NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Thursday 16th December 2021, commencing at 9:00am
via Microsoft Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT/STAFF STORY (9:00am-9:15am)							
1.	**21/22/210**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**21/22/211**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**21/22/212**	**9:17 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Thursday 25th November 2021.**	**D**	Read enclosure
4.	**21/22/213**	**9:20 (5 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**21/22/214**	**9:25 (10 mins)**	**Chair/CEO's Update.**	Chair/ J. Grinnell	To provide an update on key issues and discuss any queries from information items.	**N**	Verbal
POST COVID-19 Recovery Plan 2021/22							
6.	**21/22/215**	**9:35 (30 mins)**	**Delivering a Safe Winter; including:** - **Update on Restoration and Recovery.** - **Deep Dive into ED.** - **Update on People Issues.** - **Flu Vaccine update**	A Bateman U. Das M Swindell M. Swindell	To provide an update on the development of operational plans for the 2021 winter period. Deep Dive into performance data. To receive an update on workforce issues. To provide an update on the uptake of the flu vaccine.	**A** **A** **A** **A**	Presentation Read report Presentation Presentation

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
7.	**21/22/216**	**10:05 (5 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
8.	**21/22/217**	**10:10 (5 mins)**	**Nurse Staffing Assurance Report.**	N. Askew	To receive the staffing model for PICU.	**A**	Read report
9.	**21/22/218**	**10:15 (5 mins)**	**Q2 Mortality Report.**	N. Murdock	To receive the mortality report for Q2.	**A**	Read report
10.	**21/22/219**	**10:20 (5 mins)**	**Q2 DIPC Report.**	B. Larru	To receive the DIPC report for Q2.	**A**	Presentation
11.	**21/22/220**	**10:25 (5 mins)**	**Mental Health Services Update.**	L. Cooper	To receive a Mental Health services update.	**A**	Presentation
12.	**21/22/221**	**10:30 (15 mins)**	**Divisional updates:** - **Medicine.** - **Community & Mental Health.** - **Surgery.**	U. Das L. Cooper A. Bass	To receive Divisional updates by exception.	**A**	Read report
The Best People Doing Their Best Work							
13.	**21/22/222**	**10:45 (10 mins)**	**North West Wellbeing Pledges Action Plan.**	M. Swindell	To receive and approve the North West Wellbeing Pledges Action Plan.	**D**	Presentation
14.	**21/22/223**	**10:55 (5 mins)**	**People and Wellbeing update; including:** • **BAME Inclusion Taskforce update.**	M. Swindell C. Dove/ M. Swindell	To receive an update on the Alder Hey People Plan. To receive an update on the work conducted by the BAME Inclusion Taskforce.	**A** **A**	Read report Verbal

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Sustainability through Partnerships							
15.	**21/22/224**	**11:00 (10 mins)**	**Collaborating for Child Health: Improving CYP Life Chances and Tackling Health Inequalities**.	D. Jones	For discussion and approval.	**D**	Read report/ presentation
Game Changing Research and Innovation							
16.	**21/22/225**	**11:10 (10 mins)**	**Memorandum of Understanding:** • **North West Clinical Research Facility Alliance.** • **University of Liverpool/Alder Hey Children's NHS FT.**	J. Chester	For discussion and approval.	**D**	Presentation
Strong Foundations (Board Assurance)							
17.	**21/22/226**	**11:20 (20 mins)**	**2021/22 H2 Plan; including:** • **Financial update, M8, 2021/22.** • **Capital Plan update.**	R. Lea	To provide an overview of the H2 plan and the position for Month 8.	**A**	Presentation
18.	**21/22/227**	**11:40 (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

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19.	**21/22/228**	**11:45 (10 mins)**	**Board Assurance Committees; report by exception:** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 15.12.21.** - **Approved minutes from the meeting held on the 22.11.21** • **Safety and Quality Assurance Committee:** - **Chair's verbal update from the meeting held on the 15.12.21** - **Approved minutes from the meeting held on the 24.11.21.**	I Quinlan F. Beveridge	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes
Items for information							
20.	**22/22/229**	**11:55 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
21.	**21/22/230**	**11:59 (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, 27th January 2022, 9:00am-1:00pm, via Microsoft Teams.							

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

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
CQC Action Plan	E. Saunders
Financial Metrics, M8 2021/22	R. Lea
DIPC Monthly Exception Report	B. Larru
Campus Development Update	D. Powell

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 25th November 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)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Acting Chief Executive	(JG)
	Mrs. A. Marsland	Non-Executive Director	(AM)
	Dr. F. Marston	Non-Executive Director	(FM)
	Mrs. M. Swindell	Director of HR & OD	(MS)
In Attendance:	Mr. A. Bass	Director of Surgery	(ABASS)
	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Mr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. M. Flannagan	Director of Communications	(MF)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. R. Lea	Acting Director of Operational Finance	(RL)
	Mrs. C. Liddy	Director of Innovation	(CL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Observing	Dr. L. Crabtree	Project Manager, CYP Transformation Programme.	(LCr)
	Prof. J. Jankowski	Member of the public.	(JJ)
	Ms. L. Smith	Governor	(LS)
Apologies:	Dr. N. Murdock	Medical Director	(NM)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	Mrs. L. Shepherd	Chief Executive	(LS)
Patient Story	Ms. D. Cooke	Patient's Grandmother	(DC)
Item 21/22/186	Dr. B. Larru	Director of Infection Prevention Control	(BL)
Item 21/22/189	Dr. L. Crabtree	Project Manager, CYP Transformation Programme	(LCr)
Item 21/22/192	Dr. I. Sinha	Consultant in Respiratory Medicine	(IS)

Patient Story

The Chair welcomed Debbie Cooke who was invited to November's Trust Board to share her grandson's story.

Lisa Cooper advised that over the last two and a half years the Trust has been on a significant improvement journey, particularly in the diagnosis of ASD and ADHD. One of the real issues and challenges that was brought to light by the Parent and Carer Forum was the lack of

acknowledgement by Alder Hey of a small group of children and young people (CYP) who are often diagnosed with ASD but also exhibit pathological demand avoidance (PDA) profiles and personalities and it was reported that there was a real reluctance from the organisation's medical community to look at the development of a pathway for this. However, the Trust worked with the Patient and Carers Forum and the Education and Social Care Forum and have commissioned a joint statement which is now on the Trust's website which acknowledges the presence of PDA in a diagnosis of autism. It was pointed out that this cohort of children is small but the difference that this diagnosis and recognition has made is really significant to these children. The Board was advised that it took a huge piece of work to achieve this position which included some challenging conversations with the medical community but the huge impact that this will now have on Roman at a very young age is really positive and will help him become the amazing young person and adult that he is destined to be.

Debbie provided an overview of Roman's journey in the education system from when he was a young age. It was reported that when he was two and a half there were concerns raised by staff at the nursery he attended with regard to his interaction with other children. The staff had to work on a one to one basis with Roman as he could be aggressive and make allegations about staff members. When Roman started school at the age of four within three days the school had made contact to advise that they had concerns with Roman's behaviour. This started a pattern, after the first two weeks Roman was only attending school on a half day basis and the school decided to arrange for an Educational Psychologist to conduct an assessment where concerns were raised about Roman having PDA. Roman had been in main stream school for just six weeks and the day the family received the report the school advised that they were looking to permanently exclude him.

Debbie informed the Board of the family's shock and the quandary that they were faced with in terms of Roman's future education. The family opened an EHAT and contacted SEND who looked into the available options for Roman which were mainly pupil referral units that dealt with 'naughty' children. Eventually a place was found for Roman at Everton Nurture Base which was set up by an ex headteacher who wanted to support children like Roman who were being excluded from mainstream school. Roman remained at this school until recently and it was during this period that Roman's family realised that he wouldn't return to mainstream school and it had become apparent that his needs were different from other children with autism.

Debbie advised that the family has adapted to meet Roman's demands in order to keep his anxiety low and have looked at alternative schools where there is an understanding of PDA, but the options have been limited. Debbie pointed out that a diagnosis doesn't change anything for Roman but from an educational perspective it is really important. The family has identified an independent school that have experience of PDA, but it was very expensive, and this has led them down a tribunal route with the local authority who suggested an alternative school that wasn't as expensive which the family didn't agree was right for Roman.

It was pointed out that in order to progress with the tribunal, it was really important for Roman to be diagnosed with PDA. Debbie Described Roman's journey with Alder Hey from a clinical perspective which commenced in November 2019. In February 2021 Roman was eventually referred onto an autism pathway, which as Debbie pointed out, the family thought he was already on. Contact was made with Lyndsey Boggan who arranged for Roman to have an assessment in July 2021 for autism and arranged for a separate referral to take place so that Roman could be assessed for PDA. Debbie thanked Lyndsey for her support during the overall diagnosis process and ensuring that the assessment was concluded in time for the tribunal as without this Roman wouldn't have a place in a new school which he is starting today.

Debbie referred to the sensory diet that Roman requires and pointed out that Alder Hey don't have access to this type of facility. It was felt that it would be really useful for families if Alder Hey did have this type of service.

The Chair thanked Debbie for sharing Roman's story with the Board and felt that there are a number of areas that the Trust needs to look to bring about change in terms of the patterns of referrals, the delays in appointments and different resources such as a sensory facility. On behalf of the Board, the Chair wished Roman and his family well.

21/22/181 Welcome and Apologies

The Chair introduced the Trust's new Non-Executive Director, Garth Dallas and welcomed everyone to the meeting. The Chair noted the apologies that were received.

21/22/182 Declarations of Interest

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

21/22/183 Minutes of the previous meetings held on Thursday 28th October 2021
Resolved:
The minutes from the meeting held on the 28th October 2021 were agreed as an accurate record of the meeting.

21/22/184 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 21/22/65.1: *Approach to End of Life Care when there is a dispute (Look into agreeing a process to provide families with feedback following an end of life decision)* – A feedback and Standing Operating Procedure tool has been drafted by the Trust and tested by two families who have sadly become bereaved. The Trust is looking to implement this tool in January. **Action Closed**

Action 21/22/156.1: *Alder Hey in the Park Campus update (include a regular update in the Campus report on the cohort of staff who are moving into the Histopathology building to ensure that the Board is sighted on the final destination in terms of rehousing these staff members. Provide an update in November's report to explain why there is a Police evidence suite based on the children's Tier 4 inpatient unit)* - The Trust has sent a response to NHSE regarding access and entrance to the evidence suite that is included in the Trust's Tier 4 inpatient unit. It was pointed out that the evidence suite accommodates victims of crime and not perpetrators of crime. It was agreed to close this action once the Trust has received a response from NHSE. **ACTION TO REMAIN OPEN**

21/22/185 Chair and CEO's Update.

The Chair advised that November's Board agenda reflects the areas of work that the Trust is focussing on due to the operational issues/challenges that are being experienced and the changes to the external landscape. The Chair drew attention to the training session that Board members participated in on the UN's Convention on the Rights of the Child. It was felt that over the coming months the Board must think about how the commitment it made on that day will influence the way in which Alder Hey engages with children and young people (CYP), designs its policies and delivers services. It was reported that work is taking place to look at how CYP

express their concerns or raise a complaint about the services they are receiving care from.

John Grinnell referred to the tragic bombing incident that occurred outside Liverpool Women's Hospital (LWH) on Remembrance Sunday and advised that on behalf of the Board and Alder Hey the Trust sent its best wishes and support to LWH, which were greatly appreciated. It was reported that security measures were implemented at Alder Hey following the incident to ensure patients, families, staff and visitors were safe during their time with the Trust, and the staff briefing on the 24.11.21 concentrated on how communities come together when these situations occur. It was confirmed that further reflection will continue on this matter going forward.

Attention was drawn to the relentless pressure that the hospital is under and it was felt that it is important as a Board to recognise the outstanding work of Alder Hey's workforce in terms of their resilience and work ethic given the challenges that they are facing on a daily basis.

The Board was advised of the forthcoming changes that are taking place in external organisations; the local ICS has appointed Graham Urwin as its CEO, NHS X and digital are to amalgamate with NHSE/I, and Health Education England (HEE) are to become part of NHSE/I.

It was reported that a number of Executive Directors received an update on the outcome of Wave 1 and Wave 2 of the Brilliant Basics (BB) Programme, with staff providing feedback on the improvements that have been made. It was felt that the work that has taken place is really impressive and a suggestion was made in terms of inviting teams to a future Board meeting to enable them to showcase their work.

A number of teams were shortlisted for HSJ awards and received recognition for the work that has been done, particularly the CYP Mental Health As One Platform. The Trust is also being recognised for its leadership role in the CYP accelerator programme and the work that is taking place on the recovery of children's services. It was announced that the Trust has received HIMMS level 7 accreditation following an assessment by two national teams on the 16th and 17th of November. John Grinnell congratulated the team on their success and thanked Kate Warriner for her leadership on achieving this position.

Resolved:
The Board noted the Chair and CEO's update.

21/22/186 Post Covid-19 Recovery Plan 2021/22

Delivering a Safe Winter

The Board was advised that the purpose and aim of the Autumn and Winter Plan is to keep CYP and staff safe during a period of really high demand. A number of slides were submitted to provide an overview of the Gold Command operation going forward, the deeper dive into outstanding governance for safe care, timely emergency care, maintaining access to planned care and keeping staff safe. The following information was shared:

- *Gold Command Approach* – It was reported that Gold Command will track key workstreams in order to detect areas that are escalating under pressure. The six key aspects of the plan are:
  - Outstanding governance (*to keep staff and CYP safe*).
  - Staff PICU to meet demand and prevent out of region transfers.

- Provide timely and emergency care to CYP.
- Good patient flow to achieve timely admission from the Emergency Department (ED) to wards,
- Maintain access to planned care.
- Keep staff safe.
- The Board was advised of the reasons behind the rag rating of the pressure/escalation score and the trend.

- *Outstanding Governance* – Nine key areas have been identified that relate to oversight, assurance and governance processes that will keep staff and CYP safe if delivered well. In terms of actions and milestones delivered; a Brilliant Basics approach has been taken to focus on what matters, and clear expectations of what is required across all metrics have been shared with Divisional and Corporate teams. There is to be an increased oversight and assurance via the reinstatement of CQSG which will report to SQAC, PAWC and ARC. There will also be a focus on getting the message out to staff about the importance of each metric on safety.

  Next steps (*actions within the next 30 days to delivery improvement):*
  - Each metric will be incorporated into the winter scorecard for easy access to current state and oversight.
  - CQSG will be focussed on all metrics and improvement plans.
  - Divisional review of all open serious incidents actions and a focus on closing them down.
  - Key messaging from the Patient Safety meeting and other comms channels.
- *Provide timely urgent and emergency care to CYP* – It was reported that ED has been under immense pressure and experienced a number of challenges:
  - October attendances were 16.5% higher that October 2019.
  - Relative to September, performance has reduced to 72.5%, although c.400 additional CYP were treated within 4 hours.
  - High 'left before seen' rates have been risk assessed and rapid improvements are being tested to identify patients suitable for treatment in community settings.
  - Increase in percentage of patients admitted to hospital and highest volume of monthly admissions in 2021 which has been driven by respiratory infections.
- The analysis of the Trust's current performance in terms of time to clinical assessment indicates that it is at 2h 46m. The standard that the organisation wants to work to is 60 minutes. In order to achieve this the Trust will need to support an increase in staff availability and new ways of working. The following actions and milestones have been delivered in response, to date:
  - Alder Hey and other hospitals across Cheshire and Merseyside (C&M) have come together to establish a 111 Paediatric clinical assessment service which will enable NHS 111 call handlers to direct patients to a paediatric specialist rather than signpost to ED. An evaluation of the impact of this service will take place in due course.
  - 'Doctor in a Box' rapid clinical assessment of patients with minor illnesses by a senior clinician.
  - Pharmacy service extended to seven days.
  - Additional hours to increase clinical cover.
  - Next Steps:
    - Prioritise rapid assessment and treatment, to be delivered Monday to Friday from the 23.11.21.
    - Extensive application of streaming at triage from the 30.11.21.
    - Health visitor service in ED, in partnership with Mersey Care from the 6.12.21.

  - System check to go live on the 13.12.21.

- *Maintain access to planned care:*
  - All outpatient recovery as at the 31.10.21 is 98%. It was pointed out that the outpatient recovery data is provisional at the present time as the Trust is awaiting final verification data assurance checks.
  - Elective inpatient and day case recovery as at the 31.10.21 is 103%, with elective recovery being driven by high day case performance.
  - Radiology as at the 31.10.21 is 95%.
  - It was reported that a strong recovery performance continues despite high hospital bed occupancy.
  - The Board was advised of the latest position for long waiters which shows an increase during one week at the beginning of November. It was pointed out that this is not a trend, but a one-off occurrence owing to the conclusion of the safe waiting list work. It was reported that the Trust is expecting to reduce the long waiting list by a third over the next three to four months as a result of the Recovery Programme and has committed to having zero patients waiting 104 weeks for treatment.
  - It has been recognised that the Trust will have to innovate and work differently to provide safe care in a period of high demand. Examples of alternative ways of working were shared; 1. Pilot of a new electronic video and image capture system which was funded by the Accelerator Programme and has received positive feedback from clinicians. 2. Patient-initiated follow-up care which has 50 patients under this method of care. It is follow-up care based on needs and the goal is to deliver great patient experience and reduce overdue follow-ups. It was pointed out that this method of care is for lower risk patients.
- *Keeping staff safe* – It was reported that the Trust's overall goal is to keep staff safe with an emphasis on staff availability during the winter period. It is important to make sure staff feel safe and cared for thus enabling the workforce to carry out their respective roles. There has been a big area of focus on staff taking breaks and having access to hot food and drinks. The Trust has implemented a number of initiatives to support this area of focus; 'Wingman on Wheels' which is a mobile refreshment service that staff can access and a SALS PALS service that is being piloted in ED. The Board was advised that all of these activities are being monitored via the Brilliant Basics steering groups.
- The Staff Availability Winter Plan focusses on three areas; PICU, Theatres and ED. A detailed action plan was submitted to Gold Command to highlight what needs to be done in terms of taking a different approach and having a bespoke recruitment campaign for these three areas. The actions to address this approach are:
  - Bespoke recruitment campaign for the three areas.
  - Focus on Return to Work Interviews (>90%).
  - Focus on improving recruitment metrics including 'Time to Hire' (<28 days stretch target).
  - Review of the Retire and Return Policy.
- The Staff Wellbeing Winter Plan looks at an overall holistic approach to wellbeing and is being monitored via the Health and Wellbeing Board. Areas of focus to create a culture of wellbeing are:
  - Improving personal health and wellbeing.
  - Professional wellbeing and support.
  - Data insights.
  - Environment.
  - Managers and leaders.
  - Fulfilment at work.
  - Relationships.

- *Incident at Liverpool Women's Hospital (LWH)* – The Board was provided with an update on the incident that occurred outside LWH, and data was shared in relation to UK terror incidents over a period of time ranging from 1970 to 2021 and UK threat levels. Following the incident, the Trust implemented a number of initial actions to ensure the safety of patients, families and staff visiting Alder Hey and clear staff messaging was circulated to the workforce. It was reported that the Trust is in the process of reviewing its current on call arrangements and will review its EPPR training and major incident plans in January 2022. Specific consideration is being given in terms of plans relating to terrorist activity, in Q4.

The Chair felt that the Trust has made progress as a result of the actions that are being taken to address the organisation's pressures/challenges and drew attention to the comprehensive system approach that is being taken too. On behalf of the Board, the Chair acknowledged the extent to which everyone has been trying to find solutions in a variety of different ways. It was also pointed out that the work that is taking place in terms of wellbeing, recruitment and retention is absolutely vital when looking to recruit staff and should give Alder Hey a slight advantage when competing for nurses. The Chair referred to the incident that occurred outside LWH and felt that it is really timely that Alder Hey is reviewing its current plans and giving consideration to plans relating to terrorist activity. This will enable the Trust to conduct its own analysis and ensure that the plans in place fit with what's happening across Merseyside and the emergency services.

IPC Update

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

- It was reported that there have been two cases of C. difficile in immunocompromised patients. An RCA has been conducted for both cases but only one case was deemed as a lapse of care as detailed in September's report.
- The Covid-19 staff booster campaign commenced on the 27.9.21 for a 2- week period and 2340 doses were administered; 2337 to staff and 3 to patients.
- The staff influenza vaccination campaign commenced on the 11.10.21 for an initial 3-week program. A total of 2204 vaccines were administered both on site and in three community hubs. It was reported that the uptake of the flu vaccine is approximately 60% but further figures will be provided once the Trust has a complete set of data. It was pointed out that the uptake for the Flu vaccine is lower than the Covid-19 vaccine.
- *Fit Testing* – The Trust's overall compliance as at the 31.10.21 was 95%.
- The Trust has seen an increase in patients being admitted with Covid-19, with some requiring treatment in ICU. Approximately 10% to 15% of staff have tested positive for Covid-19 and whilst it has been suggested that there has been a decrease of RSV in all regions, there has been an increase in other respiratory viruses.
- The Board was advised that Public Health England has published new national IPC standards for the management of all respiratory viruses. As a result of this the Trust will need to change its practices therefore a discussion will take place with the members of the Clinical Advisory Group (CAG) to review this matter. It was reported that Alder Hey has invited the Director of Infection, Prevention and Control from Imperial College London, Jon Otter, to speak to colleagues about how the Trust can adapt its practices to meet the new guidance.

Attention was drawn to the new guidance which advises on the wearing of masks by all, keeping a 2 metre distance, segregating patients with respiratory symptoms, and the use PPE; change to the way gloves and aprons are used with a focus on hand washing, and more use of airborne PPE. Beatriz Larru informed the Board that an update on the outcome of the discussion at CAG re the impact of the new guidance will be provided during December's meeting.

The Chair pointed out that there are going to be some significant challenges as a result of the changes to the guidance, particularly in terms of the segregation of CYP with respiratory conditions. With regard to the Flu vaccine uptake, the Chair queried as to whether the Trust needs to focus on the campaign with support from HR and Comms. It was reported that work is taking place to acquire more granular data to enable the Trust to target those who haven't had a Flu vaccine to date.

Nathan Askew advised that work is ongoing at the present time with digital colleagues and the national team to obtain data for those who have been vaccinated elsewhere to gain an overall picture. It is expected that figures will increase, and further information will be included during the IPC update in December. On behalf of the Trust Nathan Askew thanked Beatriz Larru for her leadership on IPC.

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

21/22/187 ICS Development Update

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

- What's happening in the system:
  - ICS Development and Design Framework published in June 2021.
  - 2nd reading of the Bill on the 14.7.21.
  - Interim C&M ICS leadership.
  - Development of Provider Collaboratives and Place Based Partnerships.
- White paper themes:
  - Collaboration.
  - System working.
- What's happened in the last month nationally and regionally:
  - *Children's Hospital Alliance:*
    - Move to a delivery model from April 2022 signed off.
    - Builds on Paediatric Accelerator which ceases in March 2022.
    - Membership model.
    - Potential pre-curser to CYP Collaborative (mid to long-term).
  - *Specialist Commissioning:*
    - Ongoing lack of clarity re transition to ICS and what this means for delegation of Specialist services.
    - NW Women's and Children's Programme Board; High Dependency Care (review), Neonatal Care (review) and surgery in children (new models of care).
- What's happened in the last month:
  - Graham Urwin has been appointed as the new ICS CEO.
  - ICB Constitution – Consultation re two additional Board members (Alder Hey supported).
  - Deep dive into CYP transformation at the ICS Board.

- ICS Comms Leadership Group established.
- ICS Green Lead - Alder Hey connected for system-wide approach.
- H2 downside for Specialist Trusts.
- NHSE/I webinars to take place on finance, risk, etc.
- CMAST provider collaboration – CEO development DoS group.
- LDMHC provider collaboration – Developing lead provider thinking.

- What's happened in the last month locally; One Liverpool and Sefton Partnership governance ongoing, Place-based maturity assessments, Specialist Trusts concerns raised and CCG 'close down' commencing.
- What's planned for next month; top-level system engagement/activities.
- Next Steps:
- A one hour time out development session post December's Trust Board in order to have an open discussion on emerging questions and share the new guidance for NEDs on provider collaboratives.

The Chair thanked Dani Jones for her leadership and hard work on this complex matter. The Chair drew attention to the long and short-term risks in relation to the transformation of the system, especially from a financial perspective and the uncertainty relating to jobs in external organisations. It was felt that the Board should recognise these risks and be mindful of the impact that this may have on the Trust.

Resolved:
The Board noted the ICS development update.

21/22/188 Alder Hey in the Park Campus Development Update

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

- *Relocations* – It was reported that the fit out at Liverpool Innovation Park is now complete and staff are commencing to move into the premises. Work is also taking place on the Histology building to enable Corporate staff to move out of the old Catkin building.
- *Schemes* – Following work with two short listed bidders for the new Neonatal development contract. It was confirmed that Galliford Try was the Trust's preferred bidder for the project. The tender received from Galliford Try puts the Trust back into a position where it is able to progress with the scheme. The Trust is also in the process of finalising and signing off the design for Paediatric Assessment Unit to enable the scheme to progress. The construction of the Catkin Centre and Sunflower House is progressing well and on track to open in February 2022.

  Work is still taking place to explore the options that are available to the Trust in terms of the potential facilities for use by Alder Hey on the North East Plot, the construction of a science/research and office building and agreeing the plans for the nursing home. It was confirmed that a business case is to be compiled and submitted to the respective groups/Committees in early January 2022 for approval.

- *Park Reinstatement* - A proposal has been developed via partners and Capacity Lab to look at the establishment of a Hub in the park which would form a basis for a café, amenities and social prescribing. It was reported that the Trust is in the process of drawing up a bid ahead of submission to Sport England. Discussions are to take place with Liverpool City Council about the

bid and the suggestions that have been made in terms of creating revenue for the park and running it with community input.

David Powell advised of the tragedy that occurred on the 24.11.21. On behalf of the Board, the Chair asked for the Trust's condolences to be sent to Galliford Try and onwards. The situation was a real shock for all concerned and it was queried as to whether contact should be made with the Estates team via SALS to offer support. Fiona Marston advised that part of the Wellbeing Guardian process is to ensure that the organisation has the right procedures in place to support staff and anyone affected by an incident like this. It was pointed out that this area of the action plan is still evolving, and it was agreed to discuss this matter further outside of the meeting.

21/22/188.1 Action: MS/FM and Jo Potier

Shalni Arora referred to the contract for the new Neonatal Unit and queried as to whether the Trust will have to wait for approval from CEDEL before entering into a contract with the preferred bidder in January. If this is the case, will it affect the timing for the contracts that that the Trust is negotiating and looking to enter in the new year?

It was reported that the construction of the new Neonatal Unit is incorporated in the Trust's 2021/22 Capital Plan as funding has already been spent on design and costs that the organisation has incurred. This area of work will be included as a 'must do' in the 2022/23 Capital Plan as the Trust will be in contract by the end of March 2022. The key factor is to ensure the contract is in place and release funding in 2021 so that it can continue into 2022.

Shalni Arora queried as to whether there is a risk that CEDEL could make the Trust cut its budget after committing to a contract. The Board was advised that the C&M ICS is taking the view that any work that has been committed to contractually will be top priority. It was reported that the Trust is working closely with C&M on this matter and also conducting internal work on its 5 year Capital Plan with a focus on 2022. It was agreed to submit the Trust's Capital Plan in December/January.

21/22/188.2 Action: RL

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

21/22/189 Cheshire and Merseyside Children and Young People Transformation Programme Update.

The Board received an adapted version of the successful presentation that was submitted to the ICS Board on the 9.11.21, in order to provide an understanding of the Cheshire and Merseyside CP Transformation System Programme, the Trust's roll in the programme as hosts, contributors and active players. Share the latest data on a range of outcomes for CYP across the system and give an overview of how the system and the Trust is working to address inequalities across four key priority areas. Information was shared on the following areas:

- Case for change:
  - Health inequalities.
  - Impact of Covid-19 widening health inequalities.
- Why it matters.
- Programme development and key priorities:
  - Health weight and obesity.

  - Respiratory and asthma.
  - Learning difficulties and autism
  - Emotional wellbeing and mental health.
- Parent Champion Programme.
- Stakeholder engagement

The ask for Alder Hey is to address the needs of Children and Young People in Cheshire and Merseyside by;

- Being advocates for the programme.
- Recognise the importance of Alder Hey as an anchor institution for CYP and the programme.
- Promote excellence in delivery at Alder Hey, supporting improvement where needed.
- Promoting excellence across the ICS by being an enabler for broader system improvement.
- Recognise ICS governance of the programme and receive updates on a six monthly basis.

The Chair thank Dani Jones and Liz Crabtree for sharing the presentation with the Board and pointed out that there are lots of challenges as well as opportunities as a result of the work and collaboration that has taken place.

John Grinnell felt that the presentation was outstanding as are the plans to address health inequalities across C&M. Attention was drawn to the importance of the Trust supporting the programme whilst taking into account what it means for Alder Hey as an organisation as it starts to think about its 2030 vision and the direction of resources.

Fiona Beveridge drew attention to the opportunities of the transformation programme in terms of looking at how the programme can become a central strategic driver Trust wide, aligning R&I with the health inequality agenda, having system wide workforce planning conversations and the possibility of paediatric training in a number of specialisms to support key priorities, etc. Fiona Beveridge pointed out that the outcomes for children across C&M will decide upon the adults they become and felt that there are many opportunities that will support the long-term changes that need to be made to give this issue attention.

Shalni Arora queried as to whether there are any resources in place to support the programme and asked if the Trust is looking towards developing a resource plan that can be built into the organisation's strategic plan. Dani Jones provided an overview of the transformational funding that has been received for 2021/22 and the infrastructure that the organisation will be running the programme from. It was reported that the resource reaches further afield as the Trust has put money into the programme to fund multi-agency leadership for each of the four workstreams. The Executive Team has also made a decision to underpin some of the key roles to ensure continuity of the programme. It was reported that there are opportunities for funding via NHSE which the Trust has submitted an expression of interest. The Board was advised that a presentation will be submitted during December's meeting with regards to Alder Hey's position within the system around health, inequalities and prevention of which there is little resource for.

Fiona Marston and Garth Dallas offered their support and asked that they receive further information as the strategy develops in order to gain an oversight of what needs to be done to become a good advocate in the environments that they work, thus offering support in the best way. Adrian Hughes drew attention to the

expertise and connections that the Trust's NEDs have and felt that it would be beneficial to engage with them in terms of guidance and support.

The Chair felt that there is huge support from the Board for the CYP's Transformation Programme and the work that is being done, but noted the Trust's challenges in terms of how it supports the programme and the work that is taking place whilst ensuring it fits in with the organisation's strategic priorities.

Resolved:
The Board agreed the recommendations required to address the needs of CYP in C&M.

21/22/190 Serious Incident Report

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

- *StEIS Reference: 2021/20934* - There was one serious incident reported in October that related to a delay in treatment. It was confirmed that further detail will be provided in November's Serious Incident report.
- There were zero Never Events reported in October 2021.
- *StEIS Ref: 2021/1899* - There was one investigation closed in month that related to the unexpected death of a complex patient in HDU who had a very rare genetic condition.

Kerry Byrne felt that the Serious Incident report that is submitted to the Board requires further information as a lot of the detail has been reduced to its simplest form. It was reported that a meeting is going to take place to review the level of information that is provided in the report in terms of Board versus SQAC, and it was confirmed that a more detailed report will be provided in December/January.

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

21/22/191 Q2 PALS and Complaints Report.

The Board was provided with an update and assurance on the performance against complaints and PALS in Q2 2021/22, a thematic analysis of the top reasons for complaints and PALS, the action taken as a result of concerns raised, and proposed developments planned for 2022. The following points were raised:

- The number of complaints remains relatively static in the organisation in terms of formal complaints, with the two key areas being around communications and alleged failure in medical care or disagreement with care.
- In Q2, 95% of formal complaints received were acknowledged within 3 working days, with 33 (85%) being acknowledged on the same day. This is a sustained improvement in performance over the last 12 months towards the Trust target of 100%. The Trust has also improved its compliance around the 25 day response target with 19 of 39 (46%) complaints received in Q2 being responded to during the same quarter.

- Two second stage complaints have been received in 2021/22 to date. At the time of reporting 4 out of 77 complaints responded to in 2021/22 have resulted in a second stage complaint.
- There were 384 informal concerns received during Q2 2021/22, compared to 280 in Q2 2020/21. The PALS and Complaints teams endeavour to respond to concerns within the 5-day timeframe to try and obtain a quicker resolution for CYP. The KPI of 100% of concerns responded to within 5 days in Q2 was not met, with 63% of PALS reported to be concluded within this time period. The Board was advised that this is an area of absolute focus moving forward.
- It was reported that the Quality Hub in association with the Patient Experience Team are going to review the PALS and Complaints report to look at improving the data thus making it more meaningful.
- A significant improvement for families wishing to raise an enquiry or needing support has been through the establishment of the Family Support Helpline initially set up as a pandemic helpline. In Q2 there were 1,391 calls received this is a decrease of 283 compared to Q1 (1674). The predominant reason for calling is in relation to visiting arrangements which have been restricted due to COVID regulations.

The Chair queried as to whether the organisation needs to do more in terms of communications for families, especially around visiting arrangements. It was reported that the Trust's website has recently been updated but further work is required with regards to communicating this to families.

Resolved:
The Board received and noted the PALS and Complaints report for Q2.

21/22/192 UNCRC letter: A Child's Right to Clean Air.

The Board received a presentation on air pollution in association to child health, and Alder Hey's approach to a fatal problem. A number of slides were shared that provided information on the following areas:

- A recap was provided on the 'Freedom to Breathe' campaign and the letter that was sent to the United Nations to try and get the right to clean air written into the UN Convention of the 'Rights of the Child'. This was a global initiative and Alder Hey was one of 62 signatories who signed the letter.
- It is felt that inequalities should be seen through a human rights lens therefore the healthcare community is going to conduct work to enshrine the rights to various aspects of a happy and healthy childhood into UK laws so progress can be made.
- It was reported that there are high levels of avoidable mortality and morbidity in certain parts of the country, one of the drivers for this is the environment. As data has become more sophisticated mapping of respiratory and morbidity in children has been conducted using routinely collected business intelligence data.
- *What has been done at Alder Hey*? – It was reported that the Respiratory team has prioritised this area of work nationally and internationally as leaders in the field when it comes to air pollution. It was pointed out that children are particularly at risk from air pollution related problems for various reasons, for example, they are at the right height to breath in fumes from vehicles, they breath proportionally more air than adults and their bodies are still developing, they have decades of living with problems of air pollution and their immune system is less equipped to deal with the problems of air pollution.

- *The Injustice of Air Pollution* – The Board was advised that people who live in poverty generate minimum air pollution whilst breathing in the most and benefit the least from environmental policies around air pollution. Alongside this is indoor pollution which can be three and a half times worse than outdoor air pollution. Exposure to both is disproportionately unhealthy therefore tackling them both together is really important.
- *Respiratory Department* - The Respiratory Department was asked by the Royal College of Paediatrics and Child Health (RPCH) to write the national strategy to help healthcare institutions tackle health inequalities. The framework was compiled and incorporates four key priorities; 1. Prioritise the urgent reduction of child health inequalities. 2. Harness and use knowledge in a better way. 3. Develop health services from the beginning that reduce inequalities. 3. Develop a society that enables children to live their best life. The team has conducted a lot of work that shows the deeply ingrained structural problems that lead to poverty and thus impact on child health.
- *Clean Air Clinic:*
  - This is the first Air Clinic of its type in the world for children where there are concerns that air quality is worsening respiratory problems.
  - There is a process in place for compiling history and data in terms of the house and the area that people live in.
  - Mapping takes place of the child's respiratory morbidity (*acutely/chronically*) with levels of air pollution compared to legal frameworks.
  - The goal is to empower families to make changes and build data to advocate at local Government level.
- Contact is made with councils and landlords to try and make things better for some of the families who are living in really poor conditions. The Board was provided with an overview of the support that was given to one particular family that went to court to fight for the right of their child to breath clean air that would have concluded in a risk to health and life expectancy if nothing was done about the environmental issues of a local landfill.
- It was felt that advocacy and action go hand in hand and the right to clean air should be captured as a human rights issue.

The Chair thanked Professor Ian Sinha and Dr Sarah Mayell for the remarkable leadership and work that is taking place to improve the lives of many families and CYP. The stories that were shared with the Board really highlighted the issues that deprivation and poverty cause to health.

Board members commended the work that has been taking place and a discussion ensued about how the organisation can extend this work to make sure other children in similar circumstances have the same opportunities. Ian Sinha felt that it is necessary to work with the community as the most experienced people are the mums who talk about the issues they experience on a daily basis and by engaging them the Trust will learn how to address problems. Attention was drawn to a pilot that is being run by the clinic as a result of a grant from NHSE, where mums are placed in Children's Centres in the most deprived areas to talk to expectant or new mums about breastfeeding, smoking and community initiatives.

It was queried as to whether the organisation should test itself against the framework that was compiled for the RCPCH, to determine whether Alder Hey positively affects the lives of others. Ian Sinha reported that the Respiratory Department has conducted this exercise and found that further work needs to take place on advocacy therefore the team are looking to do things differently in order to make changes. Ian Sinha felt that it would be beneficial for the organisation to do this Trust wide.

The Chair felt that the organisation needs to look at how it approaches advocacy and give some thought in terms of how the Trust would roll out the model used by the Respiratory team.

Resolved:
The Board noted the presentation on a 'Child's Right to Clean Air.

21/22/193 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.

Urmi Das provided an overview of the work that is being put forward to support the wellbeing of the workforce in ED and advised that ED colleagues would like to present this work to the Board which ranges from the establishment of a wellbeing group, the provision of a wellbeing room in ED, refreshments, a wellbeing suggestion box and an open wellbeing session with one of the departments ANPs who is trained in pastoral care.

John Grinnell raised concerns around EDs performance which remains outside of target at 72% and has reduced further over the last few days. Following discussion, it was agreed to conduct a deep dive into ED during December's Trust Board in order to review data and trends. John Grinnell recognised the high impact changes that the team are trialling in the next two to three weeks.

21/22/193.1 Action: UD

Alfie Bass advised of the unusual pseudomonas infection in a post-operative patient. Water testing has taken place and pseudomonas bacteria has been identified in the tap in the theatre where the operation took place. Filters have now been fitted to all taps. It was reported that an investigation is to be conducted along with a whole piece of work on this matter. The Board was advised that a detailed update will be provided during December's meeting.

21/22/193.2 Action: ABASS

Kerry Byrne queried the reason behind the increase in the waiting list figures as it went from 13,000 in September 2021 to 18,500 in October 2021. It was reported that this is a one off change in terms of the way the Trust is constructing its waiting list following the Safe Waiting List Management Review. The Trust has validated all outpatient records, reconfigured the classification of patient pathways and reset its algorithm to ensure it is in line with national guidance. Kerry Byrne asked as to whether this increase raises any regulatory/reputational issues. The Board was advised that the main focus is on the organisation's long waiting list and despite the change the Trust is still in the top quartile for performance. The Trust has informed the CCG of this change and has an audit trail which provides transparency and an explanation as to why it was appropriate to conclude this piece of work.

Resolved:
The Board received and noted the Divisional updates that are highlighted in the Corporate Report.

21/22/194 Cumulative Corporate Report – Top Line Indicators

People

An update was provided to the Board on figures relating to staff absence. The

following points were highlighted:

- Following a robust conversation during PAWC on the 23.11.21 the Committee felt assured that all of the Divisions are sighted on people metrics.
- There are approximately 35 people off at the present time due to self - isolating or due to being symptomatic.
- The overall staff absence as at the 22.11.21 was 7.5%.
- It was reported that work is taking place on the winter plan in terms of nurse recruitment.

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

21/22/195 BAME Inclusion Taskforce

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

- The launch of the new BAME Network takes place on the 13th December. Claire Dove asked if the Chair and John Grinnell could write a welcome note that will be shared with the network at the beginning of the meeting.

21/22/195.1 Action: DJW/JG

- *Black History Month* – Claire Dove provided an overview of the activities that took place during Black History Month and advised that colleagues from the Liverpool City region and combined authority were interested in becoming involved with the campaign 'a face like mine'.
- The quarterly newsletter that was originally launched by the taskforce will be progressed by the BAME Network for BAME staff and the wider community of Alder Hey.
- Diversity training across the Trust will commence in the new year.
- Work is continuing in terms of access to leadership roles for BAME staff. Claire Dove raised concerns about staff leaving the Trust and going to other organisations to gain promotion, therefore it was felt that a focus on the retention of staff needs to take place. It was reported that the Academy Director, Katherine Birch is looking at National Leadership Programmes, but Claire Dove felt that it is important for the Trust to look towards having its own programme and growing its own leaders as well as having a fast track programme for talented BAME staff.
- The Trust has received positive feedback from its volunteers, who have been invited to the next taskforce meeting to enable them to share their feedback with the group. It was confirmed that the difference in the volunteers is noticeable.
- It was pointed out that Universities are responsible for the recruitment of student nurses and doctors and it was felt that the Trust should write to the respective Vice Chancellors to remind them of their responsibility towards diversity when applying recruitment practices.

21/22/195.2 Action: DJW/JG/CD

- *Board and Governor Diversity* – Progress has been made in terms of Board diversity with the recruitment of a new Non-Executive Director, Garth Dallas, which was supported by Green Park. Further work is required around governing bodies which will be progressed by the BAME Network.
- *Recruitment* – The BAME Taskforce will receive a full report during December/January on the changes in practices within Alder Hey.

- *Apprenticeships* – There were a number of applications submitted by black candidates which were unsuccessful. Work is going to take place to understand why these candidates were unsuccessful and what is required to ensure their success.
- *New Diversity Lead* – It was reported that the new Diversity Lead will be working across three trusts and it was queried as to whether there is an infrastructure in place to support this role. Claire Dove advised that the candidate is excellent but drew attention to the importance of ensuring support is in place. It was reported that both Claire Dove and Fiona Marston have been in contact with the new lead to offer their support. Claire Dove also thanked Angela Ditchfield for the excellent work that has been conducted during her time with the Trust as the interim Diversity Lead.

Resolved:
The Board noted the BAME Inclusion Taskforce update.

21/22/196 North West Wellbeing Pledges

The Board was advised of the North West Wellbeing Workshop that took place in September for Chairs, CEOs and Wellbeing Guardians to encourage top level engagement in the wellbeing agenda. As a result of the workshop a series of pledges have been agreed which organisations have been asked to commit to.

The pledge is to shift the focus from sickness absence (5%) to a holistic wellbeing for everyone, with organisations preparing their Board for the change, evidencing that wellbeing is a priority for their Board and committing to the three North West's themes of enabling work:

- Holistic wellbeing services that support all colleagues.
- A new person-centred wellbeing approach and an attendance management policy framework.
- Leadership development that supports managers in this approach.

It was reported that the Board is being asked to discuss the pledges and reflect upon them by the end of November 2021 and agree an enabling action plan for the organisation by the end of December 2021.

A discussion took place around the Trust's approach to wellbeing and it was felt that the Board is fully committed to the Health and Wellbeing agenda as is the organisation in terms of a holistic centred person approach. This can be evidenced in the work that has been conducted therefore it was felt that Alder Hey should sign up to the principle of the pledges but gain further clarity/understanding. The third theme relates to leadership development which again the Trust has been addressing via the Strong Foundations Programme. It was reported that there will be a number of working groups taking place across the North West that the Trust can become involved with to help develop and influence wellbeing across the North West region.

Nathan Askew offered his support for this area of work but in terms of the second theme advised of the importance of having an approach that not only supports staff but is also clear for managers.

Fiona Beveridge referred to the second theme in terms of a shift from 5% to a 100% and felt that in order to get the person centred approach right at the heart of managing sickness, the organisation needs to take the view that that every member

of staff could be part of that 5% at some point in their working life. It was also felt that it would be beneficial to focus on exit interviews/data.

John Grinnell referred to the point around the personalised model versus a more systematised approach to sickness management and felt that this needed to be explored further. It was pointed out that the Trust has a really good wellbeing offer for its workforce and yet it isn't impacting on sickness levels therefore it was felt that a more innovative approach may be required to address this issue.

Dani Jones reported that the Trust has signed up to the Cheshire and Merseyside prevention pledge that has a set of commitments, with one pertaining to staff wellbeing. It was felt that in the event the Trust signs up to the North West wellbeing pledges it would be part of the solution for the prevention pledge.

The Chair concluded this agenda item by providing a summary of the discussion that took place on this matter. The Chair advised that Board members are minded to support the North West wellbeing pledges, taking into account that additional information is required to gain further detail of what it means operationally for the Trust. Attention was drawn to the comments that were made about having a focus on exit interviews and understanding exit data. It was also felt that it will be challenging in terms of empowering the organisation's leaders to make a judgment in relation to staff absenteeism.

Following discussion, it was agreed to sign up to the North West wellbeing pledges whilst recognising that it brings some key questions and potentially different ways of working. The Chair requested that the People and Wellbeing Committee progress this area of work.

21/22/196.1 Action: MS

Resolved:
The Board agreed to sign up to the North West wellbeing pledges.

21/22/197 2021/22 H2 Plan; including; Financial Update, M7 2021/22.

It was pointed out that as at the end of October there was no agreed plan for H2 but since then the Trust has agreed a breakeven plan. The Trust reported on M7 based on a number of assumptions around the organisation's income levels and funding. A deficit position of £868k was reported which was driven by two key area; loss of ERF contribution from H1and a reduction in system funding which has since been resolved. The cash in the bank is £94m and the capital spend YTD is £11.1m in line with plan YTD.

It was reported that C&M has asked the Trust to look at its capital forecast as there is currently pressures within the CEDEL limit for 2021/22. This has been reviewed and the organisation has identified up to £1m that has slipped due to its demolition programme and this has been reported back to the system on the understanding that anything which is identified in 2021/22 is returned in 2022/23 as part of the CEDEL.

One of the key risks for the Trust is the non-delivery of CIP with a gap of £2.5m against a £6.1m target. It was reported that C&M has increased the level of CIP for all providers by 2.5% in H2 therefore the Trust will see a reduction in investments available in H2. A report is to be submitted to RABD in December to outline the approach that the Trust is taking to manage CIP and transformation. An overview was provided in terms of the work that is taking place to reduce costs and drive benefits from the work that is taking place on Brilliant Basics.

An update was provided on the latest H2 position which it was reported has been a very complex process with seven iterations of the plan being submitted. The key changes relate to the;

- Recalculation pay award & income = £2.1m improvement.
- Increased CIP of 2.5%
- C&M forecast to achieve above 89% and generate ERF.
- Redistribution of system funding = £1.3m improvement.
- Success in national bids approved = £1.9m for Alder Hey.
- Impact for Alder Hey - H2 residual risk as at the 18.11.21 of £3.4m

The Board received a summary of the H2 submission with a scenario analysis for Alder Hey which included ERF and mitigations along with system distribution required to achieve breakeven. It was pointed out that C&M requested that all providers are to submit a breakeven plan.

Fiona Marston queried as to whether the risk relating to reduction of ERF has been built into the risk analysis. It was confirmed that it has.

John Grinnell thanked Rachel Lea and the team for the work that has taken place to get to this point. It was pointed out that it is going to be challenging accessing the funding that sits with the C&M ICS due to various reasons and therefore it is important for the Trust to influence the national positioning and access central funding to ensure Alder Hey has enough resources to develop its services.

The Chair thanked Rachel Lea for the work that has taken place in such a complex environment. The Chair pointed out that the forthcoming years are going to challenging and therefore it is important to engage and influence the ICS and constantly demonstrate the impact that Alder Hey has on the outcomes for CYP and provide clarity on how resources are being used.

Resolved:
The Board received and noted the update the financial update on H2 and M7.

21/22/198 Board Assurance Framework

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

- It was reported that the Board Assurance Framework report provides good coverage of the strategic risks and reflects the current and challenging period that is being experienced by the Trust.
- The Board was advised that the principle risks have been scrutinised by the respective Assurance Committees.

The Chair thanked the Committees for their support on providing scrutiny and assurance on the Trust's strategic risks.

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

21/22/199 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 18.11.21 the Committee discussed how it is going to receive and provide assurance on the risks relating to the ICSs. The Chair of the Audit and Risk Committee advised that Dani Jones is going to be invited to a future meeting to discuss this matter. It was also reported that a review of the respective roles is going to take place in terms of the Audit and Risk Committee versus the Risk Management Forum. The Board was advised that the Audit and Risk Committee will conduct a self-assessment in the new year.

RABD – The approved minutes from the meeting that took place on the 21.10.21 were submitted to the Board for information and assurance purposes. During November's meeting the Committee focussed on the financial position for H2 and the Trust's Capital Plan.

SQAC – The approved minutes from the meeting that took place on the 20.10.21 were submitted to the Board for information and assurance purposes. During November's meeting the Committee focussed on quality priorities, mental health, ED attendance and the risk of patients not being seen and policies on absconding and abduction. Attention was drawn to the NICE Compliance Report that was submitted to the Committee. It was reported that this is a significant area of risk for the Trust and it has been agreed that SQAC will review this item on a monthly basis. The Divisions have also demonstrated that they are monitoring this area of work.

PAWC – The approved minutes from the meeting that took place on the 21.9.21 were submitted to the Board for information and assurance purposes. During November's meeting a discussion took place around a Trust wide review of local pay rates and the Committee focussed on people metrics, the winter People Plan, absence rates, turnover, return to work compliance, Staff Survey and initiatives.

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

21/22/200 Any Other Business

The Board was reminded that the official switch on of Alder Hey's Christmas lights takes place at 4pm on the 25.11.21.

21/22/201 Review of the Meeting

The Chair felt that the time spent on the operational issues and the work presented by Dani Jones, Liz Crabtree and Ian Sinha was appropriate, and drew attention to the Trust's key risks that were highlighted in the various reports and presentations that were shared during the meeting.

Date and Time of Next Meeting: Thursday the 16th December 2021 at 9:00am via Teams.

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for December 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	16.12.21	Feb-21	**19.3.21** - A verbal update will be provided on the 25.3.21. **25.3.21** - It was reported that the Trust is awaiting a reply from David Levy's office. **29.4.21** - It was reported that the Trust is awaiting a reply from David Levy's office. **20.5.21** - The Medical Examiner regional lead, Dr Huw Twamley, has discussed the Trust's Medical Examiner proposal with Julie Grice. He awaits national guidance with reference to the stand alone tertiary paediatric centres. The national Medical Examiner, Alan Fletcher, has also looked at this. There is no further guidance available yet, but Alder Hey's system is more rigorous than the national process.
28.10.21	21/22/156.1	Alder Hey in the Park Campus Development Update	Include an a regular update in the Campus report on the cohort of staff who are moving into the Histopathology building to ensure that the Board is sighted on the final destination in terms of rehousing these staff members. Provide an update in November's report to explain why there is a Police evidence suite based in the children's Tier 4 inpatient unit.	D. Powell	16.12.21	Oct-21	**25.11.21** - The Trust has sent a response to NHSE regarding access and entrance to the evidence suite that is included in the Trust's Tier 4 inpatient unit. It was pointed out that the evidence suite accommodates victims of crime and not perpetrators of crime. It was agreed to close this action once the Trust has received a response from NHSE. **ACTION TO REMAIN OPEN**
28.10.21	21/22/161.1	Workforce Disability Equality Standard (WDES) Report, 2021	Melissa Swindell and Dame Jo Williams to discuss job carving for people with special needs.	M. Swindell	16.12.21	Closed	**11.12.21** - This action has been addressed. **ACTION CLOSED**
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	16.12.21	June-21	**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. **11.12.21** - An update will be provided on the 16.12.21.
28.10.21	21/22/154.1	Post Covid-19 Recovery Plan 2021/22	*WNB Rates* - Include WNB rates on the RABD action log and provide an update to RABD on this area of work.	Adam Bateman	16.12.21	Closed	**11.12.21** - RABD received an update on WNB rates during November's meeting. **ACTION CLOSED**
28.10.21	21/22/155.1	ICS Development Update	Arrange for an informal Board Strategy Session to take place after November's Board to discuss emerging questions, ICS development and multiple pitches.	D. Jones	16.12.21	Closed	**23.11.21** - This item has been deferred to a later date. **11.12.21** - An informal strategy session has been scheduled for the 16.12.21. **ACTION CLOSED**
28.10.21	21/22/161.2	Workforce Disability Equality Standard (WDES) Report, 2021	Conduct a piece of work to enable the Trust to benchmark itself against other NHS providers, especially in terms of zero tolerance. As part of this work, set a target going forward so that the Trust can plot a trajectory to monitor performance.	M. Swindell	16.12.21	Oct-21	**11.12.21** - An update will be provided on the 16.12.21.
28.10.21	21/22/164.1	Department of International Child Health Update	Establish a working group, with NED involvement, to revisit the ICH agenda, gain clarity and look at whether the Trust can progress this area of work.	B. Pizer	16.12.21	Oct-21	**11.12.21** - An update will be provided on the 16.12.21.
25.11.21	21/22/188.1	Alder Hey in the Park Campus Development Update	Meeting to take place to discuss the inclusion of a procedure in the Wellbeing Guardian Action Plan to support staff who are affected by traumatic incidents such as suicide/sudden death.	M. Swindell/ F. Marston/ J. Pottier	16.12.21	On Track	**11.12.21** - An update will be provided on the 16.12.21.
25.11.21	21/22/188.2	Alder Hey in the Park Campus Development Update	Submit the Trust's 5 Year Capital Plan to the Trust Board in December.	R. Lea	16.12.21	Closed	**11.12.21** - This item has been included on December's agenda. **ACTION CLOSED**
25.11.21	21/22/193.1	Cumulative Corporate Report - Top line indicators	Conduct a deep dive into ED during December's Trust Board.	U. Das	16.12.21	Closed	**11.12.21** - This item has been included on December's agenda. **ACTION CLOSED**

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
25.11.21	21/22/193.2	Cumulative Corporate Report - Top line indicators	Provide an update on the investigation that is taking place following pseudomonas bacteria being identified in a tap in an operating theatre.	A. Bass	16.12.21	On Track	**11.12.21** - An update will be provided on the 16.12.21.
25.11.21	21/22/195.1	BAME Inclusion Taskforce	Write a welcome note that will be shared with the BAME Network at the beginning of the inaugural meeting.	Dame Jo Williams/ J. Grinnell	16.12.21	Closed	**11.12.21** - The Chair and Acting CEO have recorded a welcome note that will be shared with the BAME Network at the beginning of the inaugural meeting. **ACTION CLOSED**
25.11.21	21/22/195.2	BAME Inclusion Taskforce	Write to the Vice Chancellors of the respective universities to remind them of their responsibility towards diversity when applying recruitment practices.	Dame Jo Williams/ J. Grinnell	16.12.21	Closed	**11.12.21** - The Chair and Acting CEO are in the process of addressing this action. **ACTION CLOSED**
25.11.21	21/22/196.1	North West Wellbeing Pledges	PAWC to progress the action plan for the North West Wellbeing Pledges that the Trust has signed up to.	M. Swindell	16.12.21	On Track	**11.12.21** - An update will be provided on the 16.12.21.
Actions for June 2022							
24.6.21	21/22/65.2	Approach to End of Life Care when there is a dispute	Provide a progress update on the Trust's process that supports end of life discussions and agreements.	Nicki Murdock/ Adrian Hughes	Jun-22		

Status	
Overdue	
On Track	
Closed	

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 16th December 2021

Paper Title:	**Emergency Department (Deep Dive)**
Report of:	**Board of Directors**
Paper Prepared by:	Hannah Rogers, Service Manager for Dr Urmi Das, Divisional Director.

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

1. Introduction

This paper is intended to provide assurance to the Trust Board of the work being undertaken within the Emergency department to ensure children and young people who attend Emergency Department receive safe, effective and responsive care.

Due to increased attendances and acuity and resultant increase in admissions it is evident that we have never been busier. The Division is working incredibly hard internally, as well as externally with local partners to understand how we can deliver care differently; this paper will explore some of these options.

2. Background

In comparison to 2019/20, attendances in 21/22 YTD attendances have increased, peaking in May and October 2021. Between April and November 2021, we have seen a total of 47,850 attendances; 5994 patients more than the same period in 2019. This has impacted capacity within the department and resulting in increased waiting times for children and young people to be triaged, assessed and admitted/ discharged. This has also impacted the Trust performance against the 4-hour performance target.

Emergency Department Activity

	2019/20								2021/22							
Performance	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Attendances	4932	5259	5126	5199	4258	5243	5606	6233	5519	6797	6171	6094	4639	5912	6532	6186
Within 4 Hours	4608	4788	4569	4763	4021	4673	4867	4936	5117	5553	5280	4150	4088	4337	4733	4109
> 4 Hours	324	471	557	436	237	570	739	1297	402	1244	891	1944	551	1575	1799	2077
Performance	93.4%	91.0%	89.1%	91.6%	94.4%	89.1%	86.8%	79.2%	92.7%	81.7%	85.6%	68.1%	88.1%	73.4%	72.5%	66.4%

An overall increase of acuity of presentations has increased pressure on the Emergency Department, it is essential the department prioritises children based on their triage category. An increased number of sick children attending, coupled with an exponential increase in lower acuity children, many of whom would have accessed primary care previously has seen a significant reduction in the performance and increased waiting times for lower acuity patients.

It should be noted that whilst a large proportion of children presenting are assessed as ‘lower acuity’, they will still require some ‘work up’ review and investigations and often admission.

	2019/20								2021/22							
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
TRIAGE CATEGORY																
Green - Standard & Non Urgent	2364	2405	2362	2331	1942	2294	2775	3169	2400	3252	2813	2812	2035	2557	2723	2464
Green Seen & Treated	1312	1549	1468	1561	1182	1378	1227	1029	1504	1480	1512	1177	1015	1333	1100	1056
Yellow - Urgent	492	565	586	535	506	703	706	901	875	1035	1000	1133	841	953	1113	1031
Orange -Very Urgent	312	305	347	332	261	443	437	476	489	580	592	622	459	681	831	751
Red - Immediate Resuscitation	24	22	14	30	28	21	27	28	37	27	26	43	25	34	30	26
% Green	47.9%	45.7%	46.1%	44.8%	45.6%	43.8%	49.5%	50.8%	43.5%	47.8%	45.6%	46.1%	43.9%	43.3%	41.7%	39.8%

The table demonstrates that whilst overall conversion rate from attendance to discharge and attendance to admit has not significantly changed; the number of patients being admitted particularly since September 2021 has significantly increased, placing pressure on the hospital ward base capacity; this has consequently impacted the Emergency Department as patients are waiting longer to transfer to the wards.

Also, to note is the increase into the number of patients that have been left before seen (LBS); the Board can be assured there are robust governance processes around this patient cohort; however this does not reflect good patient experience.

	2019/20								2021/22							
OUTCOME	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Discharged	3304	3504	3334	3441	2809	3426	3861	4233	3773	4643	4276	3822	3082	3622	4177	4002
% Discharged	67.0%	66.6%	65.0%	66.2%	66.0%	65.3%	68.9%	67.9%	68.4%	68.3%	69.3%	62.7%	66.4%	61.3%	63.9%	64.7%
Admitted	688	687	673	711	581	716	714	775	719	792	821	748	616	781	928	844
% Admitted	13.9%	13.1%	13.1%	13.7%	13.6%	13.7%	12.7%	12.4%	13.0%	11.7%	13.3%	12.3%	13.3%	13.2%	14.2%	13.6%
Left Before Seen	191	276	347	253	154	323	332	578	210	507	304	761	199	536	619	539

2.1 Current Position

There are several clinical standards that all Emergency Departments must meet. These include:

- Time to triage (15minutes).
- Time for a clinician wait (60minutes)
- Time within department (4hours and a maximum of 12 hours in the department).

Over the course of the last few months we have been working hard within the department and the Division of Medicine to review departmental processes, ultimately, to reduce the overcrowding and exit block from ED.

This work is predominantly led within the Urgent and Emergency Care Collaborative (UECC) which has 5 main workstreams focusing on a full patient journey from the front door attendance to ward discharge. Each workstream has an operational lead, a clinical representative as well as a clear vision. Below are the 5 workstreams:

- WS1 – Front Door: To see the right patient at the right time, by the right person in the right place, to ultimately improve patient safety and reduce over-crowding in ED.
- WS2 – Clinically Ready to Proceed (CRTP): To implement interprofessional standard that all specialties adhere to with a focus on 60minute CRTP target.
- WS3 – Workforce: To have a sustainable workforce to support the delivery of emergency care, reduce financial spend and improve the wellbeing of staff.
- WS4 – Flow and Discharge Planning: Timely discharge from the core wards by 11am to allow the timely flow of patients from ED and Critical Care; ensuring no patient waits longer that an hour from their decision to admit.
- WS5 – Operational Management of Patient Flow: A robust approach to operational management and patient flow

A suite of metrics has been designed to track improvement across each workstreams with a set of deliverables. Each workstream has its own A3 and task and finish group

established to drive changes forward. Some of the Workstreams have already started to see some benefits as outlined below.

WS1 – Front Door

External Streaming: there are several external streams the department can triage into including

- Community Pharmacist
- Walk in centres (WIC)
- Health Visitors (commenced 6 December 2021)

Liverpool WICs are now functioning at pre-pandemic levels; our external communications team have ensured this is information has been disseminated via our website.

Internal Streaming: the team have reviewed internal streaming pathways and the following have been introduced/ reinstated:

- 'Doc in a box' – streaming lower acuity patients through dedicated clinicians
- Rapid Assessment and Treat (RAT) – Consultant led triage and assessment at the front door to reduce waiting times and prioritize investigations.
- Pharmacy – direct triage to a clinical pharmacist negating the need to see an ED clinician
- Physiotherapy – rapid assessment of respiratory patient with a view to avoiding admission (commencing December 2021)

Digital Streaming:

On 13 December the Trust will launch the Symptom Checker, which has been led clinically by Bimal Mehta and Matt Rotheram. The symptom checker allows parents to check their child's symptoms and the most appropriate location to be seen.

WS2 – Clinically Ready to Proceed

Development of clinical standards for all specialties to support timely review, intervention and admission from the ED.

Internally the department have increased their oversight on the key clinical standards of triage and first clinician review; three times daily clinical and operational huddles have been introduced to take account of the departments position and agree a tactical response if clinical standards are risk of not being delivered; this has already begun to have a positive impact.

WS3 – Workforce

The Trust commissioned Kendall Bluck, an external agency, to undertake a detailed assessment of the current workforce model against the ED activity; the analysis is complete, and the final report is being concluded.

The Division have been working closely with Kendal Bluck in recent weeks to actualize the findings of the modelling; to date a significant gap in lower level decision makers has been identified, as well as a skill mix deficit in nursing.

The Division is compiling a business case to be completed early January 2022 based on the report findings.

At present in order to offset the shortfalls in workforce the department is utilizing locum staffing; this is presenting a significant cost pressure for the Division; its worthy of note that the Division is forecasting an indicative overperformance in ED of £1.8million in 2021/22.

In the last we have received confirmation of non-recurrent funding from NHSE totaling £452K. This will be prioritized to support streaming (Respiratory Physio, GP stream and Health Visitors)

The Division will be advertising for GP's with a specialist interest in Paediatric Emergency Care and are also hoping to work with a 3rd party provider to support GP streaming in the short/medium term.

A review of the General Paediatric Workforce is also underway to ensure the acute medical and nursing team are best placed in terms of responsiveness

WS4 & 5 – Patient Flow and Discharge Planning

The Chief Operating Officer (COO) has commissioned an external review of the patient flow and discharge planning process; this will also incorporate the role of the Acute Care Team (ACT); the findings are anticipated early January 2022.

3. Conclusion

In summary, there is a significant divisional focus on the Emergency Department and General Paediatric, with some improvement initiatives already in place. The Urgent and Emergency Care Collaborative meet fortnightly to oversee the improvement works and the Divisional team remain sighted on the need to realise rapid improvement against the key clinical standards; the Division report against these standards fortnightly into the Trust Gold Command.

For information the Trust hosted a North West Winter Assurance visit recently, the feedback letter is detailed in Appendix 1. NSHE/I did recognise the pressures the

department is under and acknowledged that challenges in the primary care setting has impacted Alder Hey.

4. Recommendations

The board are requested to note the content of this report; in particular the work undertaken to date and planned to improve the care with the Emergency department. The board is also requested to note the impending investment case that is development.

Appendix 1: North West Regional Winter Assurance Feedback 2021

North West regional Winter Assurance 202

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 16th December 2021

Paper Title:	Serious Incident Board Report 1st November 2021 – 30th November 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 were two incidents reported to StEIS and zero 'Never Events' reported.

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

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

Serious Incidents												
Month	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
New	**0**	**1**	**2**	**0**	**1**	**0**	**1**	**2**				
Open (Total)	**5**	**5**	**5**	**5**	**4**	**4**	**4**	**6**				
Closed	**0**	**1**	**2**	**0**	**2**	**0**	**1**	**0**				
Never Events												
Month	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
New	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**				
Open (Total)	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**				
Closed	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**				

Note: 5 open investigations carried forward 2020/21

Table 2 Open ongoing StEIS reported investigations

StEIS Reference	Date reported	Incident	Agreed date of completion
2021/24660	25/11/2021	Near miss incident – reported due to potential for learning and improvement	28/02/2022
2021/24473	22/11/2021	Treatment delay meeting SI criteria	24/022022
2021/20934	06/10/2021	Delay in treatment	06/01/2022
2021/17974	16/07/2021	Severe Haemophilia A: Treatment outside usual clinical pathway.	06/01/2022
2021/12203	27/06/2021	Delay in treatment. Delay in transfer to HDU. Suboptimal care of deteriorating patient?	06/01/2022
2021/12387	12/06/2021	Patient ingested large overdoes of tablets, including Omeprazole and Colchicine. Patient died due to impact of Colchicine toxicity.	06/01/2022

END

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 16th December 2021

Report of:	Nathan Askew, Chief Nurse
Paper prepared by:	Pauline Brown, Director of Nursing
Subject/Title:	Winter 2021 preparedness: Nursing and midwifery safer staffing
Background Papers:	• Winter 2021 preparedness: Nursing and midwifery safer staffing NHSE/I November 2021 • NHS England and NHS Improvement: Advice on acute sector workforce models during COVID-19 • NHS England – Respiratory syncytial virus 2021 preparedness: Children's safer nurse staffing framework f or inpatient care in acute hospitals • NHS England – Nursing and midwifery e- rostering: a good practice guide • Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals: National Quality Board, November 2017 • Safe, Sustainable and Productive Staffing: An improvement resource for neonatal care: National Quality Board, November 2017 • How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time: National Quality Board, November 2013 • Defining staffing levels for children and young people's services: RCN standards for clinical professionals and service managers: Royal College of Nursing, 2013 • Quality Standards for the Care of Critically Ill Children: Paediatric Intensive Care Society, December 2015 • Categories of Care: British Association for Perinatal Medicine 2011 • Quality Network for Community CAMHS Standards for Services: Royal College of Psychiatrists, 2020 • Developing Workforce Standards: Supporting providers to deliver high quality care through safe and effective staffing: NHSI, 2018 • Covid-19: Deploying our people safely: NHSE, April 2020
Purpose of Paper:	in response to the NHSE/I paper published in November 2021: Winter 2021 preparedness: Nursing and midwifery safer staffing, this report provides the Trust Board with assurance that plans are in place to ensure safe nurse staffing over the winter period and that plans are connected to the wider system staffing planning, resourcing and mutual aid.

	The report includes a completed assurance framework against the four domains a set out by NHSE/I and identifies where any improvement in systems can be made to further enhance safety and assurance The domains are: 1. Staffing Escalation / Surge and Super Surge Plans 2. Operational Delivery 3. Daily Governance via EPRR route (when / if required) 4. Board oversight and assurance (BAU structures)
Action/Decision Required:	The Trust Board is asked to note the contents of the Assurance Framework and approve the report. The NHSE paper outlines that Boards should review their risk appetite in relation to quality and workforce risks and be clear on the tolerances the Board is willing to accept, understanding that not all risks can be fully mitigated.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• Provider of 1st choice • Deliver clinical excellence
Resource Impact:	

Introduction

A paper published by NHSE/I in November 2021 (Winter 2021 preparedness: Nursing and Midwifery Safer Staffing), sets out actions that Trusts must focus on, to ensure effective decision making and escalation processes to support safer nursing for the winter period. This builds on previous national guidance, the core fundamental principles of safe staffing, and Executive Nurse responsibilities. The NHSE/I paper incorporates planning, decision making and escalation, staff training and wellbeing, and governance and assurance. The paper also confirms additional indemnity arrangements that cover healthcare workers who are supporting the COVID-19 response, including those who have been asked to undertake duties outside of their usual role.

Through the completion of the associated Assurance Framework, this report provides the Trust Board with assurance that plans are in place to ensure safe nursing staffing over the winter period and that these plans are connected to the wider system staffing planning, resourcing and mutual aid.

Trust Board Governance and Assurance

Trust board members are collectively responsible for workforce planning, practice and safeguards. The NHSE paper outlines that Boards should review their risk appetite in relation to quality and workforce risks and be clear on the tolerances the Board is willing to accept, understanding that not all risks can be fully mitigated. An example of a risk appetite statement provided in the NHSE document can be found in Appendix I

The Care Quality Commission (CQC) recognises that services are facing tremendous challenges as result of the pandemic and that the nursing workforce is experiencing these pressures particularly acutely. This includes decisions around nursing and care staffing capacity and capability. The CQC expects Boards to make staffing decisions with a focus on mitigating emerging risks and trends using available resources effectively and responsibly, in line with national guidance, and that where staffing shortages are identified, use of temporary solutions including a multidisciplinary approach to manage immediate risks are implemented.

The following Assurance Framework demonstrates the policies, procedures, plans and strategies in place to support safe staffing over the winter period, which includes a clear nurse staffing escalation process which has been signed off by the Chief Nurse, agreed at Gold Command and is detailed in the Trust Winter Plan, and a clear strategy to provide safe staffing in critical care particularly at times of increased pressure and / or surge. These plans are in line with national guidance, particularly *Respiratory syncytial virus 2021 preparedness: Children's safer nurse staffing framework for inpatient care in acute hospitals NHSE guidance published in September 2021, and Advice on acute sector workforce models during COVID-19 published December 2020*. Of note, the Alder Hey model has been reviewed, supported and approved by the Cheshire and Mersey Paediatric Network. The Assurance Framework demonstrates the collaborative multi-disciplinary approach to safe staffing including senior nurse leaders, Human Resources, senior managers and operational teams, Finance, and a wide variety of staff support services. Active and robust nurse recruitment continues.

Assurance framework – nurse staffing

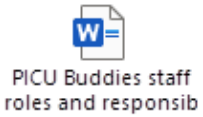
Ref	Details	Controls	Assurance (positive and negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
1. Staffing Escalation / Surge and Super Surge Plans							
1.1	Staffing escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (ie intensive care) or as per the NWB safer staffing guidance	1. Critical care Surge Plan 2. Standard Operating Procedure: Nurse Staffing Escalation Ward and Departmental Optimal and Minimum Staffing Levels: Green, Amber and Red staffing models Winter 2021	1. Escalation plans, including deployment and specific training for staff groups / role requirements, put in place in first wave of covid. Plans reviewed based on the learning and feedback from staff for the second wave of covid and subsequent winter planning 2. Specific training put in place for predicted RSV surge in August 2021 Nurse%20staffing%20escalation%20Sta PICU staffing 2021.docx	9 High level of positive assurance in planning	Include buddy system on Risk Register	Approach shared	Ongoing monitoring through Divisions, monthly Chief Nurse led staffing meeting, and Gold command and reported to SQAC

			PICU Buddies staff roles and responsib				
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter	1. Annual establishment reviews 2. Annual winter planning	1. 100% of ward and departmental annual establishment reviews undertaken in 2021 2. Review of surge staffing levels undertaken and agreed with all Ward Managers, Matrons, Heads of Nursing and Associate Chief Nurses; reviewed against the model set and approved in Covid 2020 / winter 2020. Levels signed off by Chief Nurse 3. Updated Standard Operating Procedure signed off and disseminated. SOP in line with NHSE guidance published in September 2021 *Respiratory syncytial virus 2021 preparedness: Children's safer nurse staffing framework for inpatient care in acute hospitals;* NHSE/I guidance December 2020 *Advice on acute sector workforce models during COVID-19* 4. Winter plan review	6 High level of assurance that approach in line with national guidance			

			undertaken by CCG in November 2021 5. Paper presented to Gold Command in November 2021 outlining the gap in frontline nurse staffing due to staff unavailability to work and due to gaps identified during annual establishment reviews, particularly in ensuring a supranumery clinical co-ordinator on each ward on each shift. Agreement to over recruit as able and Finance currently identifying the costing				
1.3	Staffing escalation plans have been widely consulted and agreed with Trust staff side committee	1. JCNC 2. LNP 3. PAWC	1. Staffing discussed at JCNC	4	Circulate escalation plan to staff side and review at JCNC for completeness		JCNC PAWC
1.4	Quality Impact Assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD	1. Trust policy 2. QIA template	1. QIA undertaken and signed off by Chief Nurse and Medical Director regarding the "Red, Amber, Green" staffing model 2. All Divisions aware that a QIA must be undertaken regarding any proposed changed to staffing or service. Reminder given at Divisional Governance	6 High level of assurance of QIA for surge planning and staffing escalation; less assured that QIAs undertaken consistently	Review whether QIAs are routinely undertaken; consider including in Divisional Performance reviews		

			meetings in August or September 2021				
2. Operational Delivery							
2.1	There are clear processes for review and escalation of an immediate shortfall on a shift shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze.	1. Safer Staffing SOP and related documentation 2. Standard Operating Procedure: Nurse Staffing Escalation Ward and Departmental Optimal and Minimum Staffing Levels: Green, Amber and Red staffing models Winter 2021 3. Daily Safer Staffing meetings 4. Matron / lead for staffing 5. Daily Operational meeting 6. Daily Bed meetings 7. Review of NHSP pay rates undertaken by Chief Nurse	 Safe Staffing SOP - V4 final draft - May2  Safe Staffing Huddle Checklist_08 1. Allocated leads at Matron level for safe staffing in Medical and Surgical Divisions on a daily basis Monday to Friday; ACT team at weekend. Responsible for planning safe staffing for the day / subsequent shift(s) and mitigating risks 2. Safer Staffing meeting Chaired by Associate Chief Nurse; sitrep shared at daily Operational meeting and thrice daily Bed Meetings	6 Low risk	1. Review SOPs with a view to bringing together in a single overarching safe staffing document		
2.2	Daily and weekly	1. Weekly Gold	1. Gaps in staffing due to	6			

	forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained	meeting 2. Daily Operational meeting	staff availability to work reported and escalated to Gold with plans to address including continued over recruitment of frontline nursing staff 2. Weekly Gold meeting with standing agenda item for staff redeployment to PICU (buddy system) PICU staffing 2021.docx PICU Buddies staff roles and responsib PICU Staffing 16 Nov 2021.pptx PICU Staffing Nov 2021.pptx 2. Short term staff movement (one shift only) co-ordinated within Divisions and daily Safer Staffing meeting.				
2.3	The Nurse in charge who	1. Draft Standard	1. Draft SOP for Nurse in	3			

	is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs	Operating Procedure: The Role of the Shift Co-ordinator 2. Ward / departmental TNAs 3. E-roster 4. PICU buddy roles and responsibilities	Charge (shift co-ordinator) includes 2. Skill mix incorporated into roster planning 3. Staff skill set considered when allocating patients appropriately 4. PICU buddy role clearly defined  PICU Buddies staff roles and responsib				
2.4	Staff receiving the patient(s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients being handed over	1. Draft Standard Operating Procedure: The Role of the Shift Co-ordinator 2. NMC Code of Conduct 3. Guidance for redeployed staff 4. Letter from NMC and UK CNOs to all registered nurses	1. Registered staff are bound by the professional body; nursing staff must abide by the NMC Code of Conduct and are accountable for their care delivery and acts and omissions. Staff are aware of the need to raise any concerns to the nurse in charge of the shift 2. The NMC and the four chief nursing officers in the UK have written to all registrants reminding all of the importance of working in	3	1. Review the guidelines for staff movement with a view to bringing together in a single overarching safe staffing document 2. Devise guidelines for the movement of Health Care assistants		

			partnership with people receiving care and their fellow professionals; and of using professional judgement to assess risk, informed by the values and principles set out in NMC professional standards. 2. Guidelines issued regarding movement of staff and need to raise if they do not have the right skills				
2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.	1. E6 – Induction policy includes agency staff	1. Records of local induction held at local level. 2. Very minimal use of agency nursing staff	1			
2.6	The Trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individual's scope of practice	1. Ulysses incident reporting system 2. Guidance for redeployed staff	1. Staff actively encouraged to report incidents, including staffing incidents 2. Staff expected to work within their scope of practice in line with training and support as detailed in	1			

			section 2.4				
2.7	The Trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on patient care	1. Ulysses incident reporting system 2. Weekly Patient Safety meeting 3. Weekly Executive meeting 4. Raise It Change It process for staff 5. FTSU process for staff	1. All reported incident investigated and actioned appropriately 2. Top incident reporting themes monitored weekly at Patient Safety Meeting 3. Patient safety first and standing agenda item at weekly Executive meeting and any emerging issues raised, discussed and actioned appropriately 4. Staffing incidents and risks on register included in quarterly and annual staffing reports	1			
2.8	The Trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing The Trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care	1. SALS service 2. HR team / HR Wellbeing Officers, related policies, procedures, health and wellbeing advice and support 3. Occupational Health 4. Alder Centre counselling service 5. Chaplaincy service 6. Staff side	1. The health and wellbeing of staff is of paramount importance with full Board support and reports relating to control measures 2. Specific focus on the importance of staff taking breaks based on staff feedback. Quality Ward Round undertaken to understand the issues and actions put in place to support staff break	1			

		7. Line Manager 6. Vaccination clinic 7. Weekly CEO briefing 8. Link to Cheshire and Mersey resilience Hub 9. BAF 2.2: Employee Wellbeing; current score 9	provision. Funds available through application process to improve local resources 3. SALS service accessed by high numbers of staff 4. Local wellbeing champion role being scoped; implemented in ED				
2.9	The Trust has robust mechanisms for understanding the current staffing levels and its potential impact on patient care These mechanisms take into account both those staff who are absent from clinical duties due to required self isolation, shielding, and those that are off sick Leaders and board members therefore have a holistic understanding of those staff not able to work clinically not just pure sickness absence	1. Daily Safer Staffing meetings 2. SCAMP acuity and dependency tool 3. Daily Operational meeting sitrep 4. Weekly absence data 5. Board reporting	1. HR circulate information weekly for all staff groups which breaks down reasons for absence 2. Gaps in nurse staffing due to availability to work presented at Gold Command 3. Staff redeployed to other roles as appropriate in line with Occupational Health advice	3			

2.10	Staff are encouraged to report incidents in line with the normal Trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this intelligence	1. Trust policy 2. Risk management / incident reporting training 3. Weekly Patient Safety meeting 4. FTSU	1. Staffing is continually monitored and reviewed by senior nursing team 2. Associate Chief Nurses use challenge boards to identify emerging or predicted staffing challenges in their areas 3. Feedback from all areas / routes actively encouraged and welcomed	3			
3. Daily Governance via EPRR route (when / if required)							
3.1	Where necessary the Trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver and Bronze to provider the safest and sustained care to patients and its decision making is clearly	1. Multidisciplinary workforce meeting Chaired by HR Director (as necessary) 2. Nurse / AHP workforce meeting Chaired by Chief Nurse	1. Previous MDT forum Chaired by HR Director to review and action all elements of staffing. Forum can be reconvened as required 2. Chief Nurse Chairs a monthly staffing meeting with clear action log 3. Staffing standing agenda item at Daily Operational	3			

	documented in incident logs or notes of meetings		meeting and escalated to Gold command and Executives as required in line with SOP				
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).	1. Daily Safer Staffing meeting 2. Daily Operational meeting 3. Weekly Gold meeting 4. Weekly Executive meeting	In line with control measures	3			
3.3	The Trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The Trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients	1. Regional Gold meeting 2. Monthly CQRM meeting with CCG	1. Daily CCG meeting attended by Hospital Manager of the Week; issues and risks escalated as necessary. Mutual aid arrangements discussed as required 2. Regular staffing reports to CCG via CQRM	1			
3.4	The Trust has sufficiently granular, timely and reliable staffing data to identify and where	1. E-roster 2. Electronic screens 3. Local knowledge	The most up to date data is through the Ward Managers / Team Leaders as there is a time lag with ESR. Ward	6	Work with Chief Nursing Information Officer to		

	possibly mitigate staffing risks to prevent harm to patients		Managers submit monthly data to their ACN		identify opportunities to improve / reduce manual requirement		
4. Board oversight and assurance (BAU structures)							
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short and medium term solutions to mitigate the risks	1. Quarterly SQAC report 2. Monthly Corporate report staffing at SQAC	In line with control measures Safe staffing review paper.docx Safe staffing review paper - May 2021.dc	3	Review report and ensure compliant with all reporting metrics set out by NQB and NHSE/I. Ensure report links to key quality metrics going forward		
4.2	Information from the staffing report is considered and triangulated alongside the Trusts' SI reports, patient outcomes, patient feedback and clinical harms process.	1. Quarterly SQAC report 2. Annual establishment reviews 3. Aggregated incident, complaints and investigation report	As 4.1	3	Review report and ensure compliant with all reporting metrics set out by NQB and NHSE/I. Ensure report links to key quality metrics going forward		
4.3	The Trusts integrated Performance dashboard has been updated to	1. Daily Operational meeting sitrep	1. Daily Sitrep in place which includes staffing	1			

	include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges.	2. Safer Staffing meeting Chair reports to Daily Operational meeting	2. As 2.1. Patient acuity, dependency and risk assessments undertaken underpinned by professional judgement to ensure safe quality care 3. As 2.8. Staff health and wellbeing reviewed				
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making	1. Key issues from SQAC escalated to Board by NED Chair 2. Monthly Corporate report staffing at SQAC 3. Annual staffing report to Board	In line with control measures and 4.1	3			
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur delivering care through staffing in extremis.	1. Winter plan updates at SQAC 2. Staffing report to SQAC 3. Monthly Corporate report with quality metrics at SQAC 2. Specific and triangulated quality reports and action	In line with control measure	3	Review report and ensure compliant with all reporting metrics set out by NQB and NHSE/I. Ensure report links to key quality metrics going forward.		

		plans at CQSG and SQAC for example incidents and complaints			Increase reporting to monthly at SQAC		
4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges	1. Update included as part of winter plan updates	In line with control measure	2			
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the Trusts risk register process.	1. Chief Nurse attends Board 2. Key issues from SQAC escalated to Board by NED Chair 3. Staffing risks on the Risk Register included in staffing report	In line with control measure	2	Review report and ensure compliant with all reporting metrics set out by NQB and NHSE/I. Ensure report links to key quality metrics going forward. Increase reporting to monthly at SQAC		
4.8	The Trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel	1. Red, Amber, Green staffing model 2. RSV staffing guidance 3. CYP C&M network review	1. The Trust has developed Nurse Staffing Escalation Ward and Departmental Optimal and Minimum Staffing Levels: Green, Amber and Red staffing models	3			

	risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.e risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)	4. QIA	Winter 2021 SOP. This is in line with NHSE guidance published in September 2021 *Respiratory syncytial virus 2021 preparedness: Children's safer nurse staffing framework for inpatient care in acute hospitals;* NHSE/I guidance December 2020 *Advice on acute sector workforce models during COVID-19* 2. Model reviewed and approved by Cheshire and Mersey Paediatric Network September 2021 3. Daily review of the safety to admit elective patients based on the winter plan and the staffing escalation model				
4.9	The Trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework	1. Associated risks on BAF: 1.1; 1.2; 2.1 and 2.2 2. Weekly Executive meeting	1. BAF 1.1: Inability to deliver safe and high quality services; current score 9 BAF 1.2: Inability to deliver accessible services to patients, in line with national standards, due to a surge in urgent care demand, respiratory infections and the impact of COVID-19;	1			

			current score 20 BAF 2.1: Workforce Sustainability and Development; current score 16 BAF 2.2: Employee Wellbeing; current score 9				
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus	1 Associated risks on BAF: 1.1; 1.2; 2.1 and 2.2 2. Chief Nurse is Board member	In line with control measure	1			
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges	1. Daily CCG meetings 2. Quarterly CQC engagement meetings 3. Monthly CQRM meeting with CCG	1. Daily CCG meeting attended by Hospital Manager of the Week; issues and risks escalated as necessary. Mutual aid arrangements discussed as required 2. Regular reports to CCG through CQRM and CQC through engagement meetings	1			

Appendix I: Example risk appetite statement

Category (highest impact of the risk)	Proposed Risk appetite statement	Risk appetite	Risk score
Clinical innovation	We have a HIGH risk appetite for clinical innovation that does not compromise quality of care	HIGH	8-12
Commercial	We have a HIGH risk appetite aimed at increasing the impact of services. The high risk appetite allows the Trust to explore opportunities to deliver existing and new services into new markets	HIGH	8-12
Compliance / regulatory	We have a LOW risk appetite for risks which may compromise compliance with statutory duties and regulatory requirements	LOW	1-3
Environment	We are committed to providing patient care in a safe environment; however we have a MEDIUM risk appetite for risks related to the Trust estate and infrastructure except where they adversely impact on patient safety and regulatory compliance.	MEDIUM	4-6
Financial / value for money	We have a HIGH risk appetite for financial / value for money risks which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards	HIGH	8-12
Systems and Partnerships	We have a HIGH risk appetite for system working and partnerships which will benefit our local population	HIGH	8-12
Reputation	We have a HIGH risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the Trust	HIGH	8-12
Quality – effectiveness	We have a LOW risk appetite for risks that may compromise the delivery of outcomes for our patients	LOW	1-3
Quality - experience	We have a MEDIUM risk appetite for risks to patient experience if this is required to achieve patient safety and quality improvements	MEDIUM	4-6
Quality - safety	Patient safety is paramount to the Trust and as such it we have a LOW appetite for risks which may compromise patient safety	LOW	1-3
Technology	We have a HIGH risk appetite for the adoption and spread of new technologies whilst ensuring quality for our service users	HIGH	8-12
Workforce	We have a MEDIUM appetite for risks to workforce. This medium appetite allows scope to implement initiatives that support transformational change whilst ensuring it remains a safe place to work	MEDIUM	4-6

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 16th December 2021

Paper Title:	Mortality Assessment Report Quarter 2
Report of:	Nicki Murdock, Chief Medical Officer
Paper Prepared by:	Julie Grice, HMRG Lead

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:	
Associated risk (s)	Include risk(s) reference, title of risk, and current risk score.

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY

Medical Director's Mortality Report

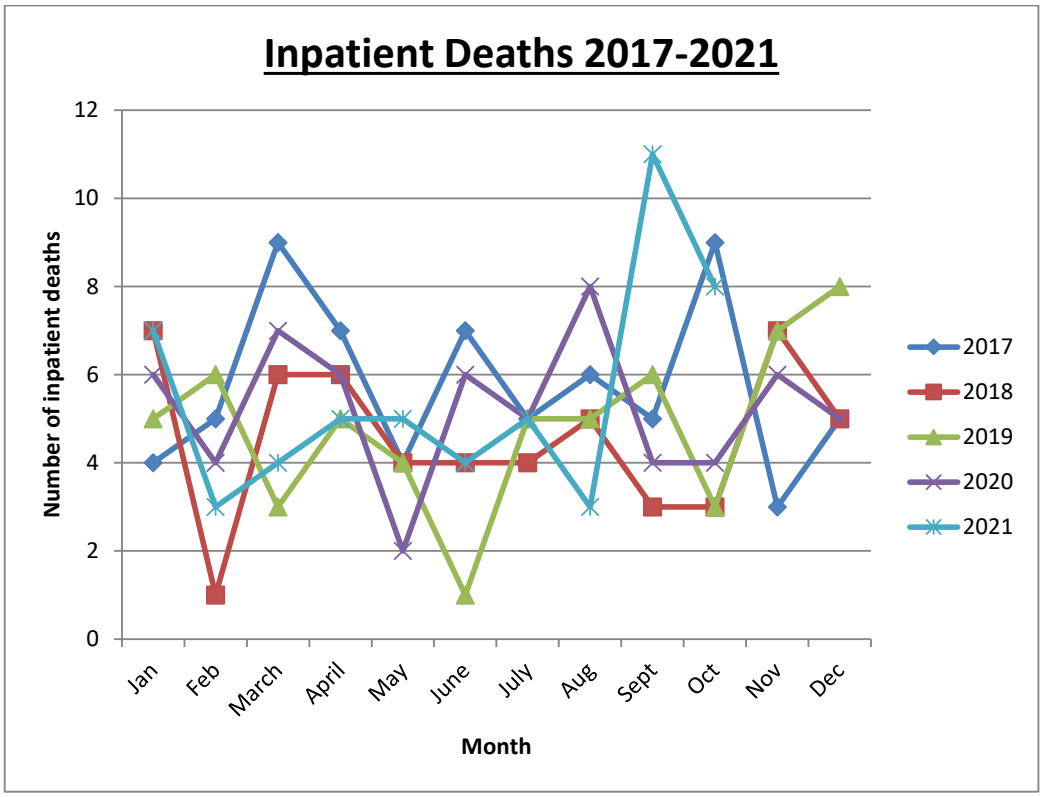
The report is split into two sections. Section one is a review of the Hospital Mortality Review Group (HMRG) including the number and types of death at Alder Hey during the calendar year to date and how the HMRG is meeting its aims.

Section two is the Quarter 2 Mortality report which includes a review of statistical analysis in PICU, followed by more detailed analysis of the place of death, teams involved and specifics about expected vs observed deaths.

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

The percentage of cases being reviewed within the 4-month target continues to decrease. There have been several very complex reviews and this figure will not improve since the number of deaths in September is unusually high as shown by the table and graph. One change in the recording of the figures over the period covered as we are now including the SUDI /SUDIC (Sudden unexpected death of an infant/child) cases in these figures whereas previously they were recorded separately as Emergency department deaths. Once this was identified they were then included in the figures. Sometimes with these cases it is difficult to stop the resuscitation for a variety of reasons although unfortunately the baby /child may have been deceased for a while.

	2017	2018	2019	2020	2021
Jan	4	7	5	6	7
Feb	5	1	6	4	3
March	9	6	3	7	4
April	7	6	5	6	5
May	4	4	4	2	5
June	7	4	1	6	4
July	5	4	5	5	5
Aug	6	5	5	8	3
Sept	5	3	6	4	11
Oct	9	3	3	4	8
Nov	3	7	7	6	
Dec	5	5	8	5	
	69	55	58	63	55



It was noted very quickly that some of the other deaths were caused by fireplaces/heavy objects and this was quickly highlighted to the Executive team and CDOP (Child death Overview panel). Communications were then released by the Trust and it was discussed at a national level to try and prevent any further deaths /injuries. The other deaths show no concerning themes and the majority have already been reviewed by the teams involved and will then be reviewed by HMRG.

There are interesting times ahead for the mortality process in the Trust and it needs to continue to evolve as a result of issues identified by HMRG members and bereaved families, plus external changes. Unfortunately, these have not moved forward since the last report:

1) One of the most significant changes will be the introduction of the Medical Examiner (ME) process. This will be a legal requirement by April 2022 providing scrutiny for all deaths. There are several reasons for the ME legislation – 'enabling families to have a voice', improving accuracy

of death certificates and ensuring every death is reviewed. Since we are a Paediatric Trust and, our mortality numbers are significantly less than our adult peers we are already able to scrutinize all deaths. The death certificates are completed by senior clinicians and in a very timely manner. In addition, if there are any concerns regarding a child death, the case follows the coronial process. Lastly, we are very fortunate in having the bereavement team who support and engage with families, so we have contact and are currently working on formalizing the feedback we receive. The main challenge for AHCH introducing the ME process is ensuring that it doesn't slow down the current process and impact negatively on the families. Currently, options are being considered as to how to achieve this.

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

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

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

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

Current Performance of HMRG

Number of deaths (Jan. 2021 – Oct 2021)	55
Number of deaths reviewed	24
Departmental/Service Group mortality reviews within 2 months (standard)	34/38 (89%)
HMRG Primary Reviews within 4 months (standard)	18/25 (72%)
HMRG Primary Reviews within 6 months	12/15 (80%)

The reviews have become much lengthier as a result of the child death review (CDR) process, involving a much wider group to ensure that the case is reviewed as completely as possible. There is now additional input from NWTS (the regional paediatric transfer team), LWH (neonatology expertise), psychology, Snowdrop (bereavement) team so we can undertake a robust review process. Some of the cases involve very complex medical conditions or situations requiring more than one discussion. The meetings are once a month and held on TEAMS enabling more people to attend including the DGH's if they wish.

The meetings have been extended to try and catch up the backlog but due to the complexity of some of the cases this has not really helped. The next option is to hold extra meetings and I have e mailed the members out to ask for support for these to happen.

Outputs of the mortality review process for hospital deaths for 2021

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2 month timescale	HMRG Reviews within 4 month timescale	HMRG Reviews within 6 month timescale	Discrepancies HMRG – Dept.	HMRG Review – Death Potentially Avoidable		RCA/72 Hour Review /	Learning Disability
							INT	EXT	AAR	
Jan-21	7	6	6	5	5	1			1	1
Feb-21	4	4	4	2	3	2		2		3
Mar-21	4	4	3	2	4	1			1	
Apr-21	5	5	4	4		2			1	2
May 21	5	5	5	5		1			2	
Jun-21	4		4							
Jul-21	5		4							
Aug-21	4		4							
Sep-21	11									

Potentially Avoidable Deaths

Over this quarter there have been no potentially avoidable deaths caused by internal causes (relating to AHCH care) and the 2 external causes shown in the table were discussed in the previous quarterly report.

Learning disabilities

The output table of the mortality process above records any children/YP that were identified as having learning disabilities. Out of the 21 cases reviewed, 7 have been identified as having learning disabilities. The HMRG policy states that the death register is reviewed every month for any patients who are recorded to have learning disabilities and are reported to the LeDeR (Learning Disabilities Mortality Review) database as soon as they are identified. This is a legal requirement for the Trust.

In the 'Mortality Report Output table', we record all the children/YP that have learning disabilities, regardless of age, whereas the LeDeR requirement is for cases where they are over the age of 4 years. The reason we record all ages

is to check there is no trend /issues in patients with learning disabilities which can occur at any age not just over 4.

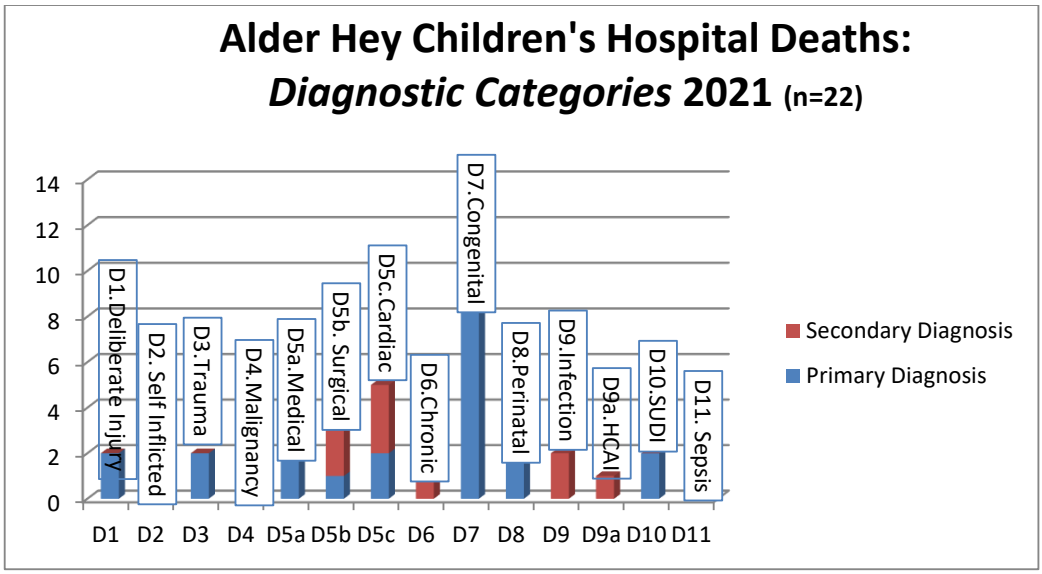
Family

The Snowdrop (bereavement team) at Alder Hey provide an exceptional service, supporting the family for a considerable time period after a patient has passed away (if wanted). There is ongoing work between HMRG, the palliative care team and the bereavement team to improve the feedback that the group receives from families, to continue to improve the care we provide.
The Operational Bereavement group which has been inactive due to the Chair retiring has now been restarted. This should help in consistency of the bereavement process across the Trust covering the letter sent out to bereaved families to the meetings.
Issues raised by families over this period:

1) inconsistencies have been perceived when different teams communicate with the same family
2) COVID visiting limitations continued to cause distress to families
3) Occasional delay in receiving medical records which was a problem that was thought to have been addressed so will be revisited

It is envisaged that by providing a feedback form for the families to fill in if they wish to, will improve the care that we provide. This is currently being reviewed by bereaved families who are providing their comments relating to the form to ensure that the form is appropriate

Primary Diagnostic Categories



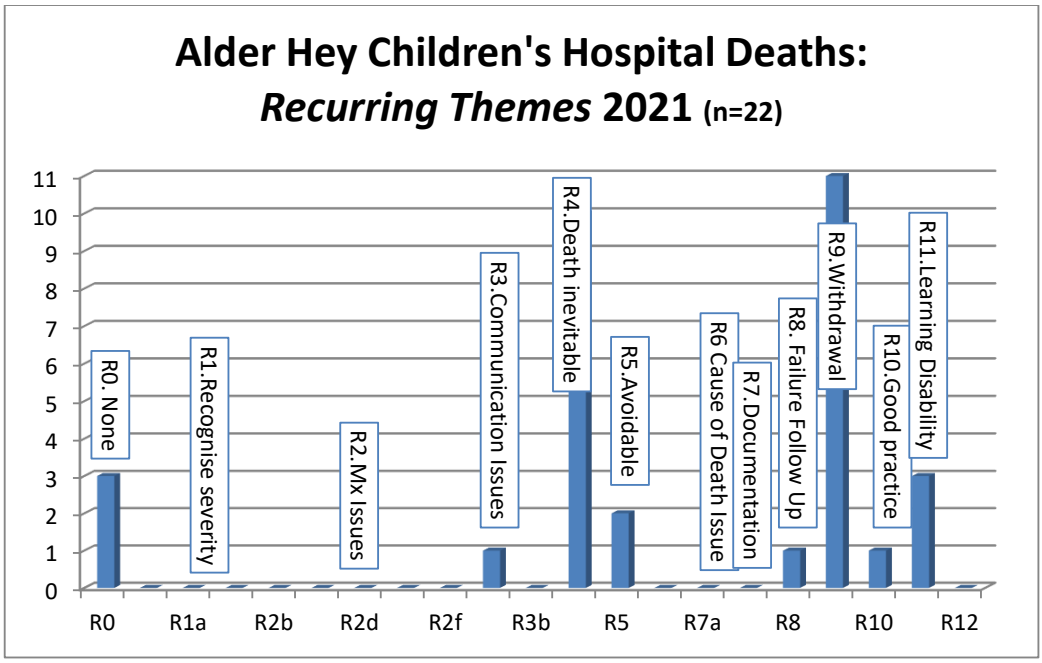
Diagnostic /Disease Categories (based on CEMACH categories - ref Arch Dis Child 2011; 96:922-6 + 927-31)

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

The number of cases reviewed so far in 2021 show that the highest diagnostic code is children with underlying congenital conditions (41%). These are often the most complex cases with several issues that need to be identified, monitored and treated. These would include the congenital cardiac cases which can be incredibly challenging and involve high risk procedures due to the nature of the underlying anatomy.

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

Recurrent themes



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

The recurrent codes that are the commonest are withdrawal of care (50 % of cases), which demonstrates that the intensive care team are working with families to ensure that no child /young person suffers unnecessarily when all treatment options are explored but are not suitable. Death was concluded to be inevitable in 45 %, regardless of the care and expertise that was provided in AHCH. This category also includes the cases where death was inevitable with hindsight. The reason these cases were included were that it has no reflection on the care AHCH provides and several children are transferred for investigations which then indicate conditions which are palliative.

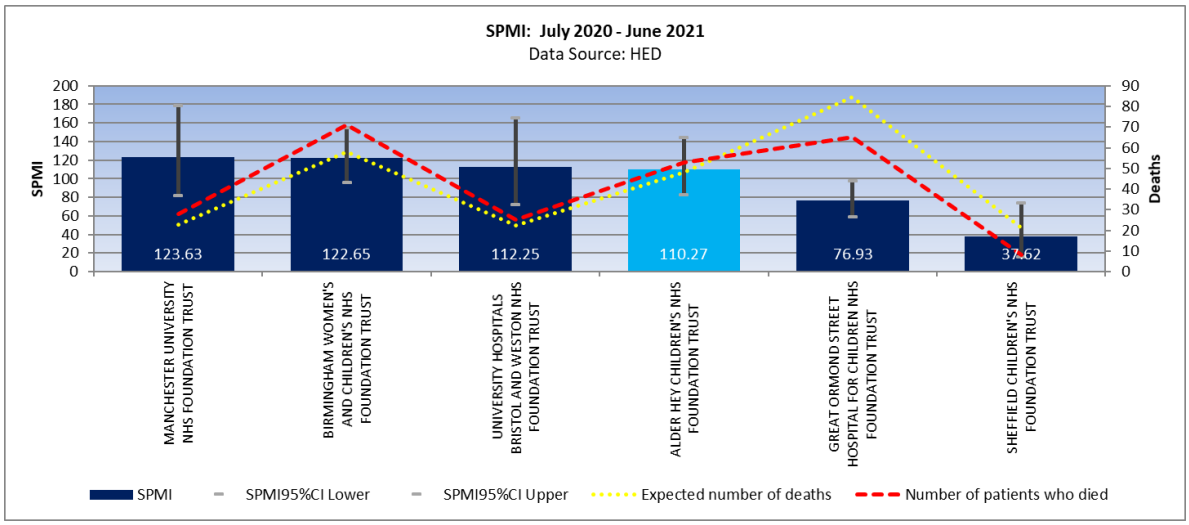
Alder Hey Children's NHS
NHS Foundation Trust

Section 2: Quarter 2 Mortality Report: July 2021 – September 2021

External Benchmarking

Standardised Paediatric Mortality Index (SPMI); – HED

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

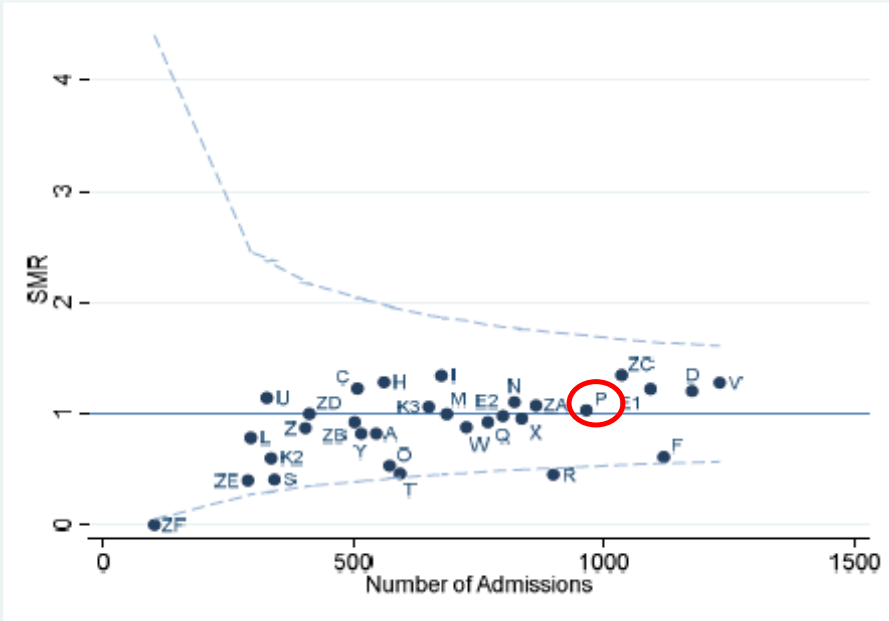


The chart shows that Alder Hey has performance of 53 deaths against 48.1 expected deaths. Although this shows a figure that is slightly higher this is probably as a result of COVID, when the workload that AHCH undertook had to be prioritised. This resulted in the higher risk, more urgent admissions and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

-PICU

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

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

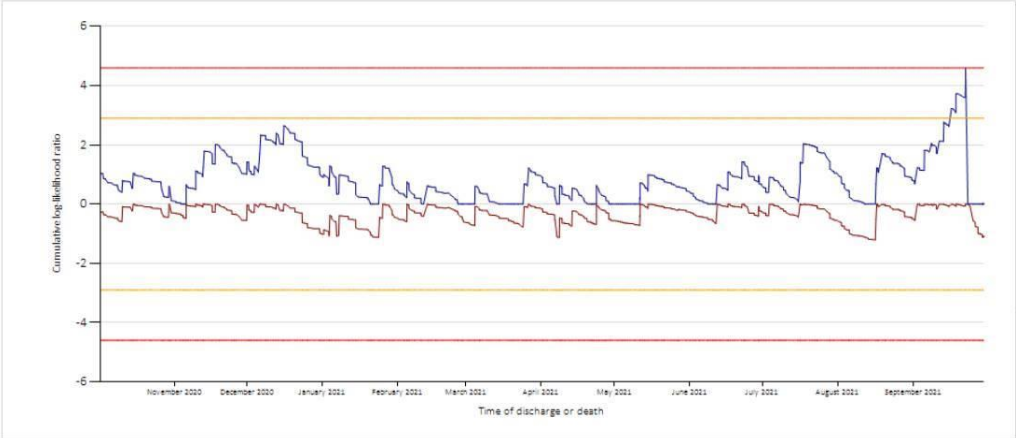


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control.

Statistical analysis of mortality:

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

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

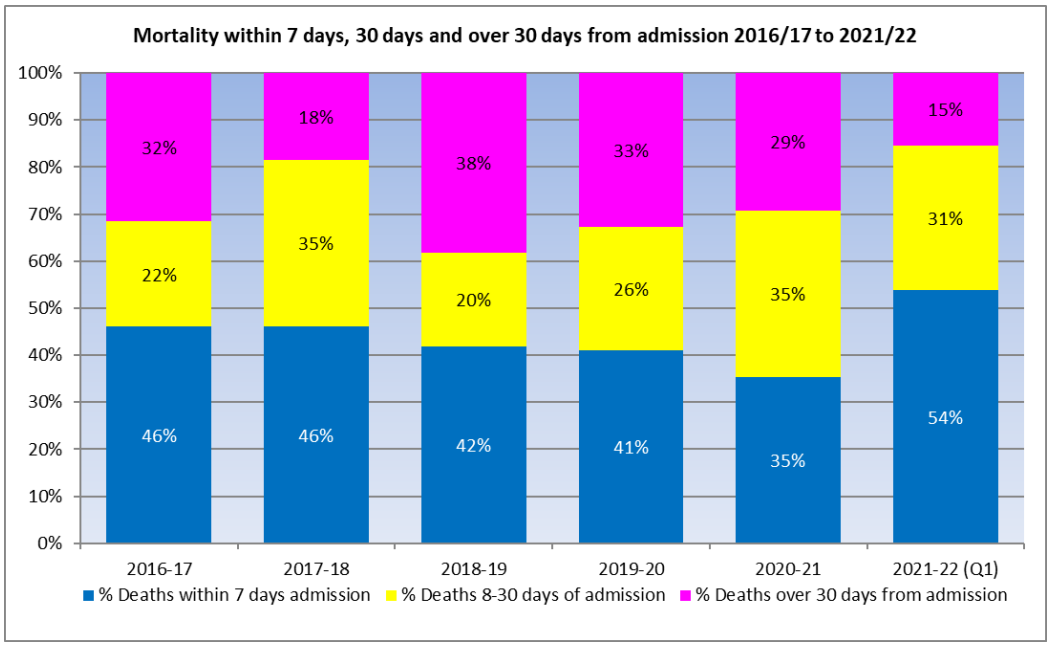


In the period July – Sept 2021 ICU discussed 17 deaths (+1 in theatre). We reviewed the RSPRT chart which reset at the end of September. We acknowledged that September had been a particularly difficult month in ICU with a run of (11) deaths. All cases had been reviewed in a timely manner in our mortality meetings and in each case, we recorded an outcome in section D of "adequate or above standard of care provided" and section E "adequate / standard practice". There were several deaths that were, in retrospect, inevitable from admission including three out of hospital cardiac arrests, severe end stage chronic lung disease and respiratory failure with an underlying mitochondrial disorder. There were no identified themes or concerns. We will continue to monitor the RSPRT.

Real time monitoring of mortality

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

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



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

Conclusion

HMRG is providing effective and comprehensive reviews in a timely manner, although the 4-month target has fallen for the reasons stated above. There are plans in place to facilitate this improving over the next few months.
The concerning trends relating to fireplace /heavy objects was identified rapidly and highlighted immediately to try and prevent any further children being hurt or killed.
Issues that have been identified relating to patient deaths or impacting on families are being worked on to try and resolve them.
The future of the process will be the integration of the ME process and the new CDR forms which again will be a period of change without impact except in a positive manner for the bereaved families.
It is vital to observe the monthly mortality figure to ensure that there is not a worrying persistent increase that would require further review

References

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

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

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

NHS
Alder Hey Children's
NHS Foundation Trust

TRUST BOARD Report November 2021

How Did We Do?

Executive Summary Month: November Year: 2021

Alder Hey Children's NHS
NHS Foundation Trust

Delivery of Outstanding Care

Safe

- The proportion of clinical incidents resulting in near miss, no harm and minor harm, was less than 99% for the first time this year, with the numbers resulting in minor harm up to 135, the highest of the year
- Continued challenges meeting the sepsis treatment targets both in ED and the wider Trust, reflecting the pressures the Teams are currently experiencing

Highlight

- 0 never events
- 0 pressure ulcers category 2 and above for 12 consecutive months
- 0 hospital acquired C Diff or MRSA

Challenges

- 3 hospital acquired MSSA in November. These occurred on the renal unit, 3A and PICU. They have yet to be formally reviewed but immediate remedial actions have been put in place to ensure patient safety is prioritised, The cases in summary: PICU -7Y girl with an undiagnosed neurodegenerative disorder probable CLABSI.
  3C- 10Y boy renal dialysis patient colonised MSSA/MRSA at HD line site
  certain CLABSI. 3A -8Y girl underwent laparotomy and bowel resection
  admitted to PICU with Multiorgan failure. Probable CLABSI
- 3 medication errors resulting in harm: A steroid eye ointment was missed from a discharge prescription resulting in a recurrence of inflammation. An infusion line was found disconnected from a patient who then developed an arrhythmia. A patient received an overdose of medication that warranted extra tests to monitor for adverse effects. All incidents have been investigated and relevant action taken.

	• 1 clinical incident resulting in moderate harm: Brief incident description as follows: Day staff Nurse receiving handover from nightshift nurse at 0700, patient upset and high pitch crying, checked peripheral cannula in right foot and blisters noticed and foot/leg swelling and hard to touch. • 1 clinical incident resulting in severe harm: Brief incident description as follows: Suboptimal management of a scalp haematoma that became infected and resulted in tissue loss; need for a skin graft and will require scalp expansion to reconstruct later. The incident has been StEIS reported as a serious incident. a 72- hour review has been completed as has Duty of Candour. A level 2 RCA is underway.

The Best People Doing their Best Work

Caring

• Improvement in the overall Friends and Family score for recommending the Trust • AED score still low reflecting continuing pressures with volumes of attendances • Complaints are consistent at 14 in month reflecting seasonality and associated pressures	**Highlight** • Family and Friends scores in in patient areas, community, mental health and OPD continue to remain well above 90%. **Challenges** • PALS numbers were initially identified at 193, a very significant increase from previous months. On further investigation this relates to 2 separate phone lines being combined. Revalidation work has been completed and the actual November number as 143, still a yearly high.

Delivery of Outstanding Care

Effective

In November we had a significant number of cancelled operations. A rise in emergency admissions led to very high bed occupancy, to the extent that we requested mutual aid from partner hospitals. In response to this we have adjusted down the level of planned inpatient operations we are undertaking via a 'cap' in in patient operations.

In urgent and emergency care services, we are concerned about the left before seen rate of 8.7% and the reduction to 66.4% of the number of children and young people treated within 4 hours. In response we have agreed additional support: a new streaming approach to other services from triage; daily senior rapid assessment and treatment; and a health visitor service. Performance has subsequently started to improve in December. Looking forward, we have received £0.45m of investment establish an urgent care service on the Alder Hey site, to commence late January 2022.

Highlight

- Low readmissions to PICU
- No patients waiting over 12 hours in the department for admission to hospital.

Challenges

- Cancelled operations.
- Number of patients waiting over 4 hours for treatment.

Delivery of Outstanding Care

Responsive

Due the work of the safe waiting list programme and high levels of elective recovery, the number of patients waiting over 52 weeks for treatment reduced to 250, from 318.

Highlight

- Significant reduction in patients waiting over 52 weeks for treatment
- Access to cancer care

Challenges

- Diagnostics completed within 6 weeks

The Best People Doing their Best Work

Well Led

For the Month of November (Month 8), control totals have now been finalised at Cheshire & Mersey System level for H2. The Trust submitted a plan of break even by the end of the financial year in line with C & M requirements. There is a risk of at least £3.4m of income which C & M are yet to confirm.

The month 8 position is showing a deficit of £0.5m which is £0.5m away from the break-even planned control total.

Cash in the bank at the end of November was £91.9m.

The overall capital expenditure year to date to November was £13.4m year to date which demonstrates that spend is ahead of plan year to date.

Mandatory Training

At the end of November 2021, Mandatory Training was at 87% overall, 3% below the Trust target of 90%. We continue to work with staff, managers and SMEs to encourage improvements in compliance.

Our key areas of concern over the last couple of months have been; Resuscitation Training, Estates and Ancillary staff and Moving and Handling Level 2 which had seen significant compliance drops due largely to the impact of COVID on face to face training restrictions.

PDR

At the end of November 2021, our Trust appraisal rate was 73%, 17% lower than our target of 90%. The 2021 PDR window has now closed but we will continue to provide an update throughout the year. The figures below will continue to flux as staff move around the organisation.

Sickness

Attendance management remains a key priority for the Trust. Long-term sickness absence levels have improved across many areas, due to planned support to managers, early intervention accessing occupational health with follow up activities; supporting well-being action plans and health risk assessments. A review of short -term absences is also

Highlight

Challenges

- Significant challenge to meet the required break-even control total by the end of the financial year
- Delivery of CIP through remainder of 2021/22 with increasing operational pressures.

an area of focus to ensure support to managers on key activities such as KPI meeting with managers, regular HR surgeries on site and monitoring absences on a case by case basis to support progression through policy stages is achieved. **Turnover** Turnover continues to be an area of focus for all divisions as most areas are either just below or just above the 10% KPI. A deep dive is underway to identify reasons, and to facilitate a plan of action, linked closely to the winter plan and the staff availability project. Return to work interviews are an additional focus for the HR teams to support all areas to improve on current KPI's. Organisational support through SALS, EAP and the Alder Centre continues to be highlighted as part of the above approaches.	

Game Changing Research and Innovation

Research and Development

Month 8 Research Activity: • 186 research studies currently open • 1038 patients recruited to research studies (8,711 in 21/22) Divisional Participation: • Division of Medicine – 152 open studies • Division of Surgical Care – 30 open studies • Division of Community & Mental Health – 4 open studies Research Assurance: • GCP training compliance – 97% • Research SOP compliance – 98%	**Highlight** • Participation in national STOP RSV study **Challenges** • Staffing levels

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Leading Metrics

SAFE

Clinical Incidents resulting in catastrophic, death	Hospital Acquired Organisms - C.difficile	Hospital Acquired Organisms - MRSA (BSI)	Medication errors resulting in harm	Never Events	Sepsis: Patients treated for Sepsis within 60 mins - Inpatients
0	0	0	3	0	82.93 %
Nov 2021	Nov 2021	Nov 2021	Nov 2021	Nov 2021	Nov 2021

Sepsis: Patients treated for Sepsis within 60 Minutes - A&E
85.71 %
Nov 2021

CARING

Friends & Family: Overall Percentage Recommended Trust
88.42 %
Nov 2021

EFFECTIVE

ED: 95% Treated within 4 Hours
66.42 %
Nov 2021

RESPONSIVE

31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	All Cancers: 31 day wait until subsequent treatments	Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	Diagnostics: % Completed Within 6 Weeks
100 %	100 %	96.43 %	88.47 %
Nov 2021	Nov 2021	Nov 2021	Nov 2021

Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	RTT: Open Pathway: % Waiting within 18 Weeks	Waiting Greater than 52 weeks - Incomplete Pathways	Waiting List Size
100 %	63.22 %	250	18976
Nov 2021	Nov 2021	Nov 2021	Nov 2021

WELL LED

Cash in Bank (£'000s)	Control Total In Month Variance (£'000s)	Mandatory Training	Safer Staffing (Shift Fill Rate)	Sickness
91971	381.83	87.33 %	87.72 %	6.23 %
Nov 2021	Nov 2021	Nov 2021	Nov 2021	Nov 2021

Delivery of Outstanding Care

SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG	Comments Available
Proportion of Near Miss, No Harm & Minor Harm	D	100.0%	99.8%	99.8%	99.8%	99.8%	99.8%	99.1%	99.6%	99.6%	99.8%	100.0%	99.6%	98.8%		>=99 % N/A <99 %	
Clinical Incidents resulting in Near Miss	D	100	74	53	63	98	80	82	90	74	62	89	86	69		No Threshold	✔
Clinical Incidents resulting in No Harm	D	410	314	287	333	401	394	362	321	330	298	314	279	268		No Threshold	✔
Clinical Incidents resulting in minor, non permanent harm	D	83	75	81	76	95	91	80	72	95	88	75	86	135		No Threshold	✔
Clinical Incidents resulting in moderate, semi permanent harm	D	0	1	1	1	1	1	4	1	1	1	0	1	1		No Threshold	✔
Clinical Incidents resulting in severe, permanent harm	D	0	0	1	0	0	0	1	0	0	0	0	1	1		0 N/A >0	✔
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	0	1	0	0	0	0	0		0 N/A >0	✔
Medication errors resulting in harm	D	11	0	6	3	4	4	2	2	2	6	4	3	3		<=3 N/A >3	✔
Pressure Ulcers (Category 3)	W	0	1	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	✔
Never Events	W	0	0	0	0	1	0	0	0	0	0	0	0	0		0 N/A >0	✔
Sepsis: Patients treated for Sepsis within 60 Minutes - A&E	D P	79.2%	73.7%	89.5%	80.6%	100.0%	85.0%	94.4%	87.9%	88.9%	90.2%	76.6%	85.9%	85.7%		>=90 % N/A <90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	80.8%	70.8%	87.5%	84.0%	88.9%	83.3%	89.7%	91.7%	88.9%	86.4%	81.1%	87.0%	82.9%		>=90 % N/A <90 %	✔
Number of children that have experienced avoidable factors causing death - Internal	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - C.difficile	D	0	0	0	0	0	0	1	0	0	0	1	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MSSA	D	1	0	3	1	0	0	1	0	2	0	0	1	3		No Threshold	✔

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust	W	93.7%	91.5%	95.3%	94.9%	92.9%	94.0%	90.2%	91.0%	87.6%	92.3%	88.4%	84.9%	88.4%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust	D	89.2%	91.5%	93.2%	93.1%	88.0%	88.0%	76.2%	79.2%	59.8%	79.6%	64.3%	61.1%	64.2%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	D	98.8%	100.0%	92.7%	96.7%	93.0%	95.9%	92.4%	95.9%	97.1%	96.2%	92.7%	93.4%	93.6%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	D	95.5%	93.4%	94.2%	90.4%	89.8%	96.4%	95.1%	87.0%	88.8%	91.4%	92.9%	94.2%	92.1%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	D	91.3%	100.0%	96.3%	90.3%	87.9%	90.6%	85.7%	95.0%	94.7%	95.8%	96.3%	90.6%	96.4%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	D P	93.9%	90.4%	96.1%	96.0%	95.1%	95.3%	94.4%	94.8%	95.5%	95.4%	94.7%	91.8%	94.2%		>=95 % >=90 % <90 %	✔
Complaints	W	15	10	15	11	23	5	9	15	10	12	13	13	14		No Threshold	
PALS	W	74	65	68	88	110	101	119	150	122	88	148	136	143		No Threshold	

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG	Comments Available
% Readmissions to PICU within 48 hrs	W	4.2%	1.4%	0.0%	0.0%	1.6%	0.0%	2.6%	0.0%	1.4%	2.7%	0.0%	0.0%	0.0%		No Threshold	
ED: 95% Treated within 4 Hours	D	97.1%	98.6%	98.5%	97.8%	95.3%	92.5%	81.1%	85.5%	67.9%	87.7%	73.4%	72.5%	66.4%		>=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	16	10	5	7	12	13	7	13	13	12	32	23	59		<=20 N/A >20	✔
28 Day Breaches	W	1	3	3	1	2	4	3	0	3	8	5	11	12		0 N/A >0	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	W	95.7%	97.5%	99.3%	93.6%	95.6%	96.0%	98.0%	94.3%	94.4%	96.2%	97.5%	95.8%	99.1%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	W	98.6%	97.5%	100.0%	98.1%	94.7%	98.5%	99.0%	94.3%	94.4%	97.8%	96.8%	97.6%	99.1%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	D P	97.8%	95.0%	98.5%	98.1%	94.2%	98.5%	92.2%	96.4%	93.9%	93.0%	95.5%	93.3%	87.2%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	W	99.3%	91.7%	100.0%	94.9%	96.1%	98.5%	98.5%	98.6%	97.0%	96.2%	96.8%	98.8%	98.3%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	D	84.9%	76.7%	80.3%	85.9%	78.2%	81.1%	80.0%	79.3%	82.7%	77.4%	75.2%	78.8%	79.5%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	D	71.9%	81.6%	94.9%	92.9%	90.9%	91.0%	91.7%	89.3%	91.9%	87.6%	89.2%	92.7%	95.7%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	58.7%	60.9%	61.1%	63.2%	68.1%	68.6%	71.9%	74.8%	72.7%	71.1%	66.5%	62.1%	63.2%		>=92 % >=90 % <90 %	✔
Waiting List Size	W	10,755	10,443	10,648	11,453	11,892	11,110	11,564	11,414	12,096	13,286	13,092	18,495	18,976		No Threshold	✔
Waiting Greater than 52 weeks - Incomplete Pathways	W	148	184	222	307	361	283	235	204	187	195	263	318	250		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%	95.7%	100.0%	100.0%	100.0%	100.0%	96.4%		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	97.1%	92.3%	93.7%	95.8%	97.5%	95.2%	95.2%	98.5%	95.5%	94.7%	97.2%	96.3%	88.5%		>=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%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
PFI: PPM%		98.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	97.0%			>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG	Comments Available
Control Total In Month Variance (£'000s)	W	332	687	243	591	3,825	-954	593	392	-588	-50	836	-853	382		>=-5% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	-1,733	1,610	-1,979	-3,207	-5,794	-910	974	13	162	234	-339	-221	-159		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	W	110,503	110,776	110,776	110,871	92,708	92,708	88,440	82,001	82,006	82,121	88,514	94,111	91,971		>=-5% >=-20% <-20%	✔
Income In Month Variance (£'000s)	W	748	235	228	2,310	18,172	-494	716	1,598	2,981	-1,713	2,767	-2,609	149		>=-5% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	W	492	-192	-373	-387	-13,171	-308	-370	-545	553	71	-2,466	2,477	676		>=-5% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	W	-909	644	387	-1,333	-1,176	-153	247	-661	-4,122	1,591	534	-720	-443		>=-5% >=-20% <-20%	✔
AvP: IP - Non-Elective	W	950	929	747	731	1,066	-98	-102	1,289	-187	-141	-69	1,371	1,363		>=0 N/A <0	✔
AvP: IP Elective vs Plan	W	411	390	340	353	455	-89	-62	448	-22	-113	-82	400	384		>=0 N/A <0	✔
AvP: Daycase Activity vs Plan	W	1,772	1,713	1,507	1,599	2,075	186	-7	2,105	269	-125	180	1,938	2,129		>=0 N/A <0	✔
AvP: Outpatient Activity vs Plan	W	24,791	21,494	23,261	23,037	27,506	2,346	5,016	28,125	5,746	922	5,884	25,162	28,248		>=0 N/A <0	✔
PDR	W	72.4%	74.6%	74.4%	74.4%	74.4%	0.9%	6.3%	19.7%	56.3%	65.0%	67.3%	71.2%	72.3%		No Threshold	✔
Medical Appraisal	W	95.6%	95.9%	95.9%	95.9%	95.9%	21.9%	30.9%	34.8%	42.4%	70.8%	55.2%	83.9%	80.2%		No Threshold	✔
Mandatory Training	W	85.8%	85.0%	86.0%	85.8%	86.8%	88.4%	87.2%	88.1%	88.0%	87.4%	87.3%	87.3%	87.3%		>=90 % >=80 % <80 %	✔
Sickness	D	5.4%	5.6%	7.1%	5.7%	4.7%	4.6%	5.3%	5.6%	6.3%	6.5%	6.3%	6.4%	6.2%		<=4 % <=4.5 % >4.5 %	✔
Short Term Sickness	D	1.3%	1.1%	2.3%	1.2%	1.2%	1.1%	1.4%	1.5%	1.8%	1.6%	1.8%	2.2%	1.9%		<=1 % N/A >1 %	✔
Long Term Sickness	D	4.2%	4.5%	4.9%	4.4%	3.6%	3.4%	3.9%	4.1%	4.5%	5.0%	4.5%	4.2%	4.4%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	D	1,365	1,392	1,373	1,279	2,272	1,071	1,040	960	1,130	1,096	1,368	1,137	1,590		No Threshold	✔
Staff Turnover	D	9.1%	9.0%	9.0%	8.9%	8.8%	9.4%	9.8%	9.4%	9.7%	9.7%	10.2%	10.7%	11.2%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	W	94.9%	93.6%	90.5%	94.5%	94.0%	97.7%	98.8%	97.6%	89.6%	92.2%	94.5%	91.6%	87.7%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	W	87.5%	90.4%	94.4%	97.7%	97.7%	97.7%	88.6%	100.0%	97.7%	100.0%	97.7%	100.0%	95.4%		>=85 % N/A <85 %	✔
NHS Oversight Framework	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 <=1 >1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

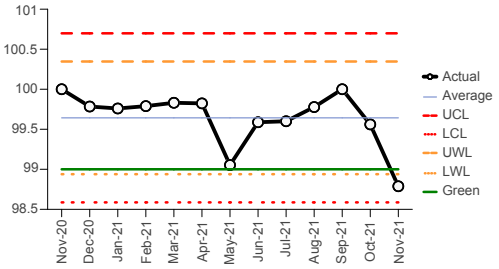
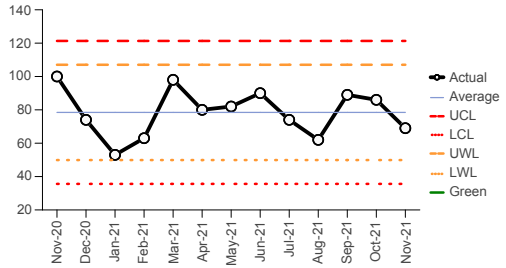
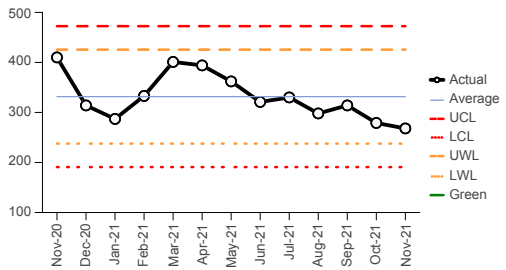
		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	71	76	80	80	90	100	103	108	117	125	132	139	142		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	37	36	36	36	36	34	36	38	37	38	40	43	44		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	4	4	1	0	6	7	2	3	7	3	7	7	4		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	1	0	0	0	2	0	3	1	1	0	2	3	3		>=1	N/A	<1	✔
Number of patients recruited	W	832	182	504	403	105	1,055	1,039	896	439	1,060	983	931	1,038		>=100	>=86	<86	✔

Delivery of Outstanding Care

7.1 - QUALITY - SAFE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Proprtion of Incidents	**Proportion of Near Miss, No Harm & Minor Harm** D Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded. **Exec Lead:** Nicki Murdock **Committee:** SQAC	98.79 %	R <99 % A N/A G >=99 %		
Incidents: Increasing Reporting	**Clinical Incidents resulting in Near Miss** D Total number of Near Miss Incidents reported **Exec Lead:** Nicki Murdock **Committee:** SQAC	69	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	268	No Threshold		

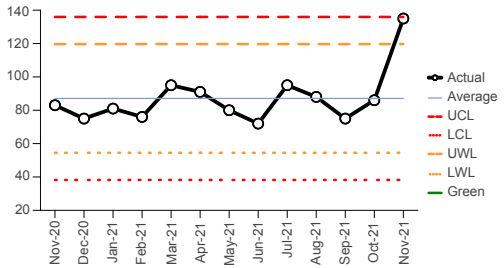
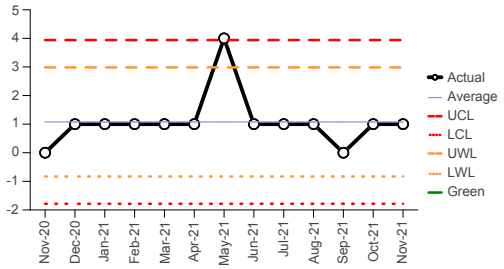
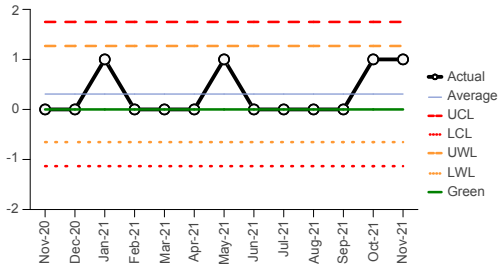
Delivery of Outstanding Care

7.2 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in minor, non permanent harm** D Total number of Minor Harm Incidents reported. **Exec Lead:** Nicki Murdock **Committee:** SQAC	135	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** D Incidents reported resulting in moderate harm. **Exec Lead:** Nicki Murdock **Committee:** SQAC	1	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	1	R >0 A N/A G 0		

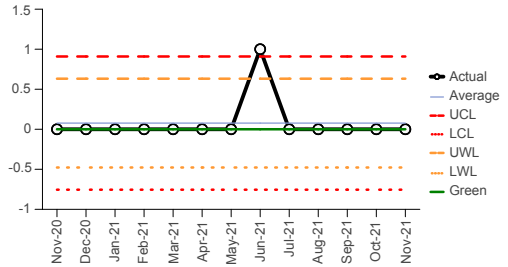
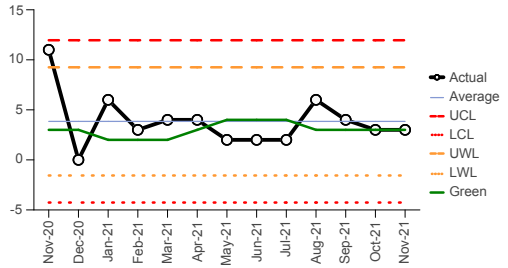
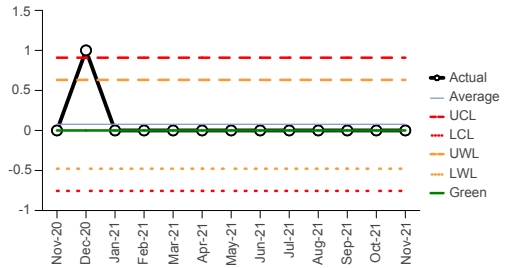
Delivery of Outstanding Care

7.3 - QUALITY - SAFE

Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

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 A N/A G 0		No Action Required
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	3	R >3 A N/A G <=3		No Action Required
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 A N/A G 0		No Action Required

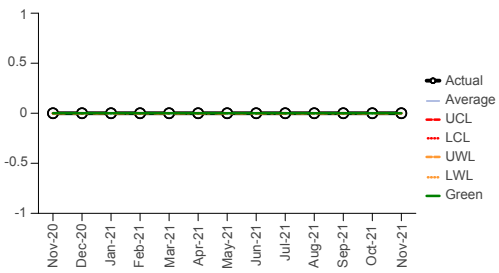
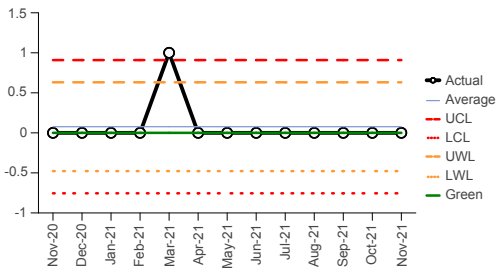
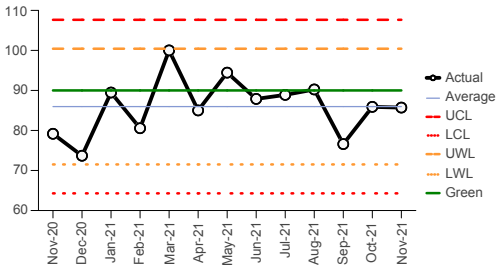
Delivery of Outstanding Care

7.4 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** W Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Never Events	**Never Events** W Never Events. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Sepsis	**Sepsis: Patients treated for Sepsis within 60 Minutes - A&E** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 21/22 aim is 90%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	85.71 %	R <90 % A N/A G >=90 %		Seven patients did not receive antibiotics within 60 minutes and 4 within 90 minutes; 4 were due to difficulty gaining intravenous access, 1 patient required stabilising initially with boluses, 1 had no clear cause for delay and was incidented for further investigation and 1 was slightly over by 3 minutes

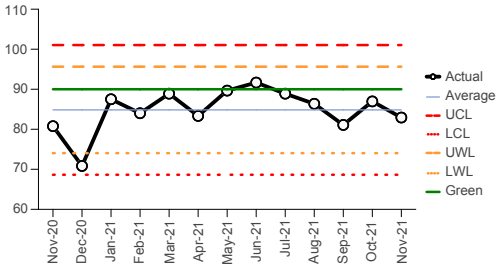
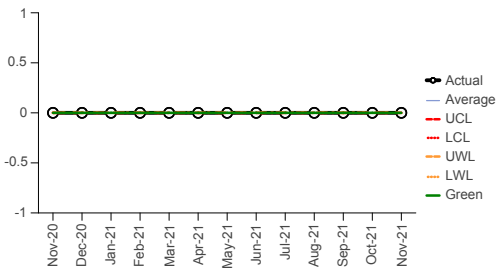
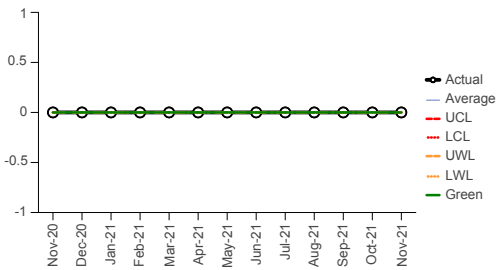
Delivery of Outstanding Care

7.5 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

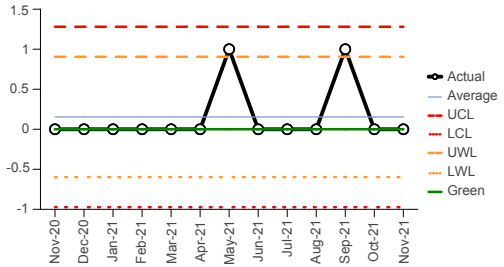
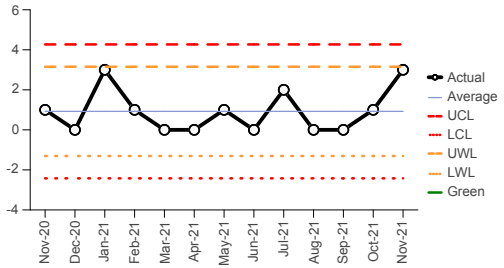
	Description	Performance	Threshold	Trend	Management Action (SMART)
Sepsis	**Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 21/22 aim is 90%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	82.93 %	R <90 % A N/A G >=90 %		7 delays identified. Incident reports completed and escalation to senior nursing leadership. Continued increase in acuity and complexity of medical conditions. Increase in number of patients requiring multiple aspects of sepsis bundle management. Learning from cases cascaded to wards with measures in place.
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 >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** D The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.6 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - C.difficile** D 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
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	3	No Threshold		1st Patient in respiratory failure after out of hospital cardiac arrest. Undiagnosed neuromuscular disorder and Chest sepsis secondary to Parainfluenza, developed Staphylococcal sepsis. Developed multiorgan failure and passed away - source of BSI undetermined. 2nd Patient with stage 4 Renal failure. Colonised with Staph at Permacath site. Treated with antibiotics recovered well - source Line. 3rd Patient transferred to Trust for Laparotomy underwent small bowel resection and anastomosis. Developed MSSA line sepsis. Line removed treated with antibiotics recovered well.

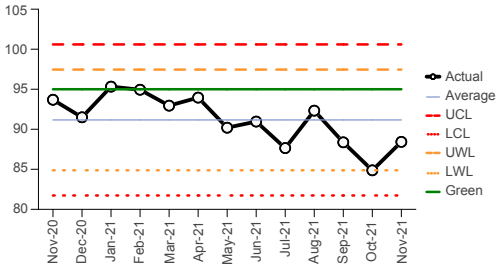
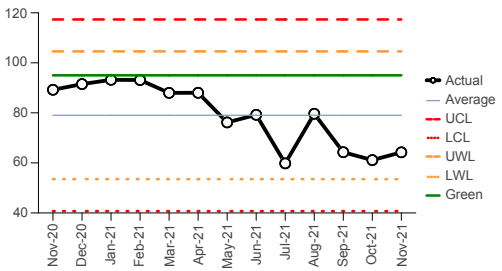
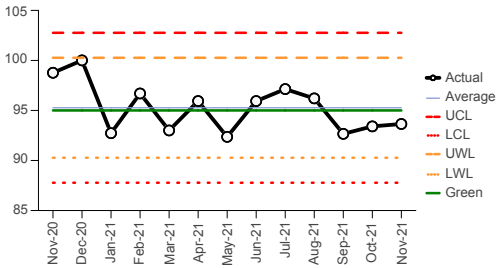
The Best People doing their best Work

8.1 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family: Overall Percentage Recommended Trust** W 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	88.42 %	R <90 % A >=90 % G >=95 %		In November 2021, there were 1,642 responses to the Family & Friends Test out of a possible average of 35,096, which gave an overall Trust FFT percentage of 88.12% who found their experiences to be either good or very good. Medicine and community have both increased from the previous month by 3%. In comparison, surgery has stayed the same the past few months at 94%.
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	64.22 %	R <90 % A >=90 % G >=95 %		A&E data has increased by 3% from the previous month, but is still significantly lower than the month of august (80%). This relates to high number of attendances which impacted on patient experiences due to long waiting times and attendees leaving without being seen. When respondents were asked how we could improve 180 comments highlighted waiting times.
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	93.65 %	R <90 % A >=90 % G >=95 %		Community overall has done well but has had some decline in the November across a few of the services. ADHD (57% scored good) service and Developmental Paediatrics (75% scored good) had declines which had affected the overall score. Comments have highlighted frustration at both parents not being able to attend consultation with the clincian and would like to be more involved with their child's care. Positive comments highlighted "Very helpful understanding member of staff, made my child feel confident answering questions and relaxed".

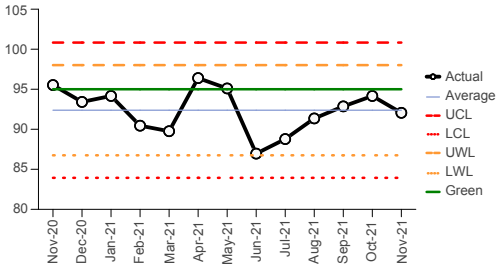
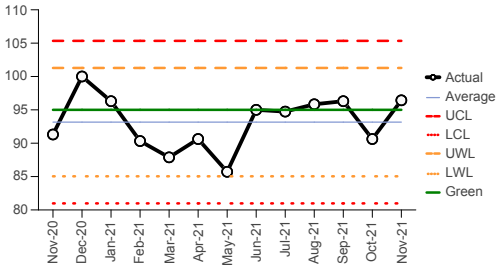
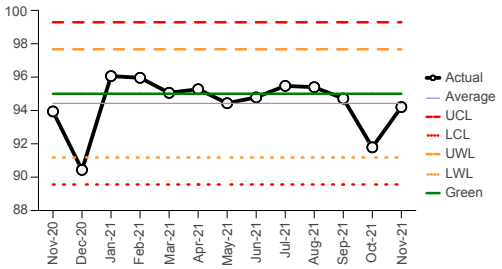
The Best People doing their best Work

8.2 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** D 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	92.05 %	R <90 % A >=90 % G >=95 %		In November there has been a slight decline of 2% in comparison to previous month, with 151 responses. Medical day case Unit, Ward 4B and 1B had the greatest decline in comparison to the previous month. Positive comments highlighted: "the whole visit from start to finish was amazing, out with ease throughout from admission to discharge". Negative comments: made suggestion for waiting times for appointments and surgeries were an issue.
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	96.43 %	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	94.20 %	R <90 % A >=90 % G >=95 %		In November in comparison to the previous month there has been 3% increase, with 966 responses. Positive comments highlighted across various departments 'staff were welcoming, consultants was thorough, caring, informative and Doctors very polite and nice. Negative comments highlighted, delays in follow up appointments may take a while to be seen which can cause further issues down the line sometimes not seen for many months causing frustration with the service.

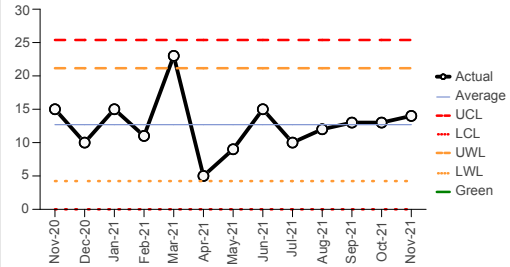
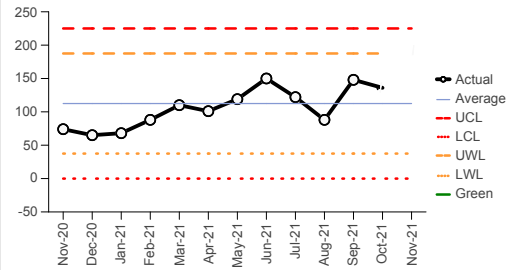
The Best People doing their best Work

8.3 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Nicki Murdock **Committee:** SQAC	14	No Threshold		
PALS	**PALS** W Total number of PALS contacts. **Exec Lead:** Nicki Murdock **Committee:** SQAC	143	No Threshold		

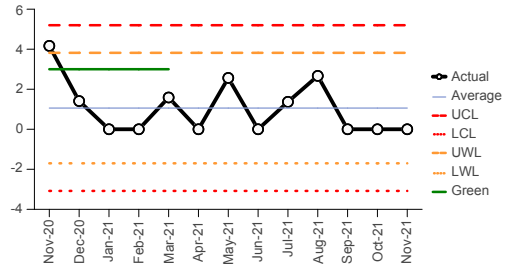
Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

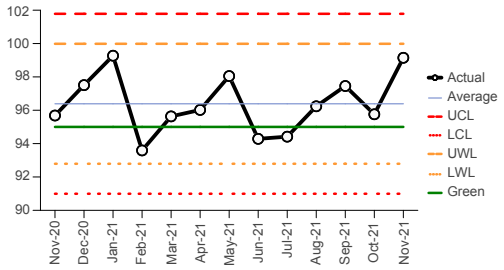
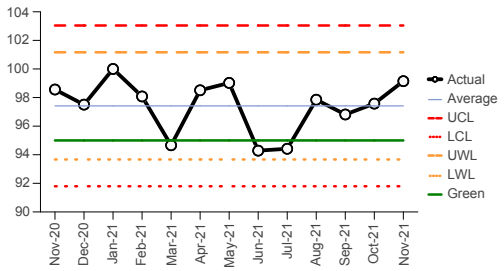
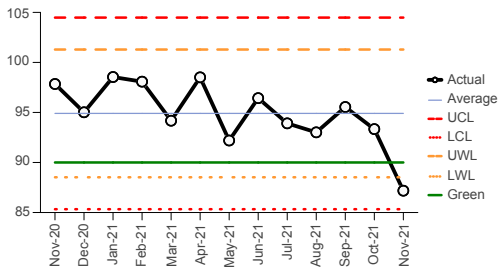
	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** W % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally 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

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** W 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	99.15 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Respect	**IP Survey: % Treated with respect** W Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 21/22 is 100%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	99.15 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** D P Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	87.18 %	R <85 % A >=85 % G >=90 %		

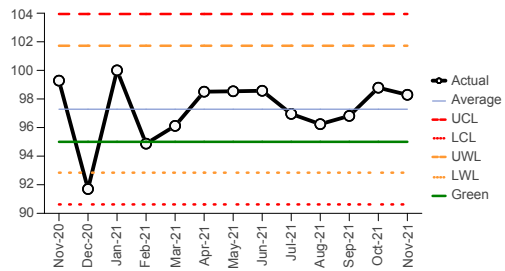
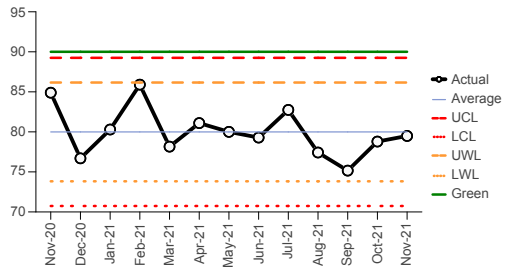
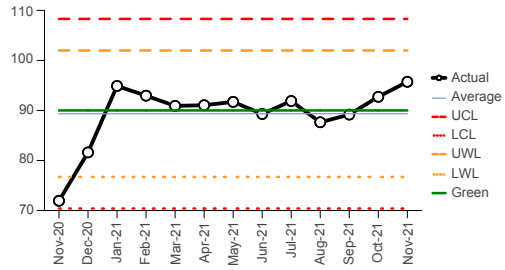
Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

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	98.29 %	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	79.49 %	R <85 % A >=85 % G >=90 %		Play has increased slightly from the previous month. As the review of play is still underway, continued improvement is needed and is still being carried out by the Director of Nursing and the Patient Experience Lead. The focus on resources for older/young persons has been a focus point to improve, as they are still working closely with the innovation team and LMarks to identify any organisations that can support and improve the play service.
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	95.73 %	R <85 % A >=85 % G >=90 %		No Action Required

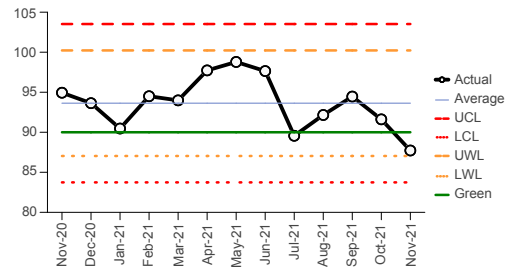
The Best People doing their best Work

11.1 - QUALITY - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** W Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** SQAC	87.72 %	R <90 % A N/A G >=90 %		

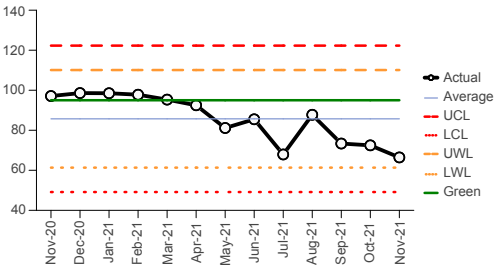
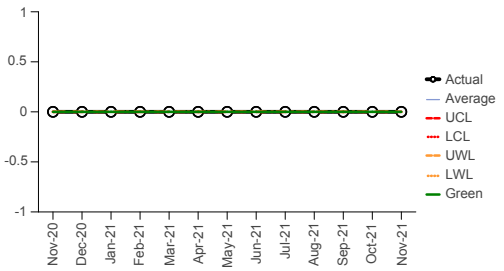
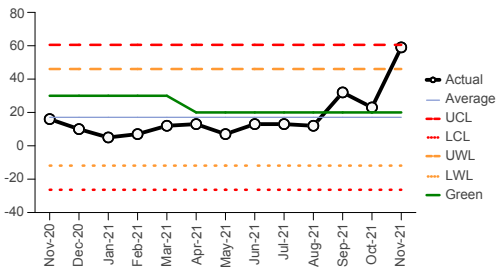
Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

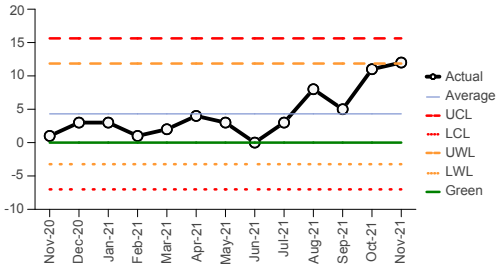
	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	66.42 %	R <95 % A N/A G >=95 %		ED performance is still deteriorating against the 95% target. Increased acuity of presentations has put pressure on ED, prioritisation of children based on their triage category is important. Increased number of sick children attending, coupled with an exponential increase in lower acuity children, many of whom previously would have accessed PC has impacted performance and increased waiting times. We have increased focus on front door streaming, including training for triage nurses as well as 3 operational meetings per day to understand/influence/change what is happening on the shop floor.
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	59	R >20 A N/A G <=20		We have a new system in place to cap the number of inpatients per day to minimise number of cancelled ops. This is a new system that is bedding in and the Division is working to the winter plan to maximise daycases.

Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** W 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	12	R >0 A N/A G 0		a forward look and capping TCIs through Winter pressures is started to reduce number of 28 day breaches through minimising cancellations on the day. The Division has a daily lunchtime huddle to review the following day's TCIs and take actions accordingly. This will minimise on the day cancellations and in turn reduce 28 day breaches.

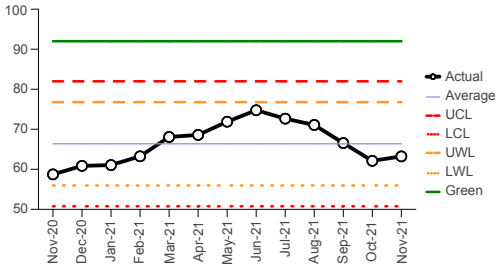
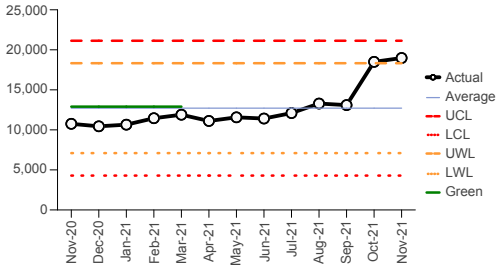
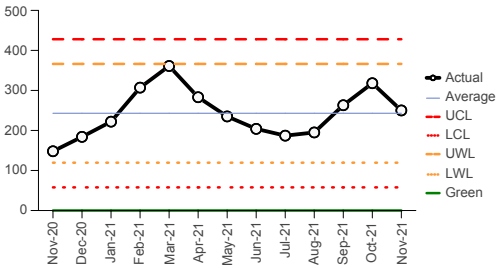
Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W 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	63.22 %	R <90 % A >=90 % G >=92 %		on going validation of patients and management via access to care. Prioritisation given to 104 week and 52 week patients.
Waiting Times	**Waiting List Size** W Total waiting list size of Inpatient and Outpatient RTT incomplete pathways **Exec Lead:** Adam Bateman **Committee:** RABD	18976	No Threshold		To address the risk of avoiding delay to care for children and young people, a validation programme was delivered validating over 50k patient records to provide accuracy and integrity of our WL. We have also rebuilt the patient tracking list to provide full visibility of all patients on appropriate pathways for safer management. This ultimately meant that we had additional patients that tipped into the PTL resulting in a higher rate of patients on the WL.
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	250	R >0 A N/A G 0		on going validation of patients and management via access to care. Prioritisation given to 104 week and 52 week patients.

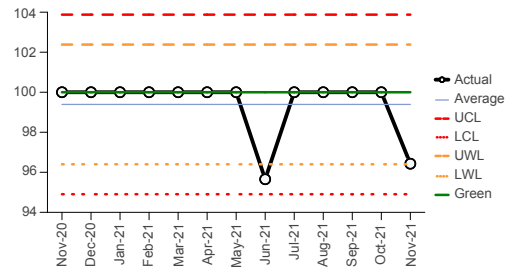
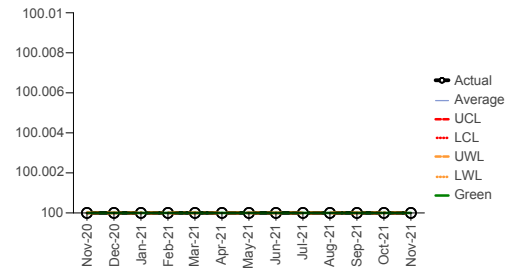
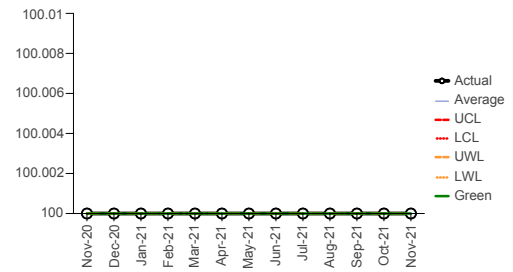
Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

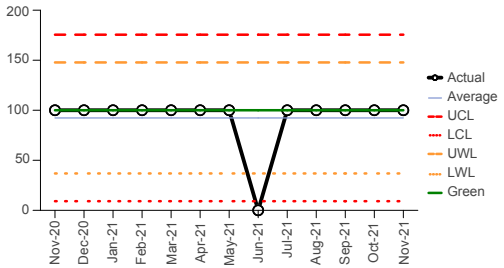
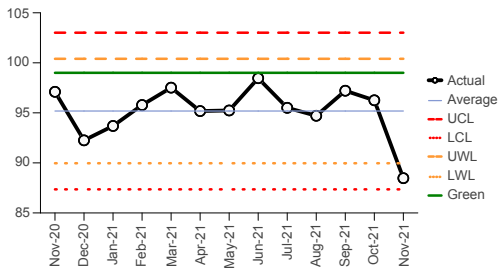
	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	96.43 %	R <100 % A N/A G 100 %		1 day over 2ww target breach in November due to patient having a scheduled op in another department, so we were unable to see them within the identified deadline.
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 % A N/A G 100 %		No Action Required
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 % A N/A G 100 %		No Action Required

Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** W Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	88.47 %	R <99 % A N/A G >=99 %		Diagnostics has seen a drop in performance overall for November due to short notice cancellations with covid isolation. Rebooking patients within 6 weeks has been challenging with capacity issues across the board.

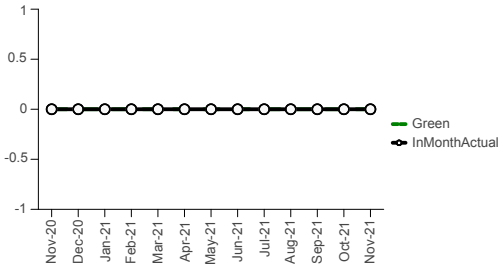
The Best People doing their best Work

14.1 - PERFORMANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Governance	**NHS Oversight Framework** W 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

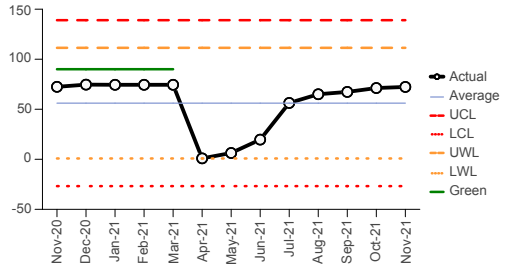
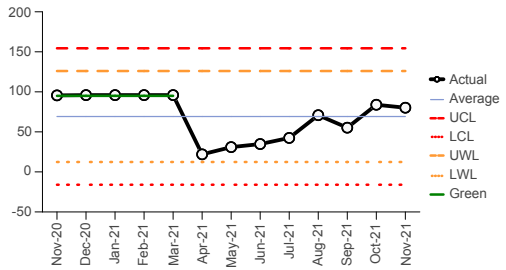
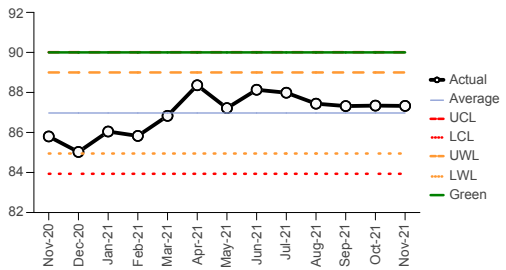
The Best People doing their best Work

15.1 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** W 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	72.29 %	No Threshold		PDR At the end of November 2021, our Trust appraisal rate was 73%, 17% lower than our target of 90%. The 2021 PDR window has now closed but we will continue to provide an update throughout the year. The figures below will continue to flux as staff move around the organisation.
Appraisal	**Medical Appraisal** W Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** PAWC	80.16 %	No Threshold		
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** PAWC	87.33 %	R <80 % A >=80 % G >=90 %		At the end of November 2021, Mandatory Training was at 87% overall, 3% below the Trust target of 90%. We continue to work with staff, managers and SMEs to encourage improvements in compliance. Our key areas of concern over the last couple of months have been; Resuscitation Training, Estates and Ancillary staff and Moving and Handling Level 2 which had seen significant compliance drops due largely to the impact of COVID on face to face training restrictions.

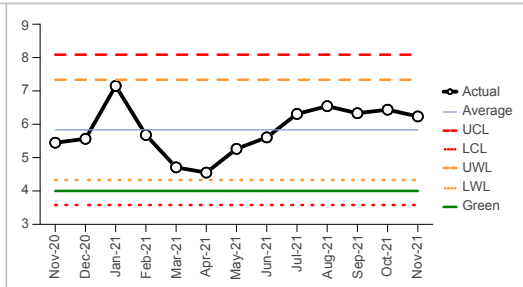
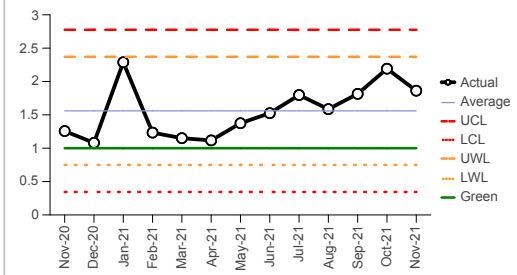
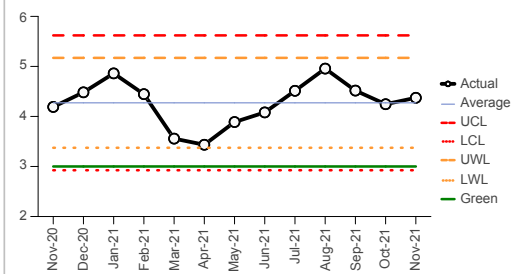
The Best People doing their best Work

15.2 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Sickness** D % 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	6.23 %	R >4.5 % A <=4.5 % G <=4 %		Sickness Attendance management remains a key priority for the Trust. Long-term sickness absence levels have improved across many areas, due to planned support to managers, early intervention accessing occupational health with follow up activities; supporting well-being action plans and health risk assessments. A review of short -term absences is also an area of focus to ensure support to managers on key activities such as KPI meeting with managers, regular HR surgeries on site and monitoring absences on a case by case basis to support progression through policy stages is achieved.
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	1.86 %	R >1 % A N/A G <=1 %		See Above
Sickness	**Long Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** PAWC	4.37 %	R >3 % A N/A G <=3 %		See Above

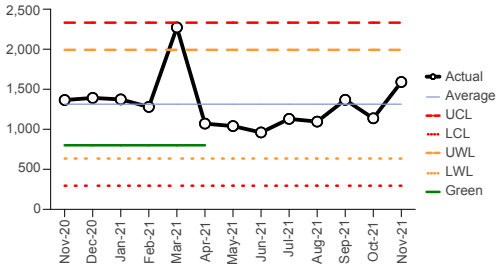
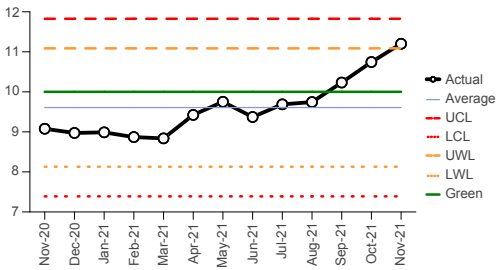
The Best People doing their best Work

15.3 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Temporary Spend	**Temporary Spend ('000s)** D Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** PAWC	1590.30	No Threshold		
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** PAWC	11.20 %	R >11 % A <=11 % G <=10 %		Turnover Turnover continues to be an area of focus for all divisions as most areas are either just below or just above the 10% KPI. A deep dive is underway to identify reasons, and to facilitate a plan of action, linked closely to the winter plan and the staff availability project. Return to work interviews are an additional focus for the HR teams to support all areas to improve on current KPI's. Organisational support through SALS, EAP and the Alder Centre continues to be highlighted as part of the above approaches.

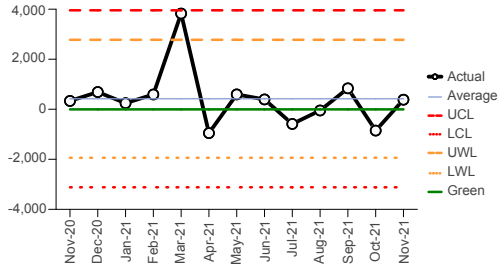
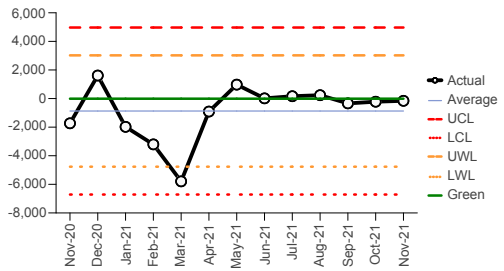
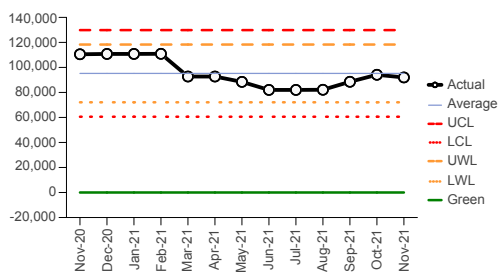
The Best People doing their best Work

16.1 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

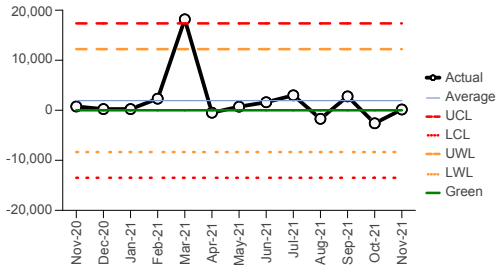
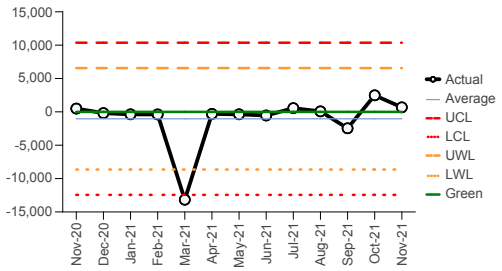
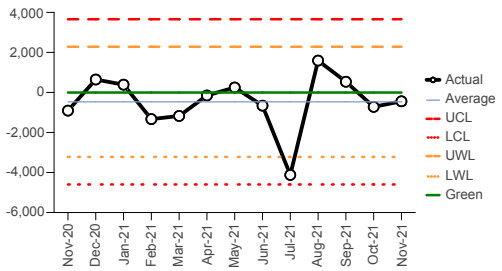
	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Control Total In Month Variance (£'000s)** W Variance from Control Total plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	382	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	-159	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	91,971	R <-20% A >=-20% G >=-5%		No Action Required

The Best People doing their best Work

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	149	R <-20% A >=-20% G >=-5%		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	676	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Non Pay In Month Variance (£'000s)** W Variance from non pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-443	R <-20% A >=-20% G >=-5%		No Action Required

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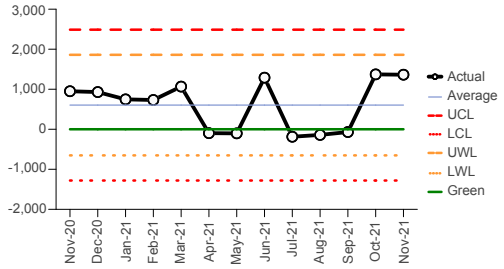
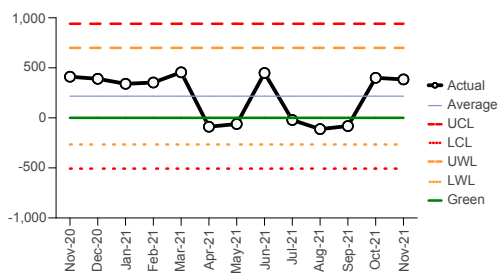
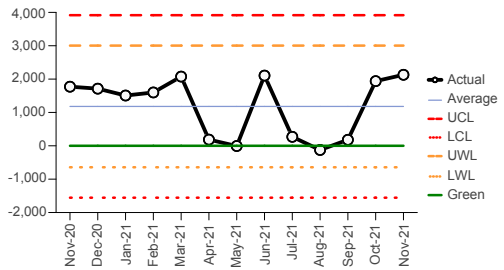
16.3 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: 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	1363	R <0 A N/A G >=0		No Action Required
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	384	R <0 A N/A G >=0		No Action Required
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	2129	R <0 A N/A G >=0		No Action Required

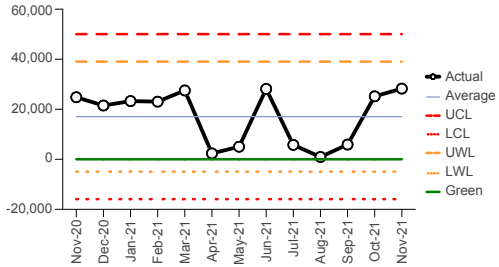
The Best People doing their best Work

16.4 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: Outpatient Activity vs Plan** W Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	28248	R <0 A N/A G >=0		No Action Required

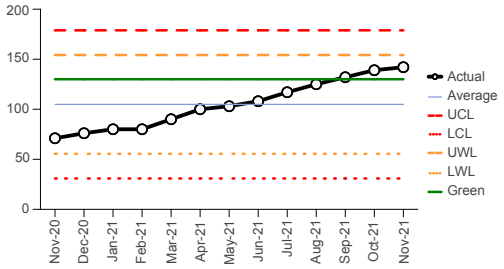
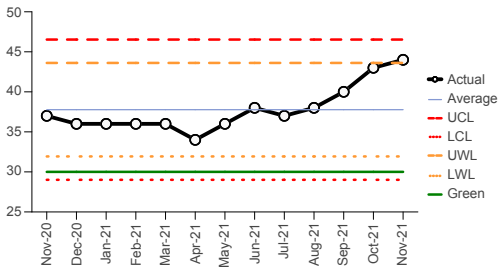
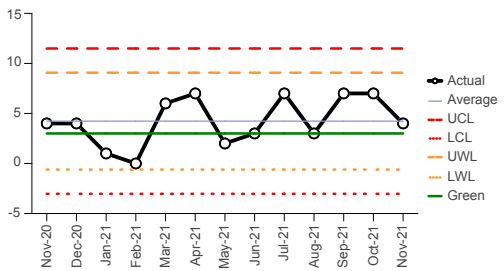
Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

GROW THE FUTURE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Academic** W Number of academic studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	142	R <111 A >=111 G >=130		No Action Required
Clinical Research	**Number of Open Studies - Commercial** W Number of commercial studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	44	R <21 A >=21 G >=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	4	R <2 A >=2 G >=3		No Action Required

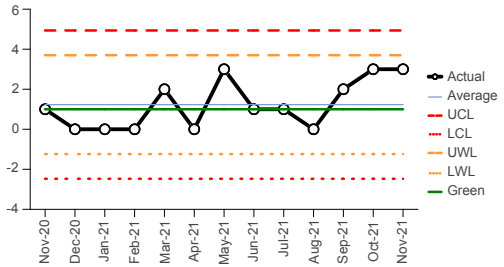
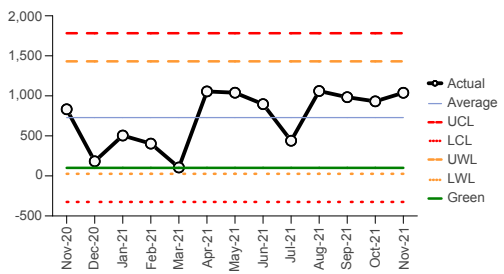
Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	3	R <1 A N/A G >=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	1038	R <86 A >=86 G >=100		No Action Required

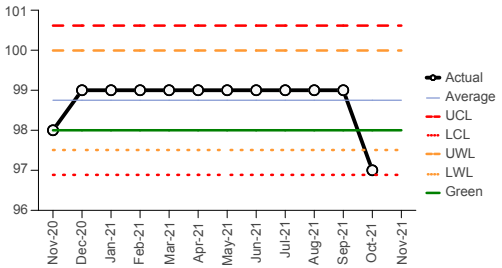
Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

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		R <98 % A N/A G >=98 %		No Action Required

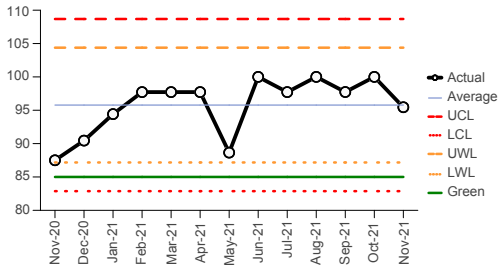
The Best People doing their best Work

19.1 - FACILITIES - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** W Auditing for Domestic Services, aim is to ensure National Cleaning Standards. **Exec Lead:** Nicki Murdock **Committee:** SQAC	95.45 %	R <85 % A N/A G >=85 %		No Action Required

All Divisions

D Drive W Watch P Programme

SAFE

		COMMUNITY	MEDICINE	SURGERY	RAG
Clinical Incidents resulting in Near Miss	D	3	26	35	No Threshold
Clinical Incidents resulting in No Harm	D	55	86	114	No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	7	26	82	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	1	No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	1	0 N/A >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0 N/A >0
Medication errors resulting in harm	D	0	0	3	No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0 N/A >0
Pressure Ulcers (Category 4)	W	0	0	0	0 N/A >0
Never Events	W	0	0	0	0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P		83.3%	82.4%	>=90 % N/A <90 %
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0 N/A >0
Hospital Acquired Organisms - C.difficile	D	0	0	0	0 N/A >0
Hospital Acquired Organisms - MSSA	D	0	1	2	No Threshold

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	2	6	6	No Threshold
PALS	W	46	49	41	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		66.4%		>=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	5	54	No Threshold		
28 Day Breaches	W	0	2	10	0	N/A	>0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		100.0%	98.7%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		100.0%	98.7%	>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P		89.7%	85.9%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		94.9%	100.0%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		84.6%	76.9%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		97.4%	94.9%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	54.5%	65.9%	63.1%	>=92 %	>=90 %	<90 %
Waiting List Size	W	1,629	5,842	11,505	No Threshold		
Waiting Greater than 52 weeks - Incomplete Pathways	W	1	10	239	0	N/A	>0
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W		96.4%		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		88.7%	80.0%	>=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	60	-199	-598	No Threshold
Income In Month Variance (£'000s)	W	59	1,138	68	No Threshold
Pay In Month Variance (£'000s)	W	319	15	-452	No Threshold
Non Pay In Month Variance (£'000s)	W	-318	-1,352	-215	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective	W	0	954	409	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	121	263	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		1,306	822	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	4,585	8,279	13,175	>=0	N/A	<0
PDR	W	83.4%	74.0%	61.6%	No Threshold		
Medical Appraisal	W	60.0%	75.7%	89.3%	No Threshold		
Mandatory Training	W	91.5%	86.6%	87.4%	>=90 %	>=80 %	<80 %
Sickness	D	5.4%	7.3%	0.0%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.8%	2.2%	0.0%	<=1 %	N/A	>1 %
Long Term Sickness	D	3.6%	5.1%	0.0%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	166	373	631	No Threshold		
Staff Turnover	D	11.9%	9.9%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	98.2%	83.7%	89.0%	>=90 %	>=80 %	<90 %

Medicine Division

SAFE	Quality Assurance & Compliance Manager and Risk & Governance Lead reviewing no harm incidents and closing with agreed strapline where appropriate: current position is 524.	**Highlight** • Treatment for Sepsis within 60 minutes improving – watch metric for Division **Challenges** • Quality Assurance & Compliance Manager and Risk & Governance Lead working closely with all managers to reduce the number of open incidents over 10 days.
CARING	Complaints process needs review to identify areas to make improvements to reduce delays in responses. Risk & Governance Lead working with Complaints and PALS officer to escalate areas of hold ups. MIAA trust audit of complaints process carried out week of 6th December 2021 to help identify areas requiring improvement and develop an action plan.	**Highlight** • 3 formal complaints received in month; consistent with 21/22 run-rate **Challenges** • Reducing number of overdue incidents
EFFECTIVE	The Division had a challenged month in November regarding performance in a number of areas; key areas of focus being: ➢ ED 4 Hour performance ➢ ED % left before being seen ➢ OP appointments being cancelled by hospital	**Highlight** • Zero 12-hour trolley waits • Was Not Brought rate improving **Challenges** • Volume of attendance in the minor stream creating significant pressure on triage and wait to be seen measures in ED; programme of improvement in place • Increase in clinical team sickness has led to a number of clinic cancellations during the period.
RESPONSIVE	Challenges remain regarding the provision of play on wards due to COVID IPC restrictions The Division continues to be challenged with regards to Diagnostics waiting times The Division did not meet the 14-day standard for new cancers in month. FDS standard achieved but number of breaches in single service. The new OP PTL launched in month; there remains a process of validation of the new waiting list to correctly determine the Divisions RTT position	**Highlight** ▪ The Division maintained the Faster Diagnosis standard along with the 31 and 62 day treatments standards in month. ▪ MR waiting times (6 weeks) improved to 100% in month **Challenges** ▪ CT and USS waiting times continue to be challenged; the Division is reviewing capacity in light of new emerging pressure ▪ Cancer TWW deterioration relating to single breach related to family delaying appt due to other ongoing treatments. 5 x FDS breaches due to delays from clinic cancellations. Escalation agreed within division to highlight potential breaches earlier.
WELL LED	The Divisions financial position deteriorated significantly in month; revision to H2 funding, ongoing pressures in relation to increased NEL activity and non-recurrent workforce issues impacted. The Division continues to review its forecast closely, particularly in relation to accruals and vacancy rate. Divisional sickness rates continue to present a challenge; focus remains on proactive management.	**Highlight** • Activity recovery continues • Focus remains on improving mandatory training and PDR compliance rates **Challenges** • Mitigating financial pressures particularly in ED when faced with significant increase in demand

Alder Hey Children's NHS
NHS Foundation Trust

Medicine

D Drive W Watch P Programme

SAFE

	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	34	22	18	23	33	43	33	36	31	28	31	36	26		No Threshold
Clinical Incidents resulting in No Harm (D)	126	99	89	97	125	122	124	90	100	99	134	95	86		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	18	19	21	17	19	23	24	17	18	17	15	29	26		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	0	0	1	1	0	2	1	1	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	1	0	0	0	1	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)	0	0	4	1	2	0	0	1	0	2	3	1	0		No Threshold
Medication Errors (Incidents)	32	36	34	28	39	29	41	26	14	20	35	25	20		No Threshold
Pressure Ulcers (Category 3) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	0	1	0	2	4	1	3	2	0	2	1	6	6		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)	75.0%	90.9%	83.3%	84.6%	87.5%	90.9%	88.2%	93.3%	96.2%	75.0%	85.7%	91.3%	83.3%		>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI) (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile (D)	0	0	0	0	0	0	1	0	0	0	1	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	0	2	2	2	1	5	0	0	2	3	3	4	0		No Threshold
Hospital Acquired Organisms - MSSA (D)	0	0	1	1	0	0	0	0	0	0	0	1	1		No Threshold
Cleanliness Scores	96.0%	95.1%	98.4%	97.2%	98.6%	98.7%	98.2%	98.6%	98.6%	98.7%	98.8%	99.4%	98.5%		No Threshold
Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region.	99.7%														>=95 % N/A <95 %
Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed.	64.6%	71.3%	53.9%	68.2%											>=50 % N/A <50 %
Pharmacy - Dispensing for Out Patients - Routine within 30 minutes	85.0%	85.0%	85.0%	84.0%											>=90 % N/A <90 %
Pharmacy - Dispensing for Out Patients - Complex within 60 minutes	77.0%		100.0%	100.0%											>=90 % N/A <90 %

CARING

	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
Complaints (W)	7	6	8	3	12	4	5	2	4	4	3	5	6		No Threshold
PALS (W)	28	27	25	20	37	25	23	41	41	25	48	51	49		No Threshold

EFFECTIVE

	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
Referrals Received (Total)	2,103	1,707	2,089	1,693	2,236	2,141	2,243	2,413	2,253	1,917	2,460	2,597	2,645		No Threshold
ED: 95% Treated within 4 Hours (D)	97.1%	98.6%	98.5%	97.8%	95.3%	92.5%	81.1%	85.5%	67.9%	87.7%	73.4%	72.5%	66.4%		>=95 % N/A <95 %
ED: Percentage Left without being seen (W)	1.0%	0.6%	0.5%	0.7%	2.2%	3.8%	7.4%	4.9%	12.5%	4.3%	9.1%	9.5%	8.7%		<=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	1	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	1	0	0		0 N/A >0
ED: Re-attendance within 7 days of original attendance (%) (W)	7.8%	7.9%	9.0%	7.9%	7.5%	8.3%	9.5%	8.6%	9.8%	9.7%	8.4%	9.1%	9.6%		No Threshold

Alder Hey Children's NHS
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D Drive W Watch P Programme

	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
ED: Number of patients spending >12 hours from decision to admit to admission W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Theatre Utilisation - % of Session Utilised W	82.2%	84.0%	83.7%	87.8%	86.3%	86.6%	81.9%	80.1%	82.4%	80.2%	82.7%	81.4%	80.7%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons D	1	2	0	0	1	2	0	1	0	3	2	3	5		No Threshold
28 Day Breaches W	0	0	1	0	0	0	0	0	0	0	1	1	2		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	20	47	16	14	18	21	19	21	37	42	30	43	45		No Threshold
OP Appointments Cancelled by Hospital %	12.0%	13.4%	12.3%	12.4%	11.6%	9.9%	10.6%	11.6%	15.1%	15.1%	14.1%	15.8%	12.6%		<=5 % N/A >10 %
Was Not Brought Rate W P	10.5%	10.5%	11.2%	9.4%	9.0%	9.3%	8.9%	9.9%	12.0%	15.6%	12.3%	11.1%	10.7%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) W	12.2%	11.5%	11.7%	10.9%	9.4%	12.3%	10.1%	11.2%	10.7%	11.9%	10.4%	10.4%	8.9%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) W	10.1%	10.3%	11.1%	9.1%	9.0%	8.7%	8.6%	9.6%	12.3%	16.4%	12.7%	11.3%	11.2%		<=14 % <=16 % >16 %
Coding average comorbidities	5.45	5.50	5.45	5.54	5.41	5.14	5.17	5.59	5.47	5.58	5.48	5.67	5.56		No Threshold

RESPONSIVE

	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care W	96.9%	95.8%	100.0%	96.4%	95.2%	96.2%	98.3%	93.5%	87.9%	100.0%	92.7%	88.7%	100.0%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect W	100.0%	95.8%	100.0%	100.0%	95.2%	98.1%	100.0%	89.1%	87.9%	97.9%	92.7%	94.3%	100.0%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge D P	100.0%	91.7%	96.9%	98.2%	91.9%	96.2%	91.5%	95.7%	86.2%	91.5%	92.7%	86.8%	89.7%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care W	100.0%	87.5%	100.0%	92.9%	95.2%	94.3%	100.0%	97.8%	93.1%	87.2%	90.2%	100.0%	94.9%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play D	84.4%	81.2%	75.0%	89.3%	85.5%	84.9%	88.1%	71.7%	81.0%	72.3%	75.6%	73.6%	84.6%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning D	62.5%	81.2%	93.8%	94.6%	80.0%	90.6%	89.8%	80.4%	87.9%	74.5%	85.4%	86.8%	97.4%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks W	81.0%	88.1%	89.5%	90.8%	92.9%	92.0%	93.1%	92.5%	86.8%	83.3%	77.5%	65.4%	65.9%		>=92 % >=90 % <90 %
Waiting List Size W	1,778	1,785	1,731	2,110	2,280	2,509	2,819	3,122	3,338	3,507	3,565	5,605	5,842		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways W	0	0	1	16	4	4	3	6	11	7	13	23	10		0 N/A >0
Waiting Times - 40 weeks and above	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%	95.7%	100.0%	100.0%	100.0%	100.0%	96.4%		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	97.7%	91.7%	94.6%	96.0%	97.7%	95.5%	95.1%	98.4%	95.6%	94.4%	97.1%	96.4%	88.7%		>=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%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Pathology - % Turnaround times for urgent requests < 1 hr	90.6%	90.4%	90.4%	90.4%	91.9%	91.1%	92.6%	91.1%	91.6%	91.9%	89.8%	89.8%	90.0%		>=90 % >=85 % <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs	99.8%	100.0%	99.9%	100.0%	100.0%	100.0%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=90 % >=85 % <90 %
Imaging - % Report Turnaround times GP referrals < 24 hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <95 %
Imaging - % Reporting Turnaround Times - ED	97.0%	95.0%	99.0%	99.0%	100.0%	89.0%	96.0%	100.0%	99.0%	100.0%	96.0%	91.0%	98.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Inpatients	98.0%	92.0%	99.0%	98.0%	99.0%	89.0%	96.0%	95.0%	92.0%	93.0%	79.0%	73.0%	81.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Outpatients	72.0%	51.0%	75.0%	77.0%	58.0%	65.0%	57.0%	52.9%	54.0%	61.0%	57.0%	51.0%	66.0%		>=85 % N/A <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks	100.0%	94.2%	100.0%	95.0%	98.0%	98.7%	100.0%	91.9%	89.4%	83.1%	86.7%	100.0%	84.5%		>=99 % N/A <99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.5%	91.7%	100.0%	97.1%	94.3%		>=99 % N/A <99 %
Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	99.3%	100.0%	100.0%	98.0%	98.7%		>=99 % N/A <99 %

Medicine

D Drive W Watch P Programme

WELL LED

		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG		
Control Total In Month Variance (£'000s)	W	153	41	189	160	-586	263	200	-1,036	-347	-58	253	-127	-199				
Income In Month Variance (£'000s)	W	561	142	10	36	170	37	-26	-1	209	-490	201	-184	1,138				
Pay In Month Variance (£'000s)	W	338	30	-61	-52	-148	-64	60	-150	48	47	121	-35	15				
AvP: IP - Non-Elective	W	595	586	405	416	676	-153	-78	807	-82	-19	-42	1,002	954		>=0	N/A	<0
AvP: IP Elective vs Plan	W	147	136	123	138	154	-16	-10	157	-25	-58	-26	119	121		>=0	N/A	<0
AvP: OP New		1,484.00	1,051.00	1,180.00	1,087.00	1,229.00	-383.97	-406.28	1,294.00	-511.93	-573.20	-328.45	1,312.00	1,374.00		>=0	N/A	<0
AvP: OP FollowUp		5,688.00	5,000.00	5,810.00	5,212.00	6,141.00	1,657.17	1,393.80	6,465.00	1,136.46	873.03	1,536.47	5,557.00	6,226.00		>=0	N/A	<0
AvP: Daycase Activity vs Plan	W	1,092	1,071	1,003	1,030	1,264	246	187	1,315	229	79	376	1,210	1,306		>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	8,243	7,020	7,832	7,399	8,528	828	694	8,766	47	-352	620	7,456	8,279		>=0	N/A	<0
PDR	W	69.1%	74.6%	74.2%	74.2%	74.2%	2.6%	6.8%	18.5%	50.2%	61.7%	65.8%	72.8%	74.0%				
Medical Appraisal	W	96.0%	94.1%	94.1%	94.1%	94.1%	23.4%	28.6%	33.9%	42.0%	75.9%	52.2%	81.8%	75.7%				
Mandatory Training	W	88.9%	86.7%	88.1%	87.1%	88.5%	89.1%	87.6%	87.9%	87.2%	86.9%	87.0%	86.1%	86.6%		>=90 %	>=80 %	<80 %
Sickness	D	4.7%	4.9%	6.3%	5.1%	4.1%	4.4%	5.5%	5.3%	6.4%	7.2%	6.4%	6.6%	7.3%		<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.5%	1.3%	2.0%	1.4%	1.1%	1.2%	1.5%	1.6%	2.0%	1.9%	1.8%	2.3%	2.2%		<=1 %	N/A	>1 %
Long Term Sickness	D	3.3%	3.7%	4.3%	3.7%	3.0%	3.3%	4.0%	3.7%	4.4%	5.3%	4.6%	4.3%	5.1%		<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	239	213	247	267	261	210	262	230	265	263	292	311	373				
Staff Turnover	D	6.9%	7.2%	6.6%	6.5%	6.0%	6.5%	6.8%	7.3%	7.5%	8.3%	9.4%	9.6%	9.9%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	93.6%	93.2%	91.2%	97.8%	93.9%	101.7%	97.9%	96.0%	87.2%	90.6%	95.0%	83.8%	83.7%		>=90 %	>=80 %	<90 %

Surgery Division		
SAFE	• Overall increase in clinical incidents • 1 clinical incident resulting in moderate harm • 1 clinical incident resulting in severe harm • Significant reduction in medication error incidents • No pressure ulcers • 1 HAI RSV	**Highlight** • No pressure ulcers **Challenges** • 1 incident resulting in moderate harm. • 1 incident resulting in severe harm • 1 HAI RSV case.
CARING	• Reduced number of complaints • Significant reduction in PALs.	**Highlight** • Reduction in number complaints and PALs. **Challenges** • Maintaining response times to complainants.
EFFECTIVE	• No readmissions to PICU within 48 hours • Increased referrals • Increased AVLoS for both EL and NEL • Reduction in theatre utilisation • Reduced OPD appointments cancelled by hospital.	**Highlight** • No readmissions to PICU within 48 hours. • Reduced OPD appointments cancelled by the hospital. **Challenges** • Increased referrals • Increased AvLoS. • Reduced theatre utilisation
RESPONSIVE	• Consistently strong feedback for patients who feel involved in their care. • Deteriorating position for patients involved in play • Slight improvement on RTT/52 weeks. • Highest number of super stranded patients since April 2021.	**Highlight** • Strong feedback from patients who feel involved in care. • Reduced number of patients waiting over 52 weeks. **Challenges** • Deteriorating position for patients involved in play. • Highest number of super stranded patients
WELL LED	• Deteriorating control total • Strong income position • Adverse variance in month for pay. • Deteriorating mandatory training position	**Highlight** • Strong income position **Challenges** • Deteriorating position on control total • Adverse variance in month for pay. • Deteriorating mandatory training position

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SAFE

	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	46	31	24	25	46	23	32	43	26	25	42	33	35		No Threshold
Clinical Incidents resulting in No Harm (D)	190	143	108	140	174	166	165	163	119	114	107	103	114		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	45	42	38	27	33	35	28	38	32	49	39	42	82		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	1	1	0	0	1	2	0	0	1	0	1	1		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	0	0	0	0	0	0	0	0	1	1		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm (D)	11	0	1	2	2	4	2	1	2	3	1	1	3		No Threshold
Medication Errors (Incidents)	68	44	23	40	45	43	36	29	24	27	26	21	26		No Threshold
Pressure Ulcers (Category 3) (W)	0	1	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
Never Events (W)	0	0	0	0	1	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)	90.0%	53.8%	91.7%	83.3%	90.9%	76.9%	91.7%	88.9%	66.7%	100.0%	75.0%	82.6%	82.4%		>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	0	1	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI) (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA (D)	1	0	2	0	0	0	1	0	2	0	0	0	2		No Threshold
Cleanliness Scores	96.0%	97.9%	98.9%	97.0%	97.9%	98.9%	98.4%	98.2%	98.7%	98.2%	98.6%	98.5%	97.4%		No Threshold

CARING

	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
Complaints (W)	4	2	2	3	7	0	4	5	3	4	6	4	6		No Threshold
PALS (W)	22	23	16	22	27	34	42	43	33	25	30	27	41		No Threshold

EFFECTIVE

	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
Readmissions to PICU within 48 hrs (D)	2	1	0	0	1	0	2	0	1	2	0	0	0		No Threshold
% Readmissions to PICU within 48 hrs (W)	4.2%	1.4%	0.0%	0.0%	1.6%	0.0%	2.6%	0.0%	1.4%	2.7%	0.0%	0.0%	0.0%		No Threshold
Referrals Received (Total)	2,987	2,812	2,696	2,904	4,045	3,962	4,115	4,370	3,745	3,218	3,886	3,529	3,874		No Threshold
Theatre Utilisation - % of Session Utilised (W)	88.6%	85.0%	87.6%	90.3%	89.5%	84.0%	88.8%	85.2%	85.1%	86.8%	85.3%	87.8%	85.5%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons (D)	15	8	5	7	11	11	7	12	13	9	30	20	54		No Threshold
28 Day Breaches (W)	1	3	2	1	2	4	3	0	3	8	4	10	10		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	38	45	38	50	37	47	46	59	63	74	54	78	43		No Threshold
OP Appointments Cancelled by Hospital %	11.9%	10.6%	10.6%	10.9%	11.8%	10.1%	10.2%	11.3%	9.8%	11.6%	11.6%	10.9%	9.0%		<=5 % <=10 % >10 %
Was Not Brought Rate (W P)	8.7%	9.9%	10.4%	7.8%	7.2%	6.2%	6.9%	7.1%	8.9%	9.8%	8.6%	8.8%	9.7%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) (W)	9.5%	11.6%	11.5%	10.3%	8.4%	6.9%	8.9%	8.4%	11.2%	11.6%	9.7%	9.5%	10.3%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	8.5%	9.3%	9.9%	6.9%	6.7%	5.9%	6.1%	6.6%	8.1%	9.1%	8.2%	8.6%	9.4%		<=14 % <=16 % >16 %
Coding average comorbidities	4.40	4.48	4.40	4.43	4.54	4.63	4.40	4.49	4.62	4.56	4.50	4.50	4.27		No Threshold
CCAD Cases	27	28	25	29	34	34	31	39	28	19	23	29	24		No Threshold

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RESPONSIVE

		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	W	95.3%	99.2%	99.0%	92.0%	95.8%	95.9%	97.9%	94.7%	97.1%	95.0%	99.1%	99.1%	98.7%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect	W	98.1%	99.2%	100.0%	97.0%	94.4%	98.6%	98.6%	96.8%	97.1%	97.8%	98.3%	99.1%	98.7%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge	D P	97.2%	98.4%	99.0%	98.0%	95.1%	99.3%	92.5%	96.8%	97.1%	93.5%	96.6%	96.4%	85.9%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care	W	99.1%	95.9%	100.0%	96.0%	96.5%	100.0%	97.9%	98.9%	98.6%	99.3%	99.1%	98.2%	100.0%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play	D	85.0%	72.1%	81.9%	84.0%	75.0%	79.7%	76.7%	83.0%	83.5%	79.1%	75.0%	81.2%	76.9%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning	D	74.8%	82.0%	95.2%	92.0%	95.8%	91.2%	92.5%	93.6%	93.5%	92.1%	90.5%	95.5%	94.9%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	53.4%	54.3%	54.5%	56.2%	61.8%	61.6%	64.2%	67.9%	68.5%	67.4%	63.8%	61.7%	63.1%		>=92 % >=90 % <90 %
Waiting List Size	W	8,221	7,858	8,132	8,432	8,701	7,773	7,980	7,484	7,787	8,632	8,319	11,360	11,505		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	W	147	183	221	291	357	276	232	197	174	186	249	294	239		0 N/A >0
Diagnostics: % Completed Within 6 Weeks	W	87.5%	100.0%	50.0%	90.0%	94.1%	91.3%	100.0%	100.0%	93.8%	100.0%	100.0%	88.9%	80.0%		>=99 % N/A <99 %

WELL LED

		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	58	-498	-241	57	-708	-716	217	108	583	-5	-137	-349	-598		
Income In Month Variance (£'000s)	W	1	34	0	83	152	47	49	209	223	28	-144	-43	68		
Pay In Month Variance (£'000s)	W	-62	-394	-360	-157	-526	-599	28	-116	541	-64	-158	-82	-452		
AvP: IP - Non-Elective	W	355	343	341	308	390	56	-22	482	-104	-121	-26	369	409		>=0 N/A <0
AvP: IP Elective vs Plan	W	262	254	217	215	300	-74	-51	290	2	-55	-57	279	263		>=0 N/A <0
AvP: OP New		2,087.00	1,916.00	1,955.00	2,065.00	2,600.00	369.54	-64.15	2,827.00	709.90	-106.72	404.80	2,778.00	2,877.00		>=0 N/A <0
AvP: OP FollowUp		6,837.00	5,835.00	6,182.00	6,419.00	7,887.00	-2,424.10	590.79	8,048.00	1,750.00	-1,025.90	1,256.00	7,585.00	8,777.00		>=0 N/A <0
AvP: Daycase Activity vs Plan	W	680	642	502	569	808	-61	-193	789	37	-205	-197	726	822		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W	10,160	9,001	9,332	9,753	12,061	-2,007	549	12,417	2,764	-1,315	1,946	11,661	13,175		>=0 N/A <0
PDR	W	67.5%	67.6%	66.1%	66.1%	66.1%	0.1%	9.0%	20.3%	47.2%	52.8%	54.2%	60.0%	61.6%		
Medical Appraisal	W	94.1%	96.8%	96.8%	96.8%	96.8%	24.0%	34.8%	37.8%	44.2%	66.7%	59.5%	87.0%	89.3%		
Mandatory Training	W	84.8%	85.6%	86.7%	86.9%	87.8%	89.0%	87.1%	87.8%	88.2%	88.4%	88.9%	88.4%	87.4%		>=90 % >=80 % <80 %
Sickness	D	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		<=1 % N/A >1 %
Long Term Sickness	D	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	505	415	434	382	542	515	457	332	445	469	532	363	631		
Safer Staffing (Shift Fill Rate)	W	95.3%	93.5%	89.6%	92.7%	93.7%	95.8%	99.2%	98.4%	90.0%	92.5%	94.1%	94.8%	89.0%		>=90 % >=80 % <90 %

Community & Mental Health Division

SAFE	Improvement changes from incidents: • **Incident 53553** (Booking and Scheduling) – Mobile number of another family on the child's record, resulting in a text for appointment being sent to wrong family **Improvement** - Patient demographics to be checked by staff at each contact • **Incident 53550** (Community Speech and Language) Referral to Community Paediatrics not received, evidence of completed task from EMIS record sent. **Improvement** - All internal referrals to be sent electronically so that there is an audit trail of when and who sent the referral • **Incident 53545** (Outpatients) - Unlabelled sample received in laboratory **Improvement** - Staff to take time with labelling, ensuring safely attached to bottle.	**Highlight** • Zero clinical incidents resulting in moderate harm, severe harm or death • Zero grade 3 or 4 pressure ulcers • 98 incidents reported in November 2021 **Challenges** • Spotlight session delivered at Divisional Governance meeting on lone working safety, following an incident at a home visit which was discussed at patient safety meeting
CARING	Improvement changes from complaints: • **SO18528** (Developmental Paediatrics) - Wait for review by a Paediatrician and lack of diagnosis – complaint partially upheld **Improvement -** Need to ensure that parents are kept informed about decisions / referrals made on behalf of their children • **SO18706** (ASD/ADHD) - Parent unhappy due to not being included in all relevant communication regarding her daughter. Complaint not upheld **Improvement** include staff training regarding legal framework in relation to parental status, our responsibilities and restrictions – this has been procured and will be rolled out across the division.	**Highlight** • 15 Excellence Reports submitted in November • 10 Compliments submitted in November • New phone system implemented for community paediatrics/ASD/ADHD with very positive feedback on improved contact and reduced time waiting on the phone for these services. • FFT scores 93% scores of Good or Very Good **Challenges** • 46 PALS reported in November • 25 "PALS" recorded relating to Attend Anywhere helpline this is inaccurate recording has been raised with Patient Experience Team • 2 Formal Complaints received in November – 1 x waiting times for Community Paediatrics and 1 x communication and appointments issues in ASD/ADHD
EFFECTIVE	Alder Hey presented at NHS National Benchmarking Webinar 2021 for Mental Health on implementation of CYP1 referral platform	**Highlight** • Zero hospital clinic cancellations with < 6 weeks' notice in November

		Challenges • Referral logging turnaround exceeded past targets of 2 days in November – further capacity is being provided in this service to increase resilience. • Ongoing increase in referrals received to Community and Mental Health services • Continued high number of calls to Crisis Care Service (765 calls)
RESPONSIVE	Hearing Impairment Network involved with collation of service user views by CHSWG (Children's Hearing Services Working Group) regarding joint working with other deafness-related services Calm and Connected Lottery funding awarded for 2 years	**Highlight** • 100% compliance with Urgent Eating Disorder waiting time targets in November • Community Nursing Team continue to support acute inpatient units with clinical review and facilitating early discharge where possible **Challenges** • Challenges with routine waiting time compliance for Eating Disorders (18.2% in November) due to surge in referrals which exceeds available capacity. Recruitment is ongoing and a new assessment clinic is in place to increase throughput.
WELL LED	Staff Survey 2021 compliance in the Community & Mental Health Division was 65.4%	**Highlight** • Mandatory training remains above Trust target at 91.5% • Recruitment and retention initiatives reviewed and agreed at Divisional Board **Challenges** • Sickness decreased but remains above Trust target at 5.9%, management drop-in sessions provided on a weekly basis to divisional leads • Staff turnover is above Trust target at 11.9%

Alder Hey Children's NHS
NHS Foundation Trust

Community

D Drive W Watch P Programme

SAFE

		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	10	16	5	5	9	7	12	7	11	4	8	5	3		No Threshold
Clinical Incidents resulting in No Harm	D	76	53	63	75	84	74	54	51	92	65	50	65	55		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	12	9	11	21	35	28	19	11	20	10	14	7	7		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	0	1	0	0	0	0	0		0 N/A >0
Medication Errors (Incidents)		26	16	19	17	23	17	9	9	10	8	12	18	13		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						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

		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
Complaints	W	4	2	5	4	3	1	0	8	0	3	4	2	2		No Threshold
PALS	W	17	15	14	39	41	40	50	55	39	34	62	50	46		No Threshold

EFFECTIVE

		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
Referrals Received (Total)		1,048	847	776	883	1,106	911	1,317	1,322	1,059	725	1,017	1,114	1,219		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice		2	5	7	10	7	11	5	9	21	22	17	25	41		No Threshold
OP Appointments Cancelled by Hospital %		11.4%	8.1%	12.7%	9.9%	12.4%	11.6%	9.0%	10.4%	12.0%	13.7%	10.8%	14.9%	8.4%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts)	W	8.3%	8.1%	8.8%	10.2%	13.5%	12.7%	14.0%	10.3%	15.5%	10.2%	13.9%	16.1%	24.1%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	W	11.0%	12.9%	12.3%	10.8%	12.8%	13.7%	13.0%	12.1%	15.2%	15.4%	13.0%	12.6%	17.3%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics		10.6%	9.3%	10.5%	15.1%	17.5%	16.7%	17.7%	13.3%	18.3%	14.7%	16.8%	14.8%	21.4%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics		12.3%	16.2%	17.6%	14.5%	17.6%	17.4%	16.8%	18.4%	22.2%	24.2%	23.8%	20.3%	21.8%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS		13.3%	13.5%	20.3%	11.5%	15.1%	6.9%	15.8%	11.7%	23.4%	19.7%	12.6%	16.2%	21.6%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS		11.5%	13.1%	11.9%	10.8%	12.7%	14.0%	13.3%	12.0%	15.8%	15.3%	10.9%	12.1%	16.2%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday		91.0%	109.7%	110.1%	106.6%	114.3%	113.3%	114.3%	112.9%	100.0%	99.5%	101.4%	122.6%	103.8%		No Threshold
CAMHS: Tier 4 DJU Bed Days		190	239	238	210	248	239	248	237	217	216	214	267	217		No Threshold
Coding average comorbidities		3.33	3.00	3.00		4.00	9.00		2.00		8.00			4.50		No Threshold
CCNS: Number of commissioned packages		0														No Threshold

RESPONSIVE

		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU		2	2		1		1					1	1	1		No Threshold
CAMHS: Referrals Received		417	340	268	351	469	396	536	638	373	297	475	526	566		No Threshold
CAMHS: Referrals Accepted By The Service		232	198	158	182	251	198	253	316	172	141	233	302	307		No Threshold

Community

D Drive W Watch P Programme

	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
CAMHS: % Referrals Accepted By The Service	55.6%	58.2%	59.0%	51.9%	53.5%	50.0%	47.2%	49.5%	46.1%	47.5%	49.1%	57.4%	54.2%		No Threshold
RTT: Open Pathway: % Waiting within 18 Weeks (W)	64.3%	64.4%	66.2%	64.5%	66.0%	63.3%	74.0%	69.6%	57.1%	61.2%	52.8%	53.3%	54.5%		>=92 % / >=90 % / <90 %
Waiting List Size (W)	756	800	785	911	911	828	765	808	971	1,147	1,208	1,530	1,629		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways (W)	1	1	0	0	0	3	0	1	2	2	1	1	1		0 / N/A / >0
CAMHS: Crisis / Duty Call Activity	720	698	650	804	807	744	756	717	573	367	674	563	765		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks (W)	70.0%	69.9%	65.9%	67.9%	67.3%	65.6%	68.0%	70.1%	69.3%	68.3%	63.8%	63.9%	68.2%		>=92 % / >=90 % / <88 %
ASD: Completed Pathways	130	61	90	93	107	102	138	126	74	210	33	54	61		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	90.0%	85.2%	64.4%	76.3%	66.4%	24.5%	23.2%	15.9%	8.1%	4.3%	12.1%	7.4%	4.9%		>=92 % / >=90 % / <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%) (P)			91.7%	100.0%	46.2%	16.7%	23.5%	28.6%	6.7%	21.4%	10.5%	23.8%	21.7%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%) (P)			100.0%	100.0%	100.0%	100.0%	25.0%	100.0%	50.0%	100.0%	66.7%	100.0%	100.0%		>=95 % / >=92 % / <92 %
CCNS: Number of Referrals (W)	151	127	119	139	169	120	135	150	582	144	143	165	168		No Threshold
CCNS: Number of Contacts (D)	877	844	783	826	896	791	821	835	959	809	736	931	959		No Threshold

WELL LED

	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s) (W)	270	45	321	221	-41	14	212	-11	287	250	540	16	60		
Income In Month Variance (£'000s) (W)	155	75	148	996	150	94	88	50	154	75	118	-78	59		
Pay In Month Variance (£'000s) (W)	30	12	65	-81	137	5	-49	-87	260	167	15	142	319		
AvP: OP New	781.00	589.00	643.00	522.00	614.00	113.50	351.95	652.00	-102.00	-2.30	-114.00	591.00	591.00		>=0 / N/A / <0
AvP: OP FollowUp	3,810.00	3,396.00	3,815.00	3,794.00	4,123.00	1,446.90	1,415.84	4,231.00	1,013.00	688.30	1,238.00	3,421.00	3,994.00		>=0 / N/A / <0
AvP: Outpatient Activity vs Plan (W)	4,591	3,985	4,460	4,316	4,737	1,561	1,768	4,883	911	686	1,125	4,012	4,585		>=0 / N/A / <0
PDR (W)	81.9%	81.9%	83.1%	83.1%	83.1%	0.0%	1.5%	21.5%	71.5%	78.8%	81.0%	80.9%	83.4%		
Medical Appraisal (W)	100.0%	100.0%	100.0%	100.0%	100.0%	6.2%	24.0%	24.0%	36.0%	68.0%	48.0%	80.0%	60.0%		
Mandatory Training (W)	89.2%	88.4%	89.2%	88.6%	89.3%	91.8%	91.0%	92.3%	92.1%	91.9%	91.4%	91.6%	91.5%		>=90 % / >=80 % / <80 %
Sickness (D)	4.3%	4.5%	5.7%	4.7%	3.9%	3.1%	3.9%	4.9%	5.6%	6.4%	5.8%	6.0%	5.4%		<=4 % / <=4.5 % / >4.5 %
Short Term Sickness (D)	1.2%	0.9%	1.9%	1.0%	1.0%	0.9%	1.2%	1.5%	1.4%	1.5%	1.5%	2.1%	1.8%		<=1 % / N/A / >1 %
Long Term Sickness (D)	3.2%	3.6%	3.8%	3.7%	2.9%	2.2%	2.7%	3.5%	4.2%	4.9%	4.3%	3.9%	3.6%		<=3 % / N/A / >3 %
Temporary Spend ('000s) (D)	212	355	226	169	141	183	192	229	171	127	168	192	166		
Staff Turnover (D)	9.0%	8.7%	9.3%	9.5%	9.8%	10.7%	9.6%	9.8%	9.8%	9.9%	10.1%	10.9%	11.9%		<=10 % / <=11 % / >11 %
Safer Staffing (Shift Fill Rate) (W)	98.5%	98.6%	99.9%	99.4%	100.2%	97.2%	99.1%		99.2%	98.9%	96.3%	108.0%	98.2%		>=90 % / >=80 % / <90 %

Research Division

SAFE	• Divisional Mandatory training demonstrates good compliance • All current risks compliant with review dates • CRF achieved Gold accreditation on the perfect ward inspection • COVID 19 secure space with pre-screening in place prior to hospital visit. • All Incidents reported onto Ulysses system and thematic reviews conducted periodically. • Trust metrics discussed at monthly 121's with staff to encourage compliance.	**Highlight** • PDR Target of >91% met • Mandatory Training > 94% • GCP training 97% • SOP compliance 98% • ANTT compliance 100% • CRD ICP compliant • CRD involved in Trust Quality Rounds **Challenges** • Limited storage space on CRF causing H&S risk • Out of hours research blood samples for oncology trials • X1 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 patient experience data • Patient compliments received for CRF	**Highlight** • X 0 Complaints or PALS concerns • Collaborative working with local services and teams are being established • Research participating in Trust PEG **Challenges** • More work to do on local patient internal audits • Low numbers of electronic survey questionnaires from patients on system. • Compliments to be added to Ulysses
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 • Trust participating in extension COV09 vaccine study with LSTM. • AH sponsoring flagship Asymptomatic Study • AH participating in Stop RSV trial. (one of two national sites) • Portfolio growth in line with plan. **Challenges** • CRF housekeeping • CRD working with local system partners to improve research participation. • 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 • All staff given protected time to complete annual staff survey.

		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 continue to reduce to Trust benchmark. • 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 action plan in complete. • CRD engaging staff with SALS • All bids submitted from to CRN for contingency funding to support performance with recovery plan where successful with additional funding of £81k • Above funding secured for support services totalling £60k • 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 long term sickness absence is currently above Trust Target.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 16th December 2021

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

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ☐
Background Papers and/or supporting information:	None
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	
Associated risk (s)	2100;1925; 2085, 2415;2435

1. Purpose

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

2 Wellbeing

2.1 Winter Wellbeing Plan

An organisational health and wellbeing approach

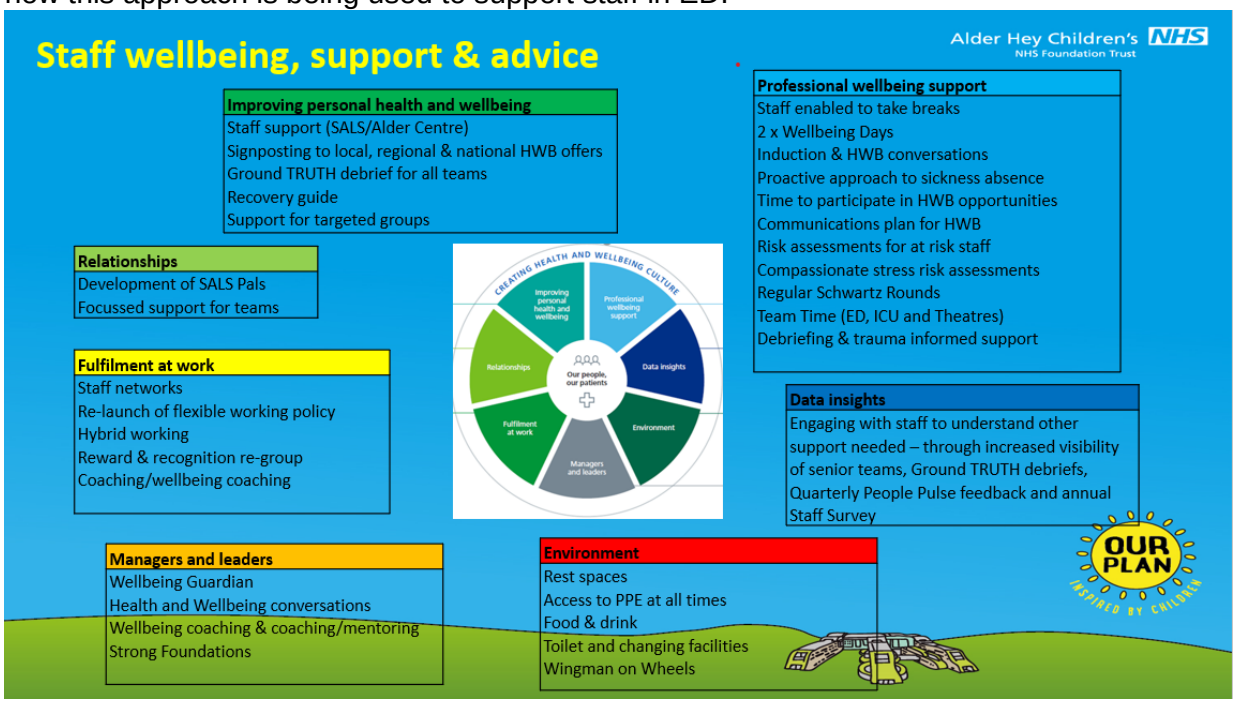
Our approach to staff support has been and continues to be closely informed by the developing evidence base around what works for whom and in what context. What we know clearly, and what our staff routinely tell us, is that wellbeing interventions alone are not sufficient without interventions that more closely address hygiene factors affecting the daily experience of work and working relationships.

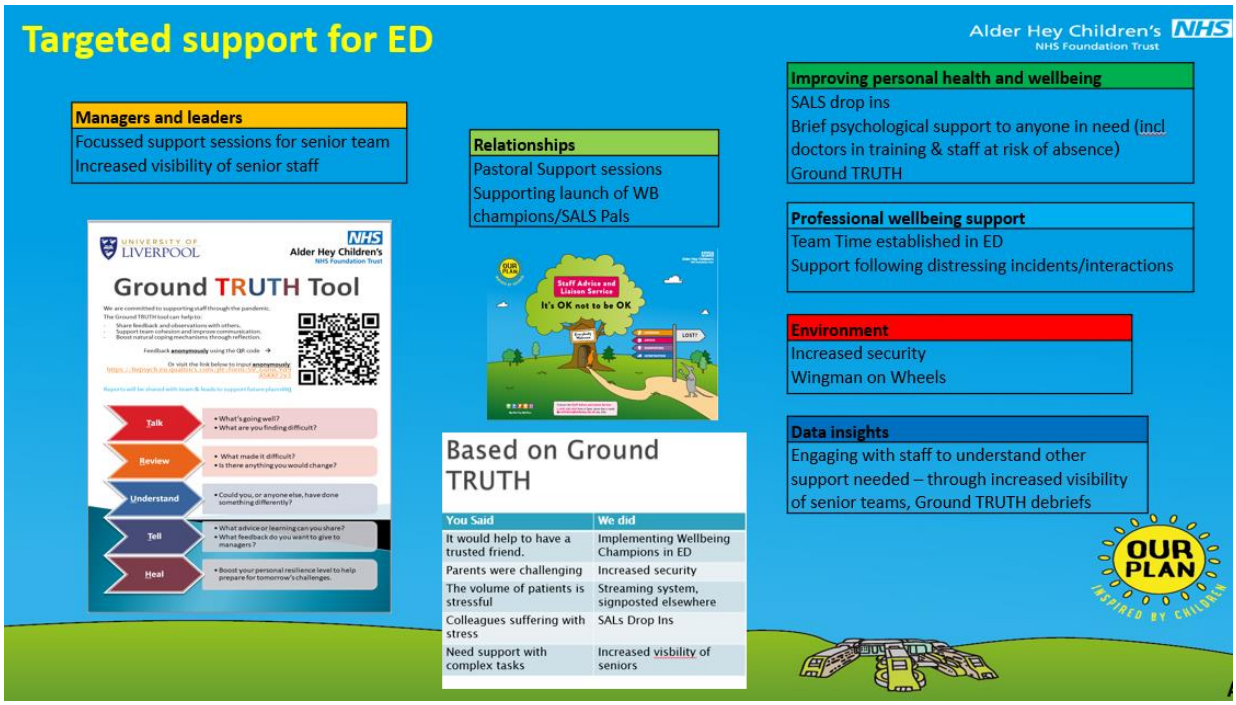
Given the evidence and our learning to date through SALS and other support mechanisms in the organisation, we take an organisational health and wellbeing approach. NHS England have developed an Organisational Health and Wellbeing plan based on the evidence and insights gathered about staff health and wellbeing, and those actions and factors that are likely to have the most impact when staff are working under pressure, since the start of the COVID-19 pandemic in early 2020. The plan is also consistent with the 9 principles underpinning the Wellbeing Guardian role.

The content is based on evidence from academic literature about the impact of COVID-19 on the healthcare workforce and insights gained through the national health and wellbeing programme, including from frontline staff, people who are classed as clinically extremely

vulnerable, feedback form support lines and mental health hubs, people pulse and other sources of data and insight.

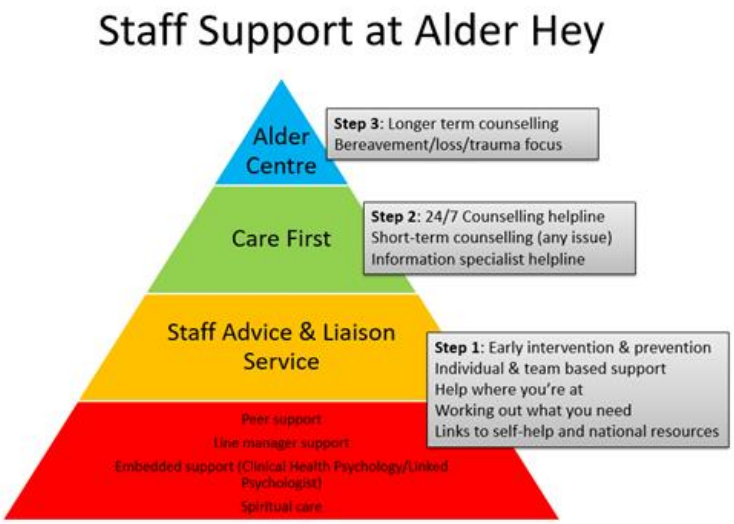
At Alder Hey, we are using this checklist to understand what is most needed for our staff and what key aspects of health and wellbeing support will be needed through the coming months. The diagrams below outline the organisational approach and also an example of how this approach is being used to support staff in ED.





2.2 Staff Support

At Alder Hey, staff have access to a range of support for their health and wellbeing including Occupational Health services, Care First Employee Assistance Programme, Staff Advice & Liaison Service (SALS) and the Alder Centre staff counselling service. Staff in medical specialties and Critical Care can also access support from Clinical Health Psychology services via Clinical Psychologists embedded in teams.



Through the Covid-19 pandemic, support for staff health and wellbeing has been amongst the top strategic priorities and has led to the rapid development and growth of the Staff Advice and Liaison Service, offering an open door, easy access, rapid response listening service to all staff. The service is an open access support for all staff struggling with any issues related to home or work and also provides early intervention and prevention via psychoeducational events and initiatives across the Trust. It aims to prevent staff difficulties from worsening by addressing issues in the moment and finding the right solution in the right place at the right time. Effective triage is key to this. The low numbers of onward referrals to counselling and therapy services indicates that timely and effective triage with brief intervention at this stage is helpful.

There is also a focus in SALS on systemic intervention, including team support following debriefs and training, and contribution to the development of a culture which challenges the stigma associated with help seeking in the healthcare and support services. Considerable focus is also given to supporting staff to both transition to and navigate through services, providing a "safety net" of support during what can be extremely difficult journeys and processes.

SALS has seen a large rise in the number of self-referrals since August 2021, with a corresponding rise in drop-ins. The team remains busy and has had over 2,450 contacts to the service. Despite the increase in demand, the team are still able to respond quickly to all new contacts (within 24-48 hours).

The main reasons for contacting the service are:

- Staff in Crisis (many presenting with suicidal ideation)
- Burnout
- Development or management of OCD
- Trauma
- Workplace Issues
- Relationship issues within workplace
- Bereavement
- Supporting staff on Long Term sick and facilitating a return to work and often undertaking Stress Risk Assessments. The requests for stress risk assessments via SALS has increased significantly in the last three months.
- Supporting staff through formal employment processes
- Domestic Abuse
- Physical illness support (cancer)
- Issues with housing/homelessness
- Generalised stress and anxiety
- Relationship issues outside of work

- Long Covid

There has been an increase in staff presenting in crisis, notably so over the last month. This reflects both the ongoing impacts of Covid 19 and also a challenged adult mental health system where waits are long and thresholds for access to help are high. The team are doing a significant amount of liaison with external services, including Crisis services, to ensure that our staff are receiving the right interventions at the right time. They have also recently met with colleagues at the Cheshire and Mersey Resilience Hub to further develop and enhance the existing pathways that enable access for our staff into their services.
The team are also liaising closely with line managers and colleagues in HR and Occupational Health to provide a joined-up approach to managing crises that remains person centred and ensures the safety of patients and staff.

SALS are delighted to report that they won the HPMA Browne Jacobson Staff Engagement award with the awards ceremony taking place on the 7th October 2021.

2.3 Health Wellbeing Steering Group

The Health and Wellbeing Steering group continues to be well attended. It meets once a month and is currently focussed on the following.

- Financial wellbeing
- Staff Survey and the Big Conversations
- Health and Wellbeing conversations
- Menopause support – next steps
- Wellbeing Guardian role and the 9 Principles of the Wellbeing Guardian.
- Health & Wellbeing Champions/SALS Pals
- Schwartz Rounds and Team Time
- Outside Space for Staff
- Health and Wellbeing Induction & Reviewing Induction in line with 'First 100 days'
- Carers Passport
- Physical Health

Menopause

The steering group is pleased that they are now moving forward with developing a Menopause Policy, and will be reaching out to members of the menopause virtual sessions and our staff side colleagues early in the new year to form a Policy Working Group to support women experiencing menopause.

Financial Hardship

A member of our finance team has agreed to develop a Task and Finish Group to explore the financial advice and support that we can offer to our staff.

New Starters & Induction

The Steering Group are delighted to be working closely with colleagues in the Academy to develop a group which looks at the experience of staff starting in Alder Hey. A first listening event of new starters was held week commencing 29th November which provided a wealth of information to form the basis of an Induction Task and Finish Group.

Wellbeing Guardian

A separate action group has been developed attended by SALS and the Wellbeing Guardian to focus on embedding the role in the organisation via the 9 Wellbeing Guardian principles. This is monitored via an action plan which is mapped onto the Wellbeing Steering group action plan to ensure that they are coordinated. Progress against the 9 principles will be reported to Board via the People & Wellbeing Committee.

3 Staff Engagement

3.1 Staff Survey 2021

The annual NHS Staff Survey 2021 went live on the 21st September 2021. For the first time, in 2021 the questions have been aligned with the NHS People Promise to track progress against its ambition to make the NHS the workplace we all want it to be by 2024. The survey closed on the 26th November 2021. The final response rate for Alder Hey was 52% which is a significant achievement in the current circumstances and places us above average in our sector (Acute and Acute & Community) for total response rates. Initial results will be available in December/January with final results expected in March 2022.

4 Equality, Diversity & Inclusion

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

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

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

5 Flexible Working

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

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

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

6 Staff Availability (Sickness absence)

Table 6.1- Sickness position as of 6th December 2021

	Trust		Community		Corporate		Medicine		Research		Surgery	
Reason	%	No of Staff	%	No of Staff	%	No of Staff	%	No of Staff	%	No of Staff	%	No of Staff
Non Covid Related Sickness	7.02%	285	6.15%	45	6.42%	47	7.22%	88	5.80%	4	7.72%	101
Covid Related Sickness	0.49%	20	0.68%	5	0.00%	0	0.99%	12	0.00%	0	0.23%	3
Absence Related to Covid - not inc sickness	0.32%	13	0.55%	4	0.00%	0	0.57%	7	0.00%	0	0.15%	2
Absence Related to Covid Inc Sickness	0.81%	33	1.23%	9	0.00%	0	1.56%	19	0.00%	0	0.38%	5
All Absence (total of above)	7.83%	318	7.38%	54	6.42%	47	8.78%	107	5.80%	4	8.10%	106

There has been a continual increase in sickness absence across the Trust with total sickness absence (including Covid related absence) accounting for 7.83% of staff absences from work. This increased position is reflective of the position across most Trust's in the Cheshire and Mersey Region. The current position of sickness absence is being monitored closely and has been escalated on the Trust risk register. There are several measures in place to support staff and managers particularly over the winter period and a comprehensive winter staff support plan is in place. The staff availability position continues to be reported through to The Trusts Gold command structure on a weekly basis.

In addition to absences as result of sickness, other absences including maternity leave, vacancies, etc are also monitored to give a more accurate position of staff availability. Table 6.2 shows additional absence (exc of vacancy) across the Trust and hence the more accurate position of staff availability.

Table 6.2 – Staff availability position as of 6th December 2021

Org L2	Adoption	Annual Leave	Maternity	Paid Leave	Sickness	Special Leave	Study Leave	Available	Grand Total	% of Team Available	% of Team Absent
411 Alder Hey in the Park L2		1			2			17	20	85.00%	15.00%
411 Capital L2								2	2	100.00%	0.00%
411 Community L2		33	15	1	50	7		626	732	85.52%	14.48%
411 Corporate Other Department L2			1		3			55	59	93.22%	6.78%
411 Executive L2		1			1			24	26	92.31%	7.69%
411 Facilities L2		8	2		29			178	217	82.03%	17.97%
411 Finance L2		2			2			71	75	94.67%	5.33%
411 Human Resources L2		4	1		1			56	62	90.32%	9.68%
411 IM&T L2		6			5	1		158	170	92.94%	7.06%
411 Innovation L2		1						12	13	92.31%	7.69%
411 Medicine L2	1	46	48		101	9	5	1008	1218	82.76%	17.24%
411 Nursing & Quality L2		4	2		4			78	88	88.64%	11.36%
411 Research & Development L2		3	1		4			61	69	88.41%	11.59%
411 Surgical Care L2		75	39		104	10	4	1076	1308	82.26%	17.74%
Grand Total	**1**	**184**	**109**	**1**	**306**	**27**	**9**	**3422**	**4059**	**84.31%**	**15.69%**

7. Governance and Ongoing Business

7.1 Case Management

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

There has been a decrease in the number of Employee Relations case since the last reporting period. There has however been an increase in numbers of staff at the 3rd stage of the Trust Sickness absence process with 10 staff at this stage.

Table 7.11- Employee Relations Activity Per Division as of 6th December 2021

Table 7.11

Division	MHPS	Disciplinary	Grievance	B&H	Appeal	ET	Stage 3	Total
Surgery H/C 1326	1	0	1	0	1	1	4	**8**
Medicine H/C 1223	1	0	0	0	0	0	3	**4**
Community H/C 687	0	0	0	0	0	3	0	**3**
Corporate & Research H/C 695/65	0	2	0	0	0	0	3	**5**
Grand Total	**2**	**2**	**1**	**0**	**1**	**4**	**10**	**20**

8. Training

As of the 3rd of December 2021, Mandatory Training was at 87% overall, 3% below the Trust target of 90%. We continue to work with staff, managers and SMEs to encourage improvements in compliance.

Our key areas of concern over the last couple of months have been; Resuscitation Training, Estates and Ancillary staff and Moving and Handling Level 2 which had seen significant compliance drops due largely to the impact of COVID on face to face training restrictions.

In terms of Resuscitation training, we have worked with closely with the Resus team who have rolled out Basic Life Support via e-Learning on ESR and allocated additional resources to Paediatric Life Support update sessions. This has seen a consistent improvement in Resus compliance overall – up from 73% to 79% since the last report in September.

In terms of Estates and Ancillary staff we have worked closely with the department managers to identify ways we can deliver training to a staff group who were previously heavily reliant on face to face training and don't engage with e-Learning. This work has seen Estates and Ancillary staff group improve from 58% in October to 73% as of today. We will continue to push mandatory training within this staff group.

In terms of Moving & Handling, the Health & Safety team were without a designated trainer for Moving & Handling level 2 for a large portion of the year, they have now appointed someone to this role and we are working closely with them to try and put together a plan of ensuring compliance improves over the coming months.

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

Table 8.1- Mandatory Training compliance – 3rd December 2021

Trust	Overall Mandatory Training	Change (Since Last Report)
Trust	**87.34%**	-0.03%
Division	**Overall Mandatory Training**	**Change (Since Last Report)**
411 Alder Hey in the Park	**85.22%**	+0.02%
411 Capital	**70.00%**	+3.33%
411 Community	**91.31%**	+0.28%
411 Corporate Other Department	**86.44%**	+1.39%
411 Executive	**96.07%**	+6.07%
411 Facilities	**73.31%**	+7.77%
411 Finance	**90.43%**	+0.84%
411 Human Resources	**90.15%**	+1.90%
411 IM&T	**84.16%**	+2.47%
411 Innovation	**82.93%**	-14.29%
411 Medicine	**86.63%**	-0.39%
411 Nursing & Quality	**91.43%**	-0.88%
411 Research & Development	**91.85%**	-2.14%
411 Surgery	**87.35%**	-1.29%

Table 8.2 – PDR Compliance as of 3rd December 2021

As of the 3rd of December, our Trust appraisal rate was 72.88%, 17% lower than our target of 90%. The 2021 PDR window has now closed but we will continue to provide an update throughout the year. The figures below will continue to flux as staff move around the organisation.

Division	Reviews Completed %
411 Alder Hey in the Park	**60.00**
411 Capital	**100.00**
411 Community	**83.68**
411 Corporate Other Department	**50.00**
411 Executive	**54.17**
411 Facilities	**71.51**
411 Finance	**93.85**
411 Human Resources	**76.47**
411 IM&T	**94.64**
411 Innovation	**87.50**
411 Medicine	**73.95**
411 Nursing & Quality	**86.49**
411 Research & Development	**82.81**
411 Surgical Care	**61.64**
Grand Total	**72.88**

Alder Hey Trust Board
December 2021

Paper Title:	Collaborating for Child Health: Improving Children & Young People's (CYP) life chances and tackling health inequalities.
Report of:	Dani Jones, Director of Strategy, Partnerships & Transformation
Paper Prepared by:	Dani Jones Abby Prendergast, Associate Director of Strategy Jack Morton, Snr. PH Practitioner (Joint AH/ LCC Public Health)

Purpose of Paper:	Decision ■ Information ■
Background Papers and/or supporting information:	• A year of COVID-19 in the North: Regional inequalities in health and economic outcomes – Northern Health Science Alliance (Sept 2021) • Implementing phase 3 of the NHS response to the Covid-19 pandemic (Aug 2020) • The NHS Long Term Plan (Jan 2019) • Improving Health and Wellbeing in Cheshire & Merseyside - Health & Care Partnership (ICS) Strategy (2021-2025) • The One Liverpool Strategy (2019-2024) • City Plan Liverpool – Liverpool City Council (Oct 2020) • Liverpool's Covid-19 Journey – Liverpool City Council Public Health Annual Report (2020) • Build Back Better: Our Plan for Health and Social Care (Dept Health and Social Care, Sept 21) • Health Equity in England: The Marmot Review 10 years on (2020) • Child Mortality and Social Deprivation – NCMD Thematic Report (May 2021) • Child of the North – Building a fairer future after Covid-19 – NHSA/N8 Report (December 2021)
Action/Decision Required:	To note ■ To approve ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ■
Resource Impact:	Determined on case by case basis.

1. REPORT PURPOSE

The purpose of this report is to;

- Outline the national, regional, local and Alder Hey **context** pertaining to health inequalities and improving child health;
- Outline our **plan** to address health inequalities which impact upon CYP and embed prevention throughout our Trust services and system partnerships;
- Make **recommendations** on next steps to be taken as a Trust.

2. CONTEXT

Alder Hey is more than a children and young people's hospital, community and mental health provider. As a Trust **we are concerned with all aspects of CYP health and wellbeing**, and hence we recognise our obligation to focus on a CYP's physical and socio-economic environment. This in turn derives our **commitment to working with partners** in primary care, public health and population medicine, as well as those within the wider education and skills sectors. A beacon of this commitment is **Alder Hey in the Park**, our world-leading health and wellbeing campus for CYP. The Trust has a long-held commitment to Public Health[1]. There is recognition that to "build a healthier future for children and young people" the Trust needs to robustly integrate public health into its vision and strategy, and re-orientate services to promote healthy development in children, so that **at every opportunity Alder Hey improves health in Liverpool and beyond, rather than just treating illness[2].** In 'Our Plan' (strategic plan to 2024) we committed to positively impact on social value and the health and wellbeing of our communities. Our **aim** for this work is to:

Collaborate for Child Health: Improve the life chances of CYP by helping them overcome the Health Inequalities they face.

To make a positive change to poor outcomes and inequalities, we **must enable children and young people to 'start well'**. This means;

- **Listening carefully to what 'safe' and 'happy' mean to CYP;**
- Taking a **'Rights of the Child[3]' based approach**, seeking and respecting CYP's views and focusing our lens on how our actions support CYP's rights;
- **Prioritizing co-design** with CYP and families we reach *and* those we may not reach effectively; seeking routes to co-design that are inclusive across communities;

[1] Examples include: Alder Hey subscribed as a WHO Health Promoting Hospital in 2016; the Trust's Quality Strategy 2011-2015 included a focus on heath inequalities and public health; Alder Hey partook in the International Network of Health Promoting Hospitals Task Force on Health Promotion for Children & Adolescents for Hospitals in 2009.

[2] Prof. David Taylor-Robinson, Alder Hey Note, 14th February 2019

[3] The Convention on the Rights of the Child: The children's version | UNICEF

- Taking appropriate action by **working together with partners** to ensure CYP have opportunities, better life chances and the potential to lead safe and happy lives, irrespective of where they live or where they were born.

- There is a **clear association between risk of death and the level of deprivation**[4]
- **Over a fifth of all child deaths might be avoided** if children living in the most deprived areas had the same mortality risk as those living in the least deprived (over 700 fewer children dying per year)[5]

The UK continues to experience widespread inequalities in health and preventable illness; the COVID-19 pandemic has hit the country unevenly, with a disproportionate effect on the North of England - increasing regional health and economic divides[6].

In Cheshire & Merseyside, **CYP experience poorer than national average outcomes across almost every key indicator**; they are not getting the best start in life. In Liverpool City Region 27.8% of children aged 0-15 live in poverty; 14.6% live in poverty in Cheshire[7]. Evidence shows the most important drivers of good health are **wider determinants[8] such as good education, employment, housing and access to healthy food (etc.).** Greater system action on health inequalities and prevention of ill health will help CYP to become healthier adults and reduce demand on the NHS.

The NHS is increasingly focused on this agenda, reflecting this importance by requiring all Trust Boards to have a **named Health Inequalities (HI's) champion at Board Level**[9] (Deputy Medical Director Dr Adrian Hughes has been designated for Alder Hey). Alder Hey are members of the Liverpool Health Partners research collaborative, who have established a progressive **'Starting Well'** research programme which prioritises addressing health inequalities for CYP.

The recent national 'Build Back Better' publication[10] proposes the **NHS shifts further towards prevention**, implementing a new Office for Health Improvement and Disparities, developing a National Prevention Service and outlining ambitions for a new NHSE/I requirement to demonstrate yearly prevention spend, including 10 year outcome trajectories.

NHSE/I are increasing the regulatory framework around prevention. Following a commissioned national advisory group of leaders from within and beyond the NHS,

[4] The Child Mortality and Social Deprivation – NCMD Thematic Report (May 2021) found a clear association between the risk of death and the level of deprivation for children who died in England between April 2019 and March 2020. This association appeared to exist for all categories of death except malignancy. On average, there was a relative 10% increase in risk of death between each decile of increasing deprivation.

[5] Child Mortality and Social Deprivation – NCMD Thematic Report (May 2021)

[6] A year of COVID-19 in the North: Regional inequalities in health and economic outcomes – Northern Health Science Alliance (Sept 2021)

[7] Health in Cheshire and Merseyside Presentation to CYP Round Table, Eileen O'Meara, Oct 20

[8] https://www.kingsfund.org.uk/publications/what-are-health-inequalities

[9] Implementing Phase 3 of the NHS Response to the Covid-19 Pandemic, NHSE/I, August 2020

[10] Build Back Better: Our Plan for Health and Social Care (Dept Health and Social Care, Sept 21)

eight urgent actions[11] were identified to tackle HI's, building on the measures to implement the NHS Long Term Plan[12].

NHSE/I Nationally Mandated Actions for tackling Health Inequalities:

1. Protect the most vulnerable from Covid-19
2. Restore NHS services inclusively
3. Develop digitally enabled care pathways in ways which increase inclusion
4. Accelerate preventative programmes which proactively engage those at risk of poor health outcomes
5. Particularly support those who suffer mental ill-health
6. Strengthen leadership and accountability[13]
7. Ensure datasets are complete and timely[14]
8. Collaborate locally in planning and delivering actions[15]

In addition, the NHS Confederation have recently published a **Health Inequalities Board Assurance toolkit**[16], developed in conjunction with Trusts and linked with CQC, taking a similar approach to Key Lines of Enquiry (KLOEs); it is likely that this will become part of the regulatory framework for Trusts in the near future. Alder Hey will undertake to develop a gap analysis of our readiness and prepare a roadmap for identifying priorities, developing a health inequalities dashboard and an approach to Board assurance on health inequalities for the Trust during Q4 of 21/22.

2.1 CHESHIRE & MERSEYSIDE (C&M) INTEGRATED CARE SYSTEM (ICS)

Addressing health inequalities is at the heart of the C&M ICS's aspiration. The negative impact of health inequalities on the C&M population[17] has driven C&M to subscribe to a programme of work led by Sir Michael Marmot[18]. This programme is based on the recommendations of the 2010 Marmot Review, which included, among other recommendations the commitment to ''***give every child the best start in life'*** as well as systematically addressing health inequalities. The programme aims to see C&M develop as a 'Marmot Community' which enables system wide plans and progress towards these recommendations.

In C&M, there is a consensus for a '**shift-left[19]' model of care** based on prevention, population health and integrated personal care which places CYP and families at the centre. The model of care is focused on addressing health inequalities and delivery at Neighbourhood, Place and System level, organising the provision of care at different

[11] Implementing phase 3 of the NHS response to the Covid-19 pandemic (Aug 2020)
[12] The NHS Long Term Plan (Jan 2019)
[13] As pertains to Health Inequalities
[14] As pertains to Health Inequalities
[15] As pertain to Health Inequalities
[16] https://www.nhsconfed.org/articles/leadership-framework-health-inequalities-improvement
[17] A year of COVID-19 in the North: Regional inequalities in health and economic outcomes – Northern Health Science Alliance (Sept 2021)
[18] Health Equity in England: The Marmot Review 10 years on (2020)
[19] 'Shift-left' is a term used to describe a shift of resources towards supporting more people to stay well (as opposed to the current model of funding treatment of ill-health), reducing health inequalities and providing increasing levels of care and support in communities and close to people's homes.

settings, moving care closer to home and working to integrate services vertically across the NHS as well as horizontally across health, care and education.

The model of care is supported by **using real-world data to 'risk stratify' CYP into cohorts** (dividing into groups based on factors such as their health history, the severity of their health problems, and the complexity of care they require) in order to pre-select groups or individuals for early intervention, as well as targeting care and interventions effectively. C&M partners share a desire to **tackle adverse outcomes** from maternity through the life course by focussing on the **first 1001 days** of a child's life, also known as 'Starting Well' and attempting to reduce the life-limiting factors and the inequity in life-expectancy gap which has increased for many of C&M's 'Places' / Boroughs[20].

OUTCOMES

Life-course research conducted by CHAMPS[21] (Public Health Collaborative spanning all of C&M) shows that **key CYP indicators where our region is an outlier** include:

Smoking in Pregnancy	Childhood Obesity
Breast Feeding	CYP Mental Health & emotional wellbeing
School Readiness	CYP Learning Disabilities & Autism
Maternal, neonatal and infant mortality rates	CYP Respiratory illness & Asthma

2.2 'PLACE[22]' level

Alder Hey has a relationship with all 9 'Places' in Cheshire & Merseyside as a tertiary provider. As such the Trust has an opportunity to contribute, through partnership working, to early intervention and prevention pathways as they shape across the system.

As a trust we also have a direct relationship with Liverpool, Sefton & Knowsley 'Places' as a secondary care provider, and (for Liverpool and Sefton) as a community and mental health provider.

At this 'Place' level we are active contributors to partnership approaches with our Local Authority and health colleagues, for example through local Health and Wellbeing Boards and 'Place' system plans (such as 'One Liverpool' and 'Sefton 2030') and governance arrangements. All 'Place' plans essentially require a **radical upgrade in prevention and early intervention** and take a **life course approach**.

[20] C&M W&C Partnership – A Call to Action – October 20
[21] Champs | Public Health Collaborative (champspublichealth.com)
[22] 'Place' is the name used to describe the level of care and partnership delivered at a Local Authority/CCG footprint e.g. Liverpool or Sefton. There are 9 formal 'Places' in Cheshire and Merseyside ICS.

Alder Hey leads come together regularly with key CYP partners, including Local Authority Directors of Public Health and Directors of Children's Services to align work programmes for CYP.

2.3 POPULATION HEALTH

Increasingly, commissioners and providers are focusing on action, service delivery and the allocation of system resource in communities. Population Health uses data and intelligence to **understand need, improve physical health outcomes, mental health outcomes and wellbeing whilst simultaneously addressing health inequalities** across a defined population (see Glossary – Appendix 2).

This approach will **drive different behaviours and interventions for Alder Hey.** It means increasingly taking action to reduce the occurrence of ill-health, as well as treating that which already occurs. It means working together with our system partners to address the wider determinants of health. It will mean a continued shift in our thinking; towards population segmentation[23], risk stratification[24] to identify 'at risk' cohorts; towards contribution to the design and targeting of interventions to prevent ill-health and improve care and support for CYP with ongoing conditions; and towards demonstrating our added value in a system with finite resources.

It is **important that we in Alder Hey play our part** in shaping the system response and **optimising the impact for CYP**. Alder Hey is already involved in a range of prevention activities (see section 4) but a coherent view of our contribution will be developed through the proposed Health Inequalities and Prevention (HIP) Steering Group to ensure we are maximising opportunities throughout.

3. PLANNED APPROACH

This agenda is extensive, complex and already in-flight in many parts of the Trust (as demonstrated below). As a result, this paper proposes an approach that;

- **Prioritises the 'Rights of the Child[25]** through seeking and respecting CYP's views, considering our actions *with* CYP, and through the lens of their rights outlined in the UN Convention, for example the right to food, clothing, a safe home, education, protection and inclusivity;
- **Recognises the brilliance of clinician-led change** and considers applied clinical epidemiology as an approach to support implementation within the Trust;
- **Invites people in Alder Hey to see their work through the lens** of positive action on health inequalities and the wider determinants of health, establishing these as **themes** in our **quality improvement, service/pathway developments and education offer,** and **embedding into established programmes** (for

[23] See Glossary Appendix 2

[24] See Glossary Appendix 2

[25] The Convention on the Rights of the Child: The children's version | UNICEF

example, services may prioritise through their 'Brilliant Basics' quality improvement plans);

- **Works with the willing** – facilitating the growing energy and commitment across the Trust, communicating to spread ideas and adoption.

We will achieve change via a 4-point strategic plan:

A. Alder Hey Prevention Pledge
B. Targeted action on Health Inequalities
C. Partnership
D. Trust Governance

A: Alder Hey Prevention Pledge (C&M Prevention Pledge, Trust prevention activities and our role as an Anchor Institution)

C&M Prevention Pledge

The C&M ICS have tested a new model to support NHS Trusts to scale up evidence-based interventions that address local priorities, through the development of a C&M Prevention Pledge. The Pledge aims to **support and enable Trusts to become anchor institutions and system leaders in prevention**. The ICS has signed up as a 'Marmot Community', and work is commencing to embed the 'Marmot Principles[26]', including best start in life and prevention of ill-health, into local strategies.

The Alder Hey Prevention Pledge will be shaped and facilitated by this C&M Pledge programme. This requires a wide range of engagement and adoption throughout the Trust. The Pledge is a framework underpinned by 'core commitments' that NHS providers are expected to work towards plus additional bespoke commitments which are specific to the Trust. The core commitments were developed through extensive consultation with representatives from provider Trusts, NHS E/I, local authority public health teams, Public Health England, and third sector organisations. An overview of the C&M Prevention Pledge and 'core commitments' can be seen in Appendix 3.

Current Trust Activities in Prevention / Health Inequalities

Our activities in preventing health inequalities and their adverse consequences for CYP must be clearly focussed on the most important determinants and the most impactful interventions, based on robust evidence obtained from high-quality research and employing state-of-the art innovation.

Alder Hey can already demonstrate action against many of the core commitments; others require development and delivery. Examples of our existing broad portfolio of activity, focused on addressing the wider determinants of health and prevention, include:

[26] Marmot Review report – 'Fair Society, Healthy Lives | Local Government Association

Service / Area	Examples of Prevention Activities	Alder Hey Lead(s)
Respiratory	• Asthma 'heat' mapping • Data sharing with primary care for proactive management of Asthmatics	Prof. Ian Sinha & Innovation team
	• 'MOVE' – specialist coaching / physical activity programme for CYP with Cystic Fibrosis with LFC Foundation	Claire Hepworth
Obesity/weight management	• Obesity MDT and Weight Management service (LOOP)	Senthil Senniappan
	• 'MOVE' Community Obesity / Weight Management programme with LFC Foundation*	Senthil Senniappan, Peter Laing

General Paediatrics	• Infant Feeding community outreach / resilient parenting
	• Secondary prevention pathway work including;
	  ○ Constipation (underway)
	  ○ Headaches
	  ○ Diabetic ketoacidosis
		Francine Verhoeff
		
		Urmi Das

Diabetes	• Healthy Lifestyles approach	Urmi Das
Dental / Oral Health	• CYP Oral Health improvement	Susana Dominguez-Gonzales, Jo May, Julie Knowles, Lisa Cooper
Mental Health	• 'Trailblazer' early mental health support in schools (prevention focused)	Lisa Cooper
Complex Children	• AHP & Nursing preventing admissions in the community e.g. Special Schools ++	Carol Rowlands
One Liverpool	• Community Integrated Care teams (proactive identification of need & MDT intervention)	Carol Rowlands
Lobbying and Policy	• Wider Determinants of Health conference (2019)	Prof. Ian Sinha
	• LivAIR Pool clean air plan (with LCC)	Prof. Calum Semple
	• Health Inequalities, Poverty & Child Health – numerous publications (Lancet, BMJ++)	Prof. David Taylor Robinson (joint contract with Alder Hey), Prof. Ian Sinha
Clinical Epidemiology	• Development of AH resource • Hospital Clinical Epidemiology • Applied Clinical Epidemiology	Bea Larru Prof. Ian Sinha

Our Role as an 'Anchor Institution[27]'

[27] See Glossary – Appendix 2

"As well as providing health services we will use our resources, influence and work in partnership to maximise our social, economic and environmental impacts (social value) to improve the social determinants of health, health outcomes and reduce health inequalities"[28].

Exemplars of our role as an anchor institution include:

- The **wellbeing of our community** is closely tied to our Trust ambitions; **Alder Hey in the Park** is a beacon of this commitment, the world-first children's health and wellbeing campus designed to improve the wellbeing of Alder Hey's local community and users;
- Alder Hey is a **major employer, recruiter** and **contributor to the local economy; nearly 40% of our c. 4000 staff live in Liverpool**;
- We spend c. £36m annually **procuring** goods and services – increasing the proportion of this that is spent in the local economy is a core commitment of the Prevention Pledge;
- We have clear ambitions to protect the environment for future generations, through our commitment to climate change, including a move towards net zero status, outlined in our **Green Plan**.

It is important that we **recognise, formalise and communicate our role as an anchor institution** and commit further to working differently to make a tangible difference to both our immediate local community and population of Liverpool, and to contribute effectively to the emergent network of anchor institutions across Cheshire & Merseyside.

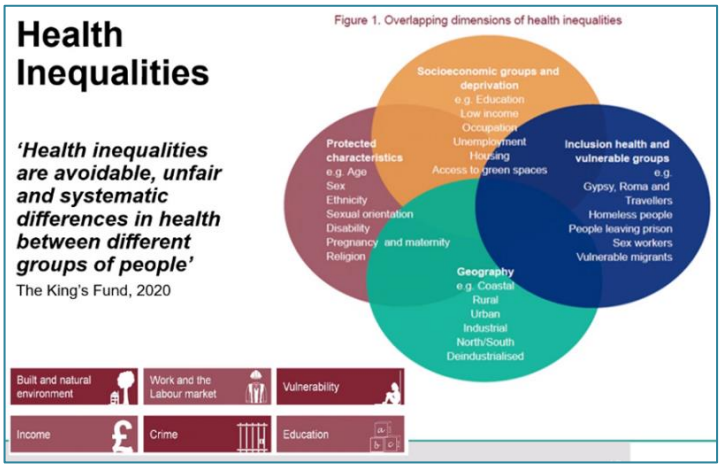
The Alder Hey Academy are already providing leadership in our offer as an Anchor, developing the Education offer, leading engagement for the Trust nationally via the Health Anchors Learning Network, and driving new approaches in partnership, for example working with the Community & Mental Health Division to establish a focused programme of **volunteering opportunities and supported internships for young people with a disability** from across the City Region. We can and should grow more initiatives and opportunities like this through our corporate and clinical plans. It is proposed that we use the framework of our Alder Hey Prevention Pledge and the new HIP Steering Group to enable this.

B: Targeted Action on Health Inequalities (internal and partnership/system)

This work stream will focus on **systematically identifying, understanding and acting on any areas of inequality**; this will range from targeted action in more deprived geographies, ensuring equity of access to (health and care) services (for groups such as BAME, those with disabilities, learning disabilities, obesity, neurodiversity, poor mental health, and other long term health conditions) to broader

[28] FUTURE DIRECTIONS: POSITION STATEMENT (Anchor Role) Dr Katherine Birch (Director, AH Academy) July 21

approaches to tackling the wider determinants of health through our Public Health/Prevention plan.



Alder Hey will **work in partnership on communications** across the city region and continue to ensure all groups understand they are able to access Alder Hey's services. Targeted health inequalities work will be shared for systematic learning and spread of best practice; this will ensure we build on examples such as our Paediatric Accelerator programme's approach to **improving outpatient non-attendance ("was-not-brought") rates,** based on routine health data and maximise the impact of health inequalities-focused system programmes such as C&M CYP Programme and One Liverpool.

Data and Intelligence

A key enabler to developing our knowledge and approach to tackling health inequalities is data and intelligence. At Alder Hey we will need to understand our **baseline data capture of key protected characteristics / indicators of health inequalities** in order to understand the scale and impact of any inequalities we find, and to evaluate the impact of interventions designed to address inequalities.

As aforementioned, good practice emergent from the NHS Confederation (and likely to develop into CQC's key lines of enquiry in this area) outlines need to develop a Board Assurance Tool[29] for health inequalities and drives towards the establishment of a **Health Inequalities Improvement Dashboard**. This would enable Board-level scrutiny of progress against key indicators, as well as driving the whole Trust towards assessing the impact of our work through the lens of addressing inequalities. There is a strong focus in the NHS Confederations example Board Assurance Tool driving the Trust to 'ensure relevant and complete data sets are collected and utilised in decision making to tackle inequality… ensure collaborative working to complete data sets across the system…include patient level data on social factors so that prioritising is based on the whole person, balance of clinical and social factors'.

[29] https://www.nhsconfed.org/sites/default/files/2021-11/Board%20Assurance%20Tool%20-%20%20Leadership%20Framework%20for%20Health%20Inequalities%20Improvement.pdf

C: Partnership

To achieve impact in preventing or reducing the effect of health inequalities, it will be essential to work in close collaboration with a range of partners in government, primary care, public health, NHS, academia and industry.

Cheshire & Merseyside

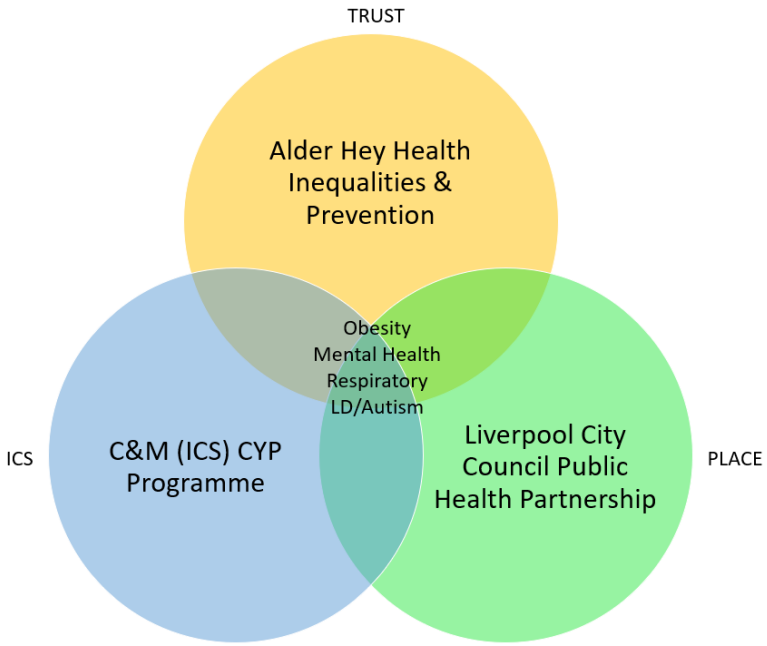
The **C&M CYP Transformation Programme** is a collaborative, hosted and led by Alder Hey on behalf of the ICS. This programme takes a system-wide approach to tackling health inequalities and improving outcomes for CYP.

Initial programme priorities have been selected through a rigorous system wide process with widespread multi-agency representation from across C&M. All 9 C&M 'Place' Joint Strategic Needs Assessments (JSNA) were reviewed, alongside the 9 local 'Place' plans for CYP, alongside an evidence based review of the priorities undertaken by the Cheshire & Merseyside 'CHAMPS' public health network with contribution from the Liverpool Health Partners 'Starting Well' research programme.

The initial priorities are to improve outcomes for the following cohorts;

- CYP with respiratory conditions
- CYP with poor emotional health and wellbeing or mental ill-health
- CYP with learning disabilities and/or autism
- CYP who are an unhealthy weight or obese

These ICS-level CYP priorities are common threads which reach across the spectrum of care and support; from community, public health and local authority services through to primary care, secondary care, mental health and tertiary care. As such coordinated activity is required across the integrated care system, at local 'Place' level and internally at Alder Hey, as shown below;



The C&M CYP Transformation Board and each of the programme workstreams have **multi-agency leadership and widespread membership** from across health and care partners system-wide, including Alder Hey.

There is naturally a two-way relationship between this programme and Alder Hey's ambition to collaborate for child health and build a healthier future for CYP. Through leadership of the C&M CYP programme the Trust is positioned at the epicentre of the system-wide work on CYP. Alder Hey are subsequently able to orientate our services, activities and plans towards these priorities, enabling a greater positive impact for CYP in our system. In turn, the Trust's clinical, professional and corporate leadership will share evidence-based approaches, best practice and new innovations with the wider system through the CYP programme, enabling greater positive impact on outcomes, health inequalities and prevention at scale.

The C&M CYP Transformation Programme is governed via an independent system-wide board (chaired by a Local Authority CEO with Alder Hey's CEO as the Senior Responsible Owner on behalf of C&M) and reports into the C&M ICS Board for governance and oversight, as well as the NHSE/I-led North West CYP Transformation Board – which ultimately reports to the national CYP Transformation Board. Section D (Governance) includes a governance diagram.

Liverpool

Alder Hey sits proudly in the heart of Liverpool; as such an equally **important partnership has been established with Liverpool City Council Public Health** (LCC PH). Alder Hey Trust Board fully endorsed the establishment of this partnership in October 2021.

To facilitate our strategic vision and partnership working with LCC PH team, we have recently recruited to an innovative new **joint Senior Public Health Practitioner role** between Alder Hey and LCC PH. Although this is initially a fixed term 12-month post; both partner organisations are currently working towards extending the partnership and expanding the collaboration with future appointments.

Our **plans for joint working are integral to the Joint Senior Public Health Practitioner's role and include**: Developing a strategy to align LCC and Alder Hey CYPs public health priorities; contributing to the aims and objectives of the Liverpool City Plan, One Liverpool and the Child Friendly City agenda; developing and communicating our shared contribution; and influencing interventions targeted at improving wider determinants of health for the local population; health service design, delivery and evaluation; embedding prevention in clinical pathways; establishing Alder Hey as a public health training location for postgraduate trainees in Public Health; aligning system datasets and creating core CYP population surveillance methods to augment existing intelligence/governance arrangements; providing PH advocacy and leadership at Trust level.

This **partnership approach is driving new opportunities for CYP and families** and the Trust. Current examples include two proposals to LCC Cabinet which suggest

allocation of Contain Outbreak Management Fund[30] (COMF) within Alder Hey to enable implementation of targeted waiting list interventions to support CYP and families while they wait (for example through support re: mental health, anxiety and food poverty) and a focused system-wide Children's Healthy Weight Programme. The value of these two proposals is £1million.

In addition, Alder Hey's Communications team will work directly with LCC and others to **develop and deliver shared public health campaigns**, working to deliver high quality joint communications activity based on what works with measured outcomes and adding the value of the Alder Hey brand.

D: Trust Governance (Health Inequalities & Prevention 'HIP' Steering Group)

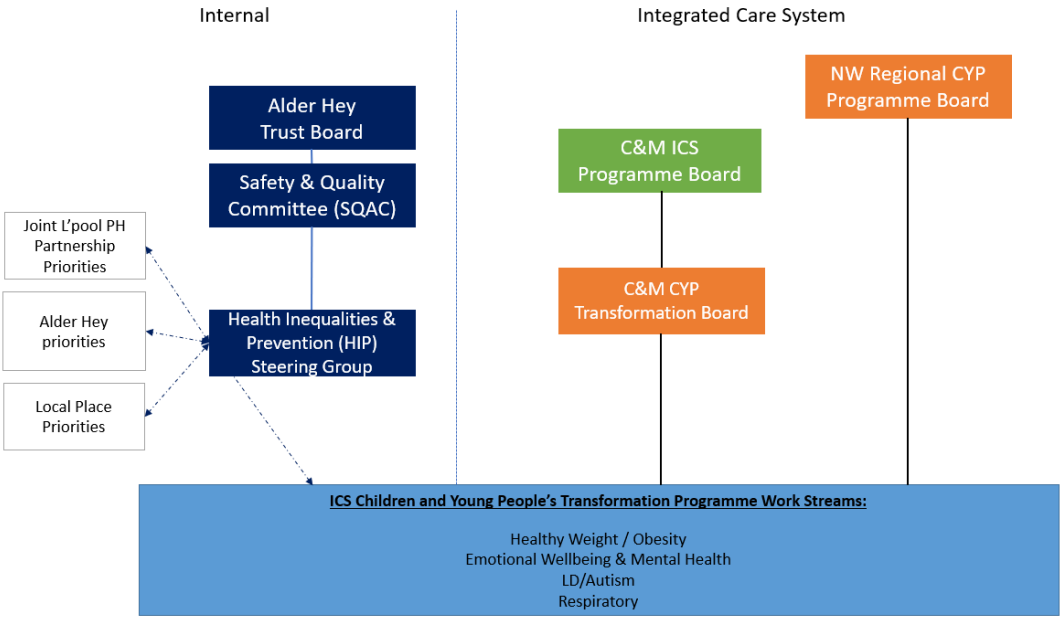
In addition to resourcing the Joint Senior Public Health Practitioner & Trust Exec lead for HI's, Alder Hey have recently mobilised a **Health Inequalities and Prevention (HIP) Steering Group**. Representation is both internal and external, and priority workstreams will be aligned with the NHSE/I nationally mandated HI agenda. This steering group will act as an oversight forum for all the Trust's health inequality and prevention activities. The HIP Steering Group will report directly into the Trust's Safety & Quality Committee (SQAC) and up to Trust Board.

Key responsibilities for the group include:

- Providing leadership around health inequalities, prevention and wider determinants of health for the Trust, coalescing understanding, evaluation and impact as well as in the local and wider system;
- Raising and embedding cultural awareness of health inequalities, prevention and wider determinants of health to all staff and services across the Trust;
- Overseeing effective implementation, across the Trust, of NHSE's 8 nationally mandated Health Inequalities priorities;
- Monitoring of the Trust's position regarding health inequalities, prevention and wider determinants of health including self-assessment and gap analysis;
- Development and oversight of implementation of the Trust's Prevention Pledge;
- Acting as Alder Hey's voice on this agenda, exerting influence locally, across the ICS and nationally;
- Evaluating the impact of Trust HIP activities.

Governance Diagram

[30] COMF exists to enable Local Authorities to sustain existing activities, manage surges in demand and develop new services required during the phases of tiered restrictions, and later national lockdowns



4. Next Steps

Recommendations to Alder Hey Trust Board:

- **Note** the content of this report and the strategic direction outlined;
- **Approve** Trust commitment to the Prevention Pledge (formally signed up via ICS);
- **Approve** the HIP Steering Group and reporting line into the Safety & Quality Committee (SQAC) and up to Trust Board;
- **Agree** oversight of the Alder Hey Prevention Pledge via the HIP Steering Group;
- **Note** the emergent regulatory environment relating to health inequalities and prevention – and the move towards Trust Board level assurance against this agenda;
- **Recognise the need for investment** in dedicated resource with committed time to deliver against this agenda;
- **Note** the partnership with Liverpool City Council Public Health and the summary joint work plan; advocate for the partnership / joint role.

Dani Jones
Director of Strategy, Partnerships & Transformation
10th December 2021

APPENDIX 1: Proposed Alder Hey action plan:

Key Action		Exec Lead	Implementation leads / oversight	Progress to Date / Kay Actions	Timescale
A1	**C&M Prevention Pledge** – subscribe and commit Board support and resource to develop and implement the Alder Hey Prevention Pledge, including our ambitions as an **anchor institution**	• Dani Jones	• HIP Steering Group – inc. • Specialty Clinical Leads • Snr Public Health Practitioner (joint w. LCC PH)	• Commitment to C&M complete • Initiation meeting scheduled 29.10.21 • Trust-wide core representation under agreement	March 2023
A2	**Prevention** - Understand breadth of Prevention activities underway and co-design further interventions to maximise the contributory impact the Trust can make	• Dani Jones	• HIP Steering Group – inc. • Specialty Clinical Leads • Snr. Public Health Practitioner (joint w. LCC PH)	• Specialty Leads within membership of HIP TOR – to provide 360 view of Prevention activities	March 2023
B	**Targeted action on Health Inequalities (HI's)** – act internally, and through aligned partnerships, system priorities and programmes to identify, implement and evaluate interventions to address health inequalities	• Adrian Hughes - Alder Hey internal	• HIP Steering Group, inc. Snr Public Health Practitioner (joint w. LCC PH)	• Exec Lead designated – Sept 2020 • HIP group established and TOR drafted for ratification	March 2023
		• Dani Jones - C&M CYP Programme	• C&M CYP Programme Director	• Programme Board & Work plan established and under implementation. • Programme Director and PMO recruited. Investment for Y2 of programme confirmed.	March 2024
		• 'Place' partnerships -One Liverpool / Sefton 2030 • Dani Jones (strategy)	• Lisa Cooper – (implementation) MH & Community Division • Urmi Das – (implementation) Medicine Division	• Liverpool defining Complex Lives & Frailty as immediate priorities – work to commence with Community/MH & Medicine Divisions and system partners re our contribution to Complex Lives*	March 2023
		• Adam Bateman - Paediatric Accelerator	• Accelerator implementation group	• Accelerator programme Health Inequalities Steering Group – Exec lead for HI's and Snr PH Practitioner are members	March 2022
		• Kate Warriner – BI / Information		• Development of a health inequalities dashboard approach for the Trust	March 2022

		• REI Strategy – John Chester, Claire Liddy, Katherine Birch		• REI Strategy under development - with Health Inequalities as a golden thread	January 22
C	**Public Health Partnership** with Liverpool City Council PH Team	• Dani Jones • Mark Flannagan - Comms	• Snr. PH Practitioner (joint) (Jack Morton) • LCC PH Consultant (Melisa Campbell) • AH Comms team	• Snr PH Practitioner appointed jointly AH & LCC PH • Joint workplan defined: key aspects identified in main paper. • Agreed to work directly with LCC and others to develop and deliver shared public health campaigns, including adding the Alder Hey brand value & delivering high quality joint communications activity with measured outcomes.	May 2022 / 23 (resource dependent Ongoing
D	**Trust Governance** – establish HIP steering group, develop internal capacity & capability, pitch for resources on a case by case basis.	• Adrian Hughes – Exec Lead HI's • Dani Jones – Prevention & Public Health	• Executive Team	• Establish Health Inequalities & Prevention (HIP) Steering Group) to drive the agenda • TOR drafted – summary objectives within main paper. • Agreed reporting line into SQAC with Chair, CEO, SQAC Chair	March 2023

APPENDIX 2: Glossary of Terms

Health Inequalities		Unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.
Prevention	Primary Prevention	Taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups
	Secondary Prevention	Systematically detecting the early stages of disease and intervening before full symptoms develop.
	Tertiary Prevention	Reducing the impact of an ongoing illness or injury that has lasting effects on quality of life chances or life expectancy.
Wider Determinants of Health		Social, economic or environmental factors affecting health, such as housing, employment, education, or parks and green spaces.
Population Health		An approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within a defined population. It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health, and requires working with communities and partner agencies
Population Health Management		Population Health data-driven planning and delivery of proactive anticipatory care to achieve maximum impact within collective resources. It includes segmentation, stratification and impact modelling to identify local 'at risk' cohorts – and in turn designing interventions to prevent ill-health and to improve care for people with ongoing health conditions and reducing unwarranted variation in outcomes.
Population Segmentation		Separating a population into distinct groups based on specific health needs, individual characteristics or specific behaviors, with the goal of grouping individuals in a population based on the type of care they need and how often they will need it.
Risk Stratification		A process in which data is used to divide patients into groups based on factors like their health history, the severity of their health problems, and the complexity of care they will require. Groups are categorized by their common levels of 'risk' enabling population health management approaches (see above)
Anchor Institution(s)		Large organisations that are unlikely to relocate and have a significant stake in their local area. They have sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities, for example, through procurement, training, employment, professional development, and buildings and land use.

APPENDIX 3: C&M Prevention Pledge – Overview

Cheshire and Merseyside Health and Care Partnership: NHS Prevention Pledge

Rationale for the NHS Prevention Pledge

It is widely acknowledged that prevention measures are needed at scale to help address the gaps identified by the NHS Five Year Forward View, the NHS Long Term Plan, and the NHS Phase 3 COVID response requirements, all of which prioritise a renewed focus on prevention.

The Cheshire and Merseyside Population Health Framework has been developed to support delivery of the prevention challenge across the sub-region at the request of the C&M Health and Care Partnership (HCP). In supporting NHS provider Trusts to take a place-based approach, the HCP's Population Health Board is now in the process of accelerating initial work carried out by public health agency Health Equalities Group (HEG) to develop and roll out an NHS Prevention Pledge for the sub-region.

What is the NHS Prevention Pledge for Cheshire & Merseyside?

The Prevention Pledge is a framework underpinned by 14 'core commitments' that NHS providers will be expected to work towards as a means of formally adopting the Pledge. The commitments have been developed through extensive consultation with representatives from provider Trusts, NHS E/I, local authority public health teams, Public Health England, and third sector organisations. Each of the 14 commitments will need to feature within a Trust's medium-term action plan for adopting the Pledge, although we anticipate a shorter-term focus on 50% of the core commitments. Additional prevention commitments that are bespoke to a Trust (e.g. reflecting work at Place, or a service speciality) can also feature as part of their prevention action plan.

The 14 core commitments are summarised on page 2 and can be grouped under these broad themes:

- Organisational and cultural change; primacy of prevention within governance structures
- Workforce development; quality improvement; workplace health & wellbeing
- Brief advice and making every contact count (MECC)
- Promoting healthier lifestyles for patients & visitors, including healthier catering, smoke-free environments, active environments
- Embedding social value, sustainability and anchor institution practices
- Using Marmot principles to address health inequalities
- Signing up to the NHS Mental Health & Suicide Prevention Concordat

Learning to date

The Pledge has already been piloted with Liverpool University Hospitals NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust in late 2020 and early 2021. The evaluation of this pilot phase has identified the following key benefits in adopting the Pledge:

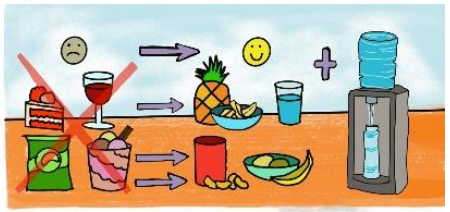
- Providing an opportunity and mechanism for Trusts to meet priorities referenced in the NHS Phase 3 COVID response requirements to support staff (C1) and action on inequalities & prevention (C2)
- For local communities: helping NHS Trusts to develop as local 'anchor institutions', supporting and modelling healthy living and prevention for patients, public and staff
- For the C&M HCP: coordination of wide-scale implementation of actions at a population level to support prevention priorities and the Population Health Framework
- Driving a cultural shift towards prevention and patient/public empowerment

Phase 2 of the Prevention Pledge roll out
HEG is has now engaged an additional seven NHS providers within the C&M footprint to start the process of adopting the Pledge from October 2021 onwards as part of long-term prevention plans for each Trust. HEG can offer a suite of support and measurement tools and will offer 1-2-1 assistance to help onboard each of the Phase 2 Trusts. Phase 2 of the Pledge's roll out will look to align with work across the C&M region on Marmot Communities that is addressing health inequalities and will be promoted as a key mechanism to evidence a Trust's journey towards Anchor Institution status.

Should you require further information at this stage, please contact the following contacts at Health Equalities Group: nicola.calder@foodactive.org.uk richard.glendinning@foodactive.org.uk

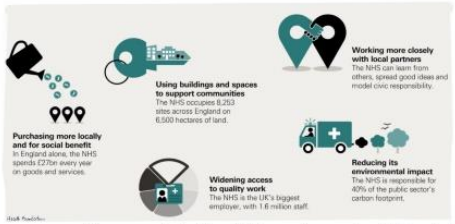
Cheshire & Merseyside: NHS Prevention Pledge

1 Prioritise long-term focus on prevention, early intervention, embedd it in governance . Appoint Exec Sponser, MECC (make every contact count) prevention is everybodys' business



11 Review food & drink provision make it healthier, convenient & affordable. limit access to high fat/sugar/salt content. Increase access to fresh water & encourage reusable bottle refills.

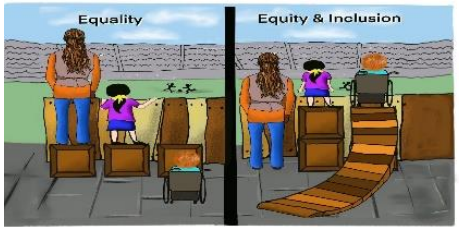
2 Create conditions to support service managers & staff to take a Quality improvement approach to review & transform services to embedd prevention.



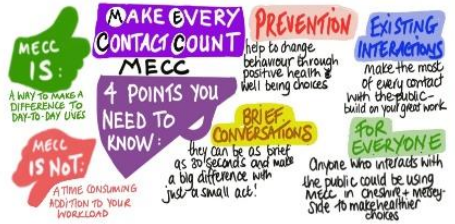
5 Increase social value by establishing anchor practices, that positively impact on the wider determinants of health AND climate health. Use Social responsibility in procurement and purchasing supplies..

8 Support workforce development, train staff in brief advice & referral in supporting people to eat well, be physically active,reduce harm from tobacco and alocohol and promote mental well-being.

12 Support the sub-regional physical activity strategy; promote & create opportunities for people to be physically active, on & off site and in line with active travel & sustainable management plans.



3 Use Marmot principles; develop approaches to prevention, work with partners 'at place' to address inequalities, deliver local priorities and prevention plans (as per NHS Plan & COVID rec'



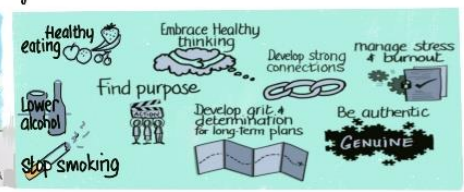
6 Adopt & embedd a MECC approach, increase the number of brief or very brief interventions, supporting people to eat well, be physically active, reduce harm from alcohol & tobacco, promote mental well-being

9 Ensure a smoke free environment, linked to support to stop smoking for patients and staff who need it

13 Sign up to the "Prevention Concordat for Better Mental Health for All' and to embedd the Prevention Concordat across health & care policies and practices.

4 Work in partnership of common prevention pathways across Trusts work on prevention that reduces the impact of disease through lifestyle advice and cardiac or stroke rehabilitation programmes.

7 Work with primary care, LA, Voluntary sector to refer to non clinical support via social prescribing, build community capacity to reduce GP, A&E, hospitalisation, medication use and social care



10 Workplace health programmes, foster org culture that promote workplace resilience, creates opportunities for staff to eat well, be active, reduce harm from alocohol, tobacco & promote MH well-being

14 Monitor the progress of the pledge against all commitments And to publishing the results of our progress at regular intervals.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 16th December 2021

Paper Title:	**Board Assurance Framework 2021/22 (November)**
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.

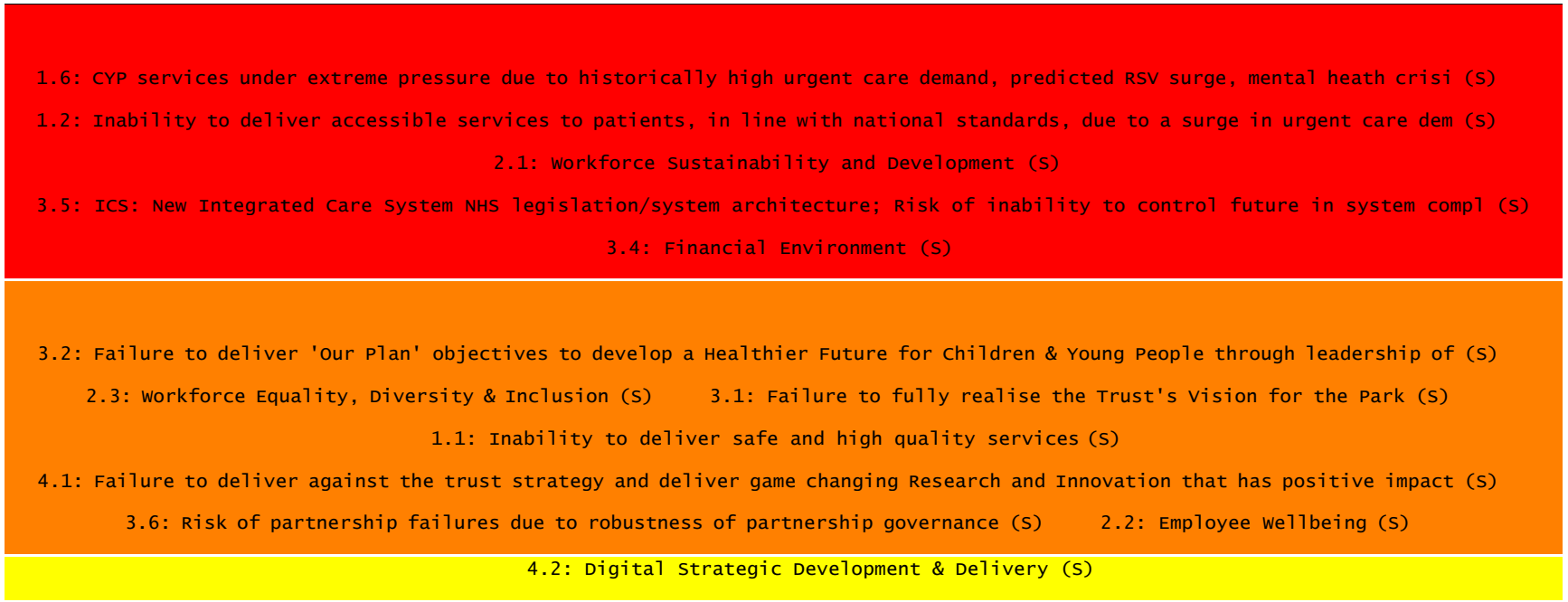
2. Review of the BAF

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

3. Overview at 9th December 2021

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



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

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

4. Summary of BAF - at the 7th December 2021

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

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

5. Summary of November'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 in score. Controls evidenced and actions updated.

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

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk reviewed; no change to score in month. Actions updated.

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

Internal risks:

- ***Inability to deliver accessible services to patients, in line with national standards, due to a surge in urgent care demand, respiratory infections and the impact of COVID-19 (AB).***
  In November we achieved high levels of outpatient recovery, at 103% of 2019 levels. High levels of emergency demand, which has led to higher hospital bed occupancy, has generated an increase in hospital admissions (9% up on 2019 levels). This has moderated elective recovery with some operations cancelled and reduced due to high ward occupancy levels. Nonetheless, we have improved access for patients with a long waiting time for treatment: the number of children and young people waiting over 52 weeks for care has reduced from a peak of 332 in mid-November to 250 on the 1 December 2021.

- ***CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of COVID (AB).***
  Our urgent and emergency care pressures has led to an Executive and Divisional joint- re-assessment of our service risk. We are concerned about the left before seen rate of 8.7% and the reduction to 66.4% in the number of children and young people treated within 4 hours. In response we have agreed additional support: a new streaming approach to other services from triage; daily senior rapid assessment and treatment; and a health visitor service. We have received £0.45m of investment to support our winter plan and we have agreed to use this funding to establish an urgent care service on the Alder Hey site, to commence late January 2022.

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

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

- ***Failure to fully realise the Trust's Vision for the Park (DP).***
  End of year review.

- ***Digital Strategic Development and Delivery (KW).***
  BAF reviewed. Good progress strategically with achievement of HIMSS7 accreditation. Some delays anticipated and being progressed with regards to Aldercare programme.

- ***Workforce Sustainability and Development (MS).***
  This risk remains high on the register. Staff availability monitored at Gold Command as part of the winter plan with specific support plans in place.

- ***Employee Wellbeing (MS).***
  Risk reviewed. Two actions closed and one new action added following crisis incident on 24.11.21. Gap in controls added to reflect initial learning from this incident and emerging evidence around Covid impacts on healthcare staff. No change to risk rating.

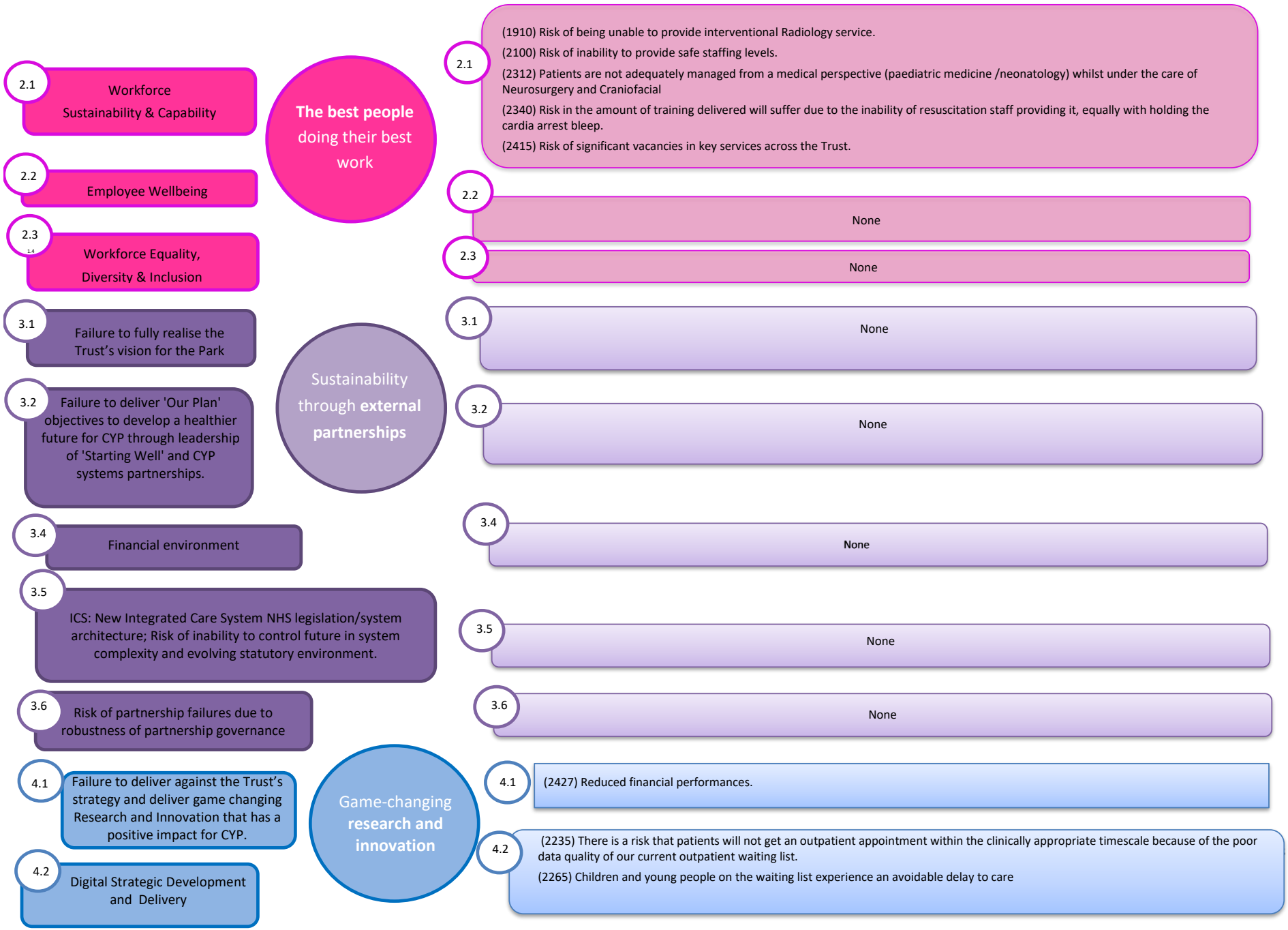
- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People (CL).***
  Dec review - no change

Erica Saunders
Director of Corporate Affairs

Appendix A

Links between BAF and high scored risks – as at 7th December 2021

BAF Risk	Strategic Aim	Related Corporate Risk
1.1 Inability to deliver safe and high quality services	Delivery of **outstanding care**	1.1 (2229) Risk of being unable to fully coordinate care of major trauma patients which could lead to delays in providing care and treatment, standard care and prolonged stay/inappropriate discharge. (2230) Risk of ten-fold medication errors resulting in serious harm to patients. (2233) Failure to meet QST Major Trauma peer review standards. (2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list. (2265) Children and young people on the waiting list experience an avoidable delay to care (2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial (2326) Delayed diagnosis and treatment for children and young people. (2332) Inadequate provision of service delivery if agreement cannot be reached by two main providers of paediatric cardiology care over how best to provide a 'joint approach' to service provision. (2383) Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Risk of negative impact on the mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation. (2384) Infection Control Risk – Risk of infection from spores to the children post op cardiac surgery. (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). (2501) Inability to safely staff the waiting list initiative clinics in OPD. (2514) Moving documents to the DMS could result in documents being amended by personnel other than the author resulting in inaccurate information being available to clinical teams. (2516) The Trust has a lack of ward clerk cover across the Surgical Division which is posing a number of issues, including lack of ward clerk presence on the ward, process failures due to daily tasks not being picked up and patients coming to harm due to daily appointments not being pended or booked correctly.
1.2 Inability to deliver accessible services to patients, in line with national standards, due to a surge in urgent care demand, respiratory infections and the impact of COVID-19		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 Employee Wellbeing
2.3 Workforce Equality, Diversity & Inclusion
The best people doing their best work
(1910) Risk of being unable to provide interventional Radiology service.
(2100) Risk of inability to provide safe staffing levels.
(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial
(2340) Risk in the amount of training delivered will suffer due to the inability of resuscitation staff providing it, equally with holding the cardia arrest bleep.
(2415) Risk of significant vacancies in key services across the Trust.
2.1
2.2
None
2.3
None
3.1 Failure to fully realise the Trust's vision for the Park
3.2 Failure to deliver 'Our Plan' objectives to develop a healthier future for CYP through leadership of 'Starting Well' and CYP systems partnerships.
Sustainability through external partnerships
3.1
None
3.2
None
3.4 Financial environment
3.4
None
3.5 ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.
3.5
None
3.6 Risk of partnership failures due to robustness of partnership governance
3.6
None
4.1 Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for CYP.
4.2 Digital Strategic Development and Delivery
Game-changing research and innovation
4.1
(2427) Reduced financial performances.
4.2
(2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list.
(2265) Children and young people on the waiting list experience an avoidable delay to care

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver safe and high quality services		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 2383, 2427, 2326, 2384, 2436, 2332, 2501, 2312, 2441, 2461, 2340, 2229, 2233, 2235, 2434, 2463, 2415, 2100, 2516, 2514, 2230, 2265		
Exec Lead: Nathan Askew	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

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

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

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

Board Assurance Framework 2021-22

NHS Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Controls for waiting time in the Emergency Department (ED): - 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

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.	31/03/2022	The new theatres utilisation policy was signed off by Medicine Divisional Board and Improvement Board and has been operational since October 2021. Discussions with Paediatric Surgery are ongoing to ensure the policy meets the specialty's specific needs after which approval will be sought from Surgery Divisional Board. Improvements in productivity are starting to be realised although more work is required to ensure the scheduling process is fully in line with the policy and to ensure sustainability. KPIs have started to be tracked to demonstrate improvements and to help to target areas/specialties that need additional support. Work is ongoing with a small number of specialties to ensure that their clinic templates are back to pre-Covid levels and a report with respect to ENT in particular is currently being prepared by the ACOO for Exec. Board to consider. The accelerator work continues with the funding being used to target specific areas of improvement and transformation including the ISLA project (monitoring of patients' conditions) and additional staff to help increase activity e.g. spinal nurse specialists. The work will continue till the end of March 2022.
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
In October we have seen a positive increase in the level of service recovery: elective care was 103% and outpatient services 94% (provisional data) relative to 2019. The increase was driven in part by an increase in weekend sessions.. Nonetheless, there are risks to in-week throughput and recovery: firstly, PICU surge requiring volunteers to move from elective care to critical care. Secondly, high bed occupancy caused by a 20% rise in attendances to ED. As contained in our previous 52 week performance there has been an increase in the number of long wait patients from the Safe Waiting List Management programme. Our recovery plan in quarter 3 is focused on in-week productivity through the new theatre scheduling policy, additional sessions and recruitment through the accelerator investment.

December 2021 - Adam Bateman
In November we achieved high levels of outpatient recovery, at 103% of 2019 levels. High levels of emergency demand, which has led to higher hospital bed occupancy, has generated an increase in hospital admissions (9% up on 2019 levels). This has moderated elective recovery with some operations cancelled and reduced due to high ward occupancy levels. Nonetheless, we have improved access for patients with a long waiting time for treatment: the number of children and young people waiting over 52 weeks for care has reduced from a peak of 332 in mid-November to 250 on the 1 December 2021.

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

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Improved internal cascade and associated comms for winter 21/22 now being planned against centrally monitored winter plan.	22/12/2021	
Revised Communication Strategy.	18/11/2021	
Develop Mitigation Strategy for areas of workforce fragility.	15/10/2021	
Shift clinical cover to later into the evening and overnight; implement a specific recommendation to have 3 doctors on shift overnight	17/01/2022	

Executive Leads Assessment

December 2021 - Adam Bateman
Our urgent and emergency care pressures has led to an Executive and Divisional joint- re-assessment of our service risk. We are concerned about the left before seen rate of 8.7% and the reduction to 66.4% in the number of children and young people treated within 4 hours. In response we have agreed additional support: a new streaming approach to other services from triage; daily senior rapid assessment and treatment; and a health visitor service. We have received £0.45m of investment to support our winter plan and we have agreed to use this funding to establish an urgent care service on the Alder Hey site, to commence late January 2022.

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

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

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

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Sustainability and Development		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 2312, 1910, 2100, 2340, 2415		
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)
7. Impact of potential Industrial Action on staff availability

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

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

Executive Leads Assessment
December 2021 - Sharon Owen This risk remains high on the register. Staff availability monitored at gold command as part of winter plan with specific support plans in place.
November 2021 - Melissa Swindell Risk score remains high. Risk of lower staff availability due to potential national strike action added to this risk.
October 2021 - Sharon Owen Risk score remains high, whilst recruitment activity has increased by 150% and service is under resourced. Recovery plan in place.

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

1. Significant gap in predicting what the likely demand for staff support will be over the coming months given the unprecedented nature of this pandemic
2. Increase in mental health crises in healthcare staff due to personal and service related impacts of the Covid 19 pandemic and corresponding decrease in availability of emergency mental health provision

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions

Agree a develop a SALS Pals (HWB champion) model across the organisation & implement model	09/01/2022	Proposal agreed at PAWC and being progressed via task and finish group to establish model in theatres as part of Winter Wellbeing plan
Action plan developed with ED including SALS drop ins in ED, weekly support sessions for senior leadership team, SALS support for wellbeing lead in ED and wellbeing champions, support for Wellbeing week in ED w/c 8th Nov, Wingman on Wheels, Massage van.	01/03/2022	
Business case to be written and taken to IRG to secure funding for proposed staff support model combining SALS and Staff counselling	09/01/2022	Proposed model agreed at Execs on 11.11.21. Agreed business case to be developed and taken to IRG for funding
After Action Review to be coordinated to inform learning from incident. Director of Nursing to ask for member of Governance team to lead the review. Risk management plan in place to ensure member of staff is safe and receiving appropriate interventions.	29/12/2021	Met Chief People Officer and Deputy Chief People Officer to agree terms of reference for learning review and timescales. Review to begin before Christmas. Date to be confirmed by Deputy Chief People Officer who will lead review.

Executive Leads Assessment

November 2021 - Jo Potier
Risk reviewed and controls and actions reviewed. Action added regarding additional support for ED through the winter period and other actions updated. No change to overall risk rating.

October 2021 - Jo Potier
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

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
PAWC Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.	-Bi-monthly reporting to Board via PAWC on diversity and inclusion issues -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.

December 2021 - Melissa Swindell
risk reviewd, actions updated

November 2021 - Melissa Swindell
Risk reviewed, actions updated

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board 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 complete
Create opportunities analysis for Park/campus	31/10/2021	
Appoint PM and legal team to review NE plot and produce Business Cases/Board papers	28/01/2022	Archus producing business case for consideration at Na 22 Board meeting.
Create oversight group with staff governor and LCC input	01/02/2022	
Round table working session with CoG	01/02/2022	

Executive Leads Assessment

December 2021 - David Powell
End of year review

November 2021 - David Powell
Prior to November Board

October 2021 - David Powell
Prior to October Board

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Divisional Performance Management Framework - includes clear trajectories for challenged specialties to deliver	Monthly to Board via RABD and Board. (Example of monthly divisional-level detail attached)
Compliance with All Age ACHD Standard	ACHD Level 1 service now up and running; developing wider all-age network to support - agreement to host at Alder Hey
Capacity Plan identifies beds and theatres required to deliver BD plan	Daily activity tracker and forecast monitoring performance for all activity.
Sustainability through external partnerships is a key theme in the Change Programme: assurance received through Programme Board and Trust Board	Growth of specialist services through partnerships included in approved trust strategic plan to 2024 (Our Plan). Monitored at Programme Board and via Strategy and Operations Delivery Board.
Internal review of service specification as part of Specialist Commissioning review	Compliance with final national specifications
Compliance with Neonatal Standards	Single Neonatal Services Business Case approved by NHS England.
Alder Hey working in partnership with Manchester Children's to ensure collaboration/sustainability where appropriate, and support North West in national centralisation agenda	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (quarterly)
'Our Plan' - Final - Strategic Plan to 2024: Explicit and clear about partnership plans, our role in the system and growth that supports children and young people's needs as well as system needs	'Our Plan' approved at Trust Board October 2019
'One Liverpool' plan to 2024: system plan detailing clear strategic intent re: Starting Well and children and young people's services	Evidences alignment of Alder Hey's plan with those of our integrated care system and evidences the drivers for key partnerships within.
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	ToR & minutes - NW Paediatric Partnership Board
Gap / risk analysis against all draft national service specification undertaken and action plans developed	Annual assessment against all service specifications led through quality team; SDIPs put in place in agreement with commissioners as a result to reach compliance
Involvement of Trust Executives in partnership governance arrangements	ToR & minutes - NW Paediatric Partnership Board. Hosted ODN Assurance reporting to RABD (2 x per year)
Implementation of the 'Starting Well' partnership group for One Liverpool(developing - replaces Children's Transformation Board). SRO Louise Shepherd confirmed.	
C&M C&YP Recovery Plan - Alder Hey Leadership ensures alignment with Our Plan	C&M C&YP Recovery Plan Narrative
One Liverpool - Provider Alliance action plan	Agreed plan per Provider Alliance 25.9.20 - inclusive of Children, Young People and Families priorities.
C&M Children's Transformation Programme - AH hosting agreed and new programme for 2021+ under implementation	Presentation to C&M W&C Programme to agree C&M priorities - led by Alder Hey (Dec 20). Approved paper to C&M HCP re establishment of the new C&M CYP Programme (Nov 20). Programme submission to C&M HCP for set up of new CYP Programme (Mar 21) supported by HCP (ICS) 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. 9.11.21 - Presentation to ICS (HCP) Board - successful. Confirmation of funding for Y2 of programme received. 25.11.21 - Presentation of programme to Alder Hey Board
Coordinated system-wide action planning for predicted RSV surge	NW & C&M Surge Plans
ICPG led Refreshed One Liverpool Delivery Plan - under development	

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

Gaps in Controls / Assurance		
1. Inability to recruit to highly specialist roles due to skill shortages nationally. 2. Trust has sought derogation in a number of service areas where it does not meet certain standards and is progressing actions to ensure compliance by due date.		
Actions required to reduce risk to target rating	**Timescale**	**Latest Progress on Actions**
6.Develop Operational and Business Model to support International and Private Patients	31/03/2022	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	31/03/2022	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.	
Executive Leads Assessment		
December 2021 - Dani Jones Risk reviewed; no change in score. Controls evidenced and actions updated.		
November 2021 - Dani Jones Risk reviewed; no change to score in month. Recognition that this risk will develop alongside evolving 2030 Strategy in the new year. Action re CYP programme complete.		
October 2021 - Dani Jones Risk reviewed; no change to score in month. Actions updated and & new evidence for C&M CYP control added.		

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Organisation-wide financial plan.	Monitored through Corporate Report. H2 Plan has been submitted to NHSI for a breakeven position. However, achievement for this is subject to significant challenge.
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	31/12/2021	Capital prioritisation with nominated executive leads underway due to be completed with output being an executive review panel. Output to be presented to Trust Board and RABD to agree plans based on affordability. External capital funding also being maximised with bids submitted where appropriate.
1. Uncertainty of H2 21/22 framework and beyond	31/01/2022	H2 financial plans have been submitted to NHSI however delivery of the breakeven target agreed with C&M contains significant risk. Discussion around risk management continue at C&M level.
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

December 2021 - Ken Jones
Risk reviewed and updated with latest position and progress on actions. Key area still remains around the uncertainty of the deliverability of H2 targets and capital plans.

Board Assurance Framework 2021-22

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

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Trust Board

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
H2 Planning Guidance / Associated Finance strategy for H2 to be developed (See BAF 3.4)	30/11/2021	Financial plan for H2 complete and put to Trust Board in Nov
Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	28/04/2022	
Continue to develop collaborative arrangements with key partners and shape the service offering	31/03/2022	

Executive Leads Assessment

December 2021 - Dani Jones
Risk reviewed; no change to score. Controls, evidence and actions updated.

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

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

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
identify a willing partner to co-design and test the approach live with an existing partnership	31/01/2022	

Executive Leads Assessment

December 2021 - Dani Jones
Risk reviewed; no change to score in month. Actions updated.

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

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

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Innovation Committee

Risk Description

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

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

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

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

Gaps in Controls / Assurance

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

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

Discovery and business case under way to create case for change to build with a partner a science/innovation / technology expansion space on Alder Hey Health campus	31/01/2022	
Executive Leads Assessment		
November 2021 - Claire Liddy NOV review - risk static		
October 2021 - Claire Liddy OCT review - no change		
September 2021 - Claire Liddy risk review SEPT. no change		

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

BAF 4.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Digital Strategic Development & Delivery		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 2143, 2235, 2265		
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
Development of new strategy from 22/23	01/04/2022	
Implementation of Alder Care Programme	01/05/2022	Some issues highlighted with programme, risking dates to delivery. Review underway

Executive Leads Assessment

December 2021 - Kate Warriner
BAF reviewed. Good progress strategically with achievement of HIMSS7 accreditation. Some delays anticipated and being progressed with regards to Aldercare programme.

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

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

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 22nd November 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)
	Rachel Lea	Acting Director of Finance	(RL)
	Melissa Swindell	Director of HR & OD	(MS)
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance:	Nathan Askew	Chief Nursing Officer	(NA)
	John Chester	Director of Research and Innovation	(JC)
	Urmi Das	Director of Medicine	(UD)
	Mark Carmichael	Associate Chief Operating Officer Medicine	(MC)
	Audrey Chindiya	Business Accountant Medicine (Shadowing)	(AC)
	Mark Flannagan	Director of Communications	(MF)
	John Grinnell	Acting CEO	(JG)
	Russell Gates	Associate Commercial Director Development	(RG)
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Emily Kirkpatrick	Associate Director Commercial Finance	(EK)
	Claire Liddy	Managing Director of Innovation	(CL)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Clare Shelley	Associate Director Operational Finance	(CS)
	Stephanie Sinnott	Commercial Accountant (Shadowing)	(SS)
	Jason Taylor	Acting Associate Chief Operating Officer Research	(JPT)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item: 321	Richard Jolley	Procurement & Contract Manager	(RJ)
319	David Powell	Development Director	(DP)

20/21/312 **Apologies:**
Apologies were received from:

Ken Jones	Acting Director of Operational Finance	(KJ)
Nicki Murdock	Chief Medical Officer	(NM)

20/21/313 **Minutes from the meeting held on 21st October 2021.**
Subject to date of the meeting being amended the minutes were approved as a true and accurate record.

20/21/314 **Matters Arising and Action log**
The Chair advised he was due to speak to JG on the reporting arrangements of the Green Plan.

AB noted an action for himself to circulate the deep dive: Was Not Brought rates, CAMHS to RABD. This had now been completed.

20/21/315 **Declarations of Interest**
There were no declarations of interest.

20/21/318 **Finance Report**
Month 7 Financial Position
CS presented the Month 7 Financial report noting a deficit of £0.9m which is largely driven by 2 key areas:

- Loss of ERF contribution from H1(April to September) – which equates to £0.7m per month.
- Reduction in system funding for H2 (October to March) as per current allocations - £0.2m per month.

As there was no agreed plan for H2 the performance was monitored against income and expenditure.

The CIP gap is at £2.8m (£6.1m target). Progress of schemes continues to be monitored.

Divisionally: Surgery, Alder Hey in the Park and the Executive Divisions are off track a deep dive into Medicine will be received later in the meeting.

H2 Update: Financial plans for Cheshire & Merseyside (C&M) have now been agreed to reach a breakeven (BE) position. Risks around this include; unable to deliver activity plans, winter costs escalate and £4.2m of CIP plans are still to be identified. CS noted operational and transformational CIP will be closely monitored to achieve the (BE) total. A CIP process was also being looked in to across C&M. RL referred to a number of bids that are in process to support a shortfall if approved. The Chair asked for details on the clauses if the (BE) position was not met. RL noted the main area would be in relation to cash going forward. KW queried given the number of risks if Alder Hey should be submitting a (BE) position. RL referred to a late paper that had been circulated to RABD, the paper outlined the generation of ERF funding and how that could be shared across (C&M). DJ suggested an outline of the transformation plan is shared at the December RABD.
Action: CS/RL/Natalie Palin to provide an update on the Transformation plans at the December RABD.

SA asked for details on what had changed at (C&M) since last month in relation to the ERF and secondly if the increase in Energy spend is a one off or is likely to continue. In relation to what had changed within a month RL advised on changes to submissions of Trust's finances within C&M and concerns around C&M baseline data. RABD also noted positions with forecasts do vary. In terms of the increased energy cost CS responded that that latest invoice was much higher than estimated. Contributors to the increase includes a change of supplier as well as a national increase on energy costs. Going forward the changes have been implemented into the forecast.

Resolved:
RABD received and noted the M7 Finance report.

Detailed position Medicine Division
CS noted the purpose of sharing this today is to articulate the deteriorating position over the financial year. Aims included highlighting historical overspend and mitigation plan.

Division of Medicine represents 31% of overall Trust spend (based on 19/20). This compares with Surgery (29%), Community (11%) and Non-Clinical Divisions (29%).

Pressures predominantly relate to historic and emerging issues particularly around Junior doctors, ED and Non pay and have been largely offset by significant workforce gaps YTD. If several vaccines are recruited as planned this will highly support the required savings for H2.

In terms of mitigations MC noted:
Kendall Bluck workforce review that had taken place, the report was expected by the end of next week.
Junior Doctor rotas are under review to understand and reduce/mitigate non-recurrent spend.
Care Group led service reviews for services with long standing cost pressures.
Continued divisional scrutiny on recruitment and Waiting List Initiative requests.

A slide was shared on the ED income position.

The Chair asked for further details on the mitigation plan. CS noted completion of the above reviews will give a clearer picture in particular a Trust wide Junior Doctors review. Whilst it will be a large piece of work to complete it will support the Trust in closing the financial gap.
Action: CS/RL Agreed to provide an update on current plans to carry out the Trust wide Junior Doctors review.

Following discussions the Chair noted the good position of the part one deep dive and requested a further update to RABD was received on 24th January 2022.
Action: CS/MC Further details on the deep dive in particular the outcome of the junior doctors review.

Write-offs for Month 7
£1,736.24 had been submitted for M7 in relation to two overpayments dated 2020 and 2018. The Chair noted the efforts made for the overpayments to be re-paid however as there had been no response and both employees had left the Trust it was highly unlikely a repayment would be made, therefore RABD APPROVED the Write Offs for month 7. RL noted changes to the overpayment process which should result in a faster and more successful outcome.
Resolved:
RABD APPROVED the Write Offs for Month 7 that total £1,736.24.

20/21/317 **2021/22 H2 Plan**
A late paper on the current and mitigating position that would also be shared with Trust Board had been circulated to RABD. RABD noted the breakeven position as well as the risks to achieve this. Mitigating factors included receiving all funding due for the rest of the financial year noting a number of bids totalling £7m that the outcome was awaited on. £1.6m from bids was approved last week.

Resolved:
RABD noted the breakeven position and the risks that had been submitted as part of the C&M submission.

20/21/318 **Capital & Cash Updates**
The 5 year Capital plan review had commenced. Some slides were shared indicating progress to date and requirement of Board approval in the new year resulting in a revised and affordable Capital Plan.

RABD noted NHS Finance regime and introduction of ICS from April 2022 fundamentally changes the way capital allocations are set and the freedoms to operate and spend cash for providers will be restraint.

Resolved:
RABD received and noted the Cash and Capital update as well as next steps.

20/21/319 **Campus & Park Updates**

The Neonatal design is going through the final stages in light of the PAU. The final bidder process is underway, the last 3 bidders are at the stage of ensuring the cost of the scheme is at it's final stages.

The Cluster is due to finish in February 2022, however there may be some issues with the deadline date, mitigations are currently being looked into.

DP went through the CAMHS housing review and were this was up to as well as possible options.

Resolved:
RABD received and noted the Campus update.

20/21/320 **Innovation and Business Development Plan**

CL gave a verbal update noting a paper would be submitted going forward.

EK has supported the team in developing a 10-year Finance Strategy in line with the Innovation Strategy, this will be presented at the December RABD for review and APPROVAL.
Action: Emma Hughes to present the Financial/Innovation Strategy at the December RABD for review and APPROVAL.

Alder Hey Charity have support Innovation over the last 2 years. CL noted an application was to be presented to the Charity Board for continued support over the next 3 years for a total of £600k. As the Charity are not in position to provide historic funding this will leave the team with a shortfall from April 2021, resolutions are being looked into.

Microsoft and Mindwave have joined forces to produce an AlderHey anywhere digital platform programme. The first prototype is due to be developed in the new year.

Reusable and non-reusable transparent masks are going through government standards and are hoped to be at approval stage soon with revenue being received in Q4.

There are 11 buyers interested in the Mental Health for Children and Young People application. A collaboration with Mindwave and a commercial partner has been set up to develop marketing and sales strategy. The Artificial Intelligence for Was Not Brought Model has been selected as part of the accelerator £1 million central funding innovation programme and will be rolled out 10 Children Trust's

Initiative for an Innovation Programme across the city is underway. Innovation are due to apply for predevelopment funding up to £1m which will support applications for further funding across the city.

Cath Kilcoyne presented a commercial plan earlier in the year to RABD, an update would be presented at the December RABD.

KW updated RABD on the digital work carried out within C&M. A programme called Amity in partnership with Mindwave. The first C&M draft did not include Children and Young People, due to this KW and CL had met with leads from C&M to include

C&P going forward including the piece on Alder Hey anywhere. KW noted the importance for Alder Hey to receive further funding it's work would need to align with the ICS piece. Further updates will be received in due course.

Resolved: Approval of the Financial/Innovation Strategy would be sought at the December meeting.

20/21/321 **Procurement**

RJ went through the Procurement paper updating RABD on the Specialists Trust Collaboration noting the name change to Health Procurement Liverpool. The recruitment of Phase 1 posts was completed in September 2021, with the HPL Senior Management team now in post and working across all four member sites. Phase 2 will include the TUPE transfer of all remaining team members into the host organisation (The Walton Centre) by 1st April 2022. An update was received on the Procurement Board, KPI's, PPE and an overview of significant projects.
Resolved: RABD received and noted the quarterly Procurement update.

20/21/322 **Communications Update**

MF updated RABD on the teams progress in relation to the lead up to Christmas. Channel 4 would be filming the installation of the Christmas tree.
Resolved:
RABD received and noted the Marketing & Communications update

20/21/323 **Recovery & Urgent Care October Update**

Emergency Department activity was up 16.5%. 9.5% of patients left before they were seen, AB noted concerns around this and changes in the approach to triaging patients to include; respiratory physiotherapy, senior decision-maker and an online symptom checker. ICS and system response are looking into an out of hours GP/Health Visitor service on site. A bid has been made for two respiratory clinics in community hubs.

A graph on the increase of respiratory infection admissions was shared with RABD, it was hoped the peak of admissions had already been seen.

Critical Care: In August and September there were 4 patients who had to go out of the region to access level 3 PICU, this caused the team to review current staffing and escalation processes. Alder Hey are currently commissioned to provide 21 PICU beds, August/September saw a range around 16-18 beds. AB went through the proposed action plan to support being able to support the commissioned 21 beds. Due this going forward it was likely AH would be able to support 18-20 beds.

Recovery of planned care: RABD noted this had escalated and was steadying out, this was required to continue to meet the H2 forecast. Plans included for no patient to be waiting over 104 weeks for treatment by March 2022.

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

20/21/324 **Safe Waiting List Management Update**

AB highlighted the new inpatient waiting list/patient tracking list (PTL) was now "live" and had been successfully supporting the operational teams for a number of months.

AB went through the processes to be put in place for follow up care to ensure any patients who are overdue their follow up appointment. It was noted there is no current national standards.

Resolved:
RABD received an update on Safe Waiting List Management. The Chair noted the good process to date.

20/21/325 **Month 7 Corporate Report**
AB went through the executive summary in the corporate report noting the WNB rate is lower than target, Community are looking into their rates as they are slightly higher.

Resolved:
RABD received and noted the M7 Corporate report.

20/21/326 **PFI Report**
GD went through the highlights from the circulated paper noting energy usage was slightly over for the month, this reflects the continued increase in ventilation requirements.

Pipework survey continues, further leaks had been reported in October. Whilst they hadn't caused significant disruption GD noted the number of leaks overall is around 200 over a period of 6 years.

Green roofs are due for completion by the end of this week.

Work on the Isolation rooms has come to a halt follow a request from clinicians.

SPV missed reporting in relation to a fire door has been logged, whilst the risk is low the key concern is the report was issued 9 months late. GD noted it was too early to provide any further detail however as soon as this was available further details would be shared with RABD.

JG asked going forward if it would be possible to include specific detail in relation to commercial discussions. GD agreed to do this going forward.
Action: GD

Resolved:
RABD received and noted the M7 PFI report.

20/21/327 **Board Assurance Framework**
ES noted the escalating risks in relation to the building as described in the previous item and ensuring these are clearly captured within the BAF as well as the wider financial framework.

ES referred to the partnership governance action that RABD were due to receive an update on in the near future.

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

20/21/328 **Any Other Business**
No other business was reported.

20/21/329 **Review of Meeting**
IQ noted further updates on Medicine, CIP and H2 are to be received.

Date and Time of Next Meeting: Wednesday 15th December 2021, 1300, via Teams.

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Confirmed Minutes of the meeting held on
Wednesday 24th November 2021
Via Microsoft Teams

Present:	Fiona Beveridge	Non-Executive Director (Chair of SQAC)	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Adam Bateman	Chief Operating Officer	(AB)
	Kerry Byrne	Non-Executive Director	(KB)
	Robin Clout	Interim Deputy CIO	(RC)
	Lisa Cooper	Director - Community & Mental Health Division	(LC)
	John Grinnell	Acting Chief Executive	(JG)
	Adrian Hughes	Deputy Medical Director	(AH)
	Dani Jones	Director of Strategy & Partnerships	(DJ)
	Beatrice Larru	Consultant, Infectious Diseases	(BL)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
	Christopher Talbot	Safety Lead, Surgery Division	(CT)

In attendance:

	Mo Azar	Chief Pharmacist	(MA)
	Julie Creevy	Executive Assistant (Minutes)	(JC)
	Andrew Hanson	Service Manager, Division of Medicine	(AH)
	Marianne Hamer		
	Cathy Umbers	Associate Director of Nursing & Governance	(CU)
21/22/111	Jennie Williams	Head of Quality Hub	(JW)
	Benedetta Pettorini	Consultant Paediatric Neurosurgeon, Lead of Quality Hub	(BP)

21/21/127 **Apologies:**

Urmi Das	Divisional Director for Medicine	(UD)
Nicki Murdock	Medical Director	(NM)
Kate Warriner	Chief Digital & Information Officer	(KW)
Pauline Brown	Director of Nursing	(PB)

FB welcomed all members and attendees to the Safety and Quality Assurance Committee (SQAC).

21/22/128 **Declarations of Interest**
SQAC noted that there were no items to declare.

21/21/129 **Minutes of the previous meeting held on 20th October 2021 –**
Resolved: Committee members were content to **APPROVE** the minutes of the meeting held on 20th October 2021.

21/21/130 **Matters Arising and Action Log**
Action Log
The action log was updated accordingly.

FB reminded committee members that the Committee are still operating under the governance light approach, and as such those starred items would be taken as read, with any questions addressed as required.

Matters Arising

Quality Improvement Progress Reports

21/22/131 Quality Priorities Monthly update

JW & BP presented the Quality Priorities Monthly update, which included highlight reports on the Deteriorating Patient, the Deep Dive on Medication Safety and update on Parity of Esteem.

On the Deteriorating Patient, BP advised that positive feedback had been received regarding trial of training on 4C which had commenced on 15th November 2021. Training had been extremely successful, with a strong plan in place to ensure sustainability for the nursing and paediatric teams. Trial due to commence on Ward 4A on 29th November 2021 for medical and nursing staff.

BP advised that the Care Flow implementation is going ahead, together with appropriate pathway.

NA welcomed Quality Update which highlighted continued improvements. NA provided reassurance and assurance that the current programme in terms of systems and processes would remain in place until such time that meditech offers the same level, or improved functionality.

NA also advised that there is a need to consider ownership regarding clinical application and function, and the requirement for this to transfer from research to digital. NA advised that offline discussion had taken place with K Warriner to raise this issue.

NA referred to Consultant/Paediatrician cover for patients, and advised that there is a larger review planned of this and the on call rotas/systems and processes which AB, NM and NA are undertaking. This is a complex review which would take time. FB sought clarity on the timelines for completion of the review. NA advised that the on call management structure would be undertaken during early January 2022. NA advised that in terms of Consultant/Paediatrician cover, NA is awaiting an update from NM regarding timeline. NA confirmed that an update would be provided at December SQAC meeting through the Quality Priorities monthly update.

Parity of Esteem is progressing on plan, with good progress made in month, Team had commenced discovery phase with the Medicine Division with regards to pathways.
Strong leadership is in place for MH champions. Quality team are looking to repeat a number of surveys by the end of March 2022, once training had taken place.

BP referred to Medication Safety and ongoing work continues regarding developing the interruption bundle, which the team had implemented based on feedback received, and which would be audited as appropriate.

FB referred to the ongoing attention required, and also the resources required. BP confirmed that all data had been reviewed for medication errors across the Trust. BP advised that this is prevalent in wrong dose, prescribing and administrating. BP stated

that the team had tried to adapt and consider good models that could be readily adopted by any areas requiring improvement. MA advised that the team are benchmarking with peers across organisations, and that the Trust is average regarding incidents, and reminded all of the need for continued focus on reducing any medication errors.

KB referred to limited resources within Pharmacy, and queried whether this would be addressed. NA confirmed that this is incorporated into the Business Case, and that the Business Case is expected within the next 2 weeks and R Lea is aware.
KB queried when EXPANSE implementation is scheduled for – NA confirmed that this is scheduled for Spring 2022. NA advised that there is a requirement for key decisions to be made during Digital Oversight Committee meeting which is scheduled for 29th November 2021, which may result in an altered implementation date depending on the strategic direction the organisation wishes to take.

KB alluded to the DMO projects and requested whether SQAC could receive a regular slide regarding progress relating to the projects. NA advised that the DMO project slides would be circulated with the SQAC notes for information, and that this could be followed up in December.

JG welcomed ES comments regarding alignment and the reintroduction of DMO Information to be shared at Committees. ES advised that she had recently met with N Palin and N Deakin and that this information would be shared at committees shortly.

Resolved: SQAC to receive copy of DMO slides with the minutes of SQAC in December 2021

SQAC **NOTED** the progress made in month across the Quality Improvement Projects.

SQAC received and **NOTED** the Quality Priorities Monthly Update
FB thanked JW, BP and Quality team for Quality Priorities monthly update and for continued focus and progress across all areas.

21/22/132 CQC Action Plan
SQAC received and **NOTED** the CQC Action plan.

21/22/133 DIPC Exception Report
SQAC received and **NOTED** the DIPC Exception Report.

21/22/134 ED Quarter 2 MH Attendance Update
SQAC received the ED Quarter 2 MH Update, key issues as follows:-

- 163 children and young people attended the Trust Emergency Department with a mental health need. This is a decrease of 28% compared to Quarter 1 (227 attendances). Presentations included Self-harm, suicidal ideation, intentional substance overdose, anxiety and depression, behavioural problems and other mental health concerns.
- 85% of number of Children & Young People who attended Alder Hey Emergency Department with mental health concerns were referred to Crisis Care service. The Emergency Department should undertake regular audits to understand reasons why Crisis Care had not been contacted.
- For the reporting period 59 (36%) of children and young people were admitted to an acute inpatient ward, slightly lower than the previous

quarter (39%).

SQAC **NOTED** the actions identified for Quarter 4

FB referred to the Medicine Division in terms of the Audit. A Hanson advised that he would follow up the audit requirements with Anne Kerr in order to ensure that this is being addressed as appropriate. AH advised that this could also be tracked through internal divisional governance meetings. FB requested an update report on what actions had been taken within the Medical Division at December 2021 SQAC meeting to ensure that this is embedded.

LC advised that any lessons learned following completed ED audits within Medicine division could be incorporated within the Quarter 3 update to SQAC

FB thanked LC for Quarter 2 ED Mental Health update.

Resolved: SQAC to receive ED Audit Compliance Report at December 2021 SQAC meeting.

21/22//135 Assurance ED Activity Monthly Update

SQAC received and **NOTED** the Assurance ED Activity Monthly update. AB highlighted a risk for the Trust with regards to the number of Children and Young People who are leaving the ED department without being seen, given the time to clinical assessment and the increased number of CYP in assessment areas. AB advised on the importance of SQAC recognising this risk. AB confirmed that those patients who had left the ED Department are being tracked and followed up as appropriate. AB advised that the team had agreed to test a new streaming and rapid treatment process to reduce the number of patients leaving the ED department prior to being assessed.

SQAC **NOTED** the contents of the report, and the wider actions required to address the current ongoing position of increased attendances, whilst also **NOTING** the risk regarding those patients that leave ED prior to being assessed or triaged, and the associated actions and mitigations in place to address.

21/22/136 RM459 Absconsion Policy

SQAC received RM459 Absconsion Policy
NA advised that the cover sheet for both policies was extremely concise and clear and suggested that all policies being shared at SQAC should include the cover sheet. This approach was welcomed by SQAC. NA advised that he is supportive of Ratification of the RM459 policy.

Resolved: SQAC received and **RATIFIED** RM459 Absconsion Policy.

SQAC received the Abduction Policy, SQAC were in agreement to Ratify the Abduction Policy.

Resolved: SQAC received and **RATIFIED** the Abduction Policy.

21/22/137 Quarter 2 Complaints/PALS report

SQAC received Quarter 2 Complaints/PALS report, key issues as follows:-

- NA confirmed that the number of formal complaints remained static, with

communication and alleged failure in clinical care remaining as the top two concerns.

- Continued good practice against the 3 day acknowledgement – 95% compliance, however the 25 day responsiveness rate is highlighted at 47%, with a requirement to review this data to ensure that this correlates with information that is reported elsewhere, as there is currently a discrepancy against the two data sources.
- Good practice is evident against the 2nd stage complaints, 2 reopened complaints within the reporting period, which is 5% of the total complaints received, which is very low, which demonstrates quality of complaints investigation is high.
- PALS remain high. However, whilst there had been an improvement to 61% compliance with the five day responsiveness, there is further improvement required.
- NA advised that PALS and Complaints data to be presented at future Quarterly reports would move to continuous run charts, and that from Quarter 3 SQAC would review Complaints and PALS data in an improved format which would be beneficial to SQAC.

KB referred to timeliness of response, and queried whether the organisation thinks that the Trust is currently at the minimum level of receipt of complaints, or where colleagues think this de minimus level is, and questioned how the Trust achieves this level of complaints.

KB also queried whether once a complaint had been received and addressed by the organisation, colleagues review whether lessons had been learned, and queried how well embedded lessons learned are throughout the organisation. NA advised that this will be a future focus, for 2022 onwards, improving the approach to learning from complaints to demonstrate that Alder Hey Children's NHS Foundation Trust is a learning organisation.

NA confirmed there is an opportunity to reduce formal complaints further by ensuring the PALS process is responsive, and referred to the ongoing review of resources to support this area. Responsiveness is the current focus of work with divisional teams, and will be monitored through CQSG.

FB thanked PB & NA for PALS & Complaints update.
SQAC received and **NOTED** the Quarter 2 Complaints/PALS report.

21/22/138 Children & Young People with Complex Behaviour (inpatient Programme)

SQAC received the Children & Young People with Complex Behaviour (inpatient programme) update, which provided background detail, programme structure, progress update and a summary of the current position, key issues as follows:-

Report detailed programme structure which included 5 task and finish groups. Wards 4C and 3A were engaged with very robust pathways in place. Updates/metrics are shared weekly at Comm cell and planned to be shared at Gold Command meetings. 2nd mini survey had just been completed with Point of Care Foundation to demonstrate areas of improvement and collect views on how staff are feeling.

Improvement Board commenced in February 2021 and continue to meet on a fortnightly basis, albeit attendance from members had sometimes been poor

due to hospital pressures. Whilst the focus and improvement had been significant, this work is still not fully embedded within the acute hospital. Updates were provided across a range of actions within the workstreams.

FB commended LC on leadership and exemplary ongoing improvements. FB highlighted the importance of Divisions being fully engaged and involved in attending Improvement Board meetings, whilst recognising ongoing challenges.

JG reiterated FB's comments and expressed thanks to LC and colleagues. JG highlighted that as the organisation moves to a closure, there is a need to understand how the team are feeling, and referred to Parity of Esteem and ensuring that this is fully embedded. LC advised that results from the 2nd survey demonstrate positive improvement, with further areas for improvement. LC advised that she is undertaking a session with the wards with regards to sharing information, detailing what work is undertaken to prevent patients being admitted to wards.

LC had offered ongoing support to nursing and medical colleagues, and would continue to meet with nursing colleagues on a monthly basis to ensure a robust pathway for patients.

A Hughes commended the work undertaken to date, and advised that it is a challenge across the region, and referred to challenges in the system, and queried what metrics may there be for the system. AH referred to paediatric network and queried whether the metrics which Alder Hey have could be reviewed across the region, particularly in terms of restrictive practice. LC confirmed that there are no objections to sharing of information with the network, and she is happy to be involved in wider discussions.

SQAC **NOTED** the significant improvements in supporting this cohort of children and young people, whilst also acknowledging the ongoing work that is evident to support these patients.

SQAC **NOTED** that the aim is to close down this programme on 18th December 2021, with a closure report to SQAC in February 2022 demonstrating actions that had been taken from the learning.

Clinical Governance Effectiveness

22/22/139 CQSG Key issues update

NA advised that with regards to the governance light approach that there had been no CQSG meeting in month, with meeting papers reviewed virtually. Several policies and procedures had been ratified and published in month.

NA stated that CQSG meetings would be reinstated formally from December 2021, due to a lack of progress across a range of indicators over the last couple of months, in order to ensure sustained improvements are made going forward.

SQAC received and NOTED CQSG Key issues verbal update.

FB thanked NA for CQSG key issues update.

21/22/140 Confidential Enquiries/national guidance assurance report which details NICE Compliance Project Plan and Report and clinical Audit & Effectiveness Report Quality Assurance Rounds, themes and risks Report, NICE Compliance Project Plan report

CU presented the National Institute for Health and Care Excellence (NICE) Guidance compliance position report, which provided a Trust position summary and and assurance overview, key issues as follows:-

- There was a total of 46 NICE guidance open during this reporting period where baselines assessments are ongoing.
- SQAC **NOTED** position summary and assurance overview for each of the Divisions.
- CU advised that all baseline assessments are due to be completed by year end.
- CU stated that there is a requirement for all guidance going forward to include expected dates for both baseline assessment completion and expected dates of completion for identified compliance requirements from recommendations. SQAC **NOTED** that while this is evident in many cases, there remain some gaps to be addressed going forward.
- Report highlighted limited assurance of progress with NICE guidance compliance since the last report presented to SQAC in September 2021. However, the position is likely to improve going forward, with more robust divisional processes in place, with closer corporate scrutiny via monthly divisional progress reports to be presented to Clinical Quality Steering Group.

FB welcomed comments from each of the Divisions with regards to engagement and assurance in order to accelerate progress as a priority.

NA expressed concern regarding this significant risk for the organisation, and requested that SQAC receive a monthly update for scrutiny, in order to ensure close monitoring/tracking, until such time that SQAC are content with sustained improvements in terms of compliance. SQAC welcomed scrutiny at future SQAC meetings, and requested that the monthly updates be displayed in a different format to ensure updates are clearly evident each month and clearly articulate position.

SQAC received and **NOTED** the National Institute for Health & Care Excellence (NICE) Guidance compliance position report, and **NOTED** the limited assurance of progress with NICE guidance since previous report presented to SQAC in September 2021. SQAC to receive monthly compliance reports.

Resolved: SQAC to receive monthly NICE Guidance compliance report

FB thanked CU for NICE Compliance update.

21/22/141 Board Assurance Framework

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

- Risk 1.6 is clearly articulated.

KB requested risk owners to review the gaps and controls within the Board Assurance Framework with regards to addressing any identified gaps and associated actions.

Resolved: SQAC received and NOTED the Board Assurance Framework update Risk Owners to review the Board Assurance Framework, ahead of December SQAC meeting.

21/22/142 Divisional Reports by exception/Quality Metrics

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

- Division are continuing to see an increased number of referral rates for Neurodevelopmental services, ASD & ADHD, with impact on waiting list and staff wellbeing.
- Division had submitted formal letters to both Sefton and Liverpool CCG's for request for funding. It is anticipated that feedback is due to be provided from CCG over the next few days. This is significant in order to achieve agreed 30 week target.
- 3 young people with eating disorders had been detained under the Mental Health Act, within an acute patient bed, whilst awaiting specialist mental health placement.
- Funding received regarding pre and post diagnostic support for children with autism and for delivery of autism training in schools. Projects had commenced with positive feedback from children and young people and families.

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

- Ongoing challenges noted regarding ED pressures.
- Division maintain receipt of 4 complaints per month.
- Non Elective stay within Medicine had reduced.
- ED reattendance rate had reduced during August, September and October 2021
- Division have reduced waits for MRI, with regards to the 6 weeks wait, waiting time.
- RTT waiting time had reduced.

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

- Significant work had taken place regarding the STAT programme with regards to no Never Events. SQAC are due to receive a presentation on STAT at December 2021 meeting.
- The Division had no Grade 3 or Grade 4 Pressure Ulcers since December 2020, which is testament to ongoing efforts from staff, and are now working on those lesser grades, which is commendable.
- Surgical Safe Waiting list validation had identified additional patients. The Division are executing the Winter Plan to maximise day case recovery.
- Staffing levels remain challenging with increased numbers and acuity of patients, with ongoing challenges regarding bed pressures and emergency flow.

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

21/22/143 Any other business

None received.

21/22/144 Review the key assurances and highlight to report to the Board

Positive updates were received regarding: -

- Quality Priorities update received, with sustained progress made in month for Medication errors, Deteriorating Patients and Parity of Esteem, with good level of assurance provided.
- Quarter 2 Complaints & PALS Report received. SQAC welcomed improvement regarding responsiveness, with further improvements/progress required, PALS & Complaints team resource review to be undertaken to enhance service provision and help move the organisation to becoming a learning organisation.
- Children & Young People with Complex Behaviour (inpatient) programme update received, with good discussion held, programme is well embedded, whilst NOTING the wider system issues.

- NICE Compliance Project – SQAC **NOTED** that more focussed attention by SQAC and Divisions. SQAC to receive monthly NICE Compliance Reports, in order for SQAC to closely monitor and track compliance going forward.
- Divisional updates received, with resounding themes across all three divisions related to ongoing pressures within services, resulting from high clinical load, coupled with staffing issues, Covid, sickness etc with good plans in place to address ongoing issues across all 3 divisions.
- RM459 Absconsion policy was received and Ratified
- Abduction Policy was received and Ratified.

20/21/145 Date and Time of Next meeting

15th December 2021 at 9.30 via Microsoft Teams