant and ACOO in surgery will be in post from October and will continue to implement the action plan with costs needing to be controlled.

IQ noted that the Division has a budget each year, but after four months they are already adrift; CS replied that there are several things that are being looked at, one in particular being the change in pay costs from £72m last year to £70m this year.IQ asked for a plan to put this right to be developed,

RL commented that there are elements within the action plan that need to focus on the specialities making a loss, looking at benchmarking against peer hospitals to ensure we are being paid comparable rates etc.

CD added that it is an opportunity for those new staff coming in to come up with some new ideas to reduce costs.

AB noted the importance of developing a financial sustainability plan for the Division. Budget setting needs to be correct and enacted. Increased activity can still be undertaken to generate additional income, but it is now more difficult. The Division can be supported with clarity on additional income available while keeping close control on CIP, with temporary staffing being a major piece which needs focus. The financial sustainability plan needs to come back to RABD and close monitoring on delivery each month.

Action: CS to bring action plan to next RABD for the Surgical division, to be presented by the Division. (CS)

Resolved:
RABD received and noted the M3 Finance report.

20/21/260 **2021/22 Planning Update**
RL presented a brief update on Planning for 2021/22, advising that there have been some changes in H1 plans and some indication for H2.

H1 key change is the activity threshold increase to 95% for July-September, creating an additional pressure for every provider. Consequently, any ERF activity up to that 95% threshold will not now attract any additional payments. Finally, the emerging RSV surge has created a need to invest £1m in key critical roles within the Trust. The impact of these changes will be a minimum loss of £2.4m income with a worst-case scenario of £4.5m and it is looking increasingly unlikely that C&M will meet 95%.

Work is being done to review all costs and national assumption is that 95% acitivty should be delivered within existing cost base.

An RSV plan has been shared with NHSE seeking financial support for the funding required.

There have been indications for H2, that it will continue to be a block payment with "efficiency targets" renamed "waste reduction targets" and expected minimum target of 3%. There will however be some growth funding and also funding for pay awards & inflation. ERF will likely continue at the 95% level.

Areas of focus agreed by the Executive Team will be maximising new clinical income & funding; accelerating quick wins within non-clinical, commercial & business development income; hospital optimisation and driving more for the Alder Hey £. Four local Specialist Trusts will be undertaking a strategic planning exercise to identify risks, benchmark & influence regional & national planning, with output in Q3.

NM asked whether the activity level is 95% across C&M; RL confirm that this is the level.

KW noted the term "waste reduction" might want some thought. Also, in relation to RSV, what is the likelihood of receiving the requested amount, and should we be aiming for the higher level straight away; RL responded that was a good point and this will be factored into the formal letter being drafted.

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

20/21/261 **Business Development – Telemedicine Platform**
CK gave a brief update to advise on the current status of the telemedicine plan. There are now both a financial pipeline and a timeline in place, enabling the plan to move forward working with Teledoc with the aim to be up & running by 1st October 2021. The financial pipeline is over four years, with a six-month pilot. There are also four other projects with Teledoc, as well as a social value project with an international NGO who deal with craniofacial challenges in Vietnam.

KW noted that operating costs need to be really clear, in particular around licences. SA asked for further clarification of the costs and the benefit of the partnership with Teledoc.

CD queried the social value element of the project and how this will be taken forward. CD noted that once Alder Hey's social value framework is in place that will give clarity on social value.

MF asked whether the Corporate Partnership & Sponsorship Policy should be formally brought back to RABD as a first draft as it is outdated and does not reflect ambition or recognise the social value element where appropriate.

NM noted there is some social value to move from individual-based relationships with organisations to more organisation-to-organisation relationships with a more sustainable offering to overseas professionals & patients, this is a better way to support lower resource countries. IQ agreed, noting that a corporate relationship is stronger & more sustainable than a personal one.

IQ queried the choice of specialities for the telemedicine platform being Neurosurgery & Oncology; CK responded that this is a second opinion service for advice-only consultations.

RL introduced Emily Kirkpatrick as the new Associate Finance Director for Commercial Finance who will be supporting the Innovation & Business Development team.

Action: Corporate Partnership & Sponsorship Policy to be redrafted & brought to a future RABD for review (MF to identify & advise lead)

Resolved:
RABD received and noted an update on the Telemedicine Platform.

20/21/262 **Capital & Cash Updates**
KJ gave a brief update on the current cash and capital position. KJ noted that this month is a holding position with further work on going on the capital programme particular the estates projects.

KJ shared a brief forecast for the remainder of 2021/22, which has raised two risks. The forecast has shown a reduction in cash levels largely relating to the reduction in expected revenue for ERF income.

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

20/21/263 **Hosted Schemes**
KJ gave an update on the progress of regional digital schemes hosted by Alder Hey. Alder Hey is one of four hosts and in previous years capital aspects of programmes have been the main focus; all funding has been drawn down and schemes will be fully delivered and assets become live by the end of the financial year.

Discussions are ongoing with the ICS on the future revenue model for the ongoing charges relating to the assets once they become live to ensure that Alder Hey are not left with residual risk as the assets are for the benefit of the region. KW advised that the schemes were identified as high priority back for C&M in 2018 and still stand as part of the NHS Digital Strategy and NHSX work.

DJ commented that it would be beneficial to host organisations to gain clarity and a "set of principles" around hosting, as that would support other hosted schemes. KW added that Alder Hey have taken on the hosting of schemes when other organisations were unable to do so, showing a significant leadership role within C&M, adding that as the new ICS and ways of working come into place there is a need to lock in the principles going forward.

Resolved:
RABD received and noted the Hosted Schemes updates.

.20/21/264 **Campus & Park Updates**

Campus Update, Estates & Space Strategy
RG gave a brief update ahead of a more detailed paper to come to the next RABD. A significant amount of work is continuing with demolition and clearing the site which includes rehoming of staff from current buildings. The paper will highlight the context and seek early release of funds to undertake design works on a number of schemes and will advise of the moves to Innovation Park for staff currently in the Catkin building which is due to be demolished early next year.

Innovation Park will become the new location for corporate teams currently based in the Institute and also the CAMHS teams, It is expected that the moves will begin in October.

NM sought clarification on the refurbishment costs of the leased building and RG confirmed this will be a Trust cost. NM asked for clarification around the histopathology building, which RG noted was to remain for the moment but does sit within the boundary of the reinstated park.

IQ asked whether the refurbishment costs could be rentalised; RG responded that has not been done as yet, but the question can be asked of the landlord.

IQ asked for clarification of approval requested; RG responded that release of funds to carry on with Innovation Park phase two for CAMHS and Therapies, and also a

small release of funds to progress other schemes to keep design moving forward and ensure costs are controlled.

RL noted that the CAMHS work is funded.

Approved: The Committee approved the release of funds as requested in the paper.

Park Phase 2 & 3
RG gave an update on progress with managing the budget for the Park phases 2 & 3. Following previous meetings where concern had been raised about the imbalance between the original estimates and actual costs, work has been ongoing to understand and reduce costs whilst staying within the legal agreement and planning permission. The outcome of this work was shared and processes have been put in place to prevent a similar situation arising in future.

IQ noted that everything included in the scheme was included within the original estimate. IQ asked for clarification on the figure quoted for inflation over the period concerned, which was given.

MF commented that the paper is helpful, but also asked for clarification on firmness the rigour around managing development costs as accountable directors needing to be assured of the risks. There is a need to keep both within budget and within the vision to deliver. IQ commented that there is a need for both the increased rigour and value engineering review and noted that the decision on funding this will need to go to Trust Board.

RG confirmed the process in place to manage developments, outlining the process and stages, noting the rigour from having a project management board and SRO who keep reviewing costs and progress.

RL noted two points: one around governance which is now in place, but reviews need to be regularly undertaken from start to finish and that quantity surveyors are being involved earlier; also affordability across the Trust will be impacted by this, as the amount needed will put pressure on other schemes and there will be some difficult choices to be made in future months.

Resolved:
RABD received and noted the Campus, Estates & Parks updates.

20/21/265 **Capacity Lab Update**
A presentation was given by Capacity Lab on progress working with Springfield Park and local residents.

SA noted thanks for the presentation and asked whose responsibility it will be to run & maintain the physical structure once it is built; CC noted that discussions are ongoing as to the ownership of the assets and who will operate the buildings and confirmed that there is no ongoing obligation to Alder Hey.

RL asked that a conversation be taken offline around responsibilities for Alder Hey.

Resolved:
RABD received and noted the update from Capacity Lab.

.20/21/266 Marketing and Communications Update

MF noted that the report was within the papers circulated.

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

20/21/267 RSV Plan Update

AB noted that the plan was within the papers circulated, giving a brief update of the current scenario and highlighting awareness of the potential of more challenging situations in the near future.

IQ asked whether RSV is connected to Covid; AB noted that it is not connected, NM adding that it is coincidental and the current increase in numbers is as a result of the "normal" winter surge not happening die to lockdowns and people not associating with each other.

SA asked whether Covid testing as being carried out alongside any new inpatients, and what will happen if positive; NM noted that there is a respiratory test undertaken on children for RSV, Covid and other respiratory infections. If positive they would be isolated either in a single bay or a 4-bed room with other patients with the same illness.

Resolved:
RABD received and noted the RSV Plan update.

20/21/268 Safe Waiting List Management Update

RV noted that the report was within the papers circulated and gave a brief presentation on the Safe Waiting List Management program, updating the meeting that regular monitoring meetings with the CCG continue to be held.

KW noted that there will be some work linking with the new Data Quality policy which will be brought to a future RABD.

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

20/21/269 Month 3 Corporate Report

AB presented a brief update on the M3 Corporate Report, noting that the report was within the papers circulated.

Resolved:
RABD received and noted the M3 Corporate report.

20/21/270 Digital Update

KW noted that the report was within the papers circulated.

Resolved:
RABD received and noted the Digital Services report.

20/21/271 **PFI Report**

RL noted that the report was within the papers circulated.

Resolved:
RABD received and noted the M3 PFI report.

20/21/272 **Board Assurance Framework**

ES gave a brief update on the Board Assurance Framework, highlighting that there are three new external risks to be noted.

Resolved:
RABD received and noted the BAF update for June 2021.

20/21/273 **Any Other Business**

There was no other business.

20/21/274 **Review of Meeting**

Key points: surgical deep dive to understand the problem numerically and to have actions to resolve the problem; and capital projects overrun which predates everyone, is not within RABD's gift to approve and will need to go to Trust Board.

Date and Time of Next Meeting: Monday 23rd August 2021, 10am – 12.30pm, via Teams.

BOARD OF DIRECTORS

30th September 2021

Paper Title:	**Safety Quality Assurance Committee**
Date of meeting:	22nd September 2021 – Summary 21st July 2021 – Approved Minutes
Report of:	Fiona Beveridge, Chair, Safety Quality Assurance Committee
Paper Prepared by:	Fiona Beveridge, Chair, Safety Quality Assurance Committee

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 22nd September, along with the approved minutes from the 21st July 2021 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	None
Associated risk (s)	None

1. Introduction

The Safety Quality Assurance Committee 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 is responsible for providing the Trust Board with assurance on all aspects of quality including clinical quality, clinical practice and clinical governance arrangements and activities within the Trust.

2. Agenda items received, discussed / approved at the meeting at the meeting held on 22nd September 2021

Significant items received and discussed at the SQAC meeting included:

Quality Priorities – updates on progress for Parity of Esteem and Medication Safety; Deep Dive on The Deteriorating Patient, with clear progress being made in all three areas, and good discussion on moving the activity out from the Quality Improvement Team into 'how we work'. Identified the importance of the people element alongside education and system improvement etc., and agreed to hear in future meeting about the STAT programme.

Never Event (Wrong Side Block) update – progress now made on the audit issue with the deployment of online audit tools, agreed action can now be closed.

Safe Waiting List – update presented alongside detailed report, progress noted. Board should note that the CCG is no longer monitoring progress, being satisfied the issue has been addressed. The work has now moved from inpatient lists to outpatient lists, and will result in confidence and assurance across the board on waiting list management.

Consent Policy – the findings of the audit were presented and key issues which it identified were noted. Good progress is being made to deploy e-consent within Surgical Division, with the electronic workflow designed to eliminate/reduce issues. Will now be disseminated across departments to align their processes, with future audits pre-set for November and March. Ongoing discussions on option to use recordings of consent conversations in the record.

SQAC noted that consent is an issue across all three Divisions and more work needs to be done to ensure good practice everywhere, to link to Academy/CPD/Training in most effective way, and to ensure that all consent-takers have a good understanding of the Mental Capacity Act.

NICE compliance – requested more focused attention on the format of the action plan, and to address outstanding non-compliance: update to come to November SQAC.

Divisional updates included highlights, but resounding theme across all three was pressures within service resulting from high clinical load, coupled with staffing issues, Covid, sickness etc. Community highlighted positive impact of investments in Estate on team morale.

Full minutes will be available at the October Board.

3. Recommendations

The Board is asked to note the committee's regular report.

Safety and Quality Assurance Committee
Confirmed **Minutes of the meeting held on**
Wednesday 21st July 2021
Via Microsoft Teams

Present:	Fiona Beveridge	Non-Executive Director (Chair of SQAC)	(FB)
	Kerry Byrne	Non-Executive Director	(KB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	Robin Clout	Interim Deputy CIO	(RC)
	Lisa Cooper	Director - Community & Mental Health Division	(LC)
	Urmi Das	Interim Divisional Director for Medicine	(UD)
	John Grinnell	Director of Finance/Deputy Chief Executive	(JG)
	Dani Jones	Director of Strategy & Partnerships	(DJ)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
	Christopher Talbot	Safety Lead, Surgery Division	(CT)
In attendance:			
	Cheryl Brindley	Clinical Services Manager IPC/PPE	(CB)
	Julie Creevy	Executive Assistant (Minutes)	(JC)
21/22/67	Benedetta Pettorini		
21/22/68	James Ashton		
21/22/68	David Porter		
	Cathy Umbers	Associate Director of Nursing & Governance	(CU)
21/22/67	Jennie Williams	Head of Quality Hub	(JW)
	Kerry Turner	Senior Quality Improvement Practitioner Freedom to Speak Up Guardian	(KT)
22/22/74	Julie Knowles	Assistant Director of Safeguarding/Clinical Director For Statutory Services	(JK)
21/21/63	**Apologies:**		
	Adrian Hughes	Deputy Medical Director	(AH)
	Beatrice Larru	Consultant, Infectious Diseases	(BL)
	Phil O'Connor	Deputy Director of Nursing	(POC)
	Nicki Murdock	Medical Director	(NM)
	Cathy Wardell	Associate Chief Nurse, Medicine Division	(CW)
	Kate Warriner	Chief Digital & Information Officer	(KW)

FB welcomed all members and attendees to the Safety and Quality Assurance Committee (SQAC).

21/22/64 Declarations of Interest
SQAC noted that there were no items to declare.

21/21/65 Minutes of the previous meeting held on 23rd June 2021 –
Resolved: Committee members were content to **APPROVE** the minutes of

the meeting held on 23rd June 2021.

21/21/66 Matters Arising and Action Log

Action Log

The action log was updated accordingly.

Matters Arising

Quality Improvement Progress Reports

21/22/67 Quality Priorities Monthly update

BP & JW presented the Quality Priorities Monthly update.

Key milestones and activities were noted in relation to the Deteriorating Patient and the medication errors work streams, with key learning points regarding what has and hasn't worked well, and how this learning could be used to ensure any required changes in both projects.

Parity of Esteem – JW reported that there are no risks to escalate to SQAC, and that this is on trajectory with mitigating actions in place, with appropriate project support in place.

KB referred to metrics and targets and queried whether targets should be more Inspirational in order to reach 100%. JW advised that the Trust is implementing training to ensure that staff feel confident, and are able to have open conversations with C&YP, with a significant piece of work regarding meditech planned, however it is unrealistic that 100% would be achieved by the end of 2021. JW advised that aspirational target would be 100%, however the realistic target of 50% would still be aspirational, but more realistic.

JG referenced the deteriorating patient and advised that there is more depth within the report and questioned whether given the multiple systems whether or not there is a simple and clear approach, in order to manage the deteriorating child. BP advised how the links between systems would be monitored and reported. BP advised that the Care Flow implementation is essential to ensuring real time monitoring data. BP advised that should any additional resources be required in the future that this would be escalated as appropriate. NA confirmed that DETECT and Care Flow had been supported for a further year, whilst the Trust develops an in house solution.

JG referred to Parity of Esteem and the breadth of information being reviewed, and questioned whether this gives any risk to the Trust. LC provided assurance to SQAC that she did not envisage that the Trust would lose focus.

KB referred to the Pharmacy resource issue, - this had been escalated to MA the new Chief Pharmacist, with the hope of a resolution.

SQAC agreed that it would be helpful to include additional columns within the report detailing shorter and longer term targets.

BP sought support from NM with regards to Medical Leadership regarding Care Flow implementation. NA agreed that he would feedback BP request on NM return from leave on 26th July 2021.

SQAC **NOTED** the good progress made by teams in all three areas, with strong

engagement of teams, together with detailed plans and targets with strong momentum on the many different workstreams.

FB thanked BP/JW and welcomed significant progress relating to the three strong project streams and recognised significant work to do

SQAC received and **NOTED** the Quality Priorities Monthly Update regarding Deteriorating Patients, Medication Errors and Parity of Esteem.

Sepsis Update
DP & JA presented the Sepsis update which provided a 9 month update, overview of administering Antibiotics within 60 minute & 90 minute reported data, dashboard, incident reporting, training and plans for the next 6 months. The committee NOTED that there had been considerable progress since the last report and agreed with the actions for next steps.

SQAC **NOTED** that Care flow would continue for 12 months.

- Next 6 months to focus on established work, incident reporting/RCA's/Ward liaison, divisional updates, training Sepsis status across ED and Inpatients, data reporting, training compliance, DETECT and Meditech Expanse

Resolved: Sepsis update received and **NOTED**, which demonstrated progress to date with the introduction of 'Sepsis Status', with a real understanding of improved data, new dashboards, better documentation, and a consequent capacity to focus also on Antimicrobial stewardship. Support was required in terms of adapting and improving Sepsis training for the hybrid environment and ensuring recovery of a high level of training compliance
FB thanked DP and JA for Sepsis update.

21/22/68 **Never Event Report Action Plan updates and RCA**
NA presented the Never Event Action Plan; Key issues as follows:-

- NA advised that the RCA report was extremely comprehensive and provided an excellent overview.
  Root causes related to guidelines not being followed, specifically the WHO checklist process and stop before you block.
- NA advised that there is significant ongoing work required in order to address learning following the RCA with regards to contributing factors.

CT advised that the RCA/Action Plan presented to SQAC had recently been updated further, and an updated version should come back to the committee in at the September 2021 meeting

JG referred to point 8 in terms of raising awareness regarding stop before you block and sought clarity on whether any progress had been made. CT advised that there is an audit tool available, however further clarity is required in terms of support required to enable the implementation of monthly audits, and that the division are seeking support to ascertain whether support could be provided from Practice Education Facilitators.

SQAC **NOTED** that focussed leadership is required to ensure implementation of regular monthly audits, JG agreed to discuss offline with A Bass and NA in order to accelerate progress, in order to aid implementation of regular audits.

Resolved: JG to undertake follow up discussion offline with AB & NA.
Resolved: Update to be provided by NA & CT at September SQAC meeting.
Resolved: - Action plan to be presented to SQAC at September 2021 meeting.

SQAC received and **NOTED** the Never Event Update.
FB thanked NA update.

21/22/69 CQC Action Plan
SQAC received and **NOTED** the CQC Action plan.

21/22/70 DIPC Exception Report
SQAC received and **NOTED** the DIPC Exception Report.

21/22/71 Transition Update
SQAC received the Transition Update with regards to Compliance with NICE Guideline 43: Transition from Children's to Adult services for young people using health or social care services. Currently the Trust us unable to demonstrate and monitor compliance with NG43 at Division and specialty level, with further ongoing work required to fully embed the responsibility for the transition of young people to adult services.

Committee expressed concern regarding the lack of a senior lead for Transition within the Division of Medicine and within the Division of Surgery and highlighted the need for leads to be rapidly identified. SQAC **NOTED** that the Medicine Division and Surgery Division are also required to undertake a self-assessment of NICE guideline NG 43 as a priority.

FB sought comments from UD & CT, both UD and CT advised that the Divisions had emailed colleagues within each of the divisions in order to seek a transitional lead, however, unfortunately to date no responses had been received. SQAC acknowledged that colleagues are all working incredibly hard, however there is a requirement for leads to be promptly identified. SQAC agreed that a discussion would be required at Executive Team in order to ensure that Transition Leads are identified urgently.

Resolved: JG to ensure that Transition Leads are to be discussed at Executive Team discussion

Committee **NOTED** the compliance with NICE Guidance NG43 is a priority for the Trust. FB welcomed significant progress update for the next Quarterly update at October 2021 SQAC meeting.

FB thanked LC for Transition Update

Resolved: SQAC received and NOTED Transition Update

21/22/72 Aggregated Analysis Report including management of high profile inquests, complaints, incidents including lessons learned or near misses and improvement actions, legal cases and clinical claims.
CU presented the Aggregated Report. CU
advised that the report demonstrate a good reporting culture.

Key issues as follows: -

- The number of incidents reported in 2020/21 was 6706 compared to 6324 in 2019/20 demonstrating, an increase of 5.5.%, indicating an increasingly supportive culture of learning and openness
- The number of StEIS incidents reported in 2020/21 was 17 compared to 15 in 2019/21
- There was a total of 154 formal complaints and 962 PALS enquiries for 2020/21 compared to 110 complaints and 1280 PALS in 2019/20.
- There were 21 new/potential clinical negligence claims, and 10 new Coroner's cases in 2020/21, which is comparable with 24 new/potential claims in 2019/2020 and 14 new Coroners cases.
- CU advised that Neurology division are an outlier with primary issues relating to ticks/tourette's treatment with a high number of incidents.

RESOLVED: SQAC received and NOTED the Aggregated Analysis Report including management of high profile inquests, complaints, incidents including lessons learned or near misses and improvement actions, legal cases and clinical claims.

FB thanked CU for comprehensive update.

21/22//73 Safeguarding Children Annual Report

SQAC received the Safeguarding Children Annual Report which provided an overview of key achievements of 2020/21, together with priorities for the forthcoming year.

RESOLVED: SQAC received and NOTED the Safeguarding Children Annual Report

21/22/74 Children with Complex Behaviour Update

SQAC received the Children with Complex Behaviour Update, which included an overview of background, programme structure, progress update and detail regarding metrics.

Resolved: SQAC received and NOTED the Children with Complex Behaviour update

21/22/75 Assurance ED Activity Monthly Update

SQAC received the ED Activity Monthly Update, which provided an overview of the current position, urgent actions, and recommendations.

Resolved: SQAC received and **NOTED** the Assurance ED Activity Monthly update and **NOTED** the recommendations.

21/22/76 ED MH Attendance

SQAC received the MH Attendance Report. SQAC **NOTED** that the report submitted did not cover the required quarter of attendances. UD would follow up offline with CW, for the correct report to be reissued and recirculated to committee members.

Resolved: UD to follow up offline with CW to ensure that the Q1 ED MH Attendance report is shared with Committee members

SQAC received ED MH Attendance report, and **NOTED** that the correct Quarter 1 update report was required, which would be circulated to Committee

members on receipt.

21/22/77 Safety Strategy

SQAC received the Safety Strategy which both NM & NA had developed. The NHS Safety Strategy underpins and is central to the Alder Hey Safety Strategy. This strategy sits alongside other plans, including "Our People Plan", our Trust Strategic Plan. Alder Hey Safety Strategy ensure insight, involvement and improvement. NA stated that the Safety Strategy had been shared at various forums and welcomed SQAC comments, prior to presenting to Trust Board on 29th July 2021.

KB stated that on review of the Safety Strategy that the document would benefit from the background detail relating to the NHS Safety Strategy being separated or differenced, in order to clearly define AH Safety Strategy from the NHS Safety Strategy – KB suggested to potentially include the background detail within the text boxes to differentiate. NA confirmed that he would provide feedback to NM on NM's return from leave on 26th July 2021, and improvements would be made to the strategy presentation in order to make it easier to identify.

Resolved: SQAC received and endorsed the Safety Strategy.
FB thanked NA for Safety Strategy Update.

Clinical Governance Effectiveness

21/22/78 CQSG Key issues Report

NA advised that a good CQSG meeting had taken place on 13th July 2021, CQSG had discussed issue regarding Transition.

FFT continues to improve, with a good overview, however response rates remain low across the organisation compared to the national averages, with ongoing efforts in order to increase responses.
FB thanked NA for CQSG update.

Resolved: SQAC received and NOTED CQSG verbal update.

21/22/79 Quality Account

SQAC received the Quality Account, NA advised that the Quality Account is due to be presented to Trust Board on 29th July 2021. The Trust originally anticipated that the publication date of 30th June 2021 would be delayed, the Trust had been awaiting confirmation, however the Quality Account publicatrion date was not altered and had been published via e-governance. Quality Account had been presented to Commissioners on 18th June 2021.

NA expressed his thanks to CU for completion of the Quality Account following T Rigby's retirement.

Resolved: SQAC received and NOTED the Quality Account.

21/22/80 Board Assurance Framework

SQAC received the Board Assurance Framework; key issues as follows:-.

- AB referred to internal risk relating to 'Inability to deliver accessible services to patients, in line with national standards due to the adverse impact of COVID 19 on waiting times for elective care'. AB confirmed that this BAF risk had been reassessed in light of Trust planning regarding RSV, and the surge in urgent care presentations, both of which are a threat to the Trust level of recovery which the Trust had been achieving, which has been outstanding to date, however as colleagues undertake a forward look, should RSV

surge at 50% or above, then the Trust would have to retract the level of planned care delivered, given that there is no other option than requesting support from colleagues that work in outpatients, theatres and other areas for help, in order to deal with such a surge. BAF had been updated to reflect this new threat to waiting times and access to care due to the possibility of RSV and the pressures currently being experienced.

SQAC received and **NOTED** the Board Assurance Framework update.
FB thanked ES & AB for update.

21/22/81 Divisional Reports by exception/Quality Metrics

Community & Mental Health Division – LC provided key issues as follows:-

- The Division continue to see increased referrals with over 100% increase in Mental Health Referrals compared to June 2019, with 85% increase in ASD/ADHD referrals, compared to June 2019. Ongoing work continues with partner agencies and the Local Authority.
- LC advised that the Division had been given notice from Merseycare to vacate premises currently being used to provide Speech & Language Therapy services from, both JG & R Gates are both cited on this issue.

Medicine Division – UD provided an update on key issues as follows:-

- .100% acknowledgement of formal complaints within 3 working days, 100% compliance response to formal complaints within 25 working days within May 2021
- The Division have a regular 'governance hour' which takes place every month and is dedicated to patient experience, this had taken place in May & June 2021, with July meeting scheduled for 22nd July 2021

Surgery Division – CT provided an update on key issues, as follows:-
Highlights
Safe

- The Division had no Grade 3 or Grade 4 Pressure Ulcers since December 2020, CT commended the ongoing efforts of colleagues within the Division in terms of education regarding Pressure Ulcers, and with regards to developing tools to ensure continued improvement regarding Pressure Ulcers.
- Continued improvement regarding RTT waiting times over 52 weeks.
- Challenges regarding increase in inpatient and outpatient's capacity with regards to the ongoing increasing levels of referrals, with caution regarding RSV surge

FB welcomed Divisional updates and thanked colleagues for updates.
SQAC received and **NOTED** Divisional updates.

21/22/82 Any other business
None

21/22/83 Review the key assurances and highlight to report to the Board
Positive updates were received regarding: -

- Quality Improvement Programme which highlighted good progress made by teams in all three areas, with strong engagement from teams, detailed plans and targets and strong momentum on the many different workstreams. SQAC NOTED support requested regarding previously submitted Business Case for Education Governance 8A post, and NOTED the support request from NM regarding Medical leadership on Care Flow implementation.

- Sepsis Update Received which demonstrated progress to date with the introduction of 'Sepsis Status', with a real understanding of improved data, new dashboards, better documentation and a consequent capacity to focus also on Antimicrobial stewardship. Support was required in terms of adapting and improving Sepsis training for the hybrid environment and ensuring recovery of a high level of training compliance
- Aggregated Analysis Reporting including management of high-profile inquests, complaints, incidents, including lessons learned or near misses and improvement actions, legal cases and clinical claims demonstrated clear governance process in place, with a sense of a clear reporting culture.
- Safety Strategy was received and endorsed
- CQSG update received
- CQC Action Plan received
- DIPC Exception report received
- Safeguarding Annual Report received
- Children with Complex Behaviour Update received
- Assurance ED Activity Monthly update received
- ED MH Attendance report to be amended, updated and circulated as appropriate
- Quality Account was endorsed and NOTED
- Board Assurance Framework received, SQAC NOTED access to care in terms of planning for potential RSV/Surge and NOTED the threat level in terms of service recovery
- Divisional updates regarding highlights and challenges were NOTED

20/21/84 Date and Time of Next meeting

22nd September 2021 at 9.30 via Microsoft Teams

BOARD OF DIRECTORS

30.09.2021

Paper Title:	**People and Wellbeing Committee**
Date of meeting:	21st September 2021 – Summary 20th July 2021 - Approved Minutes
Report of:	Claire Dove, Committee Deputy Chair
Paper Prepared by:	Jackie Friday, PAW Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent People & Wellbeing Assurance Committee meeting 21st September 2021 along with the approved minutes from the 20th July 2021 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐
Resource Impact:	None
Associated risk (s)	BAF 1.1 – Achievement of Outstanding Quality for Children and Young People as defined by the CQC regulations – current risk IxL: 3x3 BAF 2.1 – Workforce Sustainability – current risk IxL: 3x3 BAF 2.2 - Employee Wellbeing – current risk IxL: 3x3 BAF 2.3 - Workforce Equality, Diversity & Inclusion – current risk IxL: 3x4

1. **Introduction**
The People & Wellbeing Committee 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 is responsible for providing strategic direction and board assurance in relation to all workforce matters including monitoring progress against workforce indicators and supporting the organisation in delivering a positive patient centred culture.

2. **Agenda items received, discussed / approved at the meeting)**
   - People Plan September 2021 (overview)
   - Workforce Race Equality Scheme Report (WRES)
   - Workforce Disability Equality Scheme Report (WDES)
   - Staff Survey 2021
   - National Pay Update
   - Average Pay During Holidays (National Agreement – following Flowers Case)
   - Corporate Metrics/Workforce KPI's – August 2021
   - Board Assurance Framework/Key Workforce Risks – August 2021
   - CQC Action Plan – August 2021
   - E Roster Update
   - Policies reviewed:
     - Induction Policy
   - Minutes of Sub Committee/Working Groups reporting to the Committee
     - LNC – 09.06.21
     - Health & Safety Committee – 10.06.21
     - JCNC – 25.05.2021
     - Education Governance – 24.06.2021
     - BAME Task Force – Action Log 12.07.21

3. **Key risks / matters of concern to escalate to the Board (include mitigations)**
   - National Pay Update – Trade Unions in discussion with members - ballots expected – to be picked up at SQAC.
   - WRES & WDES – to be presented at Board next month.

4. **Positive highlights of note**
   - E Roster Update – the Committee received an update on the rollout of E Roster and thanked the E Roster Manager for the achievements made.
   - Health Education England Enhanced Monitoring Status update – the Trust is no longer on the monitoring list. The Committee commended the Teams for all their hard work.
   - Health & Wellbeing/Communications – Review/refresh to the approach of connecting/listening with staff with improved information sharing.

5. **Issues for other committees**
   - SQAC – National Pay – Trade Unions in discussions with members – ballots expected.

6. **Recommendations**
The Board is asked to note the committee's regular report.

People and Wellbeing Committee
Confirmed Minutes of the last meeting held on 20th July 2021
Via Microsoft Teams

Present:	Fiona Beveridge	Non-Executive Director (Deputy Chair)
	Melissa Swindell	Director of HR & OD
	Ian Quinlan	Non-Executive Director
	Nathan Askew	Chief Nurse
	Racheal Greer	ACOO - Community
	Raman Chhokar	ACOO – Surgery (COO Deputy)
	Cath Wardell	Associate Chief Nurse – Medicine
	Alfie Bass	Divisional Director Surgery (Medical Director Deputy)
In attendance:		
	Jo Potier	Associate Director of Organisational Development
	Helen Blackburn	Medical Education & Revalidation Manager
	Sarah Tempera	HRPB - Surgery
	Dot Brannigan	Public Governor (Observing)
	Katherine Birch	Director – Alder Hey Academy
	Tony Johnson	Staff Side Chair
	Jackie Friday	Executive Assistant (Minutes)
Apologies:	Claire Dove	Non-Executive Director (Chair)
	Mark Flannagan	Director of Communications & Marketing
	Adam Bateman	Chief Operating Officer (Part attendance)
	Nicki Murdock	Medical Director
	Andy McColl	
	Rachel Hanger	Theatre Services Manager
	Pauline Brown	Director of Nursing
	Erica Saunders	Director of Corporate Affairs
	Sharon Owen	Deputy Director of HR&OD
	Jacqui Pointon	Associate Chief Nurse – Community
	Urmi Das	Interim Director – Division of Medicine

21/22/21 Declarations of Interest

No declarations of Interest.

Introduction

The Committee welcomed Dr Katherine Birch.

21/22/22 Minutes of the previous meeting held on 18th May 2021

Resolved : The minutes of the last meeting were approved as an accurate record.

21/22/23 Matters Arising and Action Log

Action Log

21/22/09 – Circulate (when ready) the updated BAME inclusion Taskforce (Plan on a Page) to PAWC for review. This action is **noted as complete.**

21/89 – To review provision to support disabled staff in the absence of Networks – Members of the SALS team initiated a series of listening events, JP advised that a number of themes were identified, particularly around the requirement for subsequent events/call for networks to take place as staff really valued the space to connect with each other. JP/MKS to pick up outside of the Committee to agree how the network will be set up. This action is **noted as complete**.

20/29 – Share Procurement strategic government guidelines/Revisit Procurement statement – In the absence of CD – MKS advised we now have a different Procurement model in place. Hosting Procurement going forward will sit with the Walton Centre as a shared collaborative service. FB suggested that a Trust position statement may be required to guide the Trust relationship as part of the wider procurement consortium. IQ pointed out that we have good leadership/information as to the expected benefits of the shared collaborative service and future results will require judgment.

Action 20/29 - MKS – to refine action outside of the meeting.

Actions 20/42, 19/51 & 15/08 - Social value/modern slavery – to be progressed with CD/MKS outside of the meeting.

21/22/11-02 – Issue a reminder note to the Divisional 3 at the top re the importance of representation at the Committee going forward – MKS confirmed contact was made. This action is **noted as complete**.

21/22/15 – Virtual ratification of policies. This action is **noted as complete**.

21/77 – Security Policy – ask Security/Emergency Planning how often the Trust received advice on security measures – MKS advised that LSMS receives regular alerts/updates/bulletins/contact from the police and is connected to the networks. FB – sought reassurance relating to whomever is the point of contact within the organisation knows when to escalate and who to escalate to. NA confirmed that Security sits under the COO in terms of Operational Delivery and receives regular updates through that cascade system that comes from LSMS. In terms of emergency plan it would come through that route and he would be notified as well. This action is **noted as complete**.

20/20 – Equality & Diversity – Review EDI – overall action plan off-line – MKS advised we do have a trust wide action plan that has been reviewed. At the moment we do not have a dedicated lead for EDI. The dedicated lead will not commence in post until January 2022. Temporary support has been secured as the Trust is heading to that point in time where we need to be ready to complete the yearly Workforce Race Equality Scheme (WRES), Workforce Disability Scheme (WDES) and Equality Delivery system (EDS2). Extra support will be required to help us do a refresher on where we got to last year, because we have had a lack of dedicated resource in that area and focus has been on the Task Force, there is some work to do to make sure we were covering the required action plans. An update will be brought to September's Committee.

18/38 – Education Governance Update – MKS acknowledged the challenges in the past with the University Assessments and recognised with the support of KB in post there will be a more systematic approach of information received at PAWC and

possibly to CQAC from a quality perspective. MKS invited KB to update the Committee.

KB shared context around what has been taking place since coming into post, highlighted as follows:

- A review of the flow of information coming through the various reporting Committees/Trust Board. Particular focus is on how PAWC are sited on both the really good work and the positive assurances that can be received in terms of what is going on across the education field along with key risks.
- Working with Director of Corporate Affairs and the Governance Team to undertake a review of Education Governance to ensure we are compliant with various regulatory frameworks and processes. This will support the Education Governance Committee itself, but also in terms of risks in relation to medical education and apprenticeships.
- Some consideration is required in relation to apprenticeships (2019 Ofsted framework) as an employer provider there are some areas that need to be thought through. Also Medical Education colleagues will be aware that there was a new NHS contract signed in April of this year for all those providing training and education and that brings with it a raft of new requirements for us in terms of how we deliver this. Work in progress. Notes of June's Education Governance Committee will be received at Septembers PAWC. It is anticipated that at November's PAWC a much more structured and focussed report in respect of Education activity will be received. The action is **noted as complete**.

Action 21/22/23 – September PAWC to receive Education Governance Committee notes for June 2021. November PAWC to receive Education Activity update.

FB thanked KB and looked forward to receiving progress at PAWC around Education Governance and for the Board to be sited on actions and risks.

19/69 - Nurse Associate Recruitment – Develop a wider plan to be reviewed – MKS advised this action has been picked up in the Nurse Workforce report and has moved on significantly. NA confirmed this action is covered in the Nurse Workforce plan (for the next 5 years). Constructive conversation has taken place with VH recently and the intention is to delay the recruitment of Nurse associates until after January 2022 to allow time to recruit a substantial cohort, working on the business case in association with that. Route to nurse training and nurse entry for a wide diverse background will be picked up as part of that recruitment plan that has been put in place for the larger cohort. For assurance the committee will receive the outcome for that phase of recruitment. This action is **noted as complete**.

Trust People Plan 2019-2024

21/22/24 **People Plan Report July 2021**

The Committee received the People Plan Update Report, this report is a regular report presented to Trust Board and is noted as read by the Committee. MKS asked JP to give the Committee a quick update on what the OD and the SALS teams have been focussing on. JP gave a brief overview of some of the key themes:

Wellbeing Plan – largely focussed on supporting teams with:

- Coaching activity
- Strong Foundation Leadership Programme
- Targeted listening events – in response to need (i.e. menopause listening event)

- A lot of information to feed through to Board/Execs monthly basis
- Monitoring actions – fed back into the organisation
- Key themes coming through from the above is burnout – people feeling exhausted. Trying to find ways in which to address that in whatever way we can, whilst acknowledging there are challenges, with particular hotspots (ED)
- Working quite closely with ED with a support plan (raised at the last meeting). Helped to develop another pastoral care volunteer team (previously successful in the last wave of Covid). Similar model set up to support ED.
- Establishing in the organisation a wellbeing guardian – 9 principles associated with that role – working through an action plan

FB referred to the feedback process where people have participated in listening events. Some actions required are general and can be shared via communication. Sometimes it might be something that is more personal and specific. FB questioned whether we feel confident that we have the range of feedback mechanism to meet that expectation, whilst noting that the different kinds of listening exercises that are going on simultaneously are bound to be rising. JP advised that information is collected from numerous areas (i.e. also pulse check/surveys), plans in place to bring all the information to one place to develop the actions required. Information is presented at a monthly slot at the Executive Team meeting which is helpful. The plan is to offer a debrief to every team in the organisation. A lot of feedback is through HR and where it is through specific Services – this enables the team to act quickly, to achieve quick wins. Being connected more to Brilliant Basics is also going to be really helpful in discussions. The Health & Wellbeing conversations have been really successful on making sure everyone has an opportunity to be heard. A lot of feedback has been received from this which leads again to actions that can be taken forward.

FB referred to the Case Management Section of the People Plan Report and asked for Committee assurance that appropriate actions being taken. MKS advised that the cases referred to are longstanding very complex cases. Working quite closely with the unions to try and resolve to conclusion. HR Business Partners are also working closely with the Divisions to support managers via Training and wrap around support. MKS acknowledged the particular area referred to is a high intensity environment and challenges are seen at other Trusts too. Fully sighted on all those cases with regular case reviews with the HR team and the Unions just to keep sited. TJ concurred.

Resolved : PAWC received and noted the People Plan

Governance

22/22/25 **Corporate Report Metrics – June 2021**

The paper is noted as read, this paper contains an overview of workforce KPI's along with divisional updates. Highlights as follows:

Trust Metrics

Community Division Metrics – RG shared an overview – Focussing the last few months on PDR compliance and trying to drive that number up as remain below the threshold. Seeing week on week increases, so confident that will continue to increase. Assurance received from all senior team that plans are in place to have that where it needs to be in the coming month. Mandatory training is above 90% and again is something that is focussed on closely. Sickness Absence, although there is some of the same impact as other divisions in terms of increases and staff self-

isolating, it's not having a huge impact just now on sickness rates, although they are starting to increase as well. Nothing specific to draw to the Committees attention. No questions raised.

Surgery Division Metrics – RS shared an overview – Focus continues on PDR compliance. Contacting teams re compliance and have a relative assurance that PDR's have been completed, there is a bit of a time lapse in updating dates on ESR, so hoping to see improvement. There is increased absence with Covid isolation. Looking at some other reasons for gaps like turnover, particularly in high impact areas, like Theatres. Some quite focussed efforts taking place on recruitment into ODA post in Theatres to both support the Wellbeing agenda of staff that are in those areas and have been covering additional work, but also to add some resilience to the team and to support their restoration aspect and restore access times. A meeting is planned with Finance to discuss temporary expenditure in surgery to discuss where are we seeing the need for additional shifts, why and what the medium to long term plans around that can be.

Medicine Division Metrics – RS stepped in for CW to share an overview. PDR effort is the same across all of the Divisions. There is some very focussed work in ED, particularly where we are seeing pressures to support wellbeing and resilience in the Team. Recognising this is not just the vacancy factor, it is also the absence due to maternity, short term sickness and long-term sickness. Looking at how we work to add some resilience to those gaps, particularly in the more senior nursing posts, to perhaps supply support with a richer skill mix. This is difficult because there has been significant change in the number of attendances/time patient start attending, so looking to dismantle the rota, then put back together to make more fitting to the patterns of inflow seen in ED. Also looking at different ways of supporting the department by asking for whole hospital response. Other elements of medicine division are looking to support ED as we are seeing increased rates of sickness/stress/anxiety and feedback received on burnout.

Colleagues have done a very good job this week in standing up capacity in general Paediatrics and other specialities where we can book patients into appointments and take some of that pressure out of ED. Also a detailed piece of work is taking place that specialises in emergency care processes/modelling activity – to review the workforce that goes with it. Insightful piece of work and will support some of the work we are doing with the rota. CW was able to join and added that ED is the main area of focus, where we are seeing high levels of sickness. Mandatory Training has fallen below where we would like it to be. There is a big push to engage staff with this, along with RSV training etc. Hotspots of sickness on the wards which are being dealt with in a robust way. Seeing higher rates of isolating, which is having an impact, although this week it has been better overall, we have seen an improvement.

AB referred to a group of staff that work in all of the Divisions - Operations Managers and asked JP whether many of them have been engaged with conversations (aware that clinical staff were sent home during lockdowns etc. but that particular group were often working 7 days a week incl of out of hours). Aware they are not mentioned in relation to burnout conversations etc. JP advised a date has been arranged with the Surgery Operational team (1st one was cancelled) and confirmed that some meetings had already taken place with the Medicine Operational teams (they were the first group of staff that engagement meetings took place with as understood that so much of the burden fell on this group of staff). JP will ensure the dates are in the diary for Surgery and all Divisions. AB thanked JP.

RC shared with the Committee all the support that the Operations Managers had given the Divisions since the onset of Covid, when we didn't really know what to expect, challenges faced highlighted as follows:

- Stood down lots of activity – this took a huge amount of work by the Operational Teams to make ensure thousands of appointments were cancelled, whilst ensuring they were tracked so no appointments were lost and clear processes were put in place to rebook.
- Manage the recovery process – all the work completed for 'safe waiting lists'
- Oncalls are getting more and more intense and difficult

RC agreed there is burnout across the Trust (whilst recognising there are certain areas who have done less work over the last 12 months (as that was the right thing to do to stand down activity). The Operational Teams have had no respite at all.

CW commented that what staff are really finding beneficial/supportive and helpful is the work that JP's team/SALS are performing (some senior staff have come through quite a bad patch with the support from JP and teams). CW thanked JP's team/SALS.

FB commented that it is great to hear those comments and requested that the notes detail the above conversation to ensure the Board is aware of all concerns raised. FB thanked JP and teams and recognised the importance of the Wellbeing conversations (part of PDR process) as every single person has a voice in that way. FB advised it was good to have all Divisions joining todays Committee and to hear all those concerns.

Resolved: PAWC received and noted the update on the content of the Corporate Report & Workforce KPI's.

20/22/26 **Board Assurance Framework – June 2021**

The Committee received a full BAF report for June, noted as read. MKS presented the report in the absence of the Director of Corporate Affairs.

MKS advised this is the standard report received by the Committee, as a people Committee we have oversight of 3 of those risks i.e. Workforce Sustainability & Development, Employee Wellbeing and Workforce Equality Diversity and Inclusion. The 3 risks have been updated this month, risks progressed and are on track. Particular attention was brought to EDI, we now have a resource to progress this. The risks have remained static since last time.

FB – suggested in light of what we are hearing (about burnout risks etc.), we need to keep an eye on the risk rating. Ensure robust conversations are had, so if we do see substantial deterioration, we are really picking that up.

KB advised that from an education perspective – currently reviewing all of the risks in the various strands within the Academy. Working to strengthen how we understand the risks that education is carrying and the mitigation required. There will probably be some changes to the risk register from an education perspective. KB is currently working with the Governance Team to fead through. So if there are new risks that appear, they are existing risks that perhaps were not being captured as effectively as they could be. KB just wanted to advise going forward there will in all probability some changes and some additions to the risk register.

MKS thanked KB and advised that this is helpful as it is probable that we don't reference as much as we should do within that Workforce Sustainability Risk elements of education. MKS advised KB we can work together to think about what to make sure they we reference as part of the BAF and then there will be a separate risk function. KB agreed.

Resolved: PAWC received and noted the latest position of the Board Assurance Framework

21/22/27 CQC Action Plan – June 2021

The Committee received a report outlining CQC regulatory requirements, monitored at PAWC. In the absence of the Director of Corporate Affairs – MKS advised it is a narrow focussed action plan related specifically to urgent care in reference to mandatory training and training compliance. The update for June – there is a slight decrease in compliance in that area to just over 86 ½%. Some of that may reflect the pressures/challenges on ED at the moment. MKS asked CW to comment in light of what has been mentioned earlier. CW confirmed it is a challenge, there are always conflicting pressures in ED i.e. RSV. As a group - wards managers/senior matrons are prioritising what needs to be completed first. The group meets regularly where this issue is discussed and the group are formulating a robust work plan so that we know what can/has been achieved. CW acknowledged the conflicting priorities but recognised that mandatory training does need to be completed to make sure it is safe. The group are working hard to prioritise this.

FB recognised the challenges faced and that it is difficult for staff to find the time and emphasised the requirement to find ways to help people to find the time and prioritise.

Resolved: PAWC received and noted the content of the CQC Action Plan

21/22/28 DBS Update

The Committee received a report prepared by the Deputy Director of HR; the paper is noted as read . In the absence of SO, MKS updated the Committee on developments. MKS advised that this huge piece of work was undertaken in response to the Lampard review around making sure all staff, regardless of role/length of service have undertaken a DBS check. Regular updates have been brought to the Committee. MKS reminded the Committee that the Trust was split into 3 priority groups: Group 1 staff who had never had a DBS because the rules were introduced after they were appointed, group 2 staff who had a DBS but it had expired, group 3 staff who had a valid DBS in place. A significant piece of work has been completed. Further to agreement at this Committee in July and with the support from the Executive Committee letters were issued to staff who had not responded to the Trust regarding their DBS (stern letter that talked about an outcome being suspension of pay if they didn't comply to request to undertake a DBS). The letter did garner response and it has not been required to act on the contents of the letter. Everybody has been contacted and the update received last week from SO is that we have only 4 people who haven't had a DBS, but all of those people were due to receive a DBS. At this moment in time there is no one in the Trust who hasn't got an up to date DBS. MKS paid testament to the HR team and acknowledged that it was a manual process and every single member of the HR team has got stuck in to help as it was a mammoth task.

The challenge will be how it is managed going forward. This week staff will be sent an amendment to contract to make people aware of the agreement that was made with Staff Side a number of years ago. This will become part of people's contractual

obligations now to ensure that they have 3 yearly DBS check. MKS shared some of the detail relating to concerns discussed with Staff Side as to what would happen if information comes out relating to convictions of staff. Only very minor issues were identified on a small number of DBS's. These have been worked through and risk assessed and none of them have been serious enough to warrant any disciplinary action or have cause for concern in terms of safeguarding. Happy to take questions.

RC referred to the challenge relating to how it will be managed going forward. RC advised that she was aware of a renewal service for DBS's and asked if people can sign up for that, or can that be implemented for new starters? MKS thanked RC and agreed there is a renewal service for DBS's and HR did encourage staff to sign up (only a 28 day window to sign up, following that you have to wait for the next one to sign up). MKS advised there are some conversations to take forward with Staff Side about the possibility of mandating that going forward. Once signed up to this service (£11 yearly), your DBS becomes 'portable' (if you go to another employer, they can check the update service). Whilst acknowledging we need to get smarter with new starters (3 year DBS is put in place when they join), the Trust didn't get the uptake on the DBS renewal service that was hoped for this time (staff currently have to register themselves to this renewal service). It is hoped in the future that processes for DBS renewal service may change in the NHS system wide. FB pointed out that people would be more inclined to sign up for it if it was managed by individual hospitals with an opt out clause.

FB recorded the Committees thanks to the Team for the considerable amount of work undertaken in getting the Trust to this point. Really a good news story and an important piece of work. RC – echoed the thanks to the Team

Resolved: PAWC received and noted the content of the DBS Update

21/22/29 Nurse Workforce Report – Year end 20-21

The Committee received a report prepared by the Director of Nursing. NA paid thanks to PB for producing the report. NA noted that next year the year-end report will be in line with the Nursing Workforce Plan. NA shared a comprehensive overview on the following:

- This year we recruited 122 band 5 nurses and through that process managed to reduce vacancy rate at the Trust to less than 2% (the ave. sits around 9-10% at most organisations in the NHS)
- Turnover has been reduced to 2.5 wte a month (translates to a turnover 4.5-4.6% - the national average sits at around 12-13% - so again much lower than other organisations in the NHS)
- Encouraging movement between departments - taken up by Band 5 staff. The biggest reason for leaving was around retire and return – which you would expect with an ageing workforce, also relocation and some staff leave for promotions (definitely some work to do in the coming year about the retention of band 5 staff).
- Key highlight was that we enrolled into the Extended Clinical Placement (ECP) work which is third year student nurses paid to work with us during the pandemic. We've managed to secure and recruit both full cohorts that went through that process (we've recruited another 50 Band 5 nurses from this cohort to start in September).
- Referred to page 87 of the pack a review against RCN standards – year on year has seen improvements in this area (we are partially compliant with one standard which relates to 24/7 provision for senior nurse/shift leader – just need to top that

up on a couple of wards. In all other standards we are compliant or have a reason with mitigation why we are not.

- Really clear objectives have been set out for next year – these align to the workforce plan – and are a real focus in terms of recruitment of varying routes of entry into nursing – such as HCA's, degree students, RNDA's and nurse associates. Also looking at widening equality and diversity as part of that. Looking at establishment review and how we will move to a sustainable model of care through alternative roles, not just the traditional model of entry.
- There will be a plan around our mental health and learning disabilities workforce and how that wraps around the patients to provide care at the time when it is needed.
- We will also be focussing on clinical academic careers, equality and diversity inclusion and our extended scope practitioners.
- Looking to focus on temporary nurse spend.
- Will be moving to the Safer Nursing care tool in the next couple of months – in terms of acuity independency scoring which is the only validated tool for use in children in the country and is widely used (not currently used at the Trust).

MKS commented – this is an excellent/comprehensive report. Great progress has been made in terms of recruitment and keeping that pipeline going with the retention of student nurses. Really exciting plans around education and opportunities to progress our EDI agenda. Also strategically there is a requirement going forward to think more about what to do around the paediatric workforce and the role in that for HR, more conversations still to be had. NA thanked MKS and noted there are some exciting developments (how do we work across Cheshire & Mersey and further afield). Hopefully we can update on this as we go through this year and next year.

FB agreed it is a really important recruitment message (you can extend your skill set and your experience without leaving). We can have arrangements with neighbouring Trust to rotate people etc.

KB echoed Melissa's comments in terms of the work that's being undertaken in respect of workforce and workforce development. KB highlighted to the Committee a couple of areas that she is working closely with NA and other colleagues on. Career progression for existing staff and routes that can be taken and that is particularly key when we start to look at apprenticeships (how we use apprenticeships creatively).

Also thinking about how the wider workforce are supported to make the most of those opportunities in core subjects such as literacy, numeracy, digital skills etc. is something that we're particularly focussed on given the requirements and expectations of some of the posts that we are making available (e.g. TNA's – there's a requirement for the basic numeracy and literacy at a certain level to be achieved. If our existing staff don't have that then clearly that actually prevents them getting through the first goal post). In terms of growing our own and supporting that real talent management, it's about building on the fabulous work that's been done already but it's also thinking about what else we might need to do and also working with our local communities. Particularly encouraging those from harder to reach groups to look at roles with us. Some really exciting work that's going on and also more to be done as well.

NA agreed and confirmed routes of entry to strength the nursing position is the focus for this year. A degree entry profession is absolutely fine, but it is known that excludes a lot of people from applying in the first place. So using those new models is key. Paediatrics has been really slow to adopt the nurse associate and the nurse apprentice routes which will give us a sustainable workforce in the future. We are still using

international recruitment as set out in the plan with another 20 to 40 expected to join the Trust this year, but it is not sustainable. We do need to move to a model where we can use our own home-grown talent and skills to be able to support our children and young people in clinical practice. We will be working with you and colleagues really closely, particularly on the apprenticeship routes.

FB thanked NA and PB for the report and looked forward to hearing continued progress.

Resolved: PAWC received and noted the content of the Nurse Workforce Report

21/22/31 **Policies**

The Committee received the following policies and Equality Assessments for formal ratification/approval.

Medical Revalidation and Appraisals Guidelines

HB outlined the following updates:

The new appraisal lead is Dr. Zahabiyah Bassi. In December 2020 a new system was introduced (L2P) this has been rolled out to all consultants and has been well received. Rollout to clinical fellows has commenced. Other than that the policy remains the same.

HB shared with the Committee that the GMC have advised that following Covid and subsequent conversations with consultants, the current practice of requesting patient feedback review once every 5 years is not really reflective enough. This will be explored further by HB, the responsible officer and Dr Bassi to look at ways this can be increased.

FB thanked HB and asked if there was a target in mind for increased frequency? HB advised that currently Trusts across the country are all pursuing their own levels of activity (i.e. in Northumbria – one of the most active – perform reviews of all clinics for consultants on a rolling programme – then phone patients following clinics 2 weeks later. They have one of the most comprehensive quality programs). We think it will probably be between 2 and 3 depending upon the service and also the activity of the consultants concerned.

KB echoed HB's point, whilst the guidance that has come out is that we need to increase the frequency of patient or family feedback – quite how that is to be done is a moot point. There are many options available to us, but something that is reasonable in terms of the resource is required and the value added is something that will have to be developed. HB is working very closely with teams to develop a range of different options. Whilst understanding that there will be added resource required to support, is something that we will have to bear in mind even with some creative use of technology, just to ensure that we've got something which is in line with expectations, but also doesn't add too significant burden on existing processes.

JP advised HB that it might be worth reviewing systems we have already in place and referred to her experience with CAHMS around work that took place implementing a service questionnaire.

Resolved: PAWC approved the guidelines

21/22/32 Board of Directors Summary

Assurance - Key risks at today's Committee to be noted:

- Welcomed KB to the Committee and the Trust.
- People plan highlighted the burnout issue within the divisions, development of the wellbeing guardian. Hotspots identified – keep risks under review. Operational Managers – think about how we can support.
- Roll out of DBS success.
- Comprehensive Nursing Workforce Year-end 20-21 report – very encouraging signs. Success of ECP on the newly qualified retention issue. Also that development and helping nurses move around between the departments.
- Medical Revalidation and Appraisals Guidelines – important piece of work – look forward to seeing the process developed.
- Race Equality Action Plan – recognised that the development of an action plan with clear targets was an important step forward.

Resolved: PAWC agreed the Board of Directors Summary

Sub Committee/ Working Groups reporting to Committee

21/22/33 The Committee received the minutes for the following for information.

- Local Negotiating Committee – 23.02.21
- Health & Safety Committee – 22.04.21
- JCNC – 28.04.21
- Education Governance – None to receive
- BAME Task Force Action Plan – 12.07.21

MKS referred to BAME Task Force developments and noted the actions and presentation went to the last Trust Board outlining focus going forward.

FB noted this is an important point in the development of that piece of work, moving from what has been a very discursive process – a listening process, towards some very smart actions with timelines attributed to some people. Really helpful to get to this point. FB thanked MKS, CD and the Team for the work that has been done to sharpen the actions.

Resolved: PAWC noted the content of the minutes

21/22/34 Any other business

PAWC noted there were no further items raised under AOB.

21/22/35 Review of Meeting

Fiona thanked everyone for attending and conducting the business in an efficient way.

21/22/36 Date and Time of Next meeting

21st September 2021, 10am-12noon, via Teams

Minute Reference	Action	Who	When	Status
Trust People Plan 2019-24				
21/22/09	• Circulate (when ready) the updated BAME Inclusion Taskforce (Plan on a Page) to PAWC for review.	MKS/CD	May 2021	20.07.21 Noted as complete
21/89	• To review provision to support disabled staff in the absence of Networks	JP/MKS	March 2021	20.07.21 Noted as complete.
Health & Wellbeing				
20/28	Sickness Absence/Shielding/Agile Working • Working from home – update on review	MKS	March 2020	
Equality, Diversity & Inclusion				
20/29	EDS2 & Workforce EDI Annual Report • Share Procurement strategic government guidelines for sourcing suppliers/services with ES/MKS • Revisit Procurement statement to get a sense of what further action is required.	CD/MKS ES/MKS	November 2020 November 2020	Noted on 23.03.2021 CD/MKS to review EDI – overall action plan off-line. Noted on 20.07.21 MKS to refine action off-line.
20/42	• Present at future Board the Government Framework for Social Value (as part of the Government covid recovery plan to be rolled out in January 2021). Raise with CEO & Chair of Board. Noted on 25.01.2021 to be progressed outside of this Committee	CD/MKS	January 2021	Noted on 25.01.2021 CD/MKS to be progressed outside of this Committee. Noted on 20.07.21 to be progressed.
Governance				
21/22/11-01	• Share an update on PDR/Mandatory Training process and compliance at a future PAWC	SO	May 2021	
21/22/11-02	• Issue a reminder note to the Divisional 3 at the top re the importance of representation at the Committee going forward.	MKS	May 2021	Noted on 20.07.21 as complete.

21/22/15	• A note to be sent out to IQ/FB for virtual formal ratification of policies to be received by the end of the week (Friday 21st May 2021)	MKS	May 2021	Noted on 20.07.21 as complete.
21/77	Policies to Review & Ratify • Security Policy – MKS to ask Security/Emergency Planning how often the Trust received advice on security measures.	MKS	March 2021	Noted on 20.07.21 as complete.
People Strategy Overview & Progress Against Strategic Aims				
	Modern Slavery			
19/51	• Liaise with Head of Procurement to progress processes, noted on 19.11.2019 that this is linked to 15/08 & 16/02, government process to be progressed. Noted on 18.05.2021 - Modern Slavery Policy – CD to send information through to MKS/ES ahead of a meeting to progress.	MKS/CD	Progressing	Noted on 20.07.21 to be progressed with CD/MKS outside of this meeting.
	Engagement			
15/08 16/02	• Develop Values in Procurement, values-based recruitment – develop opportunities to incorporate into the Procurement processes/standards for contractors. Liaise with Deputy Director of Finance to progress to review employment opportunities.	MKS/CD	Progressing	Noted on 20.07.21 to be ptoressed with CD/MKS outside of this meeting.
Equality & Diversity				
20/20 17/13 19/68	• Review a new approach to EDI - CD & MKS to meet to discuss to ensure clear measures/actions are in place • Equality Objectives Plan for 2018-2021 – Quarterly Update required & Objectives to be reviewed every 6 months • Equality Metrics Report to be brought back to next Committee • WRES/WDES Updated Plan	MKS/CD SM	TBC 1/4ly Update 6 monthly Review	Noted on 23.03.2021 CD/MKS to review EDI – overall action plan off-line Noted on 20.07.21 an update will be brought to Septembers PAWC
Education Governance Update				
18/38	• To be a regular item on the Committee Agenda.	HB	Agreed May 2019	Noted on 20.07.21 as complete.
21/22/23	• Education Governance Committee notes June 2021 • Education Activity Update	KB KB	September 2021 November 2021	

Nurse Associate Recruitment				
19/69	Develop a wider plan – to be reviewed	Vikki Hughes	April 2020	Noted on 20.07.21 as complete.