BOARD OF DIRECTORS PUBLIC MEETING
Thursday 28th October 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.	**21/22/150**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**21/22/151**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**21/22/152**	**9:17 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Thursday 30th September 2021.**	**D**	Read enclosure
4.	**21/22/153**	**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.	**21/22/154**	**9:25 (60 mins)**	• **Delivering a Safe Winter; including:** - **Update on restoration and recovery.** - **Staff safety and wellbeing.** - **IPC.** - **Governance Lite.** • **2021/22 H2 Plan; including:** - **Financial Update, M6**	A Bateman M Swindell B Larru E. Saunders R. Lea	To provide an update on the development of operational plans for the 2021 winter period. To provide an overview of the H2 plan and the position for Month 6.	**A** **A**	Presentation Presentation

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			2021/22.				
Strategic Update							
6.	**21/22/155**	**10:25 (15 mins)**	**ICS Development Update.**	D. Jones	To receive an update on the development of ICSs.	**A**	Presentation
7.	**21/22/156**	**10:40 (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							
8.	**21/22/157**	**10:50 (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
9.	**21/22/158**	**11:00 (10 mins)**	**Digital and Information Technology Update.**	K. Warriner	To provide an update.	**A**	Read report
10.	**21/22/159**	**11:10 (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
The Best People Doing Their Best Work							
11.	**21/22/160**	**11:50 (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 10*

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
12.	**21/22/161**	**11:55 (20 mins)**	- **Workforce Disability Equality Standard (WDES) Report, 2021.** - **Workforce Race Equality Standard (WRES) Report, 2021.** - **Gender Pay Gap Annual Report 2020.** • **BAME Inclusion Taskforce update.**	M. Swindell M. Swindell M. Swindell M. Swindell	To receive and note the WDES report, 2021. To receive and note the WRES report, 2021. To receive and note the Gender Pay Gap Annual Report, 2020. To receive an update on the work conducted by the BAME Inclusion Taskforce.	**A** **A** **A** **A**	Read report *(to follow)* Read report *(to follow)* Read report *(to follow)* Verbal
Lunch (12:15pm-12:35pm)							
13.	**21/22/162**	**12:35 (10 mins)**	**GMC Annual Audit and Statement of Compliance for Medical Appraisals.**	N. Murdock	For assurance purposes.	**A**	Read report (*to follow*)
14.	**21/22/163**	**12:45 (5 mins)**	**Award Nominations Summary.**	M. Flannagan	To receive an update.	**N**	Read report
Sustainability through Partnerships							
15.	**21/22/164**	**12:50 (20 mins)**	**Department of International Child Health Update.**	B. Pizer	To provide an update.	**N**	Presentation
16.	**21/22/165**	**13:10 (10 mins)**	**Neonatal Partnership – Next Steps.**	A Bateman/ N. Murdock	To receive an update on the next steps for the Neonatal partnership.	**A**	Read report
Strong Foundations (Board Assurance)							
17.	**21/22/166**	**13:20 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
18.	**21/22/167**	**13:25 (10 mins)**	**Board Assurance Committees; report by exception:** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 21.10.21.** - **Approved minutes from the meeting held on the 27.9.21.** • **Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 20.10.21.** - **Approved minutes from the meeting held on the 22.9.21.**	I Quinlan F. Beveridge	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes
Items for information							
19.	**22/22/168**	**13:35 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
20.	**21/22/169**	**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, 25th November 2021, 9:00am-1:00pm, via Microsoft Teams.							

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

Alder Hey Children's
NHS Foundation Trust

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
CQC Action Plan	E. Saunders
Financial Metrics, M6, 2021/22	R. Lea
DIPC Monthly Exception Report	B. Larru
System Oversight Framework	E. Saunders
Oversight Metrics	E. Saunders

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday30th September 2021 at 9:00am,** via Microsoft Teams

Present:	Dame Jo Williams	Chair	(DJW)
	Mr. N. Askew	Chief Nurse	(NA)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mrs. C. Dove	Non-Executive Director	(CD)
	Mr. J. Grinnell	Acting Chief Executive	(JG)
	Mrs. A. Marsland	Non-Executive Director	(AM)
	Dr. F. Marston	Non-Executive Director	(FM)
	Dr. N. Murdock	Medical Director	NM)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	Mrs. M. Swindell	Director of HR & OD	(MS)
In Attendance:	Mr. A. Bass	Director of Surgery	(AB)
	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Ms. L. Cooper	Director of Community Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. M. Flannagan	Director of Communications	(MF)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mrs. D. Jones	Director of Strategyand Partnerships	(DJ)
	Mrs. R. Lea	Acting Director of Operational Finance	(RL)
	Mrs. C. Liddy	Director of Innovation	(CL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Observing:	Prof. Janusz Jankowski	Member of the public	(JJ)
Apologies:	Mr. D. Powell	Development Director	(DP)
	Mrs. L. Shepherd	Chief Executive	(LS)
Patient Story	Jason Hargreaves	Owner of Matalan	(JH)
Staff Story	Natalie Daniels	Consultant Neurodevelopmental Paediatrician	(ND)
	Will Western	Medical Services Director	(WW)
Item 21/22/124	Mr. R. Gates	Assoc. Commercial Director for Development	(RG)
Item 21/22/129	Ms. B. Larru	Director of Infection Prevention Control	(BL)

Staff Story

The Chair welcomed Natalie Daniels, Consultant Neurodevelopmental Paediatrician, and Will Western, Medical Services Director, who had been invited to September's Trust Board to provide an overview of the Physician Associate's (PA) Programme and its progress. Natalie shared the programme story as a reflection of the journey from a new staff group at Alder Hey and the impact it had on the team and systems at the Trust.

It was reported that the establishment of the PA Programme came about as a result of having a vision in terms of tackling some of the organisation's workforce challenges and PA's who work through a medical model seemed to be a good fit to do this. This area of work had not been

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explored by Alder Hey or any other trust therefore it was agreed to commence looking at this as part of the medical workforce. It was confirmed that in April 2019 the Trust employed the first PA in the country who worked within paediatric safeguarding. This was a pioneering role and provided proof of concept. A year later the Trust recruited additional PAs making Alder Hey the largest employer of paediatric PAs in the country.

Natalie explained that the team was seeking a long-term solution and as such felt that it had to be embedded within the Trust's vision and values. The team selected its best PAs to advocate the role and to showcase the capabilities of the role. Attention was drawn to the importance of expanding the workforce, having a modern approach, setting standards and sharing learning to hopefully change the landscape of paediatric care across the country. The team's overarching aim is to become a centre of excellence for paediatric PA training. Natalie described the successes, the overcoming of challenges and the learning. It was reported that feedback has been really positive with every child who gave feedback saying that they had had a good experience. Will updated the Board on the internal and external plans for the future and shared the application video that the team had submitted as an HSJ finalist.

The Chair felt that the video was fabulous and very innovative, and it is apparent that those involved have enjoyed developing this new role. Natalie informed the Board that it has been really hard work but very rewarding especially as eighteen months down the line the Trust has a really committed PA workforce that adds value and quality to its teams

Nicki Murdock thanked Natalie and Will for a great summary of the progress that has been made over the last two years. It was reported that work is taking place with Health Education England (HEE) to set up a Centre of Excellence for paediatric PA training. A conversation took place around the lack of funding for extra PAs and it was felt that a focus on this area of work should take place as the Trust moves into longer-term planning discussions. The Chair offered thanks to Natalie, Will, Nicki Murdock and Nathan Askew for driving the PA Programme forward.

Patient Story

The Chair welcomed Jason Hargreaves, the owner of Matalan, who had been invited to September's Trust Board to provide feedback following his son's recent stay at Alder Hey.

Jason informed the Board of the reason for his son's visit to the Emergency Department. Upon arrival his son was triaged and within three to four hours had been seen by a number of doctors. A decision was made to admit his son for an overnight stay and an MRI was scheduled for the next morning. The next day a number of doctors came to see Jason's son all offering conflicting messages in terms of a possible diagnosis and what needed to be done; MRI, CT scan, medication. Jason was asked on various occasions as to who he had seen and what had been said which left him feeling worried in case he misinformed anyone. Jason's son was eventually discharged without a diagnosis which caused his family concern. Jason described his overall sense of confusion following this experience and felt that he was left to relay messages to a number of professionals. Jason pointed out that he wasn't criticising staff members as everyone was doing their best but there didn't seem to be any ownership amidst staff. Jason felt that it would have been beneficial to have one point of contact.

The Chair thanked Jason for sharing his experience with the Board and raising some important points. Nicki Murdock advised that discussions have taken place with Jason about helping to put together a video on communication.

On behalf of the Board and everyone at Alder Hey, the chair thanked Jason and Matalan for everything that they have done to support the Trust, the Charity and families. The 'Pyjama Campaign' is amazing and has raised huge amounts of money for Alder Hey. It was reported that Matalan sold 30,000 pairs of pyjamas in stores on the 29.9.21 and 10,000 online.

21/22/116 Welcome and Apologies

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

21/22/117 Declarations of Interest

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

21/22/118 Minutes of the previous meetings held on Thursday 29th July 2021
Resolved:
The minutes from the meeting held on the 29.7.21 were agreed as an accurate record of the meeting.

21/22/119 Matters Arising and Action Log

Matter Arising

There were no items to discuss.

Action Log

Action 21/22/65.1: *Approach to End of Life Care when there is a dispute (Look into agreeing a process to provide families with feedback following an end of life decision)* – An update will be provided on the 28.10.21. **ACTION TO REMAIN OPEN**

21/22/120 Post Covid-19 Recovery Plan 2021/22

Update on restoration and recovery

The Board was advised of how far the Trust has come in recovering services for children and young people (CYP). It was reported that the organisation has treated more patients this year than in 2019 despite all of the challenges. During July and August there was a reduction in the level of recovery; Outpatients 90%, Theatres 90% and Radiology 100%. Adam Bateman commended the efforts of the radiology team in maintaining this level of performance. The Trust recognised that the pressures staff were under was having an effect on health and wellbeing, therefore a decision was made to reduce some of the additional sessions that the organisation had asked staff members to do. The Trust also took a step back with the Accelerator Programme in August to enable staff to have a proper a break. Another factor in the reduction of activity was the increase in staff absence and a decrease in availability which meant that the Trust was unable to sustain high levels of activity. In terms of mitigation for the Accelerator Programme, the Trust is hoping to recruit extra staff to compensate and help teams who have been under pressure. It was confirmed that the Trust has recruited to posts in anaesthesia, radiology and PA's.

The Board was provided with benchmark information to highlight the Trust's performance in comparison to other Accelerator Programmes. It was reported that Alder Hey's total position as a trust shows that it is way ahead in comparison to other paediatric specialist trusts. There are five specialities that require additional actions to achieve the capacity that has been set out, particularly in dentistry. It was felt that overall recovery has gone well and remains high. The Trust has been open in terms of identifying the pressures that it is facing in terms of sustaining recovery over the winter period.

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The Chair thanked Adam Bateman for the update and felt that the report was very realistic and clear, whilst highlighting the risks and the plans that are in place to mitigate risks.

Winter preparedness

A number of slides were submitted to the Board to provide an overview of the Autumn and Winter Plan. Information on the following areas was shared:

- Introduction:
  - This year's plan needs to ensure readiness for potentially higher rates of admission of CYP due to a range of winter viruses potentially requiring a higher level of clinical care that is above the usual seasonal variation. This is as a result of continued community prevalence of Covid 19 and an increase in the numbers of CYP that haven't been exposed to common winter viruses such as RSV.
- Demand:
  - In the year to date the attendances at the front door have increased by 20% which means longer waiting times and a lower proportion of patients that are being treated within four hours.
  - The GP stream that supported the care of c.5% of all attendances has been withdrawn. Work is taking place to address this deficit.
- Referral source:
  - 2021 has seen an increase in self-referrals in comparison to 2019.
  - The greatest increase in referral source is NHS 111. This is due to there not being a strong enough paediatric service offer within the 111 service at the present time. It was reported that Alder Hey and colleagues in Cheshire and Merseyside are seeking to pilot a dedicated paediatric clinic assessment service later in 2021. If the pilot is successful work will take place to look at expanding this service to address the amount of referrals directed from NHS 111.
  - There has also been a significant increase in referrals from GPs.
- Outcome of attendance (ED activity):
  - The rate of admission is stable. It is slightly down in July and August relative to these months in previous years.
  - Admissions have been higher in every month of 2021 relative to 2019 with the increase most pronounced in May and June.
  - During July there was a sharp increase in patients leaving without being seen, a manifestation of overcrowding and low acuity. It was pointed out that there are some potential reforms in how the Trust organises its emergency and urgent care service.
- RSV peaked in July but since the school break there has been a continual decline in patients presenting with this virus so hopefully the season started early, has peaked early and has passed. This was a major concern in terms of planning for a 50% to a 100% rise in RSV admissions in comparison to previous years. The indication is that it was an early start that matched peaks in previous years, but the Trust will continue to be vigilant.
- Key deliverables of the Autumn and Winter Plan:
  - Escalating capacity in critical care and emergency care.
  - Focus on patient flow.
  - Staff wellbeing, support and advice.
  - Staff vaccination: Covid-19 boosters and flu.
- Escalating capacity in emergency care and critical care:
  Additional support or services in place;
  - Acute paediatric clinics.

- New on-site community pharmacy service which is seeing patients with minor illnesses.
- Additional junior doctors recruited with more cover in the evenings.
- Signposting for minor illness.
- Increasing appointment capacity in Walk-in Centres.

Working on:

- Staffing review and recruitment.
- Digital symptom checker.
- Virtual urgent care appointments.
- NHS 111 Paediatric clinical assessment service.
- Health visitor service.

- Patient flow:
  - Tactical command.
  - Morning discharges.
  - Timely speciality reviews.
  - Focus on time to admissions to a bed.
  - Clarification of site management responsibilities for flow and staffing.
  - Participation in regional Gold Command and Cheshire and Merseyside paediatrics.
  - Cohorting capacity and revised isolation procedure to help with patient flow.
- Staff wellbeing, support and advice:
  - Step 1: SALS - Early intervention and prevention, individual and team-based support, working out what you need, links to self-help and national resources.
  - Step 2: Care First - 24/7 Counselling helpline, short-term counselling for any issue, information specialist helpline.
  - Step 3: Alder Centre - Longer term counselling (*bereavement, loss and trauma focus).*

Fiona Beveridge asked as to whether the Trust is focussing on the positive aspects of wellbeing before support is required, for example, reminding staff about taking breaks, having a healthy work life balance, exercising, eating well, etc. It was reported that a lot of work in terms of the practicalities of health and wellbeing is done by SALS, but it was felt that the organisation needs to focus on managers helping them to fulfil their role in keeping staff well and in work.

Mark Flannagan advised the Board that the organisation is looking to launch a very clear set of pledges for staff which will incorporate the practical elements of health and wellbeing along with the system elements. Work is also taking place to improve the processes in place for sharing information with staff.

Nathan Askew highlighted the importance of having a clear message for staff in terms of looking after themselves, and the Chair drew attention to the importance of senior leaders modelling the health and wellbeing approach.

- Vaccination programme for staff:
  - Staff 3rd dose (Covid booster). Staff are being encouraged to access this through the vaccination hubs and community provision.
  - Staff seasonal flu vaccine.
  - CYP of school age will be offered the flu vaccine which will be managed via the school vaccination program. The Trust will also offer the flu vaccination to CYP opportunistically on site and will vaccinate vulnerable young people with the Covid vaccination.
- Risk mitigation.

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- A final thought on the Trust's medium-term urgent and emergency and acute medical care strategy:
    - The Board was informed of the opportunity that the ground floor of the new Neonatal Unit will provide in terms of enabling the Trust to look at enhancing the organisation's services for urgent, emergency and acute medical care. It was reported that one of the options that the Trust would like to pursue with clinical teams is the establishment of an effective paediatric assessment unit, and an urgent care stream for minor cases where patients will be seen in a separate facility rather than ED. It was felt that the Trust should be working in partnership so that GPs and HVs can wrap around ED.

      Alder Hey is also pursuing self-care through a symptom checker that can be accessed via Alder Hey's website from October onwards. Once the symptom checker has been rolled out the Trust is going to make it available for use to all health care providers in Cheshire and Merseyside who deliver children's services. Lastly, virtual consultations are to be a component of this wider offer. Over the next two years these workstreams will help form the Trust's Urgent Care Strategy.

The chair thanked Adam Bateman for his leadership on this work and drew attention to the exciting opportunity that the new facility will provide thus enabling the Trust to be creative and work differently with its partner organisations. It was agreed that the compilation of an Urgent Care Strategy that builds on the workstreams, as highlighted, is the right way forward.

John Grinnell felt the information in the slides provides the Board with assurance that the organisation is responding in the appropriate way. A discussion took place about the opportunities of using the ground floor of the new Neonatal Unit, the long-term benefits and the potential for local system funding in terms of addressing the issues appertaining to the present urgent care system. It was agreed to submit a proposal to RABD and the Board in October on the use of the space on the ground floor of the new Neonatal Unit to enhance the organisation's services for urgent, emergency and acute medical care.

21/22/120.1 Action: AB

Resolved:
The Board supported the compilation of an Urgent Care Strategy that builds on the workstreams that will enhance the organisation's services for urgent, emergency and acute medical care

Staff safety and support

An update was provided to the Board on the figures relating to staff absence as at the 27.9.21. The following points were highlighted:

- Total absence = 7.07%
- Non-Covid absence = 6.13%
- Covid related absence = 0.45%
- The Board was advised that the Trust has focussed in detail on staff absence over the last two weeks, and looked at the learning from a recent report that has been published in the North West on trusts with low sickness rates and what they are doing to improve/maintain these figures. It was reported that Alder Hey is on a level par with most trusts in terms of what is being done but it was pointed out that the Trust has a slightly different make-up than others trusts. Most trusts outsource their estates and facilities

staff whereas Alder Hey doesn't. The Trust's estates and facilities sickness absence is at 11% which has a big impact on the overall total.

- It was pointed out that one of the reasons for an increase in figures could be related to the improved accuracy of sickness reporting following deployment of the e-roster.
- It was confirmed that the Trust is reviewing absence figures on a daily basis, maintaining a focus on this area of work and ensuring staff on long-term sick have wrap around support.

Investment in recruitment

Vacancy Activity –The Trust has invested c.£2m in a number of projects and processes designed to make sure the organisation is fit for purpose; mental health investment in ERF and the Accelerator Programme.

In 2020 Alder Hey recruited 211 posts in comparison to 2021 when the organisation recruited 534. This highlights how Alder Hey is investing in its services and what it has meant in terms of activity, increase in resources and an increase in people. It also highlights how challenging it is to retain staff members. It was pointed out that when new staff commence in post it brings with it the need for induction and support from the existing workforce.

Resolved:
The Board noted the updates provided under the Covid-19 Assurance Plan Progress Update.

21/22/121 Build Back Better

The Board received a presentation on Build Back Better, the Government's plan for Health and Social Care. The following information was shared:

- What it means for Health Care:
  - Tackling elective backlog.
  - Put the NHS on a sustainable footing.
  - Elective recovery technology fund.
  - NHSE plans for efficiency and reform.
  - Focus on prevention.
- What it means for Social Care:
  - New means test for adult social care.
  - £500m new investment in the workforce.
  - Improving the integration of health and social care.
- What it means for Alder Hey:
  - It was pointed out that the plan might appear to be adult-focussed but it was felt that it has a very positive direction for the Trust as it sets out the tone and direction for integration.
  - Commitment of funding for elective recovery, innovation, research and digital. It was confirmed that the Trust is ready to submit bids once notification is received.
  - There is a strong emphasis on prevention which sits with the Trust's strategic plans, and a focus on longer term outcomes.
  - There is an emphasis on system transformation, efficiencies, productivity, theatre capacity and advice and guidance.
  - Specific reference to paediatric accelerator.
  - The impact of the long-term plan is not yet known but the national CYP Board is putting a strong case forward in order to sustain a CYP focus.

Kate Warriner advised the Board that work has been taking place across Cheshire and Merseyside to meet the deadline for the Tech Fund bid. The informal feedback is that the Trust has been allocated an amount of funding to support elective recovery around theatres. It was reported that a wider point has been lodged with regard to children who are on the waiting list and the impact it is having on their development and education. In addition to this, a further point has been put forward in terms of the current CYP mental health crisis and the effect it is having on teenagers who are heading towards adulthood.

Mark Flannagan reported that work is taking place to map out opportunities and identify decision makers/key top-level stakeholders in terms of funding and influencing opportunities.

Resolved:
The Board noted the contents of the Build Back Better presentation.

21/22/122 Integrated Care Systems (ICS) Development Update

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

- What's happening in the system.
- ICS Design Framework:
  Revision of commissioning functions in April 2022:
  - Spec Com services to be more integrated – delegating to ICSs.
  - Consider more as pathways from Primary – Tertiary/Quaternary.
  - NHSE/I are identifying appropriate guidance for planning size – segmenting population sizes.
  - NHSE/I to retain national standards but more outcome focussed.
  - 2022/23 Spec Com to form Joint Committees with ICS leads.
- New guidance for provider collaboratives:
  - There are two in Cheshire and Merseyside; Acute and Specialist Trusts (CMAST) and LD, Mental Health and Community (LDMHC).
  - Acute and Mental Health Trusts must be part of at least one collaborative by April 2022.
  - Focus on benefits of working at scale, for example, reducing unwarranted variation, health inequalities, etc.
  - Define ways of working between ICS, Places, clinical networks cancer alliances and other collaboration.
- What it means locally.
- System finance (*C&M proposed approach*):
  - Create stable financial framework for year one, 2022/23.
  - Contracts for year one will be held by ICS for each provider.
  - 2022/23 plans based upon an agreed system allocation from 2019/20.
  - Capital envelopes held at ICS level which will bring less autonomy in terms of decision making for organisations.
  - Financial Strategy for C&M to be developed in year one to achieve system financial balance with focus on; reducing variation, improving outcomes, maximising use of existing workforce and estate and working within place across the provider collaborative.
- Impact on Alder Hey and our response:
  Likely changes for AH
  - CCG contracts held by the ICS from the 1.4.22 and Specialised Commissioners from 1.4.23.
  - Capital plans will be held and agreed by the ICS.

- There will be a focus on system balance rather than individual organisations.
- National monies will flow to the system then on to the provider, for example, mental health, digital, etc.

Alder Hey's response

- The Trust will play an integral role in the system to ensure that there is a fair share of funding for CYP services.
- The Trust will ensure it is best placed and agile to respond to new national priorities and funding for CYP services.
- The Trust will significantly grow its non NHS income and work differently to deliver more care at a better value.
- The Trust will ensure best value when collaborating.
- Develop a new 5 year financial strategy.

- System Finance – 21/22/ H2 the latest funding opportunities:
  - It was reported that guidance hasn't been released to date, but the key aspects expected are:
    - Rollover of H1 blocks with; 3% pay award funding included, reduced Covid funding, 25% reduction lost income funding and higher efficiency rate.
  - Funding opportunities:
    - Elective recovery fund, elective recovery capital, digital and innovation and capacity funding.
- Next Steps by April 2022:
  - ICS's will go live as statutory bodies.
  - New ICS leadership in C&M.
  - CCGs to cease and staff move into the ICS.
  - Provider Collaboratives formalised.

Fiona Marston pointed out that the Trust has a number of challenges, as highlighted during the meeting, that is putting pressure on the organisation and staff members. At some point the new ICS structure and ways of working will filter down and create additional pressure. Fiona Marston queried as to whether staff will have to take on more work in the event that the Trust is unable to achieve the high recruitment figures that have been set out, and asked as to how this issue can be built in to the Trust's plan taking into account the organisation's approach in terms of staff health and wellbeing.

The Chair advised the Board that there is no simple answer to this question but pointed out that it will be necessary to take stock as an organisation on a regular basis. Dani Jones informed the Board that staff are aware of the new ICS structure and felt that it would be beneficial to provide clear and positive communications to staff members across the Trust. Fiona Marston felt that Alder Hey has the appropriate mechanisms in place to support the health and wellbeing of staff but highlighted the importance of ensuring that those staff affected by this issue have the opportunity to talk about how it is impacting them whilst making sure that all of the services are used by staff members.

Shalni Arora asked as to whether the Trust will have the autonomy to spend non NHS income and queried as to whether there is any guidance regarding this matter. It was reported that there is a constraint as a system and a limit as a region on what can be spent. From a capital perspective there is also a constraint on what can be spent in any given year. It was pointed out that Alder Hey is in a strong position due to its healthy cash balance and being able to put its plans forward. The Trust will continue to drive its plans forward to ensure they go through a system prioritisation. The Board was advised that part of the Trust's strategy around growing non NHS

income is about being able to re-invest which is within the organisation's remit. It is the capital element that is more challenging.

John Grinnell pointed out that there will be some uncertainty for a number of years but felt that the system will want to promote and support Alder Hey in driving its strategy forward. The issue will be progressing aspirational items versus the challenges that the System is facing presently which will take some expert navigation. John Grinnell drew attention to the opportunities that have arisen as a result of the work that has taken place around research and innovation and the academy and felt that the organisation should be driving forward with these agendas due to the sustainability element of these projects. The Trust will also be reviewing other areas of work to decide as to whether to progress them, for example, private patient/international child health. In order to support all of this the Trust needs to ensure that clinical time is appointed appropriately in terms of delivering care.

Resolved:

The Board noted the ICS development update.

21/22/123 CQC'S 5 Year Strategy

The Board received an overview of CQC's 'Our Strategy' from 2021 and what it means for Alder Hey. A number of slides were shared which provided information on the following areas:

- Overview of four key themes; people and community, smarter regulation, safety through learning and accelerating improvement.
- Where CQC are:
  - Focused on 12 key outcomes from the strategy.
  - Implementation - ongoing engagement via podcasts and surveys.
  - Themes so far; developing assessment frameworks and using people's experiences in a new regulatory model.
- Where Alder Hey are:
  - A positive and supportive relationship already in place with acute and MH inspectors.
  - Commended by Inspection Manager for response to s31 notice.
  - Core service reviews underway to provide CQC with baseline; DoM a very productive discussion.
  - More transparency re-emerging methodology – The Trust can see this is changing, for example, documentation, approach to concerns raised, proportionality.
  - Opportunity for the Trust to improve its ratings.
- Future Focus:
  - Inspection ready but informed by new approach.
  - Link to Brilliant Basics is fundamental (*demonstrate quality improvement approach).*
  - Voice of CYP.
  - Partnership governance and monitoring – emerging arrangements.
  - Optimise the organisation's R&I market leadership.
  - Address ratings issues and agree way forward.

The Chair thanked Erica Saunders for updating the Board on this important matter and felt that the presentation should be shared with the Trust's governors during a forthcoming meeting.

21/22/123.1 Action: ES

Claire Dove pointed out that to achieve an outstanding rating from CQC it's not

just about being good at what you do it's about being exceptional in creating good practice. Claire Dove suggested that the Trust look at the Government's 'levelling up' agenda and conduct a piece of equality work in association with CYP and the community to determine the social impact of health inequalities. Claire Dove advised the Board that she will be working alongside John Chester and his team to develop a framework for Alder Hey in terms of the work that is taking place around social and environmental factors.

Nathan Askew drew attention to the importance of being open and transparent with CQC to enable a constructive dialogue during engagement meetings, highlighting the Trust's issues/challenges and being clear on the plans that are in place to address them. It was also felt that it is about the Trust being able to articulate its journey to improvement and showing that it is a learning organisation.

Resolved:
The Board noted the update provided on CQC's 5 year strategy.

21/22/124 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* – Liverpool City Council has confirmed that Phase 1 of the park can be opened therefore the fencing will be removed in the next couple of weeks. It was reported that the landscaping for Phase 2 is due to commence with topsoil being deposited in the next few months.
- *Police Station (lower floor) Occupation* – 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.
- *Phase 3 Demolition* – Phase 3 demolition is now complete with remaining buildings to be removed in 2022.
- *Infrastructure Works* – The programme for the new infrastructure is progressing in line with the overall delivery programme for the campus developments. All new diversions are in place to enable the transfer of water, electricity, etc to new supplies.
- *Schemes* - The construction of the Catkin Centre and the Sunflower House is progressing well, and planning permission has been granted for the new Neonatal Centre. Tenders for the new Neonatal Unit have been returned but are over budget. Further work will take place to try and bring costs back in to an acceptable envelope.
- *North East Plot* – It was confirmed that Step Places planning application has been approved.

Fiona Marston queried as to whether a financial summary could be included in the Campus update going forward to provide an overview of the projects and whether they are on track. It was agreed to discuss this matter and look into submitting this information during the private element of Trust Board meetings.

21/22/124.1 Action: JG/RL

21/22/125 Brilliant Basics Programme Update

The Board received an update on the Brilliant Basics Programme. A number of slides were shared that provided information on the following areas:

- What is Brilliant Basics; supporting a culture of quality improvement - focus on what matters, follow a consistent approach and dedicated support.

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- Alder Hey Improvement Programme.
- Brilliant Basics approach; listen, focus, be informed, empower, challenge, data driven, adapt and vision.
- Progress to date:
  - Addressed safety priorities.
  - Delivery of overarching aims.
  - Recruited additional resource in the Quality Hub.
  - Teams are starting to use the Brilliant Basics approach in everything that they do.
  - Feedback following training is positive and there is engagement from services who weren't involved in the initial programme.
- Unit level output.
- Risks.
- Defining benefits.
- Monitoring and reporting.
- Challenges.
- Next steps:
  - Simplified communications and enhanced frequency.
  - Embed approach into Trust daily/weekly routines with role modelling from the top.
  - Bring operations to the forefront of improvement.
- The Board was asked to support the following:
  - The submission of a short paper each month which provides a summary of the monthly deep dive and an overview of the project.
  - Board engagement.
  - The submission of a report in January 2022 to redefine what is in scope for the year and approve a sustainable plan for the future.

Fiona Beveridge informed the Board that SQAC has agreed to showcase a staff/team story at the beginning of each meeting in order to receive examples of what is being delivered in terms of safety and quality. It was also felt that other Committees might be able to do something similar. Fiona Beveridge highlighted the importance of having a digital thread that runs through all of the Brilliant Basics work to enable the improvements that are being made on the ground floor to be captured via a digital improvement process which is exportable and can be used in terms of CQC evidence or sharing good practice with other organisations.

It was reported that work has been taking place to bring the DMO/Quality Hub together and simplify the Brilliant Basics approach. The Board was advised that a systematic reporting approach will be devised in terms of feeding into the sub-Committees and a number of recommendations will be shared with the Board in due course.

The Chair thanked Nathan Askew for the Brilliant Basics update and drew attention to the shift in culture across the Trust as a result of this work which is gathering momentum.

Resolved:
The Board noted the Brilliant Basics update for September 2021.

21/22/126 Serious Incident Report

The Serious Incident report was submitted to the Trust Board to provide a

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performance position for open and closed incident investigations that met the serious incident criteria and were reported externally to the Strategic Executive Information System (StEIS). The following points were highlighted:

- It was reported that there was one serious incident reported in August 2021, and zero 'Never Events' reported.
- There are four ongoing investigations which are being progressed and two closed investigations in the reporting period.
- The Board was advised of a review that is taking place relating to the care of a patient dating back to 2013. A potential harm has come to light and external input is required due to the complexity of the case. A report will be submitted to the Board in due course.

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

21/22/127 Q1 Mortality Report

The Board received the Mortality Report for quarter 1. The following points were highlighted:

- The Board was advised that the Trust has recently received six patients via ED following serious accidents at home; two patients have died; two patients have had life changing injuries and two patients recovered following treatment. Work is taking place with the Director of Public Health for Liverpool; Matt Ashton in order to circulate safety and awareness information to communities across Liverpool. The Trust is also liaising with Manchester Children's Hospital as they have experienced similar situations. Fiona Marston suggested linking in with the Fire and Rescue Service.
- *Deep Dive into Adult Covid Deaths* – Following a deep dive it was found that the care provided to the adult patients received at AHCH was of a high standard and the support provided to their families was outstanding. There were issues from the first wave that were dealt with at the time, and as an organisation the Trust learnt that it needed to improve its processes in preparation for the next time it was required to support adult patients.
- *Primary Diagnostic Categories* - 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.
- *External Benchmarking* – Alder Hey had 53 deaths against 48.1 expected deaths. Although this shows a figure that is slightly higher this is in all probability as a result of COVID. This resulted in higher risk, more urgent complex patient admissions and less of the lower risk ones. The numbers of admissions also decreased due to the COVID pandemic with only the 'sickest' patients attending and being admitted. The Board was advised that this is a similar picture to Birmingham Children's Hospital which is the best Trust against which to compare AHCH with similar caseload and demographics.
- *Hospital Mortality Review Group (HMRG)* - The percentage of cases reviewed by the group within the 4-month target have continued to decrease due to a number of pressures. Monthly HMRG meetings have been extended for the time being to try to address this matter.

Resolved:
The Board noted the contents of the Mortality update for Q1.

21/22/128 Q1 PALS and Complaints Report

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The Trust Board was provided 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 2022/23. The following points were highlighted:

- It was reported that compliance within 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
- The main reason for informal PALS concerns is regarding appointments and communication. Compliance with the 5 day target to resolve informal concerns is 74%.
- 44 compliments were recorded centrally in the Ulysses system during Q1.
- Two second stage complaints have been received in 2021/22 to date. Therefore, at the time of reporting 6% (2 out of 33) complaints responded to in 2021/22 have resulted in a second stage complaint.
- There has been a delay in the outcome of one complaint that had gone to the Ombudsman due to this matter being transferred to a new investigator.
- *Family Support Helpline* - 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 highest numbers of activity is as a result of the processing of visiting exception forms which was introduced to assist with visiting arrangements which were restricted due to COVID regulations. The second highest reason for calls to the helpline related to appointment queries, cancelled appointment and Attend Anywhere.
- The Board was advised of the slight increase in staff attitude in terms of categories of informal PALS concerns in Q1. A focus on staff behaviour and attitude will take place during Q2.

Anita Marsland queried as to whether a review of a random sample of complaints has taken place yet with NED involvement, an exercise which NEDs had found useful when it had been undertaken previously. Nathan Askew agreed to look into this over the next few weeks.

21/22/128.1 Action: NA

Resolved:
The Board noted the position statement for PALS and Complaints for Q1, 2021/22.

21/22/129 Q1 DIPC Report

The Board received an update on Infection, Prevention and Control. A number of slides were shared with the Board and the following points were highlighted:

- It was reported that there has been one case of C. difficile which was more than likely unpreventable due to the patient's condition, but a lapse in care has been identified as there were no daily descriptions recorded in terms of the consistency of the patient's stools whereas if there had been a test conducted 24 hours prior, this could have been identified.
- *Vaccination rates* – The Trust has administered 640 doses of the booster vaccine to staff members since the 29.9.21 and 222 staff members are scheduled to have a booster on the 30.9.21.
- *Fit-Testing* - All of the Divisions have had more than 80% of their staff fit-tested.

- *Norovirus Outbreak* – There was a norovirus outbreak in one patient after three days of being admitted onto Ward 3A. This affected 11 patients, 6 parents and 21 members of staff. The ward was closed for 12 days and was fully opened by the 12.9.21. As a result of this the Trust implemented rapid testing for all patients coming in via the front door with vomiting and diarrhoea and contained the threat of transmission in other areas.
- *Key updates to the revised UK IPC guidance* - It was confirmed that the Trust is compliant with the revised guidance in terms of physical distancing, use of face masks, triaging and testing. With regards to the '*removal of the three distinct Covid-19 care pathways to one for respiratory pathway applying transmission-based precautions'*, the Trust is going to make a formal proposal with regards to the use of PPE in a paediatric setting due to the problems that have been experienced across the Trust when implementing this type of PPE on previous occasions.

The Chair thanked Beatriz Larru for her leadership and the work that is taking place around Infection, Prevention and Control.

Resolved:
The Board noted the IPC update

21/22/130 EPRR Self-Assessment Assurance Report

The Board received the EPRR Self-Assessment Report in order to provide formal approval in line with its legal and statutory requirements to meet NHS England EPRR Core Standards and the Civil Contingencies Act 2004. The following points were highlighted:

- 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. It was confirmed that the Trust is fully compliant with all associated deep dive standards.
- The Board was advised that 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. It was confirmed that there are robust mitigation plans in place until the work has been completed.
- It was reported that the Trust has appointed a new Emergency Preparedness and Business Continuity Manager. Until that person commences in post the organisation has an interim manager in place to ensure the management of EPRR.

Resolved:
The Board formally approved the EPRR Self-Assessment Assurance Report.

21/22/131 Cumulative Corporate Report – Top Line Indicators

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

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.

21/22/132 Cumulative Corporate Report – Top Line Indicators

People

The Board was advised of the real focus that has taken place over the last two weeks around mandatory training; especially manual handling and resuscitation training. This area of work is being monitored via Gold Command.

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

21/22/133 Alder Hey People Plan
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

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

- *Black History Month* – It was reported that Black History Month takes place in October 2021. Blogs have evolved into a newsletter which will be distributed in October.
- *Governance* – A meeting has taken place with the Director of Corporate Affairs, in order to look at the diversity of the Trust Board and in relation to the Council of Governors to look at how the organisation can recruit CYP from all communities as trust members. The Board was advised that Green Park has supported the Trust with the recruitment of a new Non-Executive Director.
- The Trust has appointed a new EDI lead who has joined the BAME Taskforce and is supporting the leads of the LGBT Network and Staff Disability Network.
- *Nurse Recruitment* – It was reported that the Trust may be recruiting from overseas again; taking into account diversity, age profile, etc. going forward.
- The new Academy Director, Kathryn Birch, is now in post and will support the Trust in terms of encouraging BAME leaders to apply for posts at Alder Hey.

The Board was advised of the award that Angela McDonald, Matron for complex children had received. The Chair suggested inviting Angela along to a forthcoming meeting in order to share her story with Board members.

Resolved:
The Board received and noted the contents of the Alder Hey People Plan and the BAME Inclusion Taskforce update.

21/22/134 Freedom to Speak Up – Review Tool for Boards

The Board received the new FTSU review tool and guidance to help members reflect on the Trust's current FTSU position and the improvement that is needed in order to meet the expectations of NHSE/I and the National Guardian's Office.

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It was reported that this is the first iteration of the document which provides a realistic account of the work that has taken place to date and the work that needs to be progressed. Completion of the review tool is the responsibility of the Executive Lead for FTSU, Erica Saunders, but the work that is conducted to populate the document is a team effort. Attention was drawn to the focus on FTSU by CQC.

Anita Marsland referred to the section on page 9 of the review tool *'evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective'* and advised that Kerry Turner is now linking in with the Trust's Wellbeing Guardian, Fiona Marston.

The Chair thanked the team for the work that has taken place in terms of populating the review tool and asked that an update on progress be provided early in 2022. It was confirmed that FTSU review tool will be incorporated in the Board's work plan and submitted on a six-monthly basis.

21/22/134.1 **Action: KMC**

Resolved:
The Board noted the contents of the FTSU review tool.

21/22/135 **Award Nominations Summary**

This item has been deferred to October.

21/22/136 **Enhanced Monitoring Update**

It was reported that the Trust's paediatric education 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 that the organisation has with Health Education England (HEE) has provided further support and scrutiny to the Trust's improvement activities.

During the last quarter of 2020 the GMC was provided with a comprehensive update on progress following a Quality Review Panel and were pleased to learn of the positive work that had taken place to improve the training environment in paediatrics. The NTS results that were released during the summer of 2021 supported the GMCs view that Alder Hey has satisfactorily and sustainably resolved the concerns in connection with the paediatrics programme.

It was confirmed that trainees are happy with the training they are receiving. The Trust's work to further enhance the learning experience for all students and trainees is ongoing and is being monitored by both the Education Governance Committee and the People and Wellbeing Committee.

The Chair congratulated everyone involved who have made this happen.

Resolved:
The Board received and noted the enhanced monitoring update.

21/22/137 **Future Directions for Research and Innovation**

The Board received an overview of the directions for research and innovation (R&I) along with some early thoughts in terms of an evolving unified strategy for

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R&I. A number of slides were shared that provided the following information:

- R&I is an 'Improvement Family' member:
  - It was pointed out that R&I should be seen as part of the organisation's improvement process. In terms of research this is not solely within the organisation. R&I at Alder Hey is about knowledge transfer that can result in a spin-off company; Alder Hey Ventures. Attention was drawn to the increasing potential for monetisation as a result of the R&I economy, but it was pointed out that there is very little opportunity for overall net financial gain with clinical research or commercial studies.
- Evolution of R&I:
  - Keen to avoid R&I becoming separate entities or innovation becoming subsumed by a spin-off company that the organisation would have little control over.
- New R&I Strategy 2021/23:
  - Evidence gathering under way.
  - First draft by end of Q4 2021.
  - Submit to Board during Q1, 2022.
- Overall priorities:
  - Move to the next level.
  - Key elements of growth.
  - Better integrating R&I
- Mission and vision.
- Four key, patient-centred R&I priorities:
  - Being inclusive, being creative, forward thinking and outward looking.
- Content of the strategy:
  - Based on existing and emerging strengths whilst being flexible and agile.
  - Thematic, rather than specialty or technology based.
- Potential shared R&I domains:
  - Environment, body and mind.
  - 1 to 3 prioritised themes per domain.
- Next steps:
  - Determine key focus areas for development and investment.
  - Consultation.
  - Write the strategy.

The Chair welcomed the approach that has been taken in terms of the direction for research and the things that are starting to emerge.

The Board was informed of the success of the Trust's artificial intelligence (AI) innovation for 'Was Not Brought' patients that has been implemented across Alder Hey and has been taken forward by ten other children's hospitals as part of the Accelerator Programme.

It was reported that the Innovation Team is on the cusp of agreeing a deal with Microsoft. It was pointed out that this is an innovation partnership and not a procurement.

The Board received a number of slides that provided detail on the Brand Strategy and positioning. The following information was shared:

- The purpose of the Alder Hey Innovation Centre Brand project.
- The research that informed the strategy.

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- Purpose, brand key, personality of the brand and logo guidance.
- Next steps:
  - The new brand architecture will be incorporated in the new Innovation Strategy which is due to be completed and submitted for publishing.

The Chair felt that the branding was appropriate and thanked Claire Liddy and her team for the work that has taken place.

Mark Flannagan asked for it to be noted that the branding is specific to the Innovation Centre for a commercially competitive purpose and for it not to be confused with the corporate Comms Strategy. It was confirmed that both brandings will be complimentary of each other.

The Chair informed John Chester that she was heartened to see the environmental element being factored in as one of the research domains in terms of inequalities, etc. The Chair thanked all those concerned for the progress to date.

21/22/138 Financial Update

Month 5 YTD Financial Position

The Trust is reporting an in-month surplus of £0.359m which is £63k behind plan. YTD is £1.8m deficit which is £0.7m behind plan. This position is largely due to the challenges that emerged in M5 with regards to ERF as a result of threshold changes and performance across C&M. This resulted in a loss of income *(£1m behind plan*). A target break even position is expected for H1 with collective risk managed across C&M.

The Trust has a £2.3m CIP gap for the year end. Progress has been made in terms of identifying a number of schemes, but focus remains on progressing the remainder of the target. Discussions have taken place with the Divisions about the support they require to progress their schemes. Cash in the bank is £82m and Capital spend YTD is £6.9m,

Attention was drawn to the organisation's key strategic risks and it was pointed out that capital expenditure remains an area of focus in 2021/22. The Trust is refreshing its 5 year plan in order to maximise capital plans in 2021/22 ensuring minimal slippage.

It was reported that uncertainty remains with regards to the H2 framework as guidance is yet to be published. The Trust is focussing on cost analysis and areas of opportunity of cost reduction for H1 along with a strategy to ensure the maximising of new funding.
Resolved:
The Board received and noted the financial update for M5.

21/22/139 Board Assurance Framework

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

- It was reported that the risks on the BAF have been scrutinised by the respective Assurance Committees.

Resolved:

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

21/22/141 Board Assurance Committees

Audit and Risk Committee – The approved minutes from the meeting that took place on the 23.9.21 were submitted to the Board for information and assurance purposes. During the meeting on the 22.7.21 the Committee received a presentation from Kate Warriner which focussed on the current waiting list, and an update from Urmi Das on how risk management is implemented within the Medicine Division noting the challenges arising from the regular turnover of Risk and Governance Leads across all Divisions. The Audit and Risk Committee has asked the respective Executive Directors to review the Governance Lead role to ensure it is sufficiently supported.

The Committee also received an update on the implementation of L2P which records Consultant Job Plans. Significant work has been led by Urmi Das in the last twelve months to address the high risk recommendations that were raised by internal audit in 2018 regarding this area.

RABD – The approved minutes from the meeting that took place on the 21.6.21 and 26.7.21 were submitted to the Board for information and assurance purposes. During the meeting on the 24.9.21 there was a focus on the Trust's top priority areas/pressures, H2 planning, safe waiting list, the recovery for urgent care, buildings and the improvements that have been made by the Division of Surgery.

SQAC – The approved minutes from the meeting that took place on the 21.7.21 were submitted to the Board for information and assurance purposes. During the meeting on the 22.9.21 the Committee focussed on the progress that has been made in terms of Never Events along with the findings of the consent audit and the progress to deploy e-Consent.

PAWC – The approved minutes from the meeting that took place on the 20.7.21 were submitted to the Board for information and assurance purposes. During the meeting on the 21.9.21 the Committee received the Health and Wellbeing plan, discussed the risks relating to pay deals, the Staff survey, e-Rostering and induction issues.

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

21/22/142 Any Other Business

The Chair advised Board members that today is Claire Dove's final Board meeting as her term of office has come to an end. The Chair reflected upon the positive contributions that Claire has made to the Trust in her role as a Non-Executive Director whilst steering the People and Wellbeing Committee and establishing the BAME Taskforce. On behalf of the Board the Chair thanked Claire for her contribution, commitment and compassion for those employed by the NHS. The Board was informed that Claire will continue to lead on the BAME Taskforce until the end of the financial year on a consultancy basis.

21/22/143 Review of the Meeting

It was felt that the Board has addressed a number of really important items during the meeting and the Trust is advancing in a number of areas.

Date and Time of Next Meeting: Thursday the 28th October 2021 at 9:00am 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 28th October 2021							
25.2.21	20/21/252.1	Mortality Report, Q2	*National Changes to the Child Death Mortality Process* - Acquire written confirmation from David Levy's office acknowledging that the Trust's system is fully compliant and in line with the new national guidance.	Nicki Murdock	28.10.21	On Track	**19.3.21** - A verbal update will be provided on the 25.3.21. **25.3.21** - It was reported that the Trust is awaiting a reply from David Levy's office. **29.4.21** - It was reported that the Trust is awaiting a reply from David Levy's office. **20.5.21** - The Medical Examiner regional lead, Dr Huw Twamley, has discussed the Trust's Medical Examiner proposal with Julie Grice. He awaits national guidance with reference to the stand alone tertiary paediatric centres. The national Medical Examiner, Alan Fletcher, has also looked at this. There is no further guidance available yet, but Alder Hey's system is more rigorous than the national process. **ACTION TO REMAIN OPEN**
24.6.21	21/22/65.1	Approach to End of Life Care when there is a dispute	Look into agreeing a process to provide families with feedback following an end of life decision.	Adrian Hughes	28.10.21	On Track	**30.9.21** - It was agreed to provide an update on the 28.10.21. **ACTION TO REMAIN OPEN**
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	On Track	**23.10.21** - An update will be provided on the 28.10.21.
30.9.21	21/22/120.1	Post Covid-19 Recovery Plan, 2021/22	*Winter Preparedness* - Submit a proposal to RABD and the Trust Board on the use of the space on the ground floor of the new Neonatal Unit to enhance the organisation's services for urgent, emergency and acute medical care.	Adam Bateman	28.10.21	Closed	**23.10.21** - This item has been included on the private element of October's Trust Board agenda. **ACTION CLOSED**
30.9.21	21/22/123.1	CQC's 5 Year Strategy	Submit CQC's 5 Year Strategy to the governors.	Erica Saunders	28.10.21	Closed	**23.10.21** - This item will be included on December's CoG agenda. **ACTION CLOSED**
30.9.21	21/22/128.1	Q1 PALS and Complaints Report	Arrange for NED involvement to review a random sample of complaints.	Nathan Askew	28.10.21	Closed	**27.10.21** - Pauline Brown will be taking this action forward as part of the complaints improvement work. **ACTION CLOSED**
30.9.21	21/22/124.1	Alder Hey in the Park Campus Development Update	Discuss the possibility of including a financial summary in the Campus update to provide an overview of the projects to determine if they are on track.	John Grinnell/ Rachel Lea	28.10.21	Closed	23.10.21 - A Capital Plan update will be provided on the 28.10.21 during the private element of the Board meeting. **ACTION CLOSED**
30.9.21	21/22/134.1	FTSU Tool and Guidance	FTSU Tool to be submitted to the Board on a six monthly basis. Include this item on the Board work	Karen McKeown	28.10.21	Closed	**23.10.21** - This action has been addressed. **ACTION CLOSED**
Actions for the 25th November 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.
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	(red)
On Track	(green)
Closed	(blue)

Board of Directors

Thursday 28th October 2021

Report of	Development Director
Paper prepared by	Associate Development Director- (20/10/2021) 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

October 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 1 in Quarter 3 of 2021/22 the programme Delivery Timetable RAG rates projects against planned commencement date.

2. Programme Delivery Timetable

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

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

3. Project updates

Park Reinstatement Phase 1

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

Acquired Buildings Occupation (neighbouring sites)

Current Status- on hold	Risks/issues	Action/next steps
Knotty Ash Nursing Home **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. Draft Agreement for Lease has been issued to the Police for comments.	Police do not release the space while decisions are made in regard to additional police funding and its use. (Risk 2088, risk rating 12)	Meet with Police to agree documentation.

Relocations

Current status	Risks/issues	Actions
The fit out works to the Innovation park offices is proceeding well and occupation will start at the beginning of November. The additional space to allow the CAMHs team along with some therapy space to relocate and expand is now out to tender.	Timely relocation and redirection of services are delayed (2104 risk rating 9 and 2105 risk rating 12)	Work with the landlord and furniture suppliers to implement design and procure furniture in accordance with e programme. Await tender response.

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

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

Park reinstatement Phase 2/3

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

NEW Mini Master Plan for Eaton Rd frontage

Current status-	Risks/issues	Actions
No further progress required at the moment 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 electrical infrastructure work have been absorbed into the Sunflower House construction contract to avoid clashes of 2 contractors on the same site.	Early indication is that to complete all of the work will exceed budget. Must maintain programme to avoid delays to the cluster and neonates projects	The works remain on programme but close monitoring is being continued to watch for slippage.

Catkin Centre and Sunflower House Construction

Current status	Risks/issues	Actions
Contract with Galliford Try remains on programme with good visible progress. 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. Planning permission has been received. Even after a value engineering exercise, a gap of c£1m is expected.	Project Co engagement extending the programme and increasing costs. 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. Request to increase budget by £1m has been submitted.

North East Plot Development

Current status	Risks/ Issues	Actions/next steps
StepPlaces, the Developer who has purchased the north east plot of land, is currently in discussion with the trust on how the development could support. StepPlaces has received a planning consent. Discussions are taking place with Ronald MacDonald Charity to see if the current service could be relocated to a new building on the StepPlaces site.	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. Produce robust business cases to highlight any issues/risks.

Communications

Current status-	Risks / issues	Actions/next steps
Regular dialogue between development team and Communications department are now in place to cover the park development. 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.	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.
A new member of staff is being sought commence work on the implementation of a green travel plan.	Travel plan from Mott MacDonald does not provide realistic and evidenced solution.	Car parking group to continue to work with Mott MacDonald and internal group members to produce an overall green travel plan.

Orthotics move to Outpatients

Current status	Risks/Issues	Actions/next steps
Moving Orthotics service into space in the lower ground floor of outpatients is moving forward. The service will share reconfigured space with medical illustration. Tenders to be issued before the end of October. Works planned to complete in February/March 2022.	Temporary home of medical photography studio	Agreement from service as to temporary location

4. Trust Board of Directors

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

Board OF DIRECTORS

Thursday, 28th October 2021

Paper Title:	Serious Incident Board Report 1st September 2021 – 30th September 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 Zero serious incident reported in September 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 for this reporting period Duty of candour has been completed for all incidents, in line with regulation 20.

There were no closed serious incidents during this reporting period.

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

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

Note: 5 open investigations carried forward 2020/21

Table 2 Open ongoing StEIS reported investigations

StEIS Reference	Date reported	Incident	Agreed date of completion
2021/17974	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)	07/10/2021
2021/12203	27/06/2021	Delay in treatment. Delay in transfer to HDU. Suboptimal care of deteriorating patient?	29/10/2021
2021/12387	12/06/2021	Patient ingested large overdoes of tablets at home, including Omeprazole and Colchicine. Patient died due to impact of Colchicine toxicity.	12/11/2021

END

BOARD OF DIRECTORS

Thursday, 28th October 2021

Paper Title:	Digital and Information Technology Update
Report of:	Kate Warriner, Chief Digital and Information Officer
Paper Prepared by:	Kate Warriner, Chief Digital and Information Officer

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

Alder Hey Digital and Information Technology Update

1. Introduction

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

2. Executive Summary

In the last reporting period, good progress has been made against a number of key areas. Key headlines include:

- Engagement with new regional ICS digital lead
- Submission of initiatives for national Unified Tech Fund resources
- Good progress with internal programme delivery
- First iDigital staff awards and team development held
- Awarded Highly Commended for Excellence in Cyber Security at the recent Health Tech Network awards
- Progress to commence strategically looking at the next phase of Digital Futures from 22/23

The Board of Directors is asked to note operational updates and progress with technology and digital maturity programmes

3. National & Regional Digital Update

3.1 NHSX Strategy

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

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

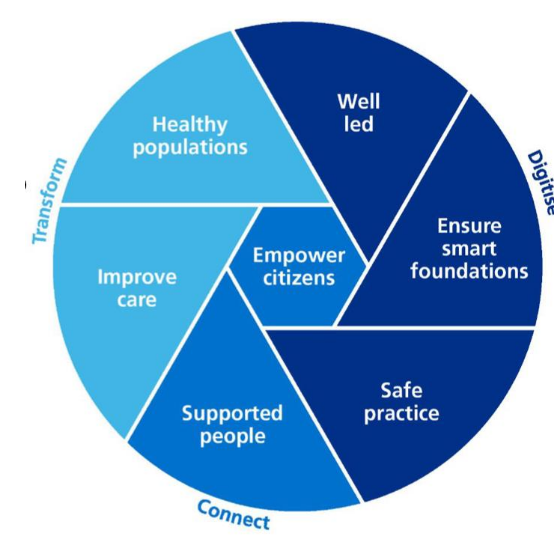
3.2 What Good Looks Like Framework

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

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

WGLL Success Measures

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



An initial assessment against WGLL success measures has been undertaken. Progress against key criteria is good, any gaps are understood and included as part of the digital programme and future plans.

3.3 Who Pays for What and Unified Tech Fund

The WPfW (https://www.nhsx.nhs.uk/digitise-connect-transform/who-pays-for-what/who-pays-for-what-proposals/) proposals are currently draft and requesting feedback. WPfW has been developed to support health and care organisations by streamlining the way in which digital funds are coordinated and distributed. The ultimate aim is to facilitate more local control over funding distribution placing a lot of emphasis on ICS leadership.

For 21/22, the proposals are to:

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

A range of bids have been submitted through the Unified Tech Fund Progress against a number of key areas to further develop our frontline digitisation in line with the published criteria.

3.4 Regional/ICS Developments

From a C&M ICS perspective, the new Chief Digital and Information Officer for C&M commenced in post in October 2021. Work is underway in partnership to review the digital strategy, governance and priorities within the ICS. AH is plating an active role both as the current host provider for ICS digital team, as a partner in the ICS and as advocate for children and young people.

3. Digital Futures Progress

Internally, progress with Digital Futures implementation remains good with work progressing at pace. Key delivery programmes continue to progress and benefits realised and tracked. The Digital Oversight Collaborative has good oversight of progress with a wide range of service and clinical representation in place.

During the next quarter, work is due to commence on the refresh of the Digital Futures strategy and plans for the next financial year.

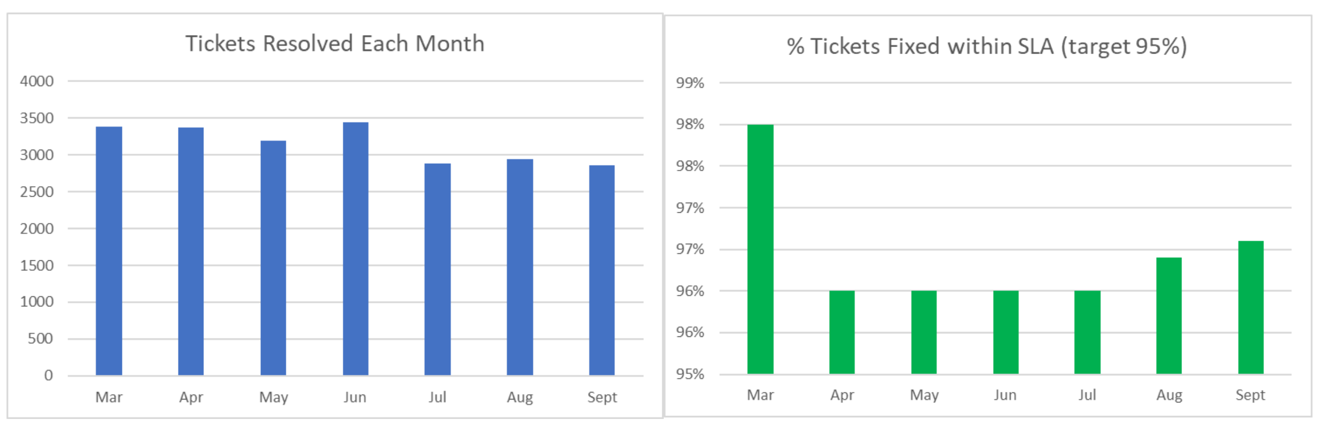
In terms of current progress to date, headlines include:

- Projects within the Digital Safety Programme continue to remain on track, to achieve HIMSS Stage 7 accreditation during 2021
- Alderc@re programme continues to progress. A significant amount of the system has been built with recent developments with regards to prototype 4 of the new build. Challenges continue in relation to prescribing with external support and resource in place to support this to progress
- Attend Anywhere continues to be utilised for virtual outpatients with AH a high performer regionally and nationally. AH are part of a regional procurement exercise as the national support ceases from March 2022. Additionally, work is underway with the Outpatient transformation programme to include other digital tools and innovations including digital communications with children, young people and families, and the development of Alderhey@nywhere as the overarching digital front door to Alder Hey
- Excellent progress with the electronic anaesthetic record with go-live scheduled for November 2021
- Digital urgent care developments including a digital symptom checker to be launched in October 2021
- Progress with BI and analytics programmes and recruitment

4. Operational IT Performance and Technology Roadmap

This report provides performance to the end of September 2021. Key highlights include:

- Maintaining an average of 3,000 Ticket resolutions per month
- SLA target of 95% achieved for the last 10 months. Processes are well embedded and now in a continual improvement cycle to look at how we can further improve processes
- 80% of all tickets were resolved in 1 Day



Summary of key digital system unplanned downtime across the last six months. Systems not listed would have exceeded the uptime target.

System	Target	Apr	May	Jun	Jul	Aug	Sept	Comments
Meditech	99.75%	99.7%	98.3	99.7%	99.7%	99.7%	99.7%	Outage in May
Remote Meditec Access	99.75%	99.7%	100%	99.9%	100%	100%	100%	

During September we received a High Severity Cyber Security CareCert notice. This was against the management system in use for the Trust Server Estate. The patch was applied within 48hours without impact to staff.

A significant number of programmes and improvements continue to be worked on and delivered to improve the digital services delivered to the trust, including the following:

- New office space at Innovation Park has been set up with Agile workspaces, new high-speed network connection and Wi-Fi throughout in preparation for staff moves over the coming weeks
- Shared infrastructure with specialist Trusts including Clatterbridge, Liverpool Womens and Liverpool Heart and Chest for a range of systems and resources

5. Digital Partnership

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

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

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

In terms of staff engagement, an all staff development session was held in August 2021. This included a range of presentations, staff development, team building, an EDI presentation and service celebration through the inaugural staff awards.

7. Summary and Recommendations

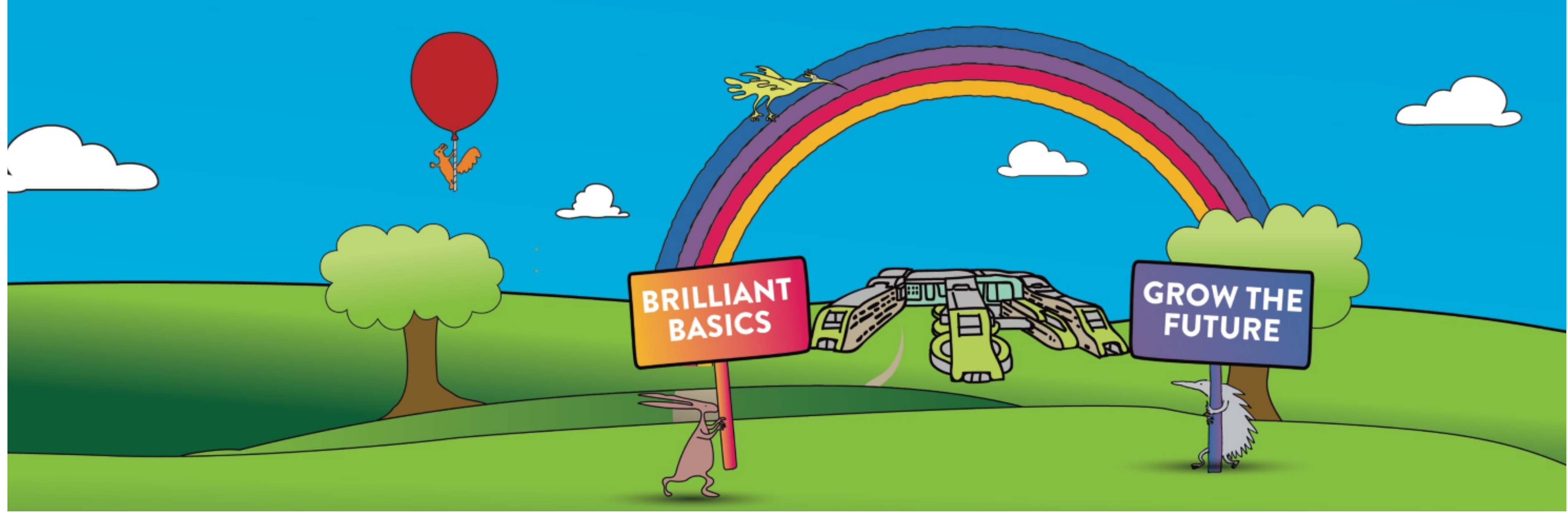
In summary, progress with digital developments and delivery at Alder Hey remain positive. Performance of operational key performance indicators are good and customer service satisfaction feedback is high.

Digital staff and service development and engagement has been a key area of development and success.

The Board of Directors is asked to:

- Note operational updates and progress with technology and digital maturity programmes

TRUST BOARD Report September 2021



How Did We Do?

Executive Summary **Month: September** **Year: 2021**

Delivery of Outstanding Care

Safe

- Consistent level of incident reporting for the time of year
- The patient safety meeting continues to provide assurance to the Trust on the all elements of clinical incident management

Highlight

- Zero clinical incidents resulting in moderate harm and above

Challenges

- 5 medication errors resulting in harm. One overdose of paracetamol; one overdose of warfarin; an 8-x overdose of omeprazole; a drug given incorrectly to the wrong patient and a patient receiving a drug that was contradicted due to age. All of these incidents have been properly investigated and appropriate action taken to ensure lessons are learned and potential for future errors is reduced.
- Sepsis performance reflects the continuing challenges with activity in AED
- 1 Hospital acquired C Difficile infection

The Best People Doing their Best Work

Caring

- Overall performance score re Friends and Family is below 90% however the score would have been significantly higher without the 64% from AED
- 2nd highest number of PALS referrals this year

Highlight

- 13 formal complaints in month from a very high number of PALS referrals
- Community Division Friends and Family scores continue to be well above 90%

Challenges

- AED Friends and Family score of 64% reflects the effects of the unprecedented activity in the Department.

Delivery of Outstanding Care

Effective

Presently, the biggest operational challenge relates to the 17% rise in emergency attendances to the Emergency Department which is generating significant pressure on staff and high hospital bed occupancy. This is causing longer waiting times for clinical assessment in the Emergency Department; longer waiting times for children to be admitted to a bed; and the cancellation of some operations (n= 16).

In response, our urgent and acute care plan has increased acute care clinics, community pharmacy cover and a tactical command operation to manage patient flow is now in place. We have also submitted a business case to the CCG to fund a paediatric urgent care service on-site.

Highlight

- Reduction in patients waiting > 28 days for treatment following a cancelled operation
- No patients waiting 12 hrs from decision to admit

Challenges

- ED waiting times
- Increase in cancelled operations

Delivery of Outstanding Care

Responsive

As forecasted, the number of reportable long wait patients has increased as we conclude the Safe Waiting List Management data assurance reviews. We expect that, subject to maintaining elective recovery at 90%- 100% and a less extreme winter plan scenario, we will reduce the number of C&YP waiting over 52 weeks in quarter 4.

Access to cancer care has remained protected and is very good, with full compliance with the national cancer access standards, including the new faster diagnosis standard.

Highlight

- Access to cancer care
- Reduction in the number of long-stay patients waiting > 21 days

Challenges

- Access to planned care (RTT and 52 weeks wait)

The Best People Doing their Best Work

Well Led

Finance

For the Month of September (Month 6), the Trust is reporting a break even position which is in line with the Cheshire & Mersey System control total.

Planning guidance has now been received for H2 and early indications show an increased efficiency requirement with overall reduced funding across C & M. Financial plans are due to be submitted to C & M by 26th October and will be required to break even as in H1 so will represent a huge challenge.

Cash in the bank at the end of September was £89m.

The overall capital expenditure in month for September was £2.4m (£9.3m year to date) against a plan of £2.1m in month (£9.4m year to date). This demonstrates that spend is in line with plan year to date.

Highlight

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

Challenges

- H2 Financial plans and the requirement to reach as break even position with expectations of increased efficiencies against a reduced funding envelope.
- Delivery of CIP through remainder of 2021/22 with increasing operational pressures.

Sickness update Sickness across the trust remains in a state of flux when considered on a daily and weekly perspective; however for the period of September 2021, absence for reasons linked to sickness has reduced to 5.9% from 6.5% when compared to August, 1.9% above the organisational KPI. Short term absence remains static at 1.5% and long term absence has decreased by 0.5%. The HR team are working alongside managers with the purpose of monitoring and instigating appropriate action linked to policies, therefore it is anticipated that there will be an increase in stage 3 activity, which may have a positive impact on long term absence figures. The top 10 reasons for absence are shown in the table below. To support our employees the following activities remain underway: • Access to Occupational Health support, the SALS team, the Employee Assistance programme and the Alder Centre, for a range of issues that impact on health and well-being e.g. counselling, financial guidance, physiotherapy etc. • The Trust has launched its annual flu campaign and the COVID booster programme is ongoing. Although engagement is not a mandatory requirement, it is encouraged. • Proper hand washing remains a priority area for COVID and also for good health including the prevention of V&D bugs. • PPE protocols remain in place. **Mandatory Training** Mandatory Training this month has remained at 87%, with the same 3 key areas as last month causing issues; Resus Training, Practical Moving & Handling and the Estates and Facilities Staff Group. There is currently a weekly review and actions being taken as part of Exec Comm Cell specifically around these 3 areas. Resus have brought in additional external trainer capacity for the next 3 months as well as looking to roll out some Basic Life Support training online.	• Managing sickness rates and staff returning to work. • PDR compliance.

Moving & Handling have a new trainer starting imminently on a secondment basis and are exploring bringing in external support whilst they re-develop a Job Description for a permanent Moving & Handling Training Lead. Estates and Facilities are working closely with the L&D function to come up with additional methods of training the staff within this area who are struggling to access ESR, this includes training Facilities management to deliver some of the courses, supervisors assessed workbooks, recorded sessions and face to face sessions. **Appraisals** As at the end of September appraisals were at 67% across the Trust overall. Whilst staff who have not had an appraisal are still encouraged to do so, the appraisal window is now closed. A campaign to ensure improvement in appraisal compliance will need to be set up for next year's window. **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 6 Research Activity:

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

Divisional Participation:

- Division of Medicine – 140 open studies
- Division of Surgical Care – 28 open studies
- Division of Community & Mental Health – 4 open studies

Research Assurance:

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

Highlight

- Recovery plan remains on track

Challenges

- Financial performance
- Staff recruitment progress

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Alder Hey Children's
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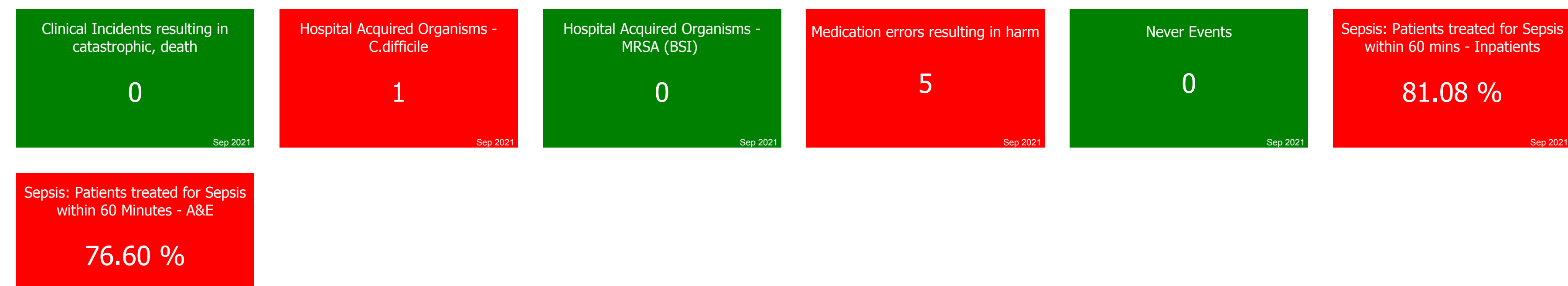
Leading Metrics

SAFE



Metric	Value	Period
Clinical Incidents resulting in catastrophic, death	0	Sep 2021
Hospital Acquired Organisms - C.difficile	1	Sep 2021
Hospital Acquired Organisms - MRSA (BSI)	0	Sep 2021
Medication errors resulting in harm	5	Sep 2021
Never Events	0	Sep 2021
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	81.08 %	Sep 2021
Sepsis: Patients treated for Sepsis within 60 Minutes - A&E	76.60 %	Sep 2021

CARING

Metric	Value	Period
Friends & Family: Overall Percentage Recommended Trust	88.37 %	Sep 2021

EFFECTIVE

Metric	Value	Period
ED: 95% Treated within 4 Hours	73.36 %	Sep 2021

RESPONSIVE

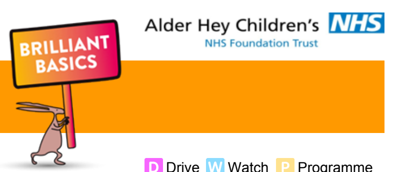
Metric	Value	Period
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	100 %	Sep 2021
All Cancers: 31 day wait until subsequent treatments	100 %	Sep 2021
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100 %	Sep 2021
Diagnostics: % Completed Within 6 Weeks	97.21 %	Sep 2021
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	100 %	Sep 2021
RTT: Open Pathway: % Waiting within 18 Weeks	66.54 %	Sep 2021
Waiting Greater than 52 weeks - Incomplete Pathways	263	Sep 2021
Waiting List Size	13092	Sep 2021

WELL LED

Metric	Value	Period
Cash in Bank (£'000s)	88514	Sep 2021
Control Total In Month Variance (£'000s)	834.92	Sep 2021
Mandatory Training	87.32 %	Sep 2021
Safer Staffing (Shift Fill Rate)	94.46 %	Sep 2021
Sickness	6.27 %	Sep 2021

Delivery of Outstanding Care

SAFE



D Drive W Watch P Programme

Measure	Type	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG	Comments Available
Proportion of Near Miss, No Harm & Minor Harm	D	100.0%	100.0%	100.0%	99.8%	99.8%	99.8%	99.8%	99.8%	99.1%	99.6%	99.6%	99.8%	100.0%		>=99 % N/A <99 %	✔
Clinical Incidents resulting in Near Miss	D	50	75	100	74	53	63	98	80	82	91	74	63	87		No Threshold	✔
Clinical Incidents resulting in No Harm	D	341	328	410	314	288	333	401	394	362	321	329	297	314		No Threshold	✔
Clinical Incidents resulting in minor, non permanent harm	D	70	67	83	75	81	76	95	91	80	71	95	88	77		No Threshold	✔
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	1	1	1	1	1	4	1	2	1	0		No Threshold	✔
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	1	0	0	0	1	0	0	0	0		0 N/A >0	✔
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	0	0	0	1	0	0	0		0 N/A >0	✔
Medication errors resulting in harm	D	8	1	11	0	6	3	4	4	2	2	2	6	5		<=3 N/A >3	✔
Pressure Ulcers (Category 3)	W	0	0	0	1	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Never Events	W	0	0	0	0	0	0	1	0	0	0	0	0	0		0 N/A >0	✔
Sepsis: Patients treated for Sepsis within 60 Minutes - A&E	D P	85.2%	74.1%	79.2%	73.7%	89.5%	80.6%	100.0%	85.0%	94.4%	87.9%	88.9%	90.2%	76.6%		>=90 % N/A <90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	86.1%	94.3%	80.8%	70.8%	87.5%	84.0%	88.9%	83.3%	89.7%	91.7%	88.9%	86.4%	81.1%		>=90 % N/A <90 %	✔
Number of children that have experienced avoidable factors causing death - Internal	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - C.difficile	D	1	1	0	0	0	0	0	0	1	0	0	0	1		0 N/A >0	✔
Hospital Acquired Organisms - MSSA	D	1	0	1	0	3	1	0	0	1	0	2	0	0		No Threshold	✔

The Best People doing their best Work

CARING

D Drive W Watch P Programme

Measure	Type	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust	W	90.6%	94.7%	93.7%	91.5%	95.3%	94.9%	92.9%	94.0%	90.2%	91.0%	87.6%	92.3%	88.4%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust	D	84.4%	92.1%	89.2%	91.5%	93.2%	93.1%	88.0%	88.0%	76.2%	79.2%	59.8%	79.6%	64.3%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	D	89.1%	94.7%	98.8%	100.0%	92.7%	96.7%	93.0%	95.9%	92.4%	95.9%	97.1%	96.2%	92.7%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	D	92.4%	94.5%	95.5%	93.4%	94.2%	90.4%	89.8%	96.4%	95.1%	87.0%	88.8%	91.4%	92.9%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	D	92.3%	89.7%	91.3%	100.0%	96.3%	90.3%	87.9%	90.6%	85.7%	95.0%	94.7%	95.8%	96.3%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	D P	94.1%	95.5%	93.9%	90.4%	96.1%	96.0%	95.1%	95.3%	94.4%	94.8%	95.5%	95.4%	94.7%		>=95 % >=90 % <90 %	✔
Complaints	W	11	19	15	10	15	11	23	5	9	15	10	12	13		No Threshold	
PALS	W	77	99	74	65	68	88	110	101	119	150	122	89	148		No Threshold	

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

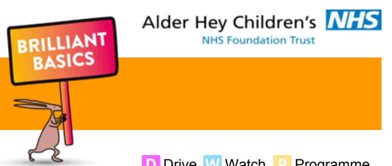
BRILLIANT BASICS

D Drive W Watch P Programme

		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG			Comments Available
% Readmissions to PICU within 48 hrs	W	0.0%	1.6%	4.2%	1.4%	0.0%	0.0%	1.6%	0.0%	2.6%	0.0%	1.4%	2.7%	0.0%		No Threshold			
ED: 95% Treated within 4 Hours	D	95.1%	96.8%	97.1%	98.6%	98.5%	97.8%	95.3%	92.5%	81.1%	85.5%	67.9%	87.7%	73.4%		>=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	17	19	16	10	5	7	12	13	7	13	13	12	31		<=20	N/A	>20	✔
28 Day Breaches	W	8	2	1	3	3	1	2	4	3	0	3	8	5		0	N/A	>0	✔

Delivery of Outstanding Care

RESPONSIVE



D Drive W Watch P Programme

Measure		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	W	95.4%	95.4%	95.7%	97.5%	99.3%	93.6%	95.6%	96.0%	98.0%	94.3%	94.4%	96.2%	97.5%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	W	96.0%	98.3%	98.6%	97.5%	100.0%	98.1%	94.7%	98.5%	99.0%	94.3%	94.4%	97.8%	96.8%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	D P	97.1%	96.7%	97.8%	95.0%	98.5%	98.1%	94.2%	98.5%	92.2%	96.4%	93.9%	93.0%	95.5%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	W	98.3%	100.0%	99.3%	91.7%	100.0%	94.9%	96.1%	98.5%	98.5%	98.6%	97.0%	96.2%	96.8%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	D	82.3%	83.3%	84.9%	76.7%	80.3%	85.9%	78.2%	81.1%	80.0%	79.3%	82.7%	77.4%	75.2%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	D	75.4%	88.3%	71.9%	81.6%	94.9%	92.9%	90.9%	91.0%	91.7%	89.3%	91.9%	87.6%	89.2%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	47.9%	53.8%	58.7%	60.9%	61.1%	63.2%	68.1%	68.6%	71.9%	74.8%	72.7%	71.1%	66.5%		>=92 % >=90 % <90 %	✔
Waiting List Size	W	10,939	10,838	10,755	10,443	10,648	11,453	11,892	11,110	11,564	11,414	12,096	13,286	13,092		No Threshold	
Waiting Greater than 52 weeks - Incomplete Pathways	W	145	145	148	184	222	307	361	283	235	204	187	195	263		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%	95.7%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	91.8%	96.4%	97.1%	92.3%	93.7%	95.8%	97.5%	95.2%	95.2%	98.5%	95.5%	94.7%	97.2%		>=99 % N/A <99 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
PFI: PPM%		99.0%	100.0%	98.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

D Drive W Watch P Programme

		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG			Comments Available
Control Total In Month Variance (£'000s)	W	-1	-359	331	686	242	590	3,824	-955	592	391	-589	-51	835		>=-5%	>=-20%	<-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	4,518	187	-1,733	1,610	-1,979	-3,207	-5,794	-910	974	13	162	234	-339		>=-5%	>=-10%	<-10%	✔
Cash in Bank (£'000s)	W	108,756	109,084	110,503	110,776	110,776	110,871	92,708	92,708	88,440	82,001	82,006	82,121	88,514		>=-5%	>=-20%	<-20%	✔
Income In Month Variance (£'000s)	W	2,492	-793	748	234	227	2,309	18,172	-494	715	1,597	2,980	-1,713	2,766		>=-5%	>=-20%	<-20%	✔
Pay In Month Variance (£'000s)	W	-1,160	20	492	-192	-373	-387	-13,171	-308	-370	-545	553	71	-2,466		>=-5%	>=-20%	<-20%	✔
Non Pay In Month Variance (£'000s)	W	-1,333	414	-909	644	387	-1,333	-1,176	-153	247	-661	-4,122	1,591	534		>=-5%	>=-20%	<-20%	✔
AvP: IP - Non-Elective	W	971	961	950	929	747	731	1,066	-98	-102	1,289	-187	-141	-69		>=0	N/A	<0	✔
AvP: IP Elective vs Plan	W	366	400	411	390	340	353	455	-89	-62	448	-22	-113	-82		>=0	N/A	<0	✔
AvP: Daycase Activity vs Plan	W	1,511	1,660	1,772	1,713	1,507	1,598	2,075	184	-7	2,103	267	-126	177		>=0	N/A	<0	✔
AvP: Outpatient Activity vs Plan	W	22,053	22,750	23,860	20,824	22,255	22,276	26,621	1,474	3,899	26,941	4,715	-47	4,068		>=0	N/A	<0	✔
PDR	W	29.5%	62.6%	72.4%	74.6%	74.4%	74.4%	74.4%	0.9%	6.3%	19.7%	56.3%	65.0%	67.3%		No Threshold			✔
Medical Appraisal	W	95.6%	95.6%	95.6%	95.9%	95.9%	95.9%	95.9%	21.9%	30.9%	34.8%	42.4%	70.8%	55.2%		No Threshold			✔
Mandatory Training	W	89.3%	88.6%	85.8%	85.0%	86.0%	85.8%	86.8%	88.4%	87.2%	88.1%	88.0%	87.4%	87.3%		>=90 %	>=80 %	<80 %	✔
Sickness	D	5.2%	6.0%	5.4%	5.6%	7.2%	5.7%	4.7%	4.6%	5.2%	5.6%	6.3%	6.5%	6.3%		<=4 %	<=4.5 %	>4.5 %	✔
Short Term Sickness	D	1.4%	1.9%	1.3%	1.1%	2.3%	1.2%	1.2%	1.1%	1.4%	1.5%	1.8%	1.6%	1.8%		<=1 %	N/A	>1 %	✔
Long Term Sickness	D	3.9%	4.1%	4.2%	4.5%	4.9%	4.4%	3.6%	3.4%	3.9%	4.1%	4.5%	5.0%	4.5%		<=3 %	N/A	>3 %	✔
Temporary Spend ('000s)	D	1,015	1,061	1,365	1,392	1,373	1,279	2,272	1,071	1,040	960	1,132	1,096	1,367		No Threshold			✔
Staff Turnover	D	9.6%	9.3%	9.1%	9.0%	9.0%	8.9%	8.9%	9.5%	9.8%	9.4%	9.8%	9.7%	10.0%		<=10 %	<=11 %	>11 %	
Safer Staffing (Shift Fill Rate)	W	94.2%	94.2%	94.9%	93.6%	90.5%	94.5%	94.0%	97.7%	98.8%	97.6%	89.6%	92.2%	94.5%		>=90 %	N/A	<90 %	✔
Domestic Cleaning Audit Compliance	W	93.8%	90.0%	87.5%	90.4%	94.4%	97.7%	97.7%	97.7%	88.6%	100.0%	97.7%	100.0%	97.7%		>=85 %	N/A	<85 %	✔
NHS Oversight Framework	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	<=1	>1	✔

Alder Hey Children's NHS
NHS Foundation Trust

GROW THE FUTURE

Game Changing Research & Innovation

R&D

D Drive W Watch P Programme

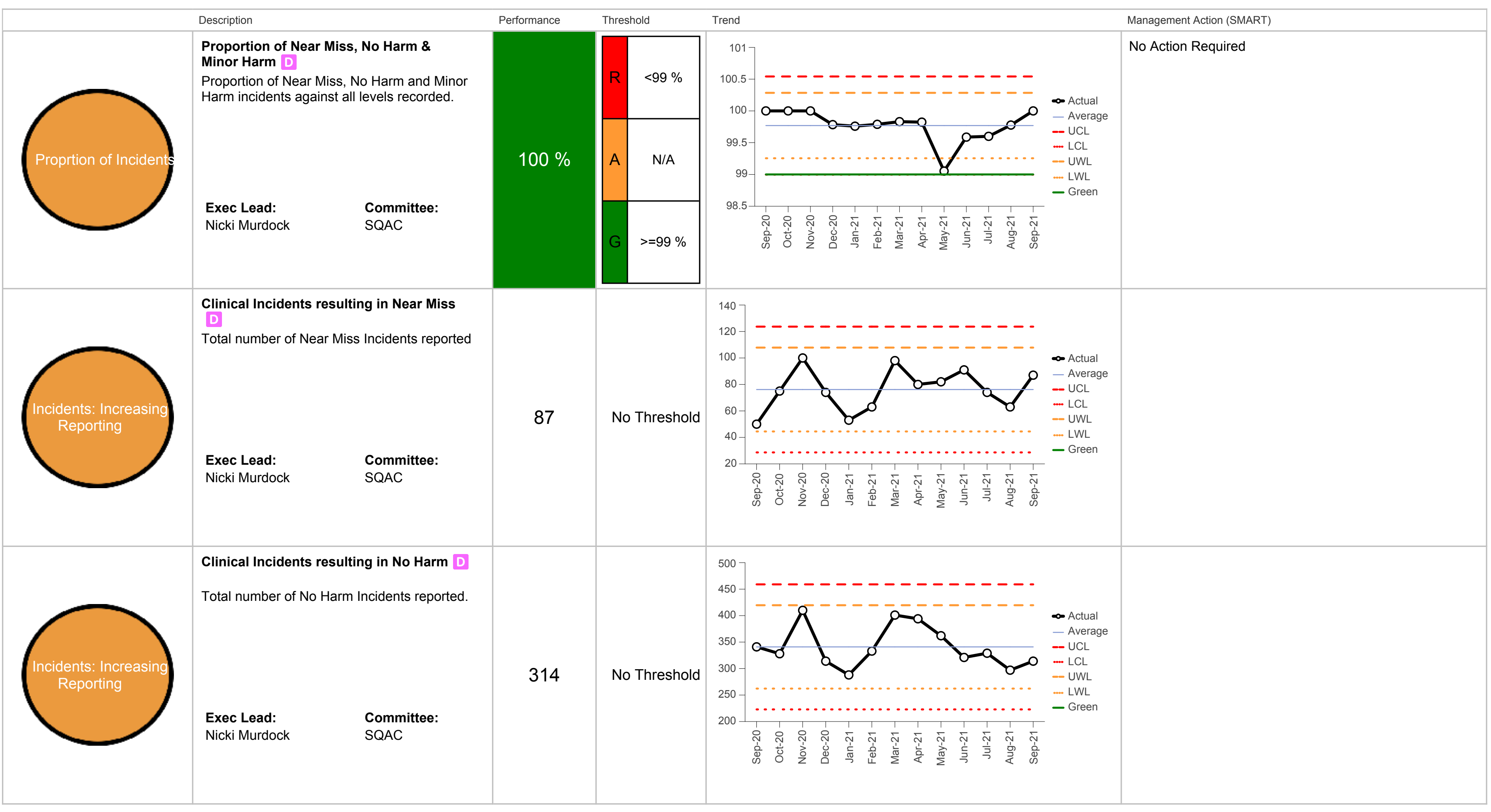
		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	61	66	71	76	80	80	90	100	103	108	117	125	132		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	28	34	37	36	36	36	36	34	36	38	37	38	40		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	4	1	4	4	1	0	6	7	2	3	7	3	7		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	0	2	1	0	0	0	2	0	3	1	1	0	2		>=1	N/A	<1	✔
Number of patients recruited	W	413	665	832	182	504	403	105	1,055	1,039	896	439	1,060	983		>=100	>=86	<86	✔

Delivery of Outstanding Care

7.1 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme



	Description	Performance	Threshold	Trend	Management Action (SMART)
Proprtion of Incidents	**Proportion of Near Miss, No Harm & Minor Harm** D Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded. **Exec Lead:** Nicki Murdock **Committee:** SQAC	100 %	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	87	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	314	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	77	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	0	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	5	R	>3		Five incidents involved minor harm in September. 3 patients received overdoses of medication that warranted extra tests to monitor for adverse effects. A dose of medication was given to the incorrect patient and a patient was given an antibiotic which was contraindicated for their age. 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

BRILLIANT BASICS

Alder Hey Children's NHS Foundation Trust

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	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	76.60 %	R <90 % A N/A G >=90 %		Eleven patients did not receive antibiotics within 60 minutes and 9 within 90 minutes; predominantly due to difficulty gaining intravenous access with many receiving antibiotics intramuscularly instead. Those with no clear cause for delay were incidented for further investigation. Two delays were due to further discussions required, regarding treatment and antibiotic choice

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	81.08 %	R A G	<90 % N/A >=90 %	Chart: Sep-20 to Sep-21 (Actual, Average, UCL, LCL, UWL, LWL, Green)	7 patients did not receive IVAB in <60mins with 4 not receiving in <90mins. Acuity of patients has increased with pressures on stabilising patients from a respiratory and/or cardiovascular clinical interventions as well as IVAB. 3 patients had difficult access needing escalation for support, 2 were complex cases with a complex medical background. 2 cases there was a lack of effective communication. Feedback given to divisional leads and wards about importance of continued awareness and effective communication during these extremely busy times. Updates given at last Sepsis Steering Group.
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	Chart: Sep-20 to Sep-21 (Actual, Average, UCL, LCL, UWL, LWL, Green)	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	Chart: Sep-20 to Sep-21 (Actual, Average, UCL, LCL, UWL, LWL, Green)	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	1	R >0 A N/A G 0	Sep-20 to Sep-21 (Actual, Average, UCL, LCL, UWL, LWL, Green)	17 year old Oncology patient . Post infection review scehduled for October 2021
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	Sep-20 to Sep-21 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No action required

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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	88.37 %	R <90 % A >=90 % G >=95 %		FFT - In September 2021, there were 1,547 responses to the Family & Friends Test out of a possible 31,462 which gave an overall Trust FFT percentage of 88.49% who found their experiences to be either good or very good. Medicine has decreased by 4.1% and community has decreased by 2.3% of their positive response compared to August and Surgery has stayed the same.
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	64.26 %	R <90 % A >=90 % G >=95 %		291 responses increase to the previous month a decrease compared to Sept 2020. 64% of people said that their experience was either good or very good. Positive comments: 'the doctor was very thorough', 'Everyone was friendly and welcoming and went out of their way to ensure my child and I understood everything that was happening', 'Great care given to my son and reassurance given when he felt worried. We really appreciate the hard work all the staff are doing'. Negative feedback: 'The security guards were appalling, the department was so busy instead of supporting doctors/nurses with the 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	92.66 %	R <90 % A >=90 % G >=95 %		36 responses over 50% increase on the previous month plus a 50% increase year on year. ASD services and Children's community services received the highest number of positive feedbacks including the highest number of responses. Positive comments 'Quick, professional, very kind and extremely positive about ADHD which is a must in our neurodivergent household', How we could improve: 'Was hard to get to the Catkin Building from where we live (other side of Springfield Park). Would be ideal if there was a way to get there through the park maybe someday (I am a wheelchair user).

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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	92.86 %	R <90 % A >=90 % G >=95 %		154 responses 31 less than last month and 16 less year on year. Surgical day case received 33 which 31 were positive 93.92%, 3A 31 received with 28 being positive 90.32%, 1c received 12 with 12 positive 100%. Positive comment: 'From the moment we got there to the time we left every staff member who spoke dealt with us were both but amazing', How we can improve: 'Ensure staff are all following the same procedures, I had different advice and guidance off different nurses, maybe some retraining in filling out medications records and two mistakes were made regarding by daughters medicine'.
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	96.30 %	R <90 % A >=90 % G >=95 %		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	94.71 %	R <90 % A >=90 % G >=95 %		889 responses 64 increase on the previous month 155 decrease year on year. Speech and language collected 84 98% with positive experience followed by cardiology 68 99% positive experience. Clinical Health Psychology received 34 with 100% positive feedback. Positive: 'When we spoke to the consultant, he was great, talked directly in a non-patronising manner to my son, and gave us the time we needed'. Negative: 'The virtual appointment system did not work for us. The link we were sent took us to an appointment at Walton at which another patient was already present, (Orthopedics clinic)

The Best People doing their best Work

8.3 - QUALITY - CARING

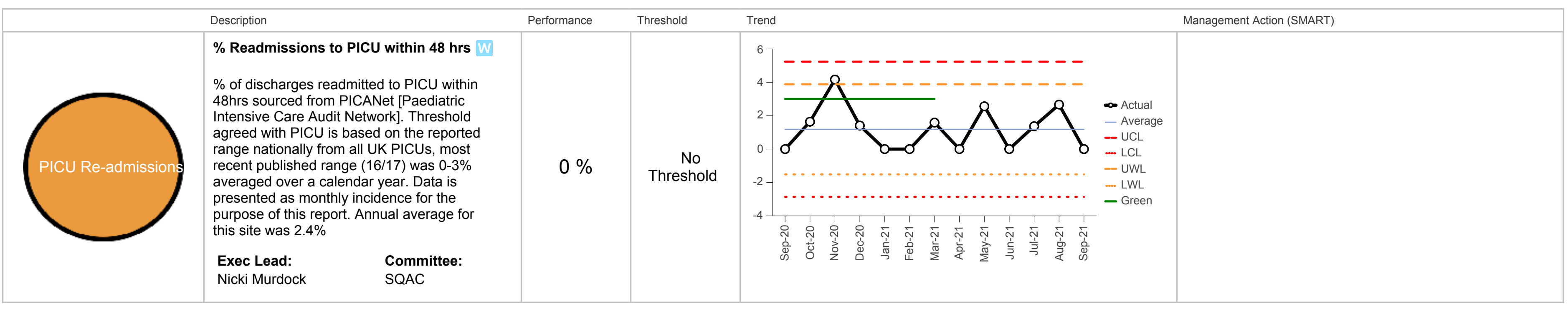
D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Nicki Murdock **Committee:** SQAC	13	No Threshold	Actual, Average, UCL, LCL, UWL, LWL, Green (Sep-20 to Sep-21)	
PALS	**PALS** W Total number of PALS contacts. **Exec Lead:** Nicki Murdock **Committee:** SQAC	148	No Threshold	Actual, Average, UCL, LCL, UWL, LWL, Green (Sep-20 to Sep-21)	

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	0 %	No Threshold		

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	97.45 %	R A G	<90 % >=90 % >=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	96.82 %	R A G	<90 % >=90 % >=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	95.54 %	R A G	<85 % >=85 % >=90 %		No Action Required

Delivery of Outstanding Care

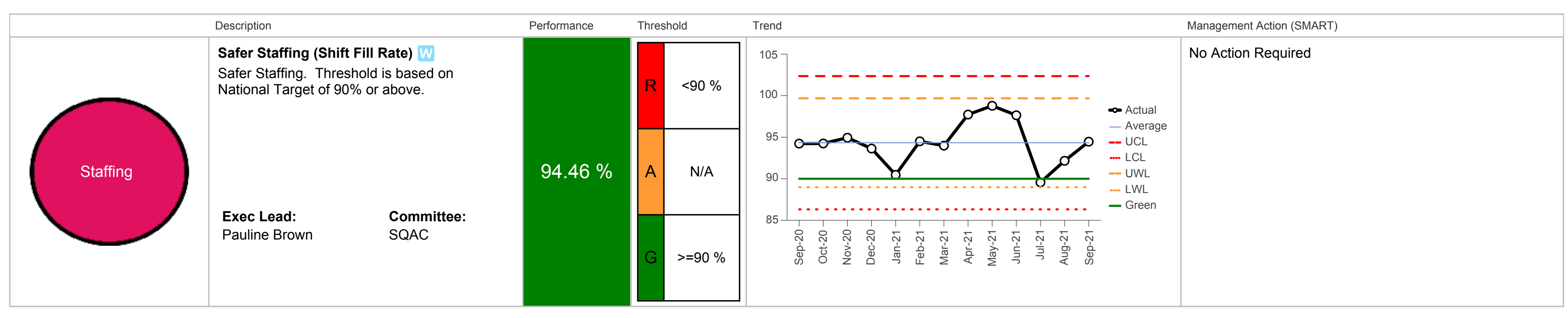
10.2 - QUALITY - RESPONSIVE

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	96.82 %	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	75.16 %	R <85 % A >=85 % G >=90 %		An overview of the play services is under way and is being carried out by the Director of Nursing and the Patient Experience/Quality Lead to identify were the improvements are required and what resources are needed including materials for the older young person. The team is working closely with the innovation team to support the Alder App and LMarks to identify any business's that can support play.
Inpatient Survey: Learning	**IP Survey: % Patients involved in Learning** D % 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	89.17 %	R <85 % A >=85 % G >=90 %		Learning continues to improve and has substantially improved year on year. Patient Experience department is working closely with the Headteacher and teachers to offer support both ways

11.1 - QUALITY - WELL LED

D Drive W Watch P Programme



	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	94.46 %	R	<90 %		No Action Required
			A	N/A		
			G	>=90 %		

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

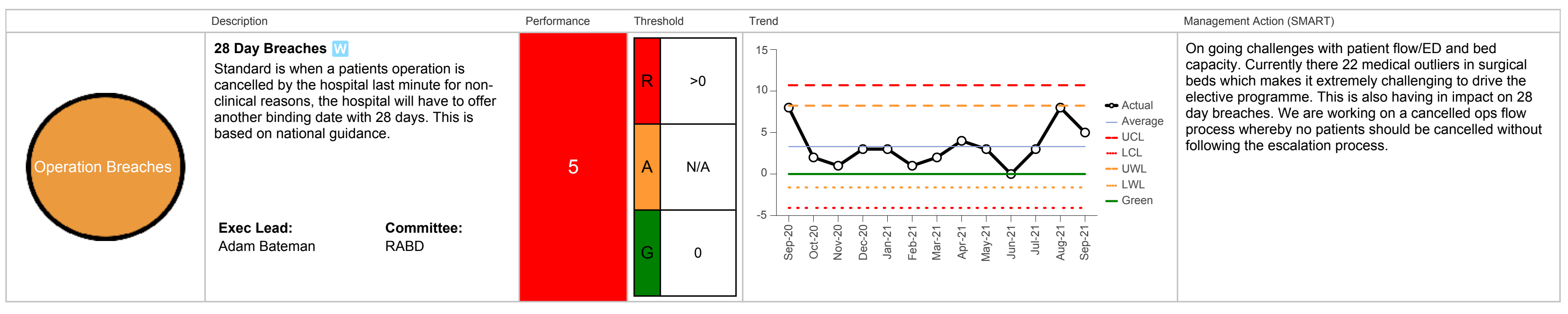
D Drive W Watch P Programme

	Description	Performance	Threshold	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	73.36 %	R: <95 % A: N/A G: >=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: >0 A: N/A G: 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	31	R: >20 A: N/A G: <=20	On going challenges with patient flow/ED and bed capacity. Currently there 22 medical outliers in surgical beds which makes it extremely challenging to drive the elective programme. This is also having in impact on 28 day breaches. We are working on a cancelled ops flow process whereby no patients should be cancelled without following the escalation process.

Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

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	5	R	>0		On going challenges with patient flow/ED and bed capacity. Currently there 22 medical outliers in surgical beds which makes it extremely challenging to drive the elective programme. This is also having in impact on 28 day breaches. We are working on a cancelled ops flow process whereby no patients should be cancelled without following the escalation process.
			A	N/A		
			G	0		

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

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	66.54 %	R <90 % A >=90 % G >=92 %		Performance has steadied following months of continued improvement with notable progress against our restoration targets. Continued challenges remain primarily within surgical specialities. Each speciality below 95% RTT has an individual delivery plan to support their achievement of RTT pathways within coming weeks or months.
Waiting Times	**Waiting List Size** W Total waiting list size of Inpatient and Outpatient RTT incomplete pathways **Exec Lead:** Adam Bateman **Committee:** RABD	13092	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	263	R >0 A N/A G 0		Performance has steadied in recent months for the number of C&YP waiting over 52wks to receive treatment. Majority of patients are waiting surgical treatment. All have received a clinical review with plans to treat asap. Challenging specialities have made significant progress by creating more capacity to accommodate as many of these C&YP. Some of the C&YP have also been established via additional validation associated with the Safe WL Programme.

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

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	<100 %		No Action Required
			A	N/A		
			G	100 %		
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	97.21 %	R	<99 %		Improved position overall in September, specifically MRI as the team have been working additional weekend lists to recover from August summer period. Referrals continue to increase for MRI with a slight spike in September; however, this is being managed inhouse with further extra weekend work. A full action plan for DM01 for medicine is being prepared for November.
			A	N/A		
			G	>=99 %		

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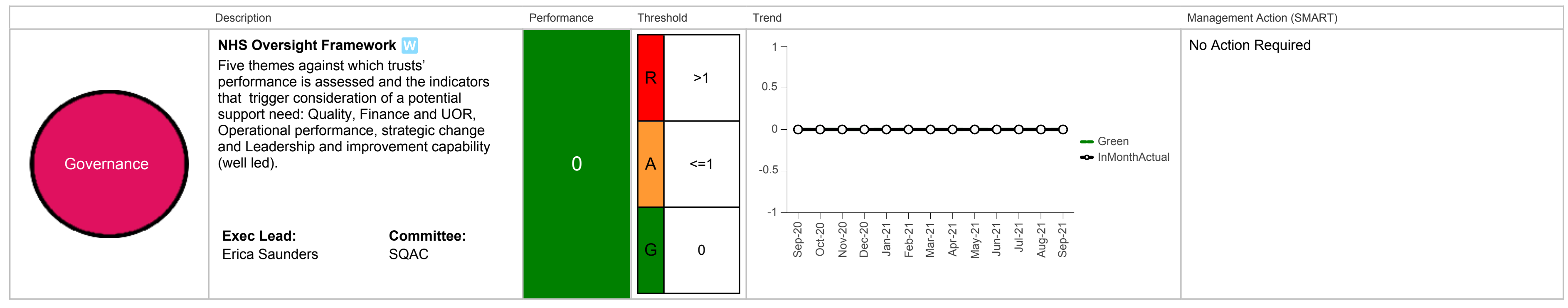
14.1 - PERFORMANCE - WELL LED

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 A <=1 G 0		No Action Required

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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	67.31 %	No Threshold		As at the end of September appraisals were at 67% across the Trust overall. Whilst staff who have not had an appraisal are still encouraged to do so, the appraisal window is now closed. A campaign to ensure improvement in appraisal compliance will need to be set up for next year's window.
Appraisal	**Medical Appraisal** W Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** PAWC	55.21 %	No Threshold		
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** PAWC	87.32 %	R <80 % A >=80 % G >=90 %		Mandatory Training this month has remained at 87%, with the same 3 key areas as last month causing issues; Resus Training, Practical Moving & Handling and the Estates and Facilities Staff Group. There is currently a weekly review and actions being taken as part of Exec Comm Cell specifically around these 3 areas. Resus have brought in additional external trainer capacity for the next 3 months as well as looking to roll out some Basic Life Support training online. Moving & Handling have a new trainer starting imminently on a secondment basis and are exploring bringing in external support.

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15.2 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	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	6.27 %	R >4.5 % A <=4.5 % G <=4 %	Sickness across the trust remains in a state of flux when considered on a daily and weekly perspective; however for the period of September 2021, absence for reasons linked to sickness has reduced to 5.9% from 6.5% when compared to August, 1.9% above the organisational KPI. Short term absence remains static at 1.5% and long term absence has decreased by 0.5%. The HR team are working alongside managers with the purpose of monitoring and instigating appropriate action linked to policies, therefore it is anticipated that there will be an increase in stage 3 activity... cont below
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	1.76 %	R >1 % A N/A G <=1 %	which may have a positive impact on long term absence figures. To support our employees the following activities remain underway: • Access to Occupational Health support, the SALS team, the Employee Assistance programme and the Alder Centre, for a range of issues that impact on health and well-being e.g. counselling, financial guidance, physiotherapy etc. • The Trust has launched its annual flu campaign and the COVID booster programme is ongoing. Although engagement is not a mandatory requirement, it is encouraged. ... cont below
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	4.51 %	R >3 % A N/A G <=3 %	• PPE protocols remain in place. • A focus on divisional /local KPI's e.g RTW completion with managers, to improve the position

The Best People doing their best Work

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	1366.74	No Threshold		
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** PAWC	10.05 %	R >11 % A <=11 % G <=10 %		

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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	835	R <-20% A >=-20% G >=-5%		No Action Required
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	-339	R <-10% A >=-10% G >=-5%		
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	88,514	R <-20% A >=-20% G >=-5%		No Action Required

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16.2 - FINANCE - WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**Income In Month Variance (£'000s)** W 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	2,766	R A G	<-20% >=-20% >=-5%	Actual, Average, UCL, LCL, UWL, LWL, Green (Sep-20 to Sep-21)	No Action Required
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	-2,466	R A G	<-20% >=-20% >=-5%	Actual, Average, UCL, LCL, UWL, LWL, Green (Sep-20 to Sep-21)	
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	534	R A G	<-20% >=-20% >=-5%	Actual, Average, UCL, LCL, UWL, LWL, Green (Sep-20 to Sep-21)	No Action Required

The Best People doing their best Work

16.3 - FINANCE - WELL LED

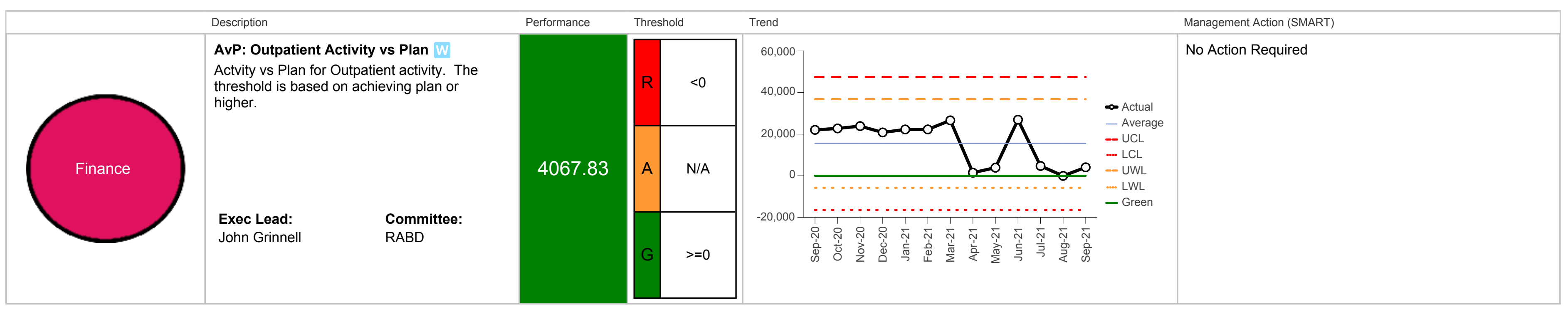
D Drive W Watch P Programme

	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	-69.27	R <0 A N/A G >=0		Non-elective inpatients have yet to recover to pre-covid 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	-82.17	R <0 A N/A G >=0		The most significant under performances were 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	177.00	R <0 A N/A G >=0		No Action Required

The Best People doing their best Work

16.4 - FINANCE - WELL LED

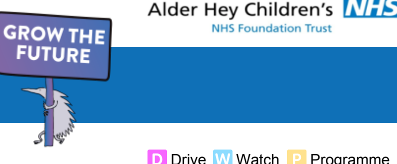
D Drive W Watch P Programme



	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	4067.83	R	<0		No Action Required
			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	132	R A G	<111 >=111 >=130		No Action Required
Clinical Research	**Number of Open Studies - Commercial** W Number of commercial studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	40	R A G	<21 >=21 >=30		No Action Required
Clinical Research	**Number of New Studies Opened - Academic** W Number of new academic studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	7	R A G	<2 >=2 >=3		No Action Required

Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

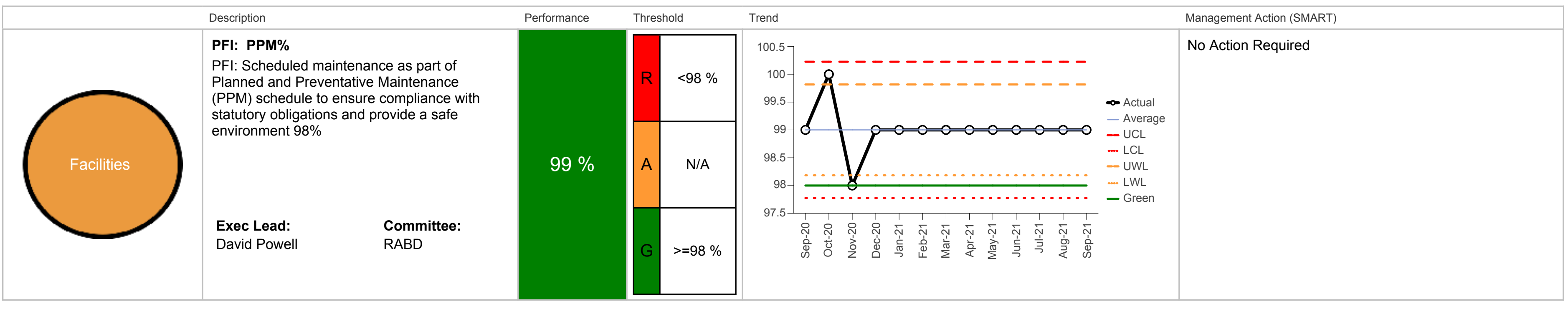
D Drive W Watch P Programme

	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	2	R A G	<1 N/A >=1		No Action Required
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Jo Blair **Committee:** RMB	983	R A G	<86 >=86 >=100		No Action Required

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

D Drive W Watch P Programme

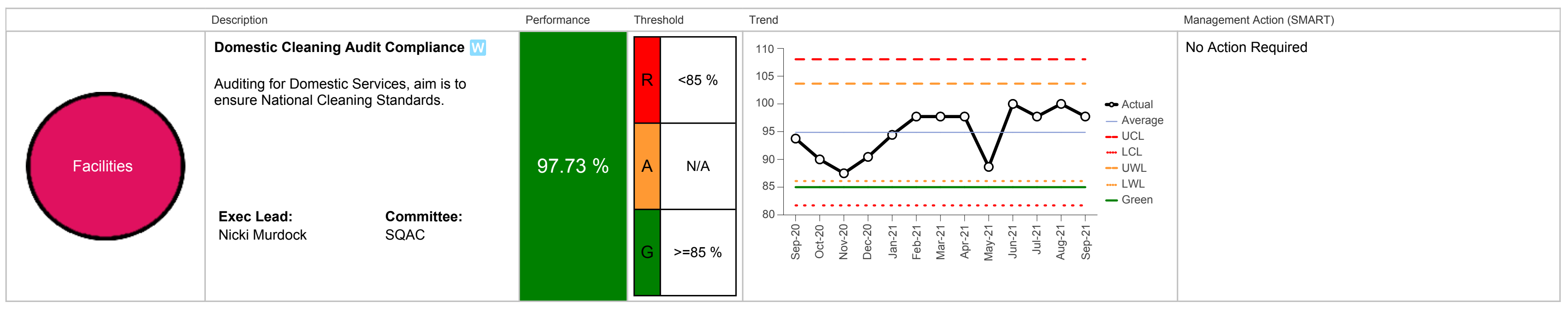


	Description	Performance	Threshold		Trend	Management Action (SMART)
Facilities	**PFI: PPM%** PFI: Scheduled maintenance as part of Planned and Preventative Maintenance (PPM) schedule to ensure compliance with statutory obligations and provide a safe environment 98% **Exec Lead:** David Powell **Committee:**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

The Best People doing their best Work

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	97.73 %	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	8	31	39	No Threshold
Clinical Incidents resulting in No Harm	D	51	132	107	No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	13	17	40	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	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	3	2	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		85.7%	75.0%	>=90 % / N/A / <90 %
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - C.difficile	D	0	1	0	0 / N/A / >0
Hospital Acquired Organisms - MSSA	D	0	0	0	No Threshold

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	4	3	6	No Threshold
PALS	W	62	47	30	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG
% Readmissions to PICU within 48 hrs	W			0.0%	No Threshold
ED: 95% Treated within 4 Hours	D		73.4%		>=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	2	29	No Threshold		
28 Day Breaches	W	0	1	4	0	N/A	>0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		92.7%	99.1%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		92.7%	98.3%	>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P		92.7%	96.6%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		90.2%	99.1%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		75.6%	75.0%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		85.4%	90.5%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	52.8%	77.5%	63.8%	>=92 %	>=90 %	<90 %
Waiting List Size	W	1,208	3,565	8,319	No Threshold		
Waiting Greater than 52 weeks - Incomplete Pathways	W	1	13	249	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		97.1%	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	540	253	-136	No Threshold
Income In Month Variance (£'000s)	W	118	201	-144	No Threshold
Pay In Month Variance (£'000s)	W	15	121	-157	No Threshold
Non Pay In Month Variance (£'000s)	W	407	-69	164	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective	W	-1	-42	-26	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	-26	-57	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		373	-198	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	717	-360	1,530	>=0	N/A	<0
PDR	W	81.0%	65.8%	54.2%	No Threshold		
Medical Appraisal	W	48.0%	52.2%	59.5%	No Threshold		
Mandatory Training	W	91.4%	87.0%	88.9%	>=90 %	>=80 %	<80 %
Sickness	D	5.6%	6.3%	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	4.2%	4.6%	0.0%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	168	292	532	No Threshold		
Staff Turnover	D	10.0%	9.1%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	96.3%	95.0%	94.1%	>=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. Outliers to be identified for separate review. Issues with Philips ventillators still being managed by LTV team. Problems with supply of parts for servicing means that machines requiring service will need to be replaced at that point (24 by December) New supplier in place but still no long term repair/replace plan from Phillips.	**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** • No new formal complaints in October to date **Challenges** • PALS increased from 25 in August to 47 in September. 21 so far in October.
EFFECTIVE	Streaming restarted in ED. Pharmacy support now 7 days. Daily green stream "doc in a box" in place along with Acute Paed clinic. Attendances to ED remain a significant concern alongside increasing acuity. Medical admission up on previous years which has led to increased medical outliers and pressures on post take wards rounds.	**Highlight** • LOS for NEL patients continues to reduce from 2 days to 1.65. **Challenges** • ED performance dropped in Sept 73.4% • % left without being seen at 9%
RESPONSIVE	Long wait figures increased due to tip ins from safe waiting list management work on waiting lists. Patients being prioritised for appointments as they are identified. Waiting times continue to increase in several specialties with plans in Dermatology, Gastro and Gen Paeds delayed. Plans to recruit still ongoing. Additional sleep bed to open alongside plans to run additional night as locum to expedite reduction in wait.	**Highlight** ▪ Patients waiting over 40 weeks from referral continues to reduce on PTL ▪ Cancer performance standards met including new Faster Diagnosis standard **Challenges** ▪ RTT compliance currently 76% in outpatients ▪ Radiology reporting turnaround continues to be challenging to manage despite outsourcing.
WELL LED	Sickness Absence remains a high priority. The HR Business Partner team are supporting Managers actioning stage 3 meetings as applicable to respond to the increase in long term sickness levels and ensuring all staff have an action plan and appropriate support to RTW	**Highlight** • Formal employment relations cases continue to be low; the HR team continue to focus on informal resolution • Staff turnover remains green at 9% • Sepsis mandatory training is now a 77.46% completion rate, making it an amber priority instead of red. Content has also been reviewed with 20 mins of material removed in response.

		Challenges
	Continued utilisation of wellbeing support services including SALs, Alder Centre, Occupational Health, First Care and HR Wellbeing Officers Mandatory Training action plan developed in draft. Awaiting views from service areas before formalising this. Managers are now receiving regular updated in report format linked to their areas of responsibility.	• Sickness levels continue to fluctuate daily. As at 19th October the level of absenteeism for the division sits at 7.15% (86 people) against a Trust total of 7.22%. 14 people are absent linked to COVID. • Short term absence showed a slight increase to 2.11% in September whereas long term absence showed a gradual decline to 4.28%, a reduction of 0.90% from the previous month. • Recruitment service pressures continue – adverts are now being placed in line with the KPI and pre employment checks are being case managed. • Mandatory Training currently sitting at 86.27% against a Trust wide picture of 86.69%. Overall Resus is an area of concern with a completion rate of 67.62% as at 5th October 21. Challenges remain releasing some people during peak times therefore some training has been reviewed to ensure it focuses on the specific needs and the delivery format e.g. e learning v face to face. • Wellbeing discussions continue to take place as part of PDR's. As at 13th October, PDR is currently running at 71.54%. The HR Advisor continues to support Managers with data input.

Alder Hey Children's NHS Foundation Trust

Medicine

D Drive W Watch P Programme

SAFE

Measure		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	17	28	34	22	18	23	33	43	33	37	30	28	31		No Threshold
Clinical Incidents resulting in No Harm	D	94	70	126	99	90	97	125	121	122	88	100	99	132		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	16	11	18	19	21	17	19	23	23	16	17	17	17		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	0	0	1	1	0	2	1	2	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	1	0	0	0	1	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	4	0	0	0	4	1	2	0	0	1	0	2	3		No Threshold
Medication Errors (Incidents)		19	24	32	36	34	28	39	28	41	25	14	20	35		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	0	0	1	0	2	4	1	3	2	0	2	0		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	91.7%	100.0%	75.0%	90.9%	83.3%	84.6%	87.5%	90.9%	88.2%	93.3%	96.2%	75.0%	85.7%		>=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	1	0	0	0	0	0	0	1	0	0	0	1		0 N/A >0
Hospital Acquired Organisms - CLABSI		0	0	0	2	2	2	1	5	0	0	2	3	3		No Threshold
Hospital Acquired Organisms - MSSA	D	0	0	0	0	1	1	0	0	0	0	0	0	0		No Threshold
Cleanliness Scores		98.0%	98.0%	96.0%	95.1%	98.4%	97.2%	98.6%	98.7%	98.2%	98.6%	98.6%	98.7%	98.8%		No Threshold
Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region.		99.8%	99.8%	99.7%												>=95 % N/A <95 %
Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed.		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		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%	77.0%		100.0%	100.0%									>=90 % N/A <90 %

CARING

Measure		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
Complaints	W	7	8	7	6	8	3	12	4	5	2	4	4	3		No Threshold
PALS	W	27	24	28	27	25	20	37	25	23	41	41	25	47		No Threshold

EFFECTIVE

Measure		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
Referrals Received (Total)		2,289	2,025	2,102	1,706	2,087	1,688	2,225	2,134	2,233	2,404	2,237	1,905	2,414		No Threshold
ED: 95% Treated within 4 Hours	D	95.1%	96.8%	97.1%	98.6%	98.5%	97.8%	95.3%	92.5%	81.1%	85.5%	67.9%	87.7%	73.4%		>=95 % N/A <95 %
ED: Percentage Left without being seen	W	2.0%	0.8%	1.0%	0.6%	0.5%	0.7%	2.2%	3.8%	7.4%	4.9%	12.5%	4.3%	9.1%		<=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	1		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	1		0 N/A >0
ED: Re-attendance within 7 days of original attendance (%)	W	7.0%	7.9%	7.8%	7.9%	9.0%	7.9%	7.5%	8.3%	9.5%	8.6%	9.8%	9.7%	8.4%		No Threshold

Medicine

D Drive W Watch P Programme

Measure		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-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	81.3%	83.6%	82.2%	84.7%	84.0%	87.0%	82.6%	84.6%	80.3%	77.8%	79.9%	77.3%	80.7%		>=90 % / >=80 % / <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons	D	2	1	1	2	0	0	1	2	0	1	0	3	2		No Threshold
28 Day Breaches	W	3	2	0	0	1	0	0	0	0	0	0	0	1		0 / N/A / >0
Hospital Initiated Clinic Cancellations < 6 weeks notice		20	33	20	47	16	14	18	21	19	21	37	42	0		No Threshold
OP Appointments Cancelled by Hospital %		12.3%	11.2%	12.4%	13.8%	12.2%	12.2%	11.8%	9.8%	10.2%	11.2%	14.4%	14.2%	13.5%		<=5 % / N/A / >10 %
Was Not Brought Rate	W P	12.0%	11.2%	9.5%	10.4%	9.7%	9.4%	8.8%	9.0%	8.9%	9.8%	10.5%	10.9%	10.7%		<=12 % / <=14 % / >14 %
Was Not Brought Rate (New Appts)	W	15.9%	12.4%	11.3%	11.5%	11.9%	10.9%	9.2%	12.4%	10.3%	11.1%	10.7%	11.8%	9.8%		<=10 % / <=12 % / >12 %
Was Not Brought Rate (Followup Appts)	W	11.2%	10.9%	9.0%	10.2%	9.2%	9.1%	8.7%	8.3%	8.6%	9.5%	10.5%	10.7%	11.0%		<=14 % / <=16 % / >16 %
Coding average comorbidities		5.17	5.31	5.45	5.50	5.45	5.54	5.41	5.14	5.17	5.59	5.47	5.57	5.47		No Threshold

RESPONSIVE

Measure		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	W	92.9%	92.9%	96.9%	95.8%	100.0%	96.4%	95.2%	96.2%	98.3%	93.5%	87.9%	100.0%	92.7%		>=95 % / >=90 % / <90 %
IP Survey: % Treated with respect	W	100.0%	97.2%	100.0%	95.8%	100.0%	100.0%	95.2%	98.1%	100.0%	89.1%	87.9%	97.9%	92.7%		>=95 % / >=90 % / <90 %
IP Survey: % Know their planned date of discharge	D P	95.2%	88.9%	100.0%	91.7%	96.9%	98.2%	91.9%	96.2%	91.5%	95.7%	86.2%	91.5%	92.7%		>=90 % / >=85 % / <85 %
IP Survey: % Know who is in charge of their care	W	97.6%	100.0%	100.0%	87.5%	100.0%	92.9%	95.2%	94.3%	100.0%	97.8%	93.1%	87.2%	90.2%		>=95 % / >=90 % / <90 %
IP Survey: % Patients involved in Play	D	88.1%	77.8%	84.4%	81.2%	75.0%	89.3%	85.5%	84.9%	88.1%	71.7%	81.0%	72.3%	75.6%		>=90 % / >=85 % / <85 %
IP Survey: % Patients involved in Learning	D	76.2%	63.9%	62.5%	81.2%	93.8%	94.6%	80.0%	90.6%	89.8%	80.4%	87.9%	74.5%	85.4%		>=90 % / >=85 % / <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	55.5%	68.0%	81.0%	88.1%	89.5%	90.8%	92.9%	92.0%	93.1%	92.5%	86.8%	83.3%	77.5%		>=92 % / >=90 % / <90 %
Waiting List Size	W	2,151	1,916	1,778	1,785	1,731	2,110	2,280	2,509	2,819	3,122	3,338	3,507	3,565		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	W	0	0	0	0	1	16	4	4	3	6	11	7	13		0 / N/A / >0
Waiting Times - 40 weeks and above		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%	95.7%	100.0%	100.0%	100.0%		100 % / N/A / <100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % / N/A / <100 %
All Cancers: 31 day wait until subsequent treatments	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % / N/A / <100 %
Diagnostics: % Completed Within 6 Weeks	W	91.4%	96.2%	97.7%	91.7%	94.6%	96.0%	97.7%	95.5%	95.1%	98.4%	95.6%	94.4%	97.1%		>=99 % / N/A / <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%		100 % / N/A / <100 %
Pathology - % Turnaround times for urgent requests < 1 hr		89.7%	90.0%	90.6%	90.4%	90.4%	90.4%	91.9%	91.1%	92.6%	91.1%	91.6%	91.9%	89.8%		>=90 % / >=85 % / <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs		100.0%	100.0%	99.8%	100.0%	99.9%	100.0%	100.0%	100.0%	99.5%	100.0%	100.0%	100.0%	100.0%		>=90 % / >=85 % / <90 %
Imaging - % Report Turnaround times GP referrals < 24 hrs		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % / >=90 % / <95 %
Imaging - % Reporting Turnaround Times - ED		100.0%	100.0%	97.0%	95.0%	99.0%	99.0%	100.0%	89.0%	96.0%	100.0%	99.0%	100.0%	96.0%		>=90 % / >=85 % / <90 %
Imaging - % Reporting Turnaround Times - Inpatients		98.0%	93.0%	98.0%	92.0%	99.0%	98.0%	99.0%	89.0%	96.0%	95.0%	92.0%	93.0%	79.0%		>=90 % / >=85 % / <90 %
Imaging - % Reporting Turnaround Times - Outpatients		71.0%	74.0%	72.0%	51.0%	75.0%	77.0%	58.0%	65.0%	57.0%	52.9%	54.0%	61.0%	57.0%		>=85 % / N/A / <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks		98.0%	98.8%	100.0%	94.2%	100.0%	95.0%	98.0%	98.7%	100.0%	91.9%	89.4%	83.1%	86.7%		>=99 % / N/A / <99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks		100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.5%	91.7%	100.0%		>=99 % / N/A / <99 %
Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks		92.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	99.3%	100.0%	100.0%		>=99 % / N/A / <99 %

Medicine

D Drive W Watch P Programme

WELL LED

Indicator		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-1,201	-264	153	41	189	160	-586	263	200	-1,036	-347	-58	253		No Threshold
Income In Month Variance (£'000s)	W	-622	-647	561	142	10	36	170	37	-26	-1	209	-490	201		No Threshold
Pay In Month Variance (£'000s)	W	-211	-143	338	30	-61	-52	-148	-64	60	-150	48	47	121		No Threshold
AvP: IP - Non-Elective	W	640	595	595	586	405	416	676	-153	-78	807	-82	-19	-42		>=0 N/A <0
AvP: IP Elective vs Plan	W	119	121	147	136	123	138	154	-16	-10	157	-25	-58	-26		>=0 N/A <0
AvP: OP New		1,000.00	1,328.00	1,390.00	1,028.00	1,113.00	1,073.00	1,220.00	-390.97	-415.28	1,280.00	-525.93	-601.20	-428.45		>=0 N/A <0
AvP: OP FollowUp		5,043.00	4,836.00	4,907.00	4,422.00	4,930.00	4,560.00	5,372.00	924.17	542.80	5,537.00	276.46	277.03	659.47		>=0 N/A <0
AvP: Daycase Activity vs Plan	W	915	1,051	1,092	1,071	1,003	1,030	1,264	245	187	1,313	229	79	373		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W	6,927	7,141	7,368	6,419	6,885	6,729	7,748	83	-174	7,818	-833	-980	-360		>=0 N/A <0
PDR	W	21.8%	60.2%	69.1%	74.6%	74.2%	74.2%	74.2%	2.6%	6.8%	18.5%	50.2%	61.7%	65.8%		No Threshold
Medical Appraisal	W	96.0%	96.0%	96.0%	94.1%	94.1%	94.1%	94.1%	23.4%	28.6%	33.9%	42.0%	75.9%	52.2%		No Threshold
Mandatory Training	W	89.9%	90.2%	88.9%	86.7%	88.1%	87.1%	88.5%	89.1%	87.6%	87.9%	87.2%	86.9%	87.0%		>=90 % >=80 % <80 %
Sickness	D	5.0%	5.8%	4.7%	4.9%	6.3%	5.1%	4.1%	4.4%	5.4%	5.3%	6.3%	7.1%	6.3%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.4%	2.2%	1.5%	1.3%	2.0%	1.4%	1.1%	1.2%	1.5%	1.5%	2.0%	1.9%	1.8%		<=1 % N/A >1 %
Long Term Sickness	D	3.6%	3.6%	3.3%	3.7%	4.3%	3.7%	3.0%	3.2%	3.9%	3.7%	4.4%	5.3%	4.6%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	266	235	239	213	247	267	261	210	262	230	265	263	292		No Threshold
Staff Turnover	D	6.5%	6.5%	6.9%	7.2%	6.7%	6.6%	6.1%	6.6%	6.9%	7.4%	7.6%	8.1%	9.1%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	94.9%	93.2%	93.6%	93.2%	91.2%	97.8%	93.9%	101.7%	97.9%	96.0%	87.2%	90.6%	95.0%		>=90 % >=80 % <90 %

Surgery Division

SAFE	• Increase in clinical incidents resulting in near misses. • Reduction in clinical incidents resulting in no harm. • Reduction in clinical incidents resulting in minor harm. • No clinical incidents resulting in moderate harm. • Consistently achieved no clinical incidents resulting in permanent harm. • Reduction in medical errors resulting in harm. • No pressure ulcers • No never events. • Increased occurrence of sepsis not treated within 60 minutes. • No hospital acquired organisms relating to MRSA and C.Difficile. • 1 hospital acquired RSV. • Increased cleanliness scores.	**Highlight** • Continued reduction in all medication errors • No pressure ulcers, cat 3 & 4 since Dec 2020 • Cleanliness scores 99%>98%:98%<99%>98% • 0 hospital acquired organisms for MRSA/C.Difficile **Challenges** • Ward Staffing levels as patient acuity increases. Increased staff sickness. Increased bed pressures due to emergency flow. • 100% achievement of sepsis patients treated within 60 mins last month has dropped to 75% in September. • Increased number of clinical incidents resulting in near misses. • 1 Hospital acquired organism related to RSV.
CARING	• Increase in formal complaints • Increase in PALs from last month. •	**Highlight** • Below peak of complaints in May 21. **Challenges** • Providing access within a timely manner for elective patients • Increased in PALs.
EFFECTIVE	• 0% readmissions to PICU within 48 hours. • Increase in number of referrals received. • Increased in average lengths of stay for both elective and non elective. • Minor reduction in theatre utilisation. • Significant increase in 28 day breaches. • 0 hospital initiated cancelled clinics in September. • Hospital initiated cancelled outpatients remains high. • Increase in CCAD cases from last month.	**Highlight** • 0 patients readmitted to PICU within 48 hours • 0 hospital initiated cancelled clinics. **Challenges** • Increase in 28 day breaches. Challenges relating to covid/staff sickness and patient flow remain. DNA's for swabbing is an issue that we are reviewing as a team with pre-op services.
RESPONSIVE	• Positive patient feedback from all indicators except patients involved in play. • Deterioration of performance in relation to RTT open pathway and patients waiting over 52 weeks.	**Highlight** • Patients noted that they knew who was in charge of their care 100%>98%<99% **Challenges** • Decrease in RTT compliance 63.8% and increase in patients waiting over 52 weeks to commence treatment (expected as part of safe waiting list validation) • Increasing OP and IP capacity required to recover waiting time position
WELL LED	• Increase in PDRs completed • Mandatory training maintained at 88%	**Highlight** • Maintaining mandatory training position.

		Challenges
		• Achieving ERF and Accelerator activity targets • Establishing increased capacity which is sustainable for all staff groups • Medical appraisals have reduced.

Alder Hey Children's NHS Foundation Trust

Surgery

D Drive W Watch P Programme

SAFE

Metric	Type	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	21	27	46	31	24	25	46	26	32	43	27	25	39		No Threshold
Clinical Incidents resulting in No Harm	D	138	154	190	143	108	140	175	169	167	165	119	114	107		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	38	37	45	42	38	27	33	35	28	38	32	49	40		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	1	1	0	0	1	2	0	0	1	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	0	0	0		0 / N/A / >0
Medication errors resulting in harm	D	4	1	11	0	1	2	2	4	2	1	2	3	2		No Threshold
Medication Errors (Incidents)		37	38	68	44	23	40	45	44	36	30	24	27	27		No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	1	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Never Events	W	0	0	0	0	0	0	1	0	0	0	0	0	0		0 / N/A / >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	75.0%	86.7%	90.0%	53.8%	91.7%	83.3%	90.9%	76.9%	91.7%	88.9%	66.7%	100.0%	75.0%		>=90 % / N/A / <90 %
Pressure Ulcers (Category 3 and above)		0	0	0	1	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Hospital Acquired Organisms - C.difficile	D	1	0	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Hospital Acquired Organisms - MSSA	D	1	0	1	0	2	0	0	0	1	0	2	0	0		No Threshold
Cleanliness Scores		98.2%	98.0%	96.0%	97.9%	98.9%	97.0%	97.9%	98.9%	98.4%	98.2%	98.7%	98.2%	98.6%		No Threshold

CARING

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

EFFECTIVE

Metric	Type	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
Readmissions to PICU within 48 hrs	D	0	1	2	1	0	0	1	0	2	0	1	2	0		No Threshold
% Readmissions to PICU within 48 hrs	W	0.0%	1.6%	4.2%	1.4%	0.0%	0.0%	1.6%	0.0%	2.6%	0.0%	1.4%	2.7%	0.0%		No Threshold
Referrals Received (Total)		3,220	3,046	2,983	2,809	2,691	2,899	4,027	3,937	4,090	4,341	3,692	3,191	3,805		No Threshold
Theatre Utilisation - % of Session Utilised	W	88.9%	89.2%	88.6%	85.0%	87.6%	90.3%	89.5%	84.1%	88.8%	85.2%	85.1%	86.8%	85.2%		>=90 % / >=80 % / <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons	D	15	18	15	8	5	7	11	11	7	12	13	9	29		No Threshold
28 Day Breaches	W	5	0	1	3	2	1	2	4	3	0	3	8	4		0 / N/A / >0
Hospital Initiated Clinic Cancellations < 6 weeks notice		52	58	38	45	38	50	37	47	46	59	63	74	0		No Threshold
OP Appointments Cancelled by Hospital %		11.3%	11.1%	11.9%	10.6%	10.6%	10.8%	11.8%	10.1%	10.2%	11.3%	9.8%	11.6%	11.8%		<=5 % / <=10 % / >10 %
Was Not Brought Rate	W P	10.1%	9.0%	8.7%	10.1%	10.4%	8.0%	7.2%	6.6%	7.9%	7.5%	9.3%	10.2%	9.0%		<=12 % / <=14 % / >14 %
Was Not Brought Rate (New Appts)	W	11.9%	9.5%	9.5%	11.7%	11.6%	10.5%	8.5%	7.1%	9.6%	8.6%	11.7%	11.9%	10.0%		<=10 % / <=12 % / >12 %
Was Not Brought Rate (Followup Appts)	W	9.5%	8.8%	8.5%	9.5%	10.0%	7.0%	6.8%	6.3%	7.2%	7.0%	8.3%	9.5%	8.6%		<=14 % / <=16 % / >16 %
Coding average comorbidities		4.46	4.39	4.40	4.48	4.40	4.43	4.54	4.63	4.40	4.49	4.62	4.55	4.47		No Threshold
CCAD Cases		31	31	27	28	25	29	34	34	31	39	28	19	23		No Threshold

Surgery

D Drive W Watch P Programme

RESPONSIVE

Measure	Type	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	W	96.2%	96.2%	95.3%	99.2%	99.0%	92.0%	95.8%	95.9%	97.9%	94.7%	97.1%	95.0%	99.1%		>=95 % / >=90 % / <90 %
IP Survey: % Treated with respect	W	94.7%	98.8%	98.1%	99.2%	100.0%	97.0%	94.4%	98.6%	98.6%	96.8%	97.1%	97.8%	98.3%		>=95 % / >=90 % / <90 %
IP Survey: % Know their planned date of discharge	D P	97.7%	100.0%	97.2%	98.4%	99.0%	98.0%	95.1%	99.3%	92.5%	96.8%	97.1%	93.5%	96.6%		>=90 % / >=85 % / <85 %
IP Survey: % Know who is in charge of their care	W	98.5%	100.0%	99.1%	95.9%	100.0%	96.0%	96.5%	100.0%	97.9%	98.9%	98.6%	99.3%	99.1%		>=95 % / >=90 % / <90 %
IP Survey: % Patients involved in Play	D	80.5%	85.7%	85.0%	72.1%	81.9%	84.0%	75.0%	79.7%	76.7%	83.0%	83.5%	79.1%	75.0%		>=90 % / >=85 % / <85 %
IP Survey: % Patients involved in Learning	D	75.2%	98.8%	74.8%	82.0%	95.2%	92.0%	95.8%	91.2%	92.5%	93.6%	93.5%	92.1%	90.5%		>=90 % / >=85 % / <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	46.8%	50.9%	53.4%	54.3%	54.5%	56.2%	61.8%	61.6%	64.2%	67.9%	68.5%	67.4%	63.8%		>=92 % / >=90 % / <90 %
Waiting List Size	W	7,737	8,127	8,221	7,858	8,132	8,432	8,701	7,773	7,980	7,484	7,787	8,632	8,319		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	W	135	143	147	183	221	291	357	276	232	197	174	186	249		0 / N/A / >0
Diagnostics: % Completed Within 6 Weeks	W	100.0%	100.0%	87.5%	100.0%	50.0%	90.0%	94.1%	91.3%	100.0%	100.0%	93.8%	100.0%	100.0%		>=99 % / N/A / <99 %

WELL LED

Measure	Type	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-1,990	-487	54	-502	-245	11	-857	-734	199	90	636	-5	-136		No Threshold
Income In Month Variance (£'000s)	W	-1,460	15	1	34	0	83	152	47	49	209	223	28	-144		No Threshold
Pay In Month Variance (£'000s)	W	-457	-68	-67	-398	-364	-169	-549	-608	21	-124	565	-64	-157		No Threshold
AvP: IP - Non-Elective	W	331	366	355	343	341	308	390	56	-22	482	-104	-121	-26		>=0 / N/A / <0
AvP: IP Elective vs Plan	W	247	279	262	254	217	215	300	-74	-51	290	2	-55	-57		>=0 / N/A / <0
AvP: OP New		1,951.00	1,807.00	2,086.00	1,911.00	1,952.00	2,061.00	2,592.00	359.54	-88.15	2,817.00	695.90	-113.72	386.80		>=0 / N/A / <0
AvP: OP FollowUp		6,633.00	6,801.00	6,817.00	5,813.00	6,161.00	6,387.00	7,848.00	-2,484.10	478.79	7,993.00	1,696.00	-1,168.90	860.00		>=0 / N/A / <0
AvP: Daycase Activity vs Plan	W	595	609	680	642	502	568	808	-62	-193	789	36	-206	-198		>=0 / N/A / <0
AvP: Outpatient Activity vs Plan	W	9,657	9,806	10,138	8,974	9,308	9,717	12,014	-2,077	410	12,351	2,696	-1,466	1,530		>=0 / N/A / <0
PDR	W	35.5%	57.8%	67.5%	67.6%	66.1%	66.1%	66.1%	0.1%	9.0%	20.3%	47.2%	52.8%	54.2%		No Threshold
Medical Appraisal	W	94.1%	94.1%	94.1%	96.8%	96.8%	96.8%	96.8%	24.0%	34.8%	37.8%	44.2%	66.7%	59.5%		No Threshold
Mandatory Training	W	88.0%	87.1%	84.8%	85.6%	86.7%	86.9%	87.8%	89.0%	87.1%	87.8%	88.2%	88.4%	88.9%		>=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	286	446	505	415	434	382	560	518	459	334	447	469	532		No Threshold
Safer Staffing (Shift Fill Rate)	W	93.6%	94.4%	95.3%	93.5%	89.6%	92.7%	93.7%	95.8%	99.2%	98.4%	90.0%	92.5%	94.1%		>=90 % / >=80 % / <90 %

Community

D Drive W Watch P Programme

SAFE

		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	8	16	10	16	5	5	9	7	12	7	11	5	8		No Threshold
Clinical Incidents resulting in No Harm	D	88	84	76	53	63	75	84	74	54	51	93	64	51		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	9	11	12	9	11	21	35	28	19	11	20	10	13		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	1	0	0	0		0 / N/A / >0
Medication Errors (Incidents)		20	33	26	16	19	17	23	17	9	9	10	8	12		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

		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
Complaints	W	2	1	4	2	5	4	3	1	0	8	0	3	4		No Threshold
PALS	W	26	32	17	15	14	39	41	40	50	55	39	35	62		No Threshold

EFFECTIVE

		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
Referrals Received (Total)		857	979	1,048	847	776	880	1,105	912	1,311	1,321	1,052	714	969		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice		25	18	2	5	7	10	7	11	5	9	21	22	0		No Threshold
OP Appointments Cancelled by Hospital %		9.9%	10.0%	11.5%	8.2%	12.7%	9.9%	12.4%	11.6%	8.9%	10.2%	11.9%	13.3%	10.1%		<=5 % / <=10 % / >10 %
Was Not Brought Rate (New Appts)	W	8.8%	11.6%	8.2%	7.5%	9.1%	10.5%	13.8%	12.7%	17.2%	13.6%	17.0%	21.2%	28.2%		<=10 % / <=12 % / >12 %
Was Not Brought Rate (Followup Appts)	W	15.1%	13.3%	11.0%	12.9%	12.3%	11.2%	13.1%	14.1%	13.9%	13.7%	15.8%	17.7%	18.7%		<=14 % / <=16 % / >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics		13.6%	16.6%	10.6%	9.4%	10.9%	15.1%	17.2%	16.7%	17.7%	13.5%	18.6%	15.0%	23.2%		<=10 % / <=12 % / >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics		20.3%	16.1%	12.3%	16.2%	17.6%	14.7%	17.7%	17.4%	16.8%	18.5%	22.4%	24.2%	36.6%		<=14 % / <=16 % / >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS		9.7%	12.8%	13.3%	13.6%	20.3%	11.5%	15.1%	6.9%	15.8%	11.7%	23.4%	19.7%	17.2%		<=10 % / <=12 % / >12 %
Was Not Brought Rate (All Other Appts) - CAMHS		13.3%	13.3%	11.6%	13.2%	12.0%	10.9%	12.9%	14.0%	13.3%	12.2%	15.6%	15.7%	11.6%		<=14 % / <=16 % / >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday		91.4%	107.8%	91.0%	109.7%	110.1%	106.6%	114.3%	113.3%	114.3%	112.9%	100.0%	99.5%	101.4%		No Threshold
CAMHS: Tier 4 DJU Bed Days		192	235	191	239	238	210	248	239	248	237	217	216	214		No Threshold
Coding average comorbidities			4.50	3.33	3.00	3.00		4.00	9.00		2.00		8.00			No Threshold
CCNS: Number of commissioned packages		0														No Threshold

RESPONSIVE

		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU		1		2	2		1		1					1		No Threshold
CAMHS: Referrals Received		357	348	417	340	268	351	469	396	536	638	373	297	475		No Threshold
CAMHS: Referrals Accepted By The Service		269	193	232	198	158	182	251	198	254	316	172	141	234		No Threshold

Community

D Drive W Watch P Programme

		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
CAMHS: % Referrals Accepted By The Service		75.4%	55.5%	55.6%	58.2%	59.0%	51.9%	53.5%	50.0%	47.4%	49.5%	46.1%	47.5%	49.3%		No Threshold
RTT: Open Pathway: % Waiting within 18 Weeks	W	40.2%	49.2%	64.3%	64.4%	66.2%	64.5%	66.0%	63.3%	74.0%	69.6%	57.1%	61.2%	52.8%		>=92 % >=90 % <90 %
Waiting List Size	W	1,051	795	756	800	785	911	911	828	765	808	971	1,147	1,208		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	W	10	2	1	1	0	0	0	3	0	1	2	2	1		0 N/A >0
CAMHS: Crisis / Duty Call Activity		517	598	720	698	650	804	807	744	756	717	573	367	673		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks	W	59.1%	68.8%	70.0%	69.9%	65.9%	67.9%	67.3%	65.6%	68.0%	70.1%	69.3%	68.3%	63.8%		>=92 % >=90 % <88 %
ASD: Completed Pathways		140	138	119	61	82	82	103	102	127	122	65	201	29		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)		80.0%	94.2%	89.9%	83.6%	63.4%	78.0%	69.9%	23.5%	20.5%	14.8%	7.7%	4.0%	13.8%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%)	P			100.0%	100.0%	91.7%	100.0%	46.2%	16.7%	23.5%	28.6%	6.7%	21.4%	10.5%		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%	66.7%		>=95 % >=92 % <92 %
CCNS: Number of Referrals	W	144	146	151	127	119	139	169	120	135	150	582	144	143		No Threshold
CCNS: Number of Contacts	D	1,035	1,038	877	844	783	826	896	791	821	835	959	809	736		No Threshold

WELL LED

		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-70	369	270	45	321	221	-41	14	212	-11	287	250	540		No Threshold
Income In Month Variance (£'000s)	W	96	397	155	75	148	996	150	94	88	50	154	75	118		No Threshold
Pay In Month Variance (£'000s)	W	-31	-81	30	12	65	-81	137	5	-49	-87	260	167	15		No Threshold
AvP: OP New		691.00	753.00	777.00	585.00	641.00	519.00	615.00	110.50	320.95	623.00	-114.00	-82.30	-206.00		>=0 N/A <0
AvP: OP FollowUp		3,293.00	3,544.00	3,783.00	3,359.00	3,783.00	3,744.00	4,065.00	1,393.90	1,337.84	4,092.00	948.00	582.30	922.00		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W	3,984	4,297	4,560	3,944	4,426	4,263	4,680	1,505	1,659	4,715	834	501	717		>=0 N/A <0
PDR	W	41.3%	73.4%	81.9%	81.9%	83.1%	83.1%	83.1%	0.0%	1.5%	21.5%	71.5%	78.8%	81.0%		No Threshold
Medical Appraisal	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	6.2%	24.0%	24.0%	36.0%	68.0%	48.0%		No Threshold
Mandatory Training	W	91.4%	91.7%	89.2%	88.4%	89.2%	88.6%	89.3%	91.8%	91.0%	92.3%	92.1%	91.9%	91.4%		>=90 % >=80 % <80 %
Sickness	D	3.8%	4.0%	4.3%	4.5%	5.7%	4.7%	3.9%	3.1%	3.9%	4.9%	5.5%	6.3%	5.6%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.3%	1.6%	1.2%	0.9%	1.9%	1.0%	1.0%	0.9%	1.2%	1.5%	1.4%	1.5%	1.4%		<=1 % N/A >1 %
Long Term Sickness	D	2.5%	2.5%	3.2%	3.6%	3.8%	3.7%	2.9%	2.2%	2.7%	3.5%	4.2%	4.9%	4.2%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	169	173	212	355	226	169	141	183	192	229	171	127	168		No Threshold
Staff Turnover	D	10.4%	9.7%	9.0%	8.7%	9.3%	9.5%	9.8%	10.7%	9.6%	9.8%	10.0%	9.9%	10.0%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	99.8%	100.1%	98.5%	98.6%	99.9%	99.4%	100.2%	97.2%	99.1%		99.2%	98.9%	96.3%		>=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 • X4 incidents reported in month
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 • Increase in short term sickness absence

Community & Mental Health Division

SAFE	**Lessons learnt from incidents include:** • Medication administration charts for Homecare Service to be printed and delivered one week in advance to allow queries or discrepancies to be resolved • AAR completed following a resuscitation incident in the Catkin building. A reminder has been shared with all staff about the process of making an emergency call to the retained estate.	**Highlight** • Zero clinical incidents resulting in moderate harm, severe harm or death. • Zero grade 3 or 4 pressure ulcers • Divisional Medication safety and Infection Control Groups meeting regularly **Challenges** • Vandalism incident resulting in 9 broken windows in the Catkin building on two occasions • Eating Disorders young people admitted to medical ward due to medication deterioration and requirement to use Mental Health Act
CARING	**Lessons learnt/actions from complaints includes:** • Online repeat prescription form improved to ensure necessary clinical information is available at the top of the form • Complaint upheld regarding communication with ADHD team	**Highlight** • 16 Excellence Reports recorded in September • 14 Compliments receiving in September • Sustained positive FFT scores for Community & Mental Health Services (96% - Mental Health; 93% Community & 94.7% OPD) **Challenges** • 4 formal complaints received in September. Complaints relate to delay in receiving appointments and ASD/ADHD diagnosis, and an issue with medication prescriptions. • 62 PALs received in September increase in PALS relating to ADHD medication
EFFECTIVE	• Digital PROMS system went live in September 2021, recording mental health routine outcome measures through software linking directly to Meditech. This will support improved compliance of recording routine outcome measures, which is a nationally monitored target for mental health services and is currently on the divisional risk register.	**Highlight** • Reduction in outpatient appointments cancelled by the hospital to 10% • Zero hospital-initiated clinic cancellations < 6 weeks' notice **Challenges** • 64% increase in referrals for Community Mental Health Services in September 2021 compared to September 2019 • Continued increase in referrals for the ASD and ADHD diagnostic pathways – paper submitted to commissioners describing investment required to deliver sufficient capacity.
		Highlight

RESPONSIVE	• Lottery funding bid approved to continue with "Calm and Connected" group for children and young people experiencing anxiety	• Tics and Tourette's bid for specialist service submitted to Commissioners for review and consideration. Positive feedback received. • 64% increase in referrals for Community Mental Health Services in September 2021 compared to September 2019 Continued increase in referrals for the ASD and ADHD diagnostic pathways – paper submitted to commissioners describing investment required to deliver sufficient capacity. **Challenges** • 1 x urgent breach of the urgent Eating Disorders target • Deterioration in Community Paediatrics RTT due to increase in referrals. Waiting list activity is commencing in October and a review of referral acceptance criteria is being undertaken • Increase in calls to crisis care service following summer holiday months (673 recorded in September)
WELL LED	• Transition team presented at the 3rd European Transition Symposium • Complex Discharge Team are part of a York University research project: Models of care for Children with Medical Complexity • Divisional Pharmacist led Cheshire & Merseyside approval of Melatonin and Circadin to be prescribed by GPs. This will support children and young people to be appropriately discharged to their GP for medication (currently remain within Community Paediatrics)	**Highlight** • Mandatory training compliance remains over 90% • PDR rate increased to 81%, work remains ongoing in teams to ensure all staff have a PDR • Current staff survey rate is 40% **Challenges** • Staff sickness in the division reduced to 5.6% in September but this remains above Trust target. Weekly HR drop-in sessions are provided to line managers • Recruitment team shortages continues to result in significant recruitment delays and risk to new investment.

BOARD OF DIRECTORS

Thursday, 28th October 2021

Paper Title:	**Staff Recognition through Awards and the National Honours Nominations Process**
Report of:	
Paper Prepared by:	**Mark Flannagan, Director of Marketing and Communication & Joe Fitzpatrick, Internal Communications 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:	**N/A**	

1. Introduction

The Board asked for a summary of the awards that Alder Hey received, in recognition of individual and teamwork in pursuit of our Strategy. This paper provides the list of as many that can be recalled at sections 2 and 3.

It also uses the opportunity to set out the process we have put in place for National Honours Recognition, to allow the Board to be sighted on this important area and to advise as it sees fit.

2. Recognition of Alder Hey through Awards

Won

Health Tech Awards 2021	Digital Mental Health Solution of the Year	
Health Tech Awards 2021	Excellence in Cyber Security (highly commended)	
Forward Healthcare Awards 2021	Innovation in Mental Health	

- *Both for Children and Young People as one online mental health referral platform*

Health Service Journal 2020	Staff Engagement Award	SALS Team
Health Service Journal 2020	Digitising Patient Services Initiative	IM&T Team
Corp Comms Magazine 2020	Editor's Award	MarComms
HPMA 2021	Excellence in employee engagement	SALS Team

NOTE: Because they are numerous, the awards related to our buildings is attached at Appendix 1.

Shortlisted but winner yet to be announced

Health Service Journal 2021	Paediatric Physician Associate Workforce
Health Service Journal 2021	Mental Health Innovation of the Year

- *for Children and Young People as one online mental health referral platform*

3. Process for awards submission

The relevant Executive lead takes responsibility for developing and submitting to any suitable awards. Key high-status ones, like the HSJ Awards, are circulated to the Executive Team at the time of the call for nominations, to encourage submissions. We don't place a limit on the number of submissions.

The Marketing and Communications Team provide support as required, principally through assistance in producing high quality video content to back up the award submissions and panel judging presentation.

4. National Honours Recognition

We have introduced a process for National Honours nominations, working with a panel comprising of Dame Jo Williams, Claire Dove, Louise Shepherd and Erica Saunders. The role of the process is to try to identify worthy individuals associated with Alder Hey (staff and volunteers) who ought to have their names put forward for national recognition. In addition,

through close liaison with the Lord Lieutenant for Merseyside we have and will continue to identify individual's worthy of thanks from his office alone.

To date we have made six submissions for national honours, which resulted in an MBE and an OBE being awarded – to Hilda Gwilliams and Prof Calum Semple respectively.

4.1 Queen's Award for Voluntary Service

Following advice from the Lord Lieutenant we submitted and were successful in being awarded the Queen's Award for Voluntary Service.

Awarded to the Alder Hey Volunteers as a whole, the QAVS is the equivalent to an MBE and allows Alder Hey to 'accredit' our volunteers with the QAVS identity in perpetuity.

Nominations are comprehensive, and detailed investigations are carried out by the Lord Lieutenant's Office, with Deputy Lieutenants conducting panel interviews of volunteers, managers and service users before passing on their recommendations to the national judging stage.

4.2 Lord Lieutenant Letters of Thanks

In liaison with the Lord Lieutenant's Office we developed and submitted a list of individuals and teams to receive a special personal letter of thanks from the Lord Lieutenant himself, which were deeply appreciated by the recipients.

The challenge now is to continue to identify worthy individuals, to seek support for their names being put forward for consideration from relevant colleagues and professional bodies and, over time, increase the recognition received by individuals colleagues for their work in or associated with Alder Hey.

5. Background

Honours given are categorised as follows:

CBE (Commander of the Most Excellent Order of the British Empire)

> A prominent national role, a conspicuous leading role in regional affairs through achievement or service to the community, or a highly distinguished, innovative contribution in his or her area of activity.

OBE (Officer of the Most Excellent Order of the British Empire)

> Distinguished regional or county-wide role in any field, through achievement or service to the community including notable practitioners known nationally.

MBE (Member of the Most Excellent Order of the British Empire)

> Achievement or service in and to the community which is outstanding in its field and has delivered sustained and real impact which stands out as an example to others.

BEM (British Empire Medal)

> Achievement or contribution of a very "hands-on" service to the community in a local geographical area. This might take the form of sustained commitment in support of very local charitable and/or voluntary activity; or innovative work that has delivered real

impact but that is relatively short (three to four years) in duration. Presentations of BEM's are made locally.

In the 2020 Birthday Honours 1,495 people received an award at the BEM, MBE and OBE level. 1,069 (72%) of the recipients are people who have undertaken outstanding work in their communities either in a voluntary or paid capacity, with 740 women, representing 49% of the total. 13% came from a BAME background and 6% of the successful candidates consider themselves to have a disability (under the Equality Act 2010).

In the 2021 New Year Honours 1,239 people received an award the BEM, MBE and OBE level. 803 (65%) of the recipients are people who have undertaken outstanding work in their communities either in a voluntary or paid capacity, with 603 women, representing 49% of the total. 14.2% came from a BAME background and 6%. consider themselves to have a disability.

6. **Process for nominations**

Our goal is to ensure that future lists, over time, contain proper representation of Alder Hey staff and volunteers, in line with our status as an international leader in children and young people's healthcare.

To identify possible individuals, we issue a bi-annual request for names to be considered directly from divisional leadership. We also have an open nomination period to all staff via the Reward and Recognition group and intranet page.

Once names are received all are followed up for further information and then they are "triaged" by the Communications Team. At this stage names that are more suitable for other awards (including our own Staff Awards) are passed through the relevant mechanism.

The initial selected nominations are then worked up into rough draft application for scrutiny by a panel that will agree final possible names for further information to be gathered and a formal submission worked up.

Once nominations have been worked into a finished form the panel is informed, given a chance to review and then final names are submitted to through the online national honours portal. At the same time the Lord Lieutenant's office is advised of these names, to allow him to offer any support for those names.

7. Status

This process is only in its infancy and there are teething problems, mainly related to availability of supporting information for names selected and/or speediness in receiving this.

We do not yet have a smooth "pipeline" of names to be brought forward and we need to keep working to try and make nominations a routine part of Alder Hey life and for them to be seen as worthy of the time and effort needed. But we will keep on with the process in the hope and expectation that we can normalise the ask for names and information and, as a result, in time we will routinely see Alder Hey names in the national honours lists.

Our current "pipeline" of names includes three individuals from across Alder Hey.

4. Recommendation

The Board is asked to note the content of this report and endorse the process for National Honours.

Mark Flannagan
Director of Marketing and Communications

Appendix 1

List of Building related awards since 2014

1. IJ (infrastructure Journal) awards 2014 – Alder Hey
2. Partnerships Awards 2014 – Best Accommodation Project – Alder Hey
3. Considerate Constructors Award 2015 - National Site Gold Award LOR & Alder Hey
4. Considerate Constructors Award 2015 – Project Team Gold Award LOR & Alder Hey
5. BPD (Building Design Partnership) GGB (Sir George Grenfall Baines) Award 2015 – Alder Hey
6. Civic Voice Awards New Build Category Winner 2016- FOSP & Alder Hey
7. Civic Voice Design Awards 2016 Overall winner – FOSP & Alder Hey
8. RIBA (Royal Institute of British Architects) North West Award 2016 – Alder Hey
9. RIBA North West Awards 2016 Sustainability award- Alder Hey
10. RIBA North West Awards 2016 Building of the year – Alder Hey
11. RICS (Royal Institute of Chartered Surveyors) Awards 2016 Project of the year – Alder Hey
12. RICS Awards 2016 Community Benefit – Alder Hey
13. RICS Awards 2016 Design Through Innovation – Alder Hey
14. RICS Awards 2016 Grand Final Winner - Alder Hey
15. LABC (Local Authority Building Control) Awards 2016 Best Public Building – Alder Hey
16. LABC Awards 2016 Best Inclusive Building – Alder Hey
17. LABC Awards 2016 Building of the Year – Alder Hey
18. BCI (British construction industry) awards 2016 Prime Ministers Award – Alder Hey
19. IHEEM (institute of Healthcare Engineering and Estates Management) Healthcare Estates Award 2016 Winner New Building Project of the year – Alder Hey
20. European Healthcare Award 2016 -Alder Hey
21. BBC North West Tonight People's Choice North West Building of the Decade Winner – Alder Hey
22. RIBA North West Award 2019 – Institute in the Park
23. Civic Trust Awards 2020 – Institute in the Park
24. EHD (European Healthcare Design) Awards 2021 Healthcare Design Under 25,000 m² - The Alder Centre
25. Not building related, Freedom of the City of Liverpool 2014 -Alder Hey

BOARD OF DIRECTORS

Thursday, 28th October 2021

Paper Title:	**Proposal for the Evolution of the Liverpool Neonatal Partnership**
Report of:	Liverpool Neonatal Partnership
Paper Prepared by:	Liverpool Neonatal Partnership

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:		

Proposal for the Evolution of the Liverpool Neonatal Partnership

21 October 2021

1. Executive Summary

Since 2018, Alder Hey NHS FT and Liverpool Women's NHS FT have been working closely together to develop and deliver the Liverpool Neonatal Partnership (LNP).

Specialised commissioners and the North West Neonatal ODN supported an initial business case in 2019 to create a one service, two site model for neonatal care, which includes the development of a new state of the art surgical unit at the Alder Hey site.

To date, a key focus of the LNP Leadership Team has been to recruit and train the workforce for the surgical service and to develop the integrated clinical governance processes needed for a two-site service delivery model. Great progress has been made to date and the benefits and outcomes for babies requiring surgery, and their families, are tangible.

A recent review of the LNP is now recommending that the Partnership is ready to move on to the next stage of its development and specifically to:

- Extend the scope of the Partnership to include all neonates not just surgical babies;
- Improve and streamline the Partnership governance arrangements;
- Simplify line reporting arrangements with LWH executives providing line management for the LNP Leadership Team through a hosting arrangement; and
- Start to develop a longer term vision and strategy that describes how the Partnership can extend its reach and support neonatal care across Cheshire and Merseyside.

The most pressing immediate priority for the LNP remains preparing for the opening of the new surgical unit in 2023, however, there is a now a desire to do this in the context of an evolving and maturing Partnership.

The AHCH and LWH Boards are therefore asked to support:

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

2. Background and Introduction

In July 2018, Alder Hey Children's FT and Liverpool Women's FT jointly developed a business case for a surgical neonatal unit at the Alder Hey site.

The original business case was developed in response to the preferred option for surgical neonatal care as described by NHS England specialised commissioners and the North West Neonatal Operational Delivery Network (NW NODN) i.e.:

All neonatal surgery to continue to be performed on the Alder Hey Children's Hospital (ACHC) site, and in collaboration with Liverpool Women's Hospital (LWH), the establishment of designated Neonatal Intensive Care provision at AHCH and enhanced post-natal support (two site single service model).

The business case centred on providing a solution to delivering outstanding neonatal care within a single service across two sites. The subsequent model of care has been developed under the auspices of an agreed partnership arrangement between the two Trusts; the Liverpool Neonatal Partnership (LNP). The shared purpose of the LNP is described in the most recent version of the memorandum of understanding agreed in 2021 (see Appendix 1).

The ambitions of the single service are to deliver full compliance with national standards for neonatal care, across both sites, and to improve outcomes for babies and their families.

To date the development of the surgical service has involved establishing a leadership team, recruiting to dedicated neonatal nursing, medical and management roles for the AHCH site, creating dedicated cots for neonates on the AHCH site, developing operational processes and pathways that align with both LWH and AHCH systems and developing the detailed plans for the new surgical neonatal build on the AHCH site.

In the summer of 2021, the executive leadership teams from AHCH and LWH agreed to review the next steps for the LNP to determine the best way forward for these important services. The review was completed in conjunction with the LNP Leadership Team during August and September 2021 and the outcomes have been shared with the executive sponsors and their teams. This paper summarises the outcome of the review, makes recommendations for the continuing evolution of the LNP and suggests next steps.

3. The Current Service

As noted earlier, only surgical neonates are currently within the scope of the Partnership; some of these babies will also have medical requirements and some are cared for in PICU/HDU e.g., those with congenital diaphragmatic hernia.

The service can currently accommodate up to 16 neonates at AHCH site which is made up of 4 critical care beds (2 PICU / 2 HDU), 9 neonatal cots on ward 1C and 3 cots on other wards; occupancy is circa 90%. The current agreed plan is to increase the number of cots in the new build to 22 by consolidating surgical cots from LWH and across the C&M network with the cots already at AHCH.

In terms of operational staffing arrangements, there is a 24/7 neonatal nurse presence at AHCH, advance neonatal nurse practitioners (ANNPs) are present 7 days per week from 8am - 8pm, there is a consultant presence from 8am - 5pm Monday to Friday and virtual

ward rounds at weekends. Consultant cover will be increasing to 7 days a week from January 2022.

Clinical governance systems and processes have been developed and refined to ensure that they are fully integrated with both of the Trusts' governance frameworks.

As well as developing and delivering the day-to-day clinical service, the focus of the team over the last 18 months has also been on developing the detailed plans (estate, workforce and digital) for the new surgical unit which is due to open in 2023.

4. Benefits and Outcomes

There are a range of benefits and outcomes that have been achieved by the LNP to date. Examples are illustrated below:

Clinical benefits and outcomes

- Reduced lengths of stay for surgical infants by circa 1 day.
- Quality of care and clinical decision making benefits derived from increased presence of ANNPs and consultants on AHCH site.
- Family integrated care model adopted at AHCH which has a significant evidence base for benefits in outcomes for mums and babies.
- Clinical standardisation across the two sites i.e., equipment - incubators and IV pumps; and operational procedures - TPN (nutrition), hyperglycaemia and resuscitation (using Neopuff).
- Joint ward rounds, agreed pathways and more integrated care with PICU / HDU.

Workforce benefits and outcomes

- Increase of 12 WTE ANNPs and 3.5 WTE consultants to date.
- Improved retention within nursing particularly Bands 5 and 6.
- Improved access to staff education through the appointment of an LNP practice educator and the establishment of a surgical education group.
- The neonatal nursing team has won a national 'Woman of the Year' award.

Estates (new build) benefits and outcomes

- Significant parent engagement which has influenced the design of the new unit.
- £16 M committed from AHCH capital programme.
- £2.5 M fundraising target from AHCH charity.
- Planning permission and tender processes commenced.
- Increased the profile of Neonates at AHCH – e.g., 360 people attended stakeholder event, recent publicity about the charity campaign.

Innovation, data and technology benefits and outcomes

- Use of telemedicine to support virtual ward rounds.

- Introduction of Neolook that enables parents to maintain virtual contact with their baby.
- Improved data collection – AHCH is now registered with National Neonatal Audit Programme and all neonatal activity is recorded on BadgerNet consistently across the LNP.

There are an extended range of benefits expected to arise from delivering the service in the new state of the art surgical unit including:

- Reductions of multiple transfers for vulnerable babies;
- Optimising neurodevelopmental care;
- Continued reduction in lengths of stay;
- Reductions in intensive care stays; and
- Improved experience for families due to improved accommodation.

5. Vision for the Service

The original vision of the LNP Leadership Team has remained constant:

To keep the baby and family central and ensure that all babies receive the right care in the right place with no delays and no declines in condition; this requires the same service quality standards to be delivered across the two sites, without variation.

The LNP Leadership Team and the Executive Directors have reviewed a number of options for clinical service delivery models and agreed that the most effective way to deliver the vision is to have a fully integrated neonatal service incorporating all neonates (surgical and medical), with a single workforce team, operating across the 2 sites.

The benefits of extending the scope of the service and creating one workforce would be to improve quality of care and outcomes for babies and their families by:

- creating a single team, with a single team identity and culture;
- simplifying governance and reporting structures;
- achieving better use of resources through economies of scale in staffing and procurement;
- creating greater learning, development and career progression opportunities;
- being able to attract the best quality staff;
- meeting the aspirations of commissioners and the NODN; and
- meeting the recommendations from the coroner's court to bring the services more closely together.

In this scenario, the LNP would continue to work with specialised commissioners and the NODN to achieve optimal clinical quality, family experience and environmental standards across the Partnership and beyond. This may include delivering some planned, routine and low complexity surgery at LWH in the future (as was explored during Covid contingency planning).

A clear long term NODN vision, coming from the critical care review, and clear specialised commissioning intentions, will also help to inform the long term model of care further.

Over time, there is the potential to expand the Partnership to incorporate other services or sites and in the longer term, there is the potential to become the hub for a Cheshire & Merseyside Neonatal Partnership if that is supported by the LNP, NODN / commissioners.

The Executive Teams are keen to explore this further in the very near future.

6. Governance and Line Reporting

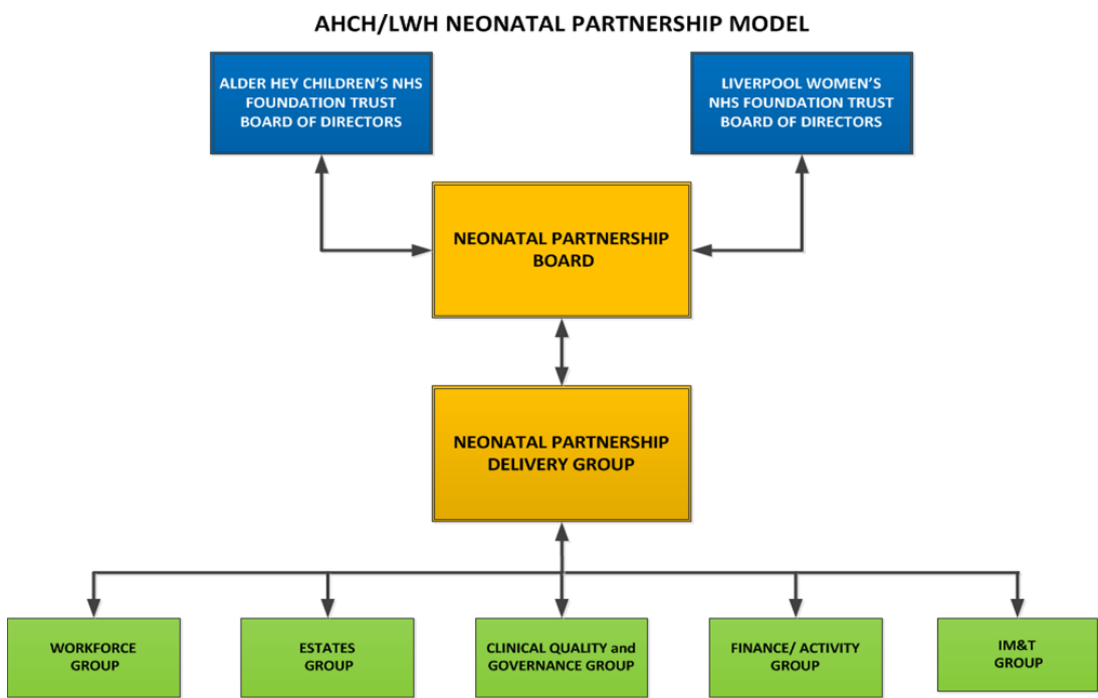
6.1 Current Governance Arrangements

The current governance arrangements for the LNP are illustrated in figure 1 below.

In addition, there have been fortnightly joint meetings of the executive teams to help keep the first phase of the LNP work on track and to create alignment and agreement about the further development of the Partnership.

The Leadership Team meet weekly and report to the Delivery Group monthly.

Figure 1: LNP Current Governance Arrangements

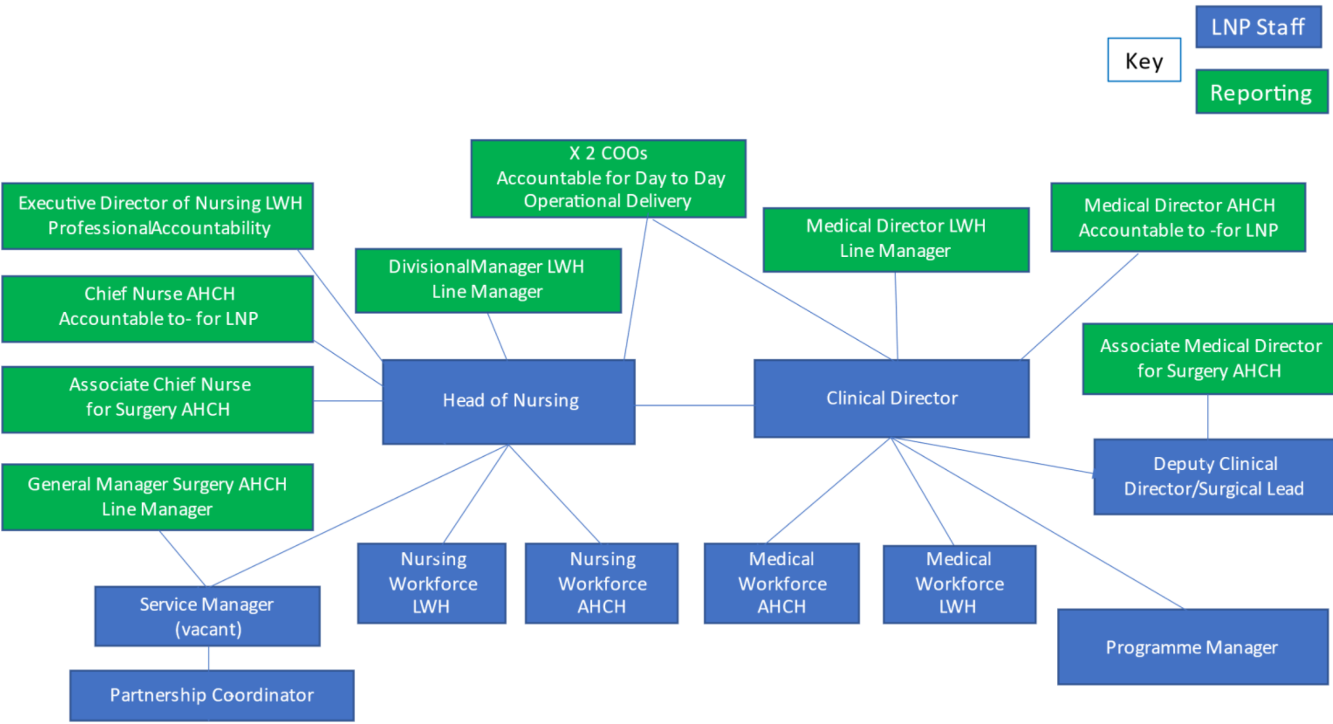


6.2 Line Reporting Arrangements

The current line reporting arrangements are shown in Figure 2 below.

As illustrated, these arrangements are complex, and for the Head of Nursing and Clinical Director in particular, there are multiple lines of accountability, which make day to day clinical governance and management decision making more complicated and time-consuming.

Figure 2: Current Line Reporting Arrangements



6.3 Proposed Governance and Line Reporting Arrangements

The AHCH and LWH Executive Teams are now proposing new governance and line reporting arrangements that would facilitate the delivery of the vision for neonatal single service supported by a single workforce; this is illustrated below in Figure 3.

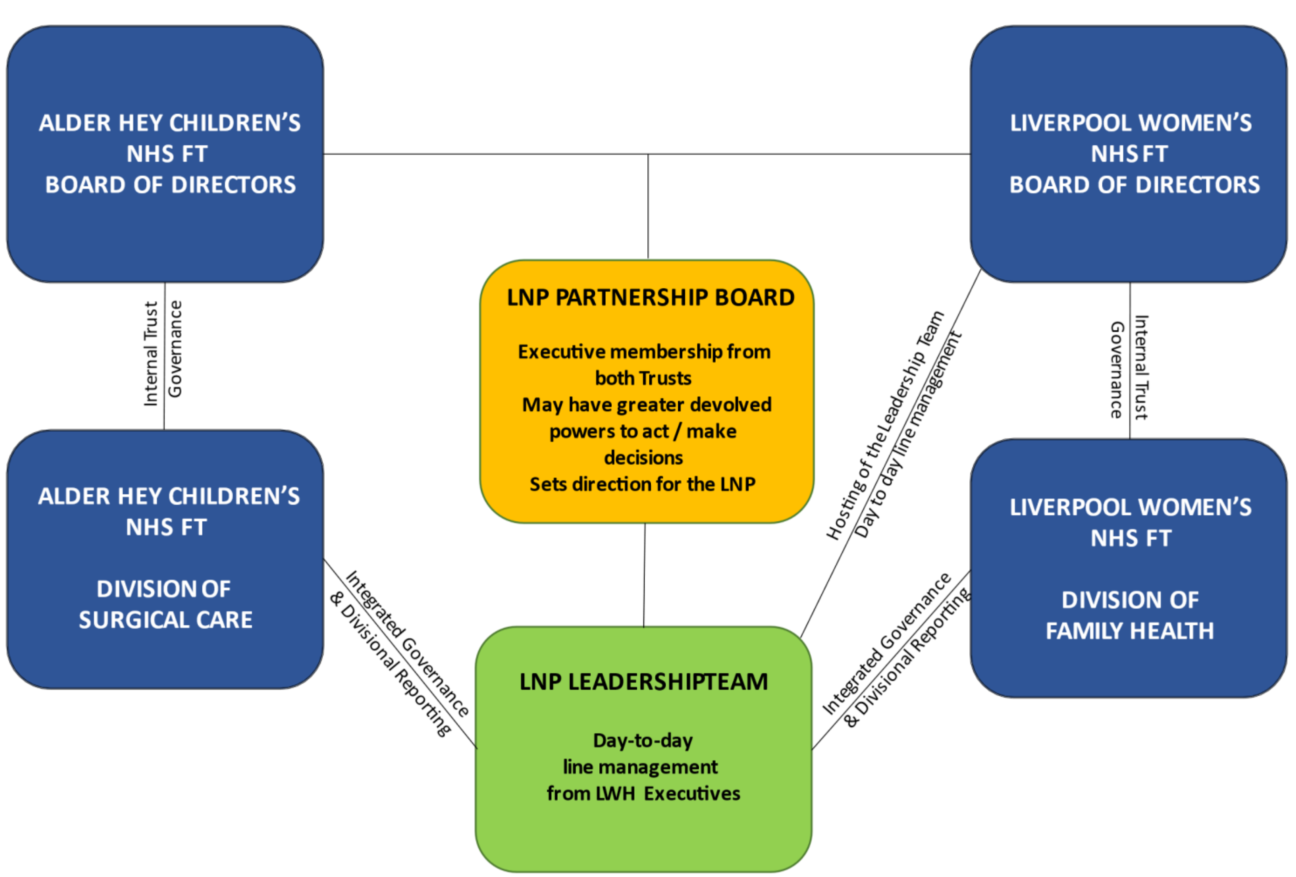
In this scenario, the current Delivery Group and Partnership Boards are disbanded and a new strategic Partnership Board is created that could have greater delegated authority for decision making from the two Trust Boards. This Board would include Executives from both Trusts and members of the LNP Leadership Team. The LNP Leadership Team would take strategic direction from the new Board.

The day-to-day line management arrangements would be simplified with the LNP Leadership team responsible to LWH executives through a 'hosting' agreement; this would support more nimble and efficient governance and decision making within the service.

In terms of accountability, the LNP Leadership Team would be accountable to the new Partnership Board and, for organisational alignment, would report into the relevant Trust divisional structures.

The detail of the new governance, hosting and reporting arrangements require further detailed development by the Executive teams and Partnership Board.

Figure 3: Proposed Governance and Line Reporting – requires further detailed development



7

7. Risks of Not Supporting the Evolution of the Partnership

There are a number of risks to not supporting the evolution of the Partnership such as:

- not having a shared, clear and articulated vision of the future for the LNP will prevent the service and team developing as it could – a clear, agreed and understood view of the future will support planning for the new unit and beyond and will make the service more attractive for staff, improving recruitment and retention;
- commissioners and the NODN will be less inclined to invest resources in the LNP if the Partnership is not continuously improving and / or the longer term vision is not clear;
- the Executive Teams will need to continue to provide significant resource to the LNP outside of the current governance to keep the current programme of work on track;
- continuing with the current operational arrangements will mean that operational complexity will remain and decision making will continue to be inefficient; potentially creating conflicting priorities for the Leadership Team;
- the Partnership will not be well positioned to take on a broader neonatal service leadership role within the Cheshire & Merseyside Integrated Care System.

8. Recommendations

The Board is asked to support:

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

9. Next Steps

Assuming the Trust Boards approve the recommendations, the suggested next steps are to:

- Establish a small subgroup of the existing Partnership Board to work up more detailed governance proposals – by mid November 2021.
- Existing Partnership Board to review proposals, terms of reference and suggested delegations – November 2021.
- Detailed recommendations made to Trust Boards – December 2021.
- Governance manuals, SOs and SFIs updated as appropriate – January 2022.
- New arrangements in place – from January 2022.
- Longer term vision and strategy developed with key stakeholders – March 2022.

Appendix 1 – Shared Purpose of the LNP (extract from MOU 2021)

The Parties [AHCH and LWH] share a commitment to the provision of the best possible care for the neonatal population of Liverpool and the North West region and will act with one voice as part of the Neonatal Network and wider health economy.

The new model of care will improve the quality of care and outcomes for babies by:

- AHCH will establish a new model of care with a designated NICU provision and enhanced post-natal support at AHCH (a two-site single service model) and will include the continuation of surgical support at LWH.
- Having a single leadership team for the Liverpool Neonatal Partnership that will support the delivery of a patient and family-centred service for babies and families.
- Neonatal surgery will continue to be performed at the AHCH site.
- Introducing a new clinical pathway which sees a significant reduction in unnecessary high-risk transfers for babies and which optimizes neonatal and surgical care provision on each site.
- Reducing unnecessary transfers that can be prevented through undertaking some minor surgical procedures at LWH following agreement of appropriate staffing and governance arrangements.
- Providing dedicated neonatal intensive care provision at AHCH with the appropriate supporting workforce.
- Providing an optimal environment where babies will receive both neonatal and surgical expertise in one place.
- Developing the clinical research capability across both trusts and their academic partners.
- Supporting outstanding educational opportunities to build the right workforce for the future.
- Babies in the NICU at AHCH requiring surgical care receive the same level of care, support, resource and specialist input as they would receive in a medical neonatal service (as per Toolkit for High Quality Neonatal Care, 2009).

BOARD OF DIRECTORS

Thursday, 28th October 2021

Paper Title:	**Board Assurance Framework 2021/22 (September)**
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 Risk Management Forum (monthly risk management meeting) is responsible for the Corporate Risk Register and for oversight of the Divisional Risk Registers and reports into the Audit and Risk Committee.

2. Review of the BAF

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

	BAF Risk	Reviewed By
1.1	Inability to deliver safe and high quality services	Safety & Quality Assurance Committee
1.2	Inability to deliver accessible services to patients, in line with national standards, due to 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 14th October 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.

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

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

2.1: Workforce Sustainability and Development (S)

3.4: Financial Environment (S)

3.5: ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system compl (W)

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

2.3: Workforce Equality, Diversity & Inclusion (S)

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

2.2: Employee Wellbeing (S)

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

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 14th October 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	**INCREASED**	STATIC
2.2 MS	**Employee Wellbeing.**	PAWC	3x3	3x2	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion.**	PAWC	4x3	3x2	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships						
3.1 DP	**Failure to fully realise the Trust's Vision for the Park.**	RABD	3x3	3x2	STATIC	STATIC
3.2 DJ	**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 x4	3 x3	STATIC	**INCREASED**
3.6 DJ	**Risk of partnership failures due to robustness of partnership governance.**	RABD	3x3	3 x2	STATIC	STATIC
STRATEGIC PILLAR: Game-Changing Research And Innovation						
4.1 CL	**Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People.**	Innovation	3x3	3x2	STATIC	STATIC
4.2 KW	**Digital Strategic Development and Delivery.**	RABD	4x1	4x1	STATIC	STATIC

5. Summary of September's updates:

External risks

- ***Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children and Young People through leadership of 'Starting Well' and Children and Young People's systems partnerships (DJ).***
  Risk reviewed; no change to score in month. Actions updated and new evidence for C&M CYP control added.

- ***New NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment (DJ).***
  Risk reviewed; score increased in month to 4 x 4 - reflecting the continued uncertainty of the ICS / system development arrangements at this time - as reflected at Trust Board Sept 21, action plan in place and agreed

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk reviewed; no change to score in month, though progress made with development and engagement on the Framework.

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

Internal risks:

- ***Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19 on waiting times for elective care (AB).***
  In September the level of recovery against 2019 was 89% for elective care and 92% for outpatient care. Our recovery performance is stable. Due to staff absence, fatigue and vacancies we have not secured a high number of additional sessions in September to increase recovery. However, we have scheduled more weekend and evening sessions in October. Nonetheless, there are risks to in-week throughout and recovery: firstly, PICU surge requiring volunteers to move from elective care to critical care. Secondly, high bed occupancy caused by a 20% rise in attendances to ED. As contained in our previous 52 week performance there has been an increase in the number of long wait patients from the Safe Waiting List Management programme. Our recovery plan in quarter 3 is focused on in-week productivity through the new theatre scheduling policy, additional sessions and recruitment through the accelerator investment.

- ***CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of COVID (AB).***
  The 20% rise in emergency attendances to the Emergency Department is generating significant pressure on staff. There is high bed occupancy and challenges to patient flow. In response to this we will look after staff by providing a winter toolkit of measures that covers refreshments, more rest facilities and psychological support. In response to the high demand for urgent care and critical care we are implementing the escalation measures contained in our Autumn & Winter Plan. In October we will reduce elective activity and increase PICU capacity by 2 beds. In urgent care, we have

increased acute care clinics and community pharmacy cover. We have also submitted a business case to the CCG to fund on a priority basis the establishment of a paediatric urgent care service in Alder Hey for this winter.

- ***Inability to deliver safe and high quality services (NA).***
  The risk has been reviewed and updates undertaken of some control actions. Work continues in relation to gaps in assurance relating to medication safety. Other controls remain in place.

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

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

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

- ***Workforce Sustainability and Development (MS).***
  Risk score remains high, whilst recruitment activity has increased by 150% and service is under resourced. Recovery plan in place.

- ***Employee Wellbeing (MS).***
  Risk reviewed and controls and actions reviewed. Two new actions added relating to Winter Plan for wellbeing and development of a SALS pals' model. No change to current risk score.

- ***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).***
  October review; no change.

Erica Saunders
Director of Corporate Affairs

Appendix A

Links between BAF and high scored risks – as at 14th October 2021

BAF Risk | **Strategic Aim** | **Related Corporate Risk**

1.1 Inability to deliver safe and high quality services

Strategic Aim: 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.
(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.
(2501) Inability to safely staff the waiting list initiative clinics in OPD.

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.

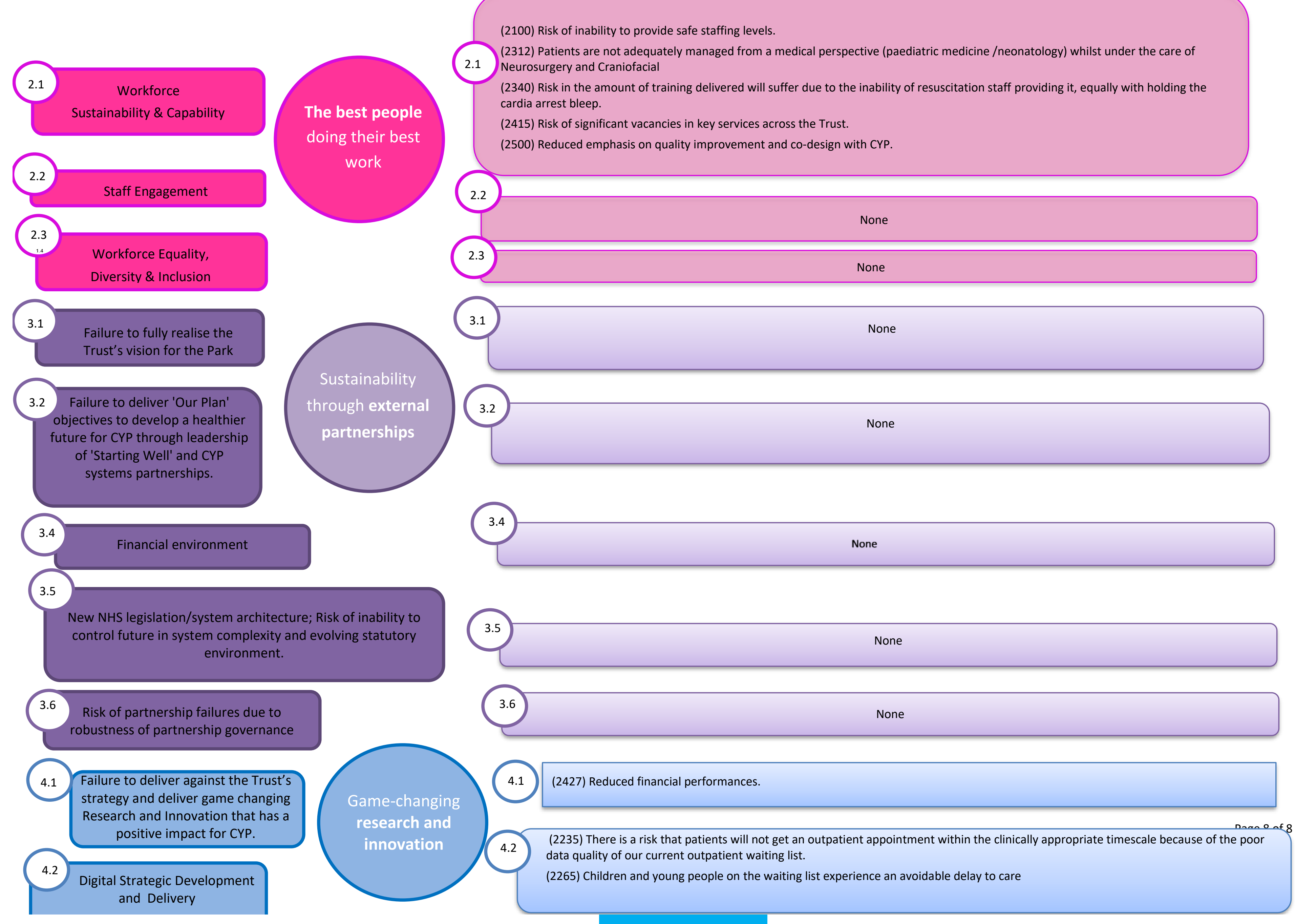
1.2

(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
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.
Sustainability through external 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
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
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.
(2500) Reduced emphasis on quality improvement and co-design with CYP.
2.2
None
2.3
None
3.1
None
3.2
None
3.4
None
3.5
None
3.6
None
4.1
(2427) Reduced financial performances.
Page 8 of 8
4.2
(2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list.
(2265) Children and young people on the waiting list experience an avoidable delay to care

Board Assurance Framework 2021-22

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, 2312, 2265, 2414, 2383, 2434, 2441, 2427, 2326, 2235, 2229, 2384, 2461, 2463, 2436, 2475, 2332, 1560, 2415, 2100, 2340, 2501		
Exec Lead: Nathan Askew	Type: Internal, Known		Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

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

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.

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 SQAC
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 - SDG forum to address challenged areas and approve cases for investment where access to care is challenged.
Urgent clinic appointment service established for patients who are clinically urgent and where a face-to-face appointment is essential	New outpatient schedule in situ
Digital outpatient channel established - 'Attend Anywhere'	Weekly tracking of training compliance and number of patients consulted via a digital appointment
Urgent operating lists	
Weekly access to care meeting to review waiting times	Minutes
Winter & COVID-19 Plan, including staffing plan	
Additional weekend working in outpatients and theatres to increase capacity	
Safe waiting list management programme to ensure no child experiences harm whilst on a waiting list for treatment	
Clinical review of long waiting patients, and harm review SOP for patients who were not tracked optimally	

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

Board Assurance Framework 2021-22

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

Executive Leads Assessment

0 - No Reviewer Entered

October 2021 - Adam Bateman
In September the level of recovery against 2019 was 89% for elective care and 92% for outpatient care. Our recovery performance is stable. Due to staff absence, fatigue and vacancies we have not secured a high number of additional sessions in September to increase recovery.

However, we do have scheduled more weekend and evening sessions in October. Nonetheless, there are risks to in-week throughput and recovery: firstly, PICU surge requiring volunteers to move from elective care to critical care. Secondly, high bed occupancy caused by a 20% rise in attendances to ED.

As contained in our previous 52 week performance there has been an increase in the number of long wait patients from the Safe Waiting List Management programme.

Our recovery plan in quarter 3 is focused on in-week productivity through the new theatre scheduling policy, additional sessions and recruitment through the accelerator investment.

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.

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: Adam Bateman	Type: Internal,		Current IxL: 4x5	Target IxL: 3x4	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Revised Communication Strategy.	21/10/2021	
Develop Mitigation Strategy for areas of workforce fragility.	15/10/2021	

Executive Leads Assessment

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

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

In response to the high demand for urgent care and criticacl care we are implementing the escalation measures contained in our Autumn & Winter Plan. In October we will reduce elective activity and increase PICU capacity by 2 beds. In urgent care, we have increased acute care clinics and community pharmacy cover. We have also submitted a business case to the CCG to fund on a priority basis the establishment of a paediatric urgent care service in Alder Hey for this winter.

September 2021 - John Grinnell
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.

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, 2500		
Exec Lead: Melissa Swindell		Type: Internal, Known	Current IxL: 4x4	Target IxL: 3x2	Trend: STATIC
Assurance Committee: People & Wellbeing Committee					

Risk Description

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

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

Gaps in Controls / Assurance

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

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	31/10/2021	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	31/10/2021	Delayed as a result of needing to respond to covid. workforce planning happening in response to backlog and nre pressures (accelerator and RSV)
5. Recruitment and Apprenticeship Strategy currently being developed in line with the actions set out in the NHS people plan	31/10/2021	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
October 2021 - Sharon Owen Risk score remains high, whilst recruitment activity has increased by 150% and service is under resourced. Recovery plan in place.
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.

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	31/10/2021	Meeting with SALS & Alder Centre to finalise proposal details and confirm resource needed for counselling provision. Proposal to

determine future service development and delivery that meets demand and is integrated with internal and external counselling provision.		finalised and discussed with HRD as next step.
Recruit to SALS/OD fixed term psychology post and permanent admin post.	29/10/2021	Admin post out to advert internally on 7.9.21. Psychology post to be advertised.
Winter wellbeing plan developed and shared with Trust Board focussing on organisational health and wellbeing and additional support needed for staff through the winter period. Plan shared with Brilliant Basics team for support in enabling changes needed to be made to support staff (e.g. enabling staff to take breaks and increasing leadership visibility). Plan to be monitored via bi-monthly wellbeing action group and outcomes assessed through whole organisation debriefing programme to begin in the next quarter	31/10/2021	Meeting with Brilliant Basics team to agree plan and discuss risks and support needed to implement. Plan submitted to Board
Agree a develop a SALS Pals (HWB champion) model across the organisation	30/11/2021	SALS Pals JD a developed. Training plan and supervision structure to be developed. Plan to be presented at the next People and Wellbeing Committee

Executive Leads Assessment
October 2021 - Jo Potier Risk reviewed and controls and actions reviewed. Two new actions added relating to Winter Plan for wellbeing and development of a SALS pals model. No change to current risk score
September 2021 - Jo Potier 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

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

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

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

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Review and update Space Strategy	29/10/2021	Space strategy in draft with a further iteration required over the next month to end September
Create opportunities analysis for Park/campus	31/10/2021	
Appoint PM and legal team to review NE plot and produce Business Cases/Board papers	19/11/2021	
Create oversight group with staff governor and LCC input	19/11/2021	

Executive Leads Assessment

October 2021 - David Powell
Prior to October Board

September 2021 - David Powell
Prior to Sept Board

August 2021 - David Powell
Prior to August Board

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 implementation	Presentation to C&M W&C Programme to agree C&M priorities - led by Alder Hey (Dec 20). Approved paper to C&M HCP re establishment of the new C&M CYP Programme (Nov 20). Programme submission to C&M HCP for set up of new CYP Programme (Mar 21) supported by HCP (ICS) 4.10.21 - C&M CYP Programme now in full flight & progressing positively. New system initiatives re: THRIVE MH model & Obesity underway; LD / Autism & Respiratory in planning. Recruitment to CYP team underway.
Coordinated system-wide action planning for predicted RSV surge	NW & C&M Surge Plans
ICPG led Refreshed One Liverpool Delivery Plan - under development	

Gaps in Controls / Assurance

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

Board Assurance Framework 2021-22

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
6.Develop Operational and Business Model to support International and Private Patients	17/12/2021	Refresh of Trust Strategic plan scheduled for Q4 21/22 - planning for non-NHS income to form part of this refresh
1. Strengthening the paediatric workforce	17/12/2021	Alder Hey making strong strides re: Physicians Associates as the largest employer of PA's in England - demonstrating new approaches to staffing skill mix. Requirement for system-based workforce planning outlined in new Gov't guidance 'Build Back Better' in September; local implementation timelines as yet unknown but Alder Hey will ensure positioning for CYP workforce played in.
Full programme proposal implementation; 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
October 2021 - Dani Jones Risk reviewed; no change to score in month. Actions updated and & new evidence for C&M CYP control added.
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

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, 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	31/10/2021	H1 achievement of break even position as per plan met through non recurrent under spends in elective recovery costs. Planning guidance has now been received for H2, although the C&M system is yet to define the income allocations for providers for H2 and therefore the uncertainty remains regarding the size of the challenge to achieve a break even position. It is expected that a higher efficiency will be allocated to providers in H2 and this will need to be met though cost reduced which is a significant risk as winter approaches. AH financial plans are being updated to reflect new guidance and to assess full financial risk.
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
October 2021 - Rachel Lea Risk reviewed and actions updated
September 2021 - Rachel Lea Risk reviewed and actions updated
August 2021 - Rachel Lea Risk reviewed and actions updated with latest progress

Board Assurance Framework 2021-22

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

Assurance Committee: Trust Board

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

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 & response to H2 (links to BAF 3.4)	
Trust Board & CoG - continued engagement and action planning	Presentations to Trust Board & CoG - updated July & Sept
C&M CEO Provider Collaborative - Membership	
C&M ICS Finance Committee - play an integral role and ensure fair share of funding for CYP services	TOR & System Finance Principles in development (to be attached once finalised)

Gaps in Controls / Assurance
NHS Bill not yet read in Parliament; final statutory arrangements cannot take place until this is completed (clarity will follow) H2 Planning Guidance landed October 21: Review of impact and associated action plan for Alder Hey to be undertaken early Oct 21

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
H2 Planning Guidance / Associated Finance strategy for H2 to be developed (See BAF 3.4)	30/11/2021	
Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	28/04/2022	

Executive Leads Assessment
October 2021 - Dani Jones Risk reviewed; score increased in month to 4 x 4 - reflecting the continued uncertainty of the ICS / system development arrangements at this time - as reflected at Trust Board Sept 21, action plan in place and agreed
September 2021 - Dani Jones Risk reviewed; no change to score in month. Continued commitment to key ICS development working groups. Ongoing engagement with Trust Board & Council of Governors.
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	
Partnership Quality Assurance Framework	P'ship Quality Assurance Framework in development. Initial review with Alder Hey Execs (MD, Chief Nurse, Corp Gov Exec) complete; awaiting comments then further work with partners to identify pilot area. Update to Risk Management Forum Nov / Jan (dependent on partner engagement)

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

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

Executive Leads Assessment
October 2021 - Dani Jones Risk reviewed; no change to score in month, though progress made with development and engagement on the Framework.
September 2021 - Dani Jones Risk reviewed; no change to score in month. Partnership framework under development during Q3
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: 2427		
Exec Lead: Claire Liddy		Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Innovation Committee

Risk Description

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

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

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
LCR/BOOM engagement and collaboration for public funding and investment.	31/08/2021	
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	

Executive Leads Assessment

October 2021 - Claire Liddy
OCT review - no change

September 2021 - Claire Liddy
risk review SEPT. no change

August 2021 - Claire Liddy
AUG 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

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

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

August 2021 - Kate Warriner
BAF reviewed, good progress, plans in place to refresh digital strategy from 22/23

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Approved Minutes of the meeting held on Monday 27th September 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)
	Melissa Swindell	Director of HR & OD	(MS)
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance:	Nathan Askew	Chief Nursing Officer	(NA)
	Asia Bibi	Associate Chief Operating Officer, Surgery	(ABi)
	Mark Flannagan	Director of Communications	(MF)
	Russell Gates	Associate Commercial Director Development	(RG)
	Sarah Gillgrass	Business Accountant, Surgery	(SG)
	Emma Hughes	Deputy Managing Director Innovation	(EH)
	Emily Kirkpatrick	Associate Director Commercial Finance	(EK)
	Rachel Lea	Deputy Director of Finance	(RL)
	Chloe Lee (part)	General Manager, Surgery	(CL)
	Andy McColl	Associate Chief Operating Officer, Planning & Service Development	(AMcC)
	Nicki Murdock	Chief Medical Officer	(NM)
	Abby Prendergast	Associate Director Strategy & Partnerships	(AP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Clare Shelley	Associate Director Operational Finance	(CS)
	Amanda Graham	Executive Assistant (*minutes*)	(AG)

20/21/275 Apologies:
Apologies were received from John Grinnell, Dani Jones, Ken Jones and Claire Liddy.

20/21/276 Minutes from the meeting held on 26th July 2021.
The minutes of the last meeting were approved as an accurate record.

20/21/277 Matters Arising and Action log
The action log was revised with the following updates:

20/21/058.2	Capacity Lab – attended last meeting, action closed
20/21/116	Business Development - now on RABD workplan, action closed
20/21/123	Green Plan – deferred due to agenda pressures
20/21/166.2	Business Development – Further conversation to be had ES /RL
20/21/223	Alder Hey Ventures – to be picked up in review of structure & governance by JC
Innovation	Actions transferred from Innovation Committee on workplan to be picked up in 1 paper, action closed
20/21/251	Building Issues – meeting held, update to October Trust Board, action closed
20/21/252	Campus risks – now included on BAF, action closed
20/21/259.1	Write-offs – work ongoing
20/21/259.2	Surgery Deep-dive – item presented at September meeting; action closed

20/21/278 Declarations of Interest
There were no declarations of interest.

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20/21/279 **Finance Report**
Month 5 Financial Position

CS presented the Month 5 Financial report, noting that the Trust continues to target a break-even position for H1 and discussions are ongoing across C&M. Challenges have emerged due to the threshold changes reported last month and C&M being behind on expected performance, resulting in a shortfall of year to date ERF income of £956k but this has been offset by a year to date underspend against ERF schemes of -£700k. The month-end position of £359k surplus which is £64k behind plan and -£1.8m YTD deficit which is £678k adverse to plan. CIP gap remains 38% adrift of the £6.1m target.

Key changes to strategic risks are that trusts have been requested to signal future years capital expenditure plans, including to highlight unavoidable capital spend and the likelihood of a 3% efficiency for C&M within H2 guidance along with a reduction in income, but as yet full guidance has not been received.

NM asked what other Trusts positions are looking like; CS replied that most are very similar to Alder Hey in that most are reporting a break-even position with a slight variance for Alder Hey and another Trust which would be managed by them. CIP is very similar, and most Trusts are struggling to find the savings while on a block contract. NM noted that other Trusts seem to be doing a bit better; RL responded that the difference is that Alder Hey & the wider C&M cell are reliant upon ERF contribution, however on inclusion in the C&M plan the system top-up was allocated on paper to those Trusts who had not put ERF income into plan. That methodology on top of guidance changes meaning a reduction in ERF income being available has resulted in Alder Hey losing that income and creating a £1m risk to achieving the break even control total as required by C & M, which is being managed across the Specialist Trusts.

SA asked for clarification of the IM&T non-pay variance on page 13; CS responded that the variance is related to HSLI (Health Systems-Led Investment) income which on paper distorts the non-pay position and a realignment would be completed for future months to reflect spend plans, whereas non-pay variance is due to the unachieved CIP across the Trust. KW added that this is a joint work project, under the C&M HSLI scheme hosted by Alder Hey; in terms of the internal position, IM&T is not overspent, is in a balance position and is meeting CIP.

KW commented that in relation to H2 and further into 2022/23 it appears that Alder Hey's planning decision has been made tactically based on the position at the time, but asked if there has been any learning from the disproportionate impact on the Specialist Trusts; RL responded that when signing up, there was not full transparency and the plan was put together quite quickly. At the time the Specialist Trust raised concerns and C&M ICS are coming together with Trusts re H2 and forming a plan with learning from H1. In relation to H2, C&M did not achieve 95% for H1 so there will be challenges ahead to reach the new system threshold.

IQ queried whether Medicine will be a future problem area similar to Surgery; CS noted that the main variance is within Non-pay: overperformance in non-PBR drugs but not being able to claw that back due to them being on block contract; there are also staffing pressures within ED; and pressures on 1:1 nursing spend. Assessment has been started towards a deep-dive but there are a lot of costs related to PCR testing which it is hoped can be costed towards a Covid cost centre which will remove them. AB added that it would be useful for a deep-dive to be undertaken, to support organisational & contractual discussions with the CCG as at times there is a 20% increase in patient demand at the front door. As a result of this extraordinary

increased demand, funding streams directed at other services that have since been withdrawn should be redirected to Alder Hey to cover the costs of this massive increase in demand. IQ asked how that can be monetised; AB replied that payment by results is still there to indicate value of activity, so an equivalence could be demonstrated under that method. IQ asked who would undertake that, as it could make a dramatic difference; RL responded that this may be included within the capacity funding within H2.

IQ asked whether there is an issue with Clinical Research and their invoicing processes; CS responded that currently R&D are ahead of plan overall by £194k and by £239k for income. Work has been done with staff to ensure timely invoicing is being done.

Resolved:
RABD received and noted the M5 Finance report.

20/21/280 **2021/22 Planning Update**

RL gave a brief update on Planning for H2, advising that the guidance was expected to be received the following day, with an expectation of submission of plans by November. Initial insights are that it will be a continuation of H1, with block payments, system funding and top-ups. The methodology used around systems in deficit will mean the NW regions are expected to have the highest efficiency targets, anticipated to be 2-2.4% reduction of H1 income.

Funding does include some capacity funding to fund pressures within urgent care, 111First and Winter which is recognition of H2 challenges and will hopefully give opportunities to secure some of that. It is expected that ERF will be set at a 95% threshold for H2, possible with a gradual increase by Q4 (but not yet confirmed).

There are some capital funding pots available, which Alder Hey are bidding for and it is anticipated that there may be more of these within the guidance and will be linked to achieving higher than pre-Covid activity levels.

Action: RL to send update on guidance to RABD members on receipt (RL)

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

20/21/281 **Division of Surgery Deep-dive Update**

CS and CL presented an update on the Surgery deep-dive. CS gave a brief financial update advising that there has been an improvement of £0.6m overall with an improvement in pay variance of £0.5m year to date. CS advised that following receipt of the H2 guidance there is likely to be some work for the Division to do on current drivers for the overspend which include restoration costs and medical staffing costs which form £2.4m of the total overspend.

CL updated on spend reductions, advising that nursing spend has been reduced in line with the action plan and a full establishment review of PICU has been undertaken to identify shortfall in staffing. Use of the E-Rostering system has commenced and it is hoped this will support intelligent staffing and reduce temporary & bank staffing costs. The renegotiation of craniofacial block funding and request for a contract uplift has been submitted and a decision is awaited from the CCG, which includes an historic deficit of £680k. Historic local sessional weekend payments (not confined to the Division of Surgery) are currently being paid but it is

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hoped consideration could be made to those being renegotiated in light of the current financial landscape.

NM asked where the currently suspended Pectus service was up to in terms of conversion to private work; CS noted that this would be picked up outside the meeting.

IQ asked whether serious consideration would be given to disinvesting the Cranio-Facial service and NM noted that the Trust is world-leading in that service; CL advised that to undertake that would result in being non-complaint with national standards but it was felt pertinent to include in the paper.

SA asked how savings were found in nursing time & costs without impacting upon patient safety & care; CL noted that from conversations with Rachael Hanger, Divisional Associate Chief Nurse, savings have been found within the Safer Staffing principles which are based on patient acuity & volume at the time, rather than having all beds open. NA added that fill rates for bank & agency staff usually around 60%, yet there is demonstrable compliance with safe staffing every month; so beds do not have staff allocated "just in case" so appropriate ratios have been maintained and fill rates have gone down and this has been a really good piece of work in Surgery.

IQ commented that there has been a dramatic turnaround in Surgery in a short space of time. CS added that some of this was the cost pressure funding agreed by the Executive team. RL noted that by undertaking the deep-dive and understanding the issues and costs, they were then relatable to compliance with legislative & regulatory requirements & organisational priorities; the challenge will be when looking at CIP and maintaining productivity without incurring further costs. The template which has been used can now be applied to the other divisions.

Action: CS to discuss privatisation of Pectus Service with CL (CS/CL)

Resolved:
RABD received and noted the

20/21/282 **Service Development Opportunity**

AMcC presented a service development opportunity paper to work towards achieving the approx. £2.5m recurrent funding required for the new NICU / PAU. By developing those there is a release of beds elsewhere in the organisation which enables incremental growth and income-generation opportunities. Details were shared of options for consideration. AMcC asked that the Committee consider the opportunities listed within the paper by commissioning a fully worked-up proposal by the Business Development team.

NM asked whether there was overcomplication and suggested undertaking one private Pectus case at a time which could commence next year. NM also noted that LHCH have a concierge service and may well be interested in providing that, adding there has been a pre-Covid offer to view their private suite.

NA noted that having previously shared concerns over mixed medical / surgical wards as the nurses work very differently and there are other models that will need to be considered; also bearing in mind that in by paying for private care, patients would be paying for increases in environment, speed (possibly not referred to within the paper) and access not available on the NHS. If day case work was to be ramped up that would give speed, pectus work helps with access and the environment is

already great. Finally, while there is probably capacity there are bed numbers below which it is not financially feasible, so more work needs to be done on the finances.

RL asked whether a small test for change could be set up using non-commissioned bed.

MF noted that this has been discussed several times and is still not clear on the position – whether whole-hearted or dipping toe in – and have not yet come to any conclusion.

IQ noted that this would be a Trust Board decision rather than RABD and agreed with MF that a decision needs to be made and once made then it needs to be progressed.

AB commented that there are a couple of contradictory points: if there are willing clinicians and interested patients then we should go ahead and commence some of that work; being realistic about the scale of work over time, there needs to be proper investment in capacity & staffing arrangements. By having something specialist as a facility that gives confidence; the model within needs ingenuity and there needs to be more systematic modelling work done by checking where GOSH and Moorfields are up to both pre- and post-Covid, whether their levels of activity & income have returned. There should not be an assumption that we can generate that level of income without prior rigorous assessment of demand and against peer-hospitals, but having already got a track record for contracting independent clinicians, there should be little pessimism about doing this; there needs to be a clear plan with a commitment to progress.

NM noted that this being held back by not having confidence that this will actually get started.

RL commented that this is an opportunity to use capacity being created by new units & associated bed moves; the biggest opportunity is to fund the running of the development and to cover incurred costs that have been agreed. There is a need to come up with the "here & now" and to then work on getting to the 7 or 8 beds.

IQ summarised by noting a need for Trust Board approval to go ahead; a lot of points have been raised which need to be addressed including starting small to eventually arise at the desired run-rate or to start big, checking against GOSH and Moorfields, checking ward sizes / effectiveness / VFM. When those are satisfactorily answered agreement will be given to prepare a full commercial business case for Trust Board's consideration.

Action CK to provide further detail to cover the points raised (CK)

Resolved:
RABD received and noted the Service Development Opportunity paper.

20/21/283 **Capital & Cash Updates**
RL gave a brief update on Capital and Cash, noting that the Capital forecast is currently on plan with a refresh of the 5-Year Plan being compiled following expected changes to capital allocations across C&M in 2022/23. Cash is largely unchanged with the expected reduction since year-end; Cash plans are dovetailing into Capital plans to support the programme.

IQ asked for clarification of the detail listed within the Cash Forecast; RL agreed this would be corrected.

IQ asked that there be a push on NHS receivables to get as much money in before year-end; RL agreed that this will be a focus for all NHS organisations following instruction for timely payment of invoices.

IQ asked whether there will be any loss on the fire claim; RL confirmed that this is pretty much covered.

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

20/21/284 **Campus & Park Updates**

RG gave a brief update on the Park & Campus, noting that Phase 3 demolition is now complete and electrical changes are underway to enable permanent electrical installation for the new Sunflower House, Catkin, Institute & Alder Centre. The new corporate office base at Innovation Park is on plan with occupation expected from next month and the CAMHS area is under design. Some additional space has become available earlier than expected in the Eaton Road police station. Other space requirements are being reviewed in line with medium & long-term plans.

Tenders for the Neonates building work have been received with the expected impact of inflation and availability of materials. Work will be done with contractors to bring this back within budget but there may be some challenges.

Insurers for the nursing home have accepted liability and discussions are ongoing around the future of the damaged building.

Finally, Liverpool City Council have now agreed a date for Phase 1 of the Park to be opened and the Estates team are working with Communications to make an event of this.

NM asked for an indication of the variance of the tenders; RG noted that it is approximately 15% and that contractors are wary of committing to delivery & costs with the current volatility in the construction materials market.

MF asked whether the nursing home is part of long-term plans; RG noted there are alternatives to using this, but it is currently a "bird in the hand" and discussions are to be held on the long-term plans.

RL asked that any variance in the costs of materials be taken into account when committing to contract; RG noted that while this will be novated to the PFI, it is being considered as part of that.

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

20/21/285 **Communications Update**

MF gave a verbal update, highlighting the fact that both the new Neonatal unit and the Step-Places housing development were both tabled for the next local authority Planning Committee session. Staff communications are ever evolving to update staff on their offer. The brand development strategy is currently being worked up to

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include Research & Innovation and also the Communications strategy is to be aligned within the Corporate Strategy.

Resolved:
RABD received and noted the Marketing & Communications update

20/21/286 **Recovery & urgent Care Update**

AB noted that a detailed report was within the papers circulated. RSV cases have not been as high as expected as yet; however, a more general rise in respiratory infections is part of the Winter Plan. Demand increases will require support from other areas which will impact on elective recovery. The wider Winter Plan will be taken to Trust Board.

Attendance at ED has dropped through August but overall attendances since May have been up to 38% higher than 2019 levels which has impacted upon the timeliness of care. Plans have been put in place to support the increased numbers and regular updates will be given on this.

Recovery levels have dropped slightly below 100% due to lower levels through August to allow staff to take rest. Accelerator recruitment has resulted in staff being appointed to assist with increased activity.

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

20/21/287 **Safe Waiting List Management Update**

AB gave a brief update on the current position with the Safe Waiting list work, noting that the detailed report is within the pack. Liverpool CCG have now stepped down their scrutiny meetings and no longer attend the monthly Oversight Group meetings.

Data assurance and validation of all inpatient records has now been completed. A primary admin review of the outpatient records has been undertaken with senior & clinical reviews to be completed by the end of October in live with the go-live of the new Outpatient waiting list.

Resolved:
RABD received an update on Safe Waiting List Management; IQ noted the effort & work that has gone into the programme.

20/21/288 **Month 5 Corporate Report**

AB presented a brief update on the M5 Corporate Report, noting that the report was within the papers circulated. The key operational challenge currently is the demand upon ED which has been reported on earlier.

Resolved:
RABD received and noted the M5 Corporate report.

20/21/289 **PFI Report**

It was noted that the report was within the papers circulated.

Resolved:
RABD received and noted the M5 PFI report.

20/21/290 Board Assurance Framework

ES gave a brief update on the Board Assurance Framework, highlighting that the Campus risk score warrants review and Partnership risks are also being reviewed to provide more assurance.

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

20/21/291 Any Other Business

IQ noted that sadly this has been CD's last meeting and thanked her for all the help and support she has given to him as Chair of the Committee and to Alder Hey Hospital. CD replied that it has been a great partnership and has seen a lot of change.

20/21/292 Review of Meeting

Key points: good discussions around the surgery deep-dive which can be applied to the other divisions; updates on H2 and planning; discussions around private patients to be taken forward and worked up into a proposal to Board; good work around the Safe Waiting list work that the CCG have stepped down their assurance & scrutiny meetings. Finally thanks to Claire Dove for her work supporting the Committee and the Hospital.

Date and Time of Next Meeting: Thursday 21st October 2021, 10am – 12pm, via Teams.

BOARD OF DIRECTORS

28th October 2021

Paper Title:	**Safety Quality Assurance Committee**
Date of meeting:	20th October 2021 – Summary 22nd September 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 20th October 2021, along with the approved minutes from the 22nd September 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 20th October 2021

Significant items received and discussed at the SQAC meeting included:

Quality Priorities – updates on progress for Medication Errors and the Deteriorating Patients received. SQAC received Deep Dive update which focused on Parity of Esteem, which demonstrated the significant ongoing work, which through flexibility and adaptation would result in ongoing progression over time.

Transition Update - Committee received Transition update with regards to Trust compliance with NICE Guidelines 43 (NG43): Transition from Children to Adults' services for young people using health or social care. Committee noted the current challenges, as the Trust is currently unable to demonstrate and monitor compliance with NG43 at Division/Specialty level, with further work required to fully embed the responsibility for transition of young people to adult services across divisions to ensure a consistent and cohesive approach which improves the experience of the young people and families involved. Committee noted the short terms actions identified in order to support compliance with NG43 and accepted and approved the request to extend the deadlines of actions 2 and 3, with the clear expectation that these deadlines would not be extended any further. SQAC would expect clear progress made when receiving Transition update at January 2022 SQAC meeting.

ED Quarter 1 MH Update– SQAC received ED Quarter 1 MH update, which provided clarity within the report on the current position, with discussion regarding linking to broader inequalities across Cheshire & Mersey.

Assurance ED Activity Monthly Update – Good analysis received, SQAC recognised progress made, with the need for continued focus through monthly updates to SQAC.

Aggregated Analysis report – SQAC received and noted the Aggregated Analysis Report which reviewed key themes from April to September 2021regarding incidents, complaints, PALS, Claims and Inquests, report detailed themes and lessons learned.

RCPCH Invited Review Update report - Committee received and noted the detailed RCPHC Invited Review Report which provided a detailed review of the original reviews and action plan stemming from an incident in 2019 and made 4 recommendations to ensure all lessons had been fully addressed.

Proposal for Interpreting Provision at Alder Hey Children's NHS Trust – SQAC received the proposal for the use of new Interpreting Providers and request to confirm the award of Framework Arrangements to providers of Language services. SQAC supported and approved the move to DA Languages for the provision of spoken interpreting services. SQAC noted next steps which included to devise an implementation plan which would include key stakeholders, (L&D, Communications,

Divisions, ED, Procurement and Finance), with a view to commence under the new contracts from 1st April 2022. Further work will be undertaken on areas of need not covered by the proposed arrangements.

Quality Assurance Rounds, themes and risks report – SQAC received the Quality Assurance Rounds report, SQAC noted good progress made with regards to closing the loop following Quality Assurance rounds, with further ongoing work required.

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.

Full minutes will be available at the November Board.

3. Recommendations

The Board is asked to note the committee's regular report.

Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday 22nd September 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)
	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)
	Adrian Hughes	Deputy Medical Director	(AH)
	Dani Jones	Director of Strategy & Partnerships	(DJ)
	Beatrice Larru	Consultant, Infectious Diseases	(BL)
	Nicki Murdock	Medical Director	(NM)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
	Christopher Talbot	Safety Lead, Surgery Division	(CT)
	Cathy Wardell	Associate Chief Nurse, Medicine Division	(CW)

In attendance:

	Julie Creevy	Executive Assistant (Minutes)	(JC)
21/22/89	Benedetta Pettorini		
	Cathy Umbers	Associate Director of Nursing & Governance	(CU)
21/22/89	Jennie Williams	Head of Quality Hub	(JW)

21/21/85 **Apologies:**

Pauline Brown	Director of Nursing	(PB)
Phil O'Connor	Deputy Director of Nursing	(POC)
Kate Warriner	Chief Digital & Information Officer	(KW)

FB welcomed all members and attendees to the Safety and Quality Assurance Committee (SQAC). FB reminded colleagues that circulation of the SQAC meeting papers had taken place in August 2021, to ensure that committee members were sighted on key issues. FB confirmed that no questions or queries were raised by committee members following receipt of meeting papers.

FB reminded colleagues of the importance of submitting reports in a timely manner. FB referred to the Governance light approach and stated that there are significant detailed reports contained within the meeting pack, and as a result the pack was extremely lengthy, with further thought required for future meetings, in terms of separating reports from background detail in order to streamline the meeting pack.

21/22/86 Declarations of Interest

SQAC noted that there were no items to declare.

21/21/87 Minutes of the previous meeting held on 21st July 2021 –
Resolved: Committee members were content to **APPROVE** the minutes of the meeting held on 21st July 2021.

21/21/88 Matters Arising and Action Log
Action Log
The action log was updated accordingly.

SQAC noted that the Research Update would be deferred until the December meeting.
Transition Update – FB requested whether each division could provide an update on Transition Lead for Divisions.

- UD advised that within the Division of Medicine that all Clinical Directors had been written to in order to request detailed update regarding current Transition position. UD confirmed that 4th October 2021 had been identified with individuals to discuss any barriers or issues relating to transition. UD thanked CT for ongoing support. UD advised that L Brook is keen to work with divisions and divisional leads in order to support Transition.
- LC confirmed that the Community & Mental Health Division had identified a Transition Lead.
- The leads for surgery are to be confirmed

Resolved:- SQAC to receive Transition Update at October 2021 meeting.

Matters Arising
NA advised SQAC that the Covid Vaccine booster immunisation programme is due to commence on 27th September 2021 and staff would be offered a booster 26 weeks after their second dose. The programme will run over a two week period, staff would book online.

Flu Vaccination programme commences from 4th October 2021, and will run for a period of three weeks, with a roaming clinic set up to capture any staff that had not been vaccinated following the second vaccine delivery in November.

Quality Improvement Progress Reports

21/22/89 Quality Priorities Monthly update
BP & JW presented the Quality Priorities Monthly update, which included highlight reports detailing risks and mitigations, key milestones and activities, key learning points and project overview.

The Deep Dive focussed on The Deteriorating Patient. The committee had a good discussion relating to progress and issues. The committee identified the importance of the people element, alongside education and system improvements, with future update to be provided to SQAC regarding the STAT programme. There were no risks to escalate to SQAC.

FB referred to resources in terms of capacity of teams, in order to maintain the delivery schedule and queried whether BP had any concerns regarding service delivery. BP stated that there is a need for operational support. NA stated that he welcomed progress relating to the 3 projects, and stated that it would be helpful for the Quality team to identify needs, during offline discussion, with the aim of quality improvement becoming 'business as usual'.
AB welcomed the next phase of Quality Improvement, ensuring staff are

aware of expectations, and ensuring projects are tracked as appropriate to ensure good practice and clarity of the custodians going forward.

SQAC **NOTED** the clear progress made in all three areas, with strong engagement of teams, together with detailed plans and targets. It was felt there was strong momentum on the 3 workstreams, and the projects associated with them.

FB thanked BP/JW and welcomed significant progress relating to the three strong project streams.

SQAC received and **NOTED** the Quality Priorities Monthly Update regarding Deteriorating Patients, Medication Errors and Parity of Esteem.

21/22/90 Never Event Report Action Plan updates and RCA

NA presented the Never Event Action Plan; Key issues as follows:-
NA advised that a phenomenal amount of work had been completed to date. NA recommended that the Action Plan be closed and removed from the Action Log.

CT advised that a clear and regular biweekly stop before you block audit program is in place. CT & anaesthetic lead review audit results, in order to establish what is working well, and whether any improvements are required. CT thanked colleagues within Theatres and anaesthetic staff for ongoing support. CT also acknowledged and thanked JG for ongoing help and support.

FB queried whether there was any shared learning, CT advised that there had been improved engagement, the simplification of audit, and audit tools had been welcomed.

CT advised that creation of STAT had allowed for increased openness within Theatres. FB welcomed a STAT update at December 2021 SQAC meeting.

Resolved: SQAC received and **NOTED** the Never Event (Wrong Side Block) update, SQAC Noted the progress made on the audit issue with the deployment of the online learning tools, and welcomed an update at December 2021 SQAC meeting regarding STAT programme

Resolved: Committee agreed that this item would be closed and removed from the action log.

SQAC received and **NOTED** the Never Event Update, and **NOTED** that the item would be closed and removed from the action log.

FB thanked NA & CT for update.

21/22/91 CQC Action Plan

SQAC received and **NOTED** the CQC Action plan.

21/22/92 DIPC Exception Report

SQAC received and **NOTED** the DIPC Exception Report.

21/22/93 Safe Waiting List update

SQAC received the Safe Waiting List Update which included an overview of progress made. SQAC NOTED that the CCG have been pleased with the openness and progress, and are therefore no longer monitoring this issue, as

they are satisfied that issues have been/are being addressed.

The committee were provided with an update on the inpatient and outpatient validation progress. The team aim is to conclude validation during October 2021. Validation had identified 187 children who had been waiting over 52 weeks for treatment, (from the 187 patients – 149 patients had already been treated, 27 patients scheduled to receive treatment within 6 weeks; 11 patients awaiting a date for treatment, with 1 Patient choosing to delay treatment.

1 patient had confirmed harm – which related to a child under Ophthalmology who potentially did not receive prescription for spectacles at an earlier opportunity

Good performance had been made regarding clinical IP prioritisation, which is well embedded, with good management and prioritisations of patients. Highest priority patients are tracked in month.

AB advised that there is further work to do regarding monitoring and improvement/high level of training – which would be reviewed at Safe Waiting List Group and Improvement Board.

SQAC **NOTED** the progress plan update, and progress regarding completed actions.

AB expressed thanks to the Safe Waiting list team and colleagues within Brilliant Basics team for ongoing support.

FB thanked AB for Safe Waiting List Update

Resolved: SQAC received and NOTED the Safe Waiting List Update

21/22/94 Assurance ED Activity Monthly Update

SQAC received the ED Activity Monthly Update, which provided an overview of the current position.

SQAC received and **NOTED** the ED Activity Monthly update.

21/22//95 Consent Report

CT presented the Consent Report update and findings of the audit, key issues as follows:-

- SQAC noted the eConsent had gone through several updates within the last 12 months. Training sessions had been delivered to specialties by E-Consent team.
- SQAC **NOTED** that good progress is being made in order to deploy e-consent with the Surgical Division, with the electronic workflow designed to eliminate/reduce issues. Plan to disseminate across departments, in order to align their processes, with future audits pre-set for November and March 2022. Ongoing discussions taking place in order to explore option to use recordings of consent conversations within the patient record.
- Issues of good practice were noted, together with areas for improvement regarding documentation and legibility, abbreviations, consent discussion documentation, ability/offering of patient leaflets, documentation of capacity/competence and correct consent form use in under 18 year olds. SQAC agreed and **NOTED** that consent issue is an issue across the three Divisions, and further work is required in order to ensure good practice across

the organisation, to link to Academy/CPD/Training in the most effective way, and to ensure that all staff who take consent have a good understanding of the Mental Capacity Act.

FB thanked CT for informative update, and referred to the language/ terminology used within Trust forms to ensure that the language is patient centred and reflected a joint/two-way discussion.

Resolved: NM and NA to undertake an offline discussion regarding information leaflets

DJ alluded to involvement of C&YP Forum in order for Consent process to be developed with the involvement of C&YP, and whether it would be possible for a Child/young person to be a champion in terms of consent and ensuring improved patient experience.

CU queried whether there is an intention to disseminate to other divisions. CT advised that he is happy to liaise with Divisional Directors to progress. UD welcomed this for Division of Medicine as they have numerous experimental process which require consent process to be clearly recorded. UD would have an offline discussion with CT & H Corbett.
Resolved: Offline discussion to take place with UD/CT & H Corbett.

RESOLVED: SQAC received and NOTED the Consent Update report

21/22/96 Consent Policy
CT presented the Consent Policy, which through collaboration with Hill Dickinson had been drafted and approved at CQSG. Plans to make this available on the Document Management System (DMS) would be made following ratification at SQAC.

Resolved: SQAC received the Consent Policy, SQAC Noted that the Consent Policy is a working/live document, and agreement was made that any minor amendments to the Policy would be made through the Surgical Division, with the expectation that any major amendments would be presented to SQAC as appropriate.

SQAC APPROVED the Consent Policy

Resolved: SQAC received and APPROVED the Consent Policy

21/22/97 RSV Surge/Winter Planning Report
SQAC received the RSV Surge/Winter Planning Report.

. **Resolved**: SQAC received and **NOTED** the RSV Surge/Winter Planning Report.

Clinical Governance Effectiveness

21/22/98 CQSG Key issues update
NA advised that with regards to the Governance light approach that there had been no CQSG meeting in month, review of meeting papers had taken place, with good progress noted regarding Policies. Some slippage noted in terms of performance, with focus on PALS and Complaints.

SQAC received and NOTED CQSG Key issues verbal update.

21/22/99 NICE Compliance Report, Action Plan & Clinical Audit & Effectiveness Report

CU presented the NICE Compliance Report, Action Plan & Clinical Audit & Effectiveness Report. CU advised that there had been some progress made since the last presentation to SQAC.

SQAC requested more focussed attention regarding the format of the action plan, in order to address outstanding non-compliance.

Resolved: SQAC to receive a focussed update at November 2021 meeting which would clearly articulate progress made.

KB referred to Clinical Audit and queried when colleagues would be in a position to update SQAC on any themes. NA advised that the project plan would be shared at SQAC at November 2021 meeting

SQAC received and **NOTED** the NICE Compliance Report, Action Plan & Clinical Audit & Effectiveness Report.

Resolved: SQAC to receive Project Plan at November 2021 meeting.
FB thanked CU for NICE Compliance and Clinical Audit & Effectiveness update

21/22/100 Patient and family feedback quarterly report

SQAC received the Patient and family feedback quarterly report.
. NA expressed his thanks to P Brown and team for production of the report. NA advised that there had been a decline in patient satisfaction from FFT returns, with further work to do, in order to improve patient satisfaction going forward.

Resolved: SQAC received and NOTED the Patient and family feedback quarterly report

21/22/101 Board Assurance Framework

SQAC received and **NOTED** the Board Assurance Framework.

Resolved: SQAC received and NOTED the Board Assurance Framework update.

21/22/102 Divisional Reports by exception/Quality Metrics

Community & Mental Health Division – LC provided key issues as follows:-

- LC advised that positive impact had been made for staff regarding investment made into the Estate and welcomed continued progress regarding the new build.
- The Division continue to see increased referrals with over 100% increase in Mental Health Referrals. Ongoing work continues with partner agencies and the Local Authority, LC advised that a bid had been supported to CCG for support.
- LC advised that there are currently 2 patients who had been admitted into acute beds who had been sectioned under Section 3 of the Mental Health Act, as these patients have an eating disorder. The CCG are currently supporting the Trust as there are currently no appropriate beds for these patients.

Medicine Division – UD provided an update on key issues as follows:-

- .ED attendance over the last 3-4 weeks had been challenging for the division with attendance at 215-250 patients per day. Division are working closely with colleagues to help alleviate pressures. 2 community pharmacists had been appointed.

Symptom tracker is being reviewed, which aids the identification of patients that should be seen in ED and provides advice on alternative services which can offer support. In conjunction with General Paediatrics, consultants are undertaking clinics to review low acuity patients in order to reduce pressures within ED.

- Mandatory training – Sepsis training is currently low, with J Ashton organising training sessions in order to encourage face to face training.
- Sickness levels had increased, UD queried whether this was as a result of improved recording of sickness on E Roster. MS advised that HR Team are currently reviewing and reconciling sickness data from E Roster.

Surgery Division – CT provided an update on key issues, as follows:-

- CT confirmed that the Division had noted a decrease in medication errors.
- 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.
- Challenges within the Division regarding Theatre Utilisation as the Division are unable to reach above 90% utilisation.
- Division noted a number of 28 day breaches which related to staffing, and Covid cases on the day of surgery.

Committee **NOTED** the pressures across the Divisions within services resulting from high clinical workload, coupled with staffing issues, Covid, sickness etc. FB welcomed Divisional updates and thanked colleagues for updates.
SQAC received and **NOTED** Divisional updates.

21/22/103 PALS & Complaints Quarterly Update

NA presented the PALS and Complaints Quarterly Update and expressed thanks to PB and Complaints Team for comprehensive report, FB echoed NA's comments, key issues as follows:-

- There had been a decrease in formal complaints received during Quarter 1 (33) compared to Quarter 4 2020/21 (53).
- The top reason for formal complaints received in Quarter 1 continues to be treatment and procedures.
- Compliance with the 3 working day acknowledgement for formal complaints is 100% in Quarter 1. Compliance with the internal Trust target of 25 working day response time is 82% in Quarter 1; this is a major improvement on 35% compliance in the previous quarter.
- Two complaints from across Quarter 1 were responded to as stage 2 complaints.
- The Trust has 0 new referrals to the PHSO in Quarter 1. The Trust had received notification of a new case holder with regards to the ongoing PHSO case.
- There has been an increase in the number of informal concerns received during Quarter 1 (378) compared to Quarter 4 2020/21 (271). The main reason for informal PALS concerns is regarding appointments and communication.
- Compliance with the 5 day target to resolve informal concerns is 74%.

LC requested if the graphics within the report could be reviewed and refreshed. NA confirmed that this would be actioned as appropriate within the next Quarterly Update.

SQAC received and **NOTED** the PALS & Complaints Quarterly report.

21/22/104 Any other business

SQAC received Brief ED Quarter 1 MH Attendance Update. LC queried whether the data had been fully validated; UD confirmed that the information had been received from the BI team. LC & UD agreed to undertake an offline discussion regarding the data in

order for SQAC to receive a detailed ED Update for Quarter 1 and Quarter 2 at October 2021 meeting.

Resolved: Offline discussion to take place with UD & LC, in advance of SQAC receiving detailed ED Quarter 1 & Quarter 2 update at October 2021 meeting.

FB referred to update provided at People & Wellbeing Committee meeting on 21st September with regards to the pay offer and potential future industrial action, and the need for SQAC to consider, should that occur, how the risks to access to care would be reflected and mitigated going forward.

21/22/105 Review the key assurances and highlight to report to the Board

Positive updates were received regarding: -

- Quality Priorities – updates on progress for Parity of Esteem and Medication Safety; Deep Dive on The Deteriorating Patient, clear progress in all three areas. 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 with regards to audit issue, with the deployment of online audit tools, agreed action can now be closed.
- Safe Waiting List – progress noted. Board to note that the CCG is no longer monitoring progress, being satisfied the issue has been addressed. The work had now moved from inpatient lists to outpatient lists and will result in confidence and assurance across the board on waiting list management.
- Consent - findings of the audit were presented and key issues which it identified were noted. Good progress being made to deploy e-consent within Surgical Division, with the electronic workflow designed to eliminate/reduce issues. Would 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.
- Consent Policy adopted, as a living document.
- NICE compliance – 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.

20/21/106 Date and Time of Next meeting

20th October 2021 at 9.30 via Microsoft Teams